CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 30, 2000

S. 1929
Native Hawaiian Health Care Improvement Act Reauthorization of 1999

As ordered reported by the Senate Committee on Indian Affairs on May 3, 2000

SUMMARY

S. 1929 would reauthorize the Native Hawaiian Health Care Improvement Act. It would amend the act to reflect how current programs are operated and to treat the Native Hawaiian health systems in a manner similar to health centers authorized under the Public Health Service Act. In addition, it would create a commission to advise the Congress whether the provision of health care services to Native Hawaiians should be an entitlement program. It also would require federal agencies to consult with Native Hawaiians and organizations providing health care services to Native Hawaiians before adopting any policy or regulation which may impact their health services or health insurance coverage.

The act is administered through the Health Resources and Services Administration. Assuming the appropriation of the necessary amounts, CBO estimates that implementing S. 1929 would cost $1 million in 2001 and a total of $19 million from 2001 through 2005. (That total assumes that the annual appropriation level is not adjusted to reflect anticipated inflation. If such adjustments are made, the five-year outlay total would be $20 million.) The legislation would not affect direct spending or receipts; therefore, pay-as-you-go procedures would not apply.

S. 1929 contains no private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA). It does contain an intergovernmental mandate, but CBO estimates that the costs of the mandate would be minimal and would not exceed the threshold established in UMRA ($55 million in 2000, adjusted annually for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 1929 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law						
Budget Authority [a]	5	5	0	0	0	0
Estimated Outlays	5	5	2	b	0	0
Proposed Changes						
Estimated Authorization Level	0	2	5	5	5	5
Estimated Outlays	0	1	3	5	5	5
Spending Under S. 1929						
Estimated Authorization Level [a]	5	7	5	5	5	5
Estimated Outlays	5	6	5	5	5	5

a. The 2000 level is the amount appropriated for that year for activities conducted under the Native Hawaiian Health Care Improvement Act.
b. Less than $500,000.

BASIS OF ESTIMATE

For this cost estimate, CBO assumes that the bill will be enacted by or near the start of fiscal year 2001, that the necessary amounts will be appropriated each year, and that outlays will follow historical spending rates for the authorized activities.

Current programs in the act were authorized at such sums as necessary through 2001. S. 1929 would reauthorize the administrative grant for Papa Ola Lokahi, extending it through 2010. It also would reauthorize the Native Hawaiian health systems and the scholarship assistance programs, extending their authorization through 2011. Because these activities are currently authorized through 2001, this provision would not affect spending until 2002.

S. 1929 would amend the requirements for Native Hawaiian health systems to remove differences in treatment between them and health centers which perform similar functions, but are authorized under the Public Health Service Act. It would remove the requirement

that health systems provide matching funds to receive the full amount of the cost of providing health services under a grant or contract. Providers of services in health systems could be treated as if they were members of the Public Health Service and covered under section 224 of the Public Health Service Act, which provides for defense and payment of claims in certain malpractice and negligence suits. In addition, it would enable health systems, like health centers, to receive and use surplus buildings and equipment owned by the federal government. CBO estimates these provisions would have a negligible impact on federal spending.

S. 1929 would create a commission composed of members of the Congress, individuals appointed by Hawaiian health entities, and individuals appointed by the Secretary of the Department of Health and Human Services. The initial members would be appointed within 90 days after enactment. Not later than 18 months after the last member was appointed, the commission would submit a written report to the Congress containing a recommendation of policies and legislation to establish a health care system for native Hawaiians based on the delivery of health care services as an entitlement. The bill would authorize $1.5 million in appropriations to carry out this section.

S. 1929 would require federal agencies providing health care financing and carrying out health care programs to consult with Native Hawaiians and organizations providing health care services to Native Hawaiians prior to adopting any policy or regulation which may impact the provision of health services or health insurance coverage for Native Hawaiians. The consultation would include, but not be limited to, the identification of the impact of proposed policies, rules, or regulations. Depending on how the consultation would be defined, this provision could have budgetary implications. Should the consultation require a significant amount of work and time, it could delay the promulgation of rules and regulations affecting federal payment for programs such as Medicare and Medicaid. CBO cannot estimate the budgetary impact of this provision since it would depend on the rule or regulation being considered and the time necessary to perform the consultation.

PAY-AS-YOU-GO CONSIDERATIONS: None.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The bill would require the state of Hawaii to consult with Native Hawaiians and health care organizations that provide services to Native Hawaiians before making policy changes or initiating new programs. That requirement would be an intergovernmental mandate as defined in UMRA, but CBO estimates that the costs of the mandate would be minimal and

would not exceed the threshold established in UMRA ($55 million in 2000, adjusted annually for inflation).

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains no private-sector mandates as defined in UMRA.

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