CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 28, 2006

H.R. 5312
Indian Health Care Improvement Act Amendments of 2006

As ordered reported by the House Committee on Resources on June 21, 2006

SUMMARY

H.R. 5312 would authorize the appropriation of such sums as are necessary through 2015 for the Indian Health Care Improvement Act, the primary authorizing legislation for the Indian Health Service (IHS). The bill also contains provisions that would affect direct spending, primarily in the Medicaid program.

CBO estimates that implementing H.R. 5312 would cost $2.6 billion in 2007 and $30.4 billion over the 2007-2016 period, assuming appropriation of the necessary amounts. We also estimate that enacting the bill would increase direct spending by $8 million in 2007, by $67 million over the 2007-2011 period, and by $163 million over the 2007-2016 period.

H.R. 5312 would preempt state licensing laws in certain cases, and this preemption would be an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA); however, CBO estimates that the costs of that mandate would be small and would not approach the threshold established in UMRA ($64 million in 2006, adjusted annually for inflation). The bill also would place new requirements on Medicaid and the State Children's Health Insurance Program (SCHIP) that would result in additional spending of about $93 million over the 2007-2016 period. Other provisions of the bill would benefit tribal governments by establishing new or expanding existing programs for Indian health care. This bill contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 5312 is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

TABLE 1. ESTIMATED BUDGETARY EFFECTS OF H.R. 5312

	By Fiscal Year, in Millions of Dollars									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Estimated Authorization Level	3,117	3,188	3,261	3,336	3,412	3,491	3,571	3,654	3,740	0
Estimated Outlays	2,571	2,998	3,160	3,303	3,378	3,456	3,536	3,617	3,702	634
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	7	14	14	15	15	15	16	21	21	22
Estimated Outlays	8	15	14	15	15	15	16	21	21	23

BASIS OF ESTIMATE

For the purpose of this estimate, CBO assumes that H.R. 5312 will be enacted near the start of fiscal year 2007 and that the necessary amounts will be appropriated for each fiscal year.

Spending Subject to Appropriation

H.R. 5312 would authorize the appropriation of such sums as are necessary for the Indian Health Service through 2015. The agency's responsibilities under the bill would be broadly similar to those in current law. In 2006, the agency received an appropriation just over $3 billion. CBO's estimate of the authorized level for IHS programs is the appropriated amount for 2006 adjusted for anticipated inflation in later years. The estimated outlays reflect historical spending patterns for IHS activities.

Direct Spending

H.R. 5312 contains several provisions, primarily related to the Medicaid program, that would affect direct spending. The bill's estimated effects on direct spending are shown in Table 2. Overall, CBO estimates that enacting the bill would increase direct spending by $8 million in 2007 and $163 million over the 2007-2016 period.

TABLE 2. ESTIMATED EFFECTS OF H.R. 5312 ON DIRECT SPENDING

	By Fiscal Year, in Millions of Dollars									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Exemption from Cost Sharing and Premiums										
Medicaid										
Estimated Budget Authority	5	10	10	10	10	10	10	15	15	15
Estimated Outlays	5	10	10	10	10	10	10	15	15	15
SCHIP										
Budget Authority	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	1	1	*	-1	*	*	*	*	*	*
Consultation with Indian Health Programs										
Estimated Budget Authority	*	*	1	1	1	1	1	1	1	1
Estimated Outlays	*	*	1	1	1	1	1	1	1	1
Medicaid Managed Care Provisions										
Estimated Budget Authority	2	3	3	4	4	4	5	5	5	6
Estimated Outlays	2	3	3	4	4	4	5	5	5	6
Exclude Outreach Spending from Limit on Administrative Costs										
Estimated Budget Authority	*	*	*	*	*	*	*	*	*	*
Estimated Outlays	*	*	*	*	*	*	*	*	*	*
Scholarship and Loan Repayment Recovery Fund										
Estimated Budget Authority	*	*	*	*	*	*	*	*	*	*
Estimated Outlays	*	*	*	*	*	*	*	*	*	*
Total Changes in Direct Spending										
Estimated Budget Authority	7	14	14	15	15	15	16	21	21	22
Estimated Outlays	8	15	14	15	15	15	16	21	21	23

NOTES: Components may not sum to totals because of rounding. SCHIP is the State Children's Health Insurance Program.

* = Costs or savings of less than $500,000.

The effects of each provision are discussed in more detail below. IHS-funded health programs are commonly divided into three groups: those operated directly by the Indian Health Service, those operated by tribes and tribal organizations under self-governance agreements, and those operated by urban Indian organizations. For this estimate, they are referred to collectively as Indian health programs.

Exemption from Cost Sharing and Premiums. Section 204 would prohibit Medicaid and SCHIP programs from charging cost sharing or premiums to Indians for services that are

provided directly or upon referral by Indian health programs. The provision also would prohibit states from reducing payments to providers for those services by the amount of cost sharing that Indians otherwise would pay.

Medicaid. CBO anticipates that this provision's budgetary effect would stem largely from eliminating cost sharing for referral services. Current law already prohibits Indian health programs from charging cost sharing to Indians who use their services. In addition, Medicaid pays almost all facilities operated by IHS and tribes based on an all-inclusive rate that is not reduced to account for any cost sharing that Indians would otherwise have to pay. Finally, very few states charge premiums to their Medicaid enrollees.

Using Medicaid administrative data, CBO estimates that about 270,000 Indians are Medicaid recipients who also use IHS, and that federal Medicaid spending on affected services would be about $275 per person annually in 2007. The amount of affected spending would be relatively low because Medicaid already prohibits cost sharing in many instances, such as long-term care services, emergency services, and services for many children and pregnant women. For the affected spending, CBO assumes that cost sharing paid by individuals equals 2 percent of total spending—Medicaid law limits the extent to which states can impose cost sharing—and that eliminating cost sharing would increase total spending by about 5 percent as individuals consume more services. Overall, CBO estimates that the provision would increase federal Medicaid spending by $5 million in 2007 and by $110 million over the 2007-2016 period.

State Children's Health Insurance Program. SCHIP regulations already prohibit states from charging cost sharing or premiums to Indian children enrolled in the program. As a result, the provision's impact on SCHIP spending largely reflects higher payments to Indian health programs and the use of additional services by adult enrollees that a handful of states cover in waiver programs. CBO estimates that the additional spending would total $2 million over the 2007-2016 period. The provision's effects would be limited in later years because total funding for the program is capped.

Consultation with Indian Health Programs. Section 206 would encourage state Medicaid programs to consult regularly with Indian health programs on outstanding Medicaid issues by allowing states to receive federal matching funds for the cost of those consultations. Those costs would be treated as an administrative expense under Medicaid and divided equally between the federal government and the states. CBO anticipates that a small number of states would take advantage of this provision, increasing federal Medicaid spending by less than $500,000 in 2007 and by $7 million over the 2007-2016 period.

Medicaid Managed Care Provisions. Section 208 would make several changes to improve the ability of Indian health programs to receive payments for Indians who receive Medicaid benefits through managed care arrangements. Those changes include:

- Managed care organizations (MCOs) would have to pay Indian health programs at least the rates used for preferred providers. States also would have the option of making those payments directly to Indian health programs.

- MCOs would have to accept claims submitted by Indian health programs instead of requiring enrollees to submit claims personally.

- Some requirements that MCOs must now meet to participate in Medicaid would be waived or modified for Indian health programs that seek to operate as MCOs. (For example, MCOs run by Indian health programs would be able to limit enrollment to Indians only.)

- States would be required to offer contracts to Indian health programs seeking to operate their own MCOs.

Based on administrative data on Medicaid enrollment and spending for Indians who receive benefits via managed care, CBO estimates that those provisions would increase federal Medicaid spending by $2 million in 2007 and $41 million over the 2007-2016 period. We anticipate that the additional costs would be relatively modest because some states already use similar rules in their Medicaid managed care programs and Indian health programs would have a limited interest in participating as MCOs.

Exclude Outreach Spending from Limit on Administrative Costs. Under current law, spending by SCHIP programs on administration and certain other activities cannot exceed 10 percent of overall spending. Section 203 would exclude spending on outreach activities to enroll additional Indian children from the 10 percent limit.

CBO estimates that this provision would increase or decrease SCHIP spending by less than $500,000 in any fiscal year. Federal funding for SCHIP is limited, and we anticipate that most states with a significant Indian population would spend all of their SCHIP funds under current law. In addition, some of the states with unspent funds are not currently constrained by the 10 percent limit and thus would not be affected by the provision.

Scholarship and Loan Repayment Recovery Fund. H.R. 5312 would allow the Secretary of Health and Human Services to spend amounts collected for breach of contract from recipients of certain IHS scholarships. Under current law, those funds are deposited in the Treasury and not spent. Because the Secretary's ability to spend those funds would not be

subject to appropriation, the provision would increase direct spending. Based on historical information from IHS, CBO estimated that the provision would increase spending by less than $500,000 a year and about $4 million over the 2007-2016 period.

ESTIMATED LONG-TERM DIRECT SPENDING EFFECTS

Pursuant to section 407 of H. Con. Res. 95 (the Concurrent Resolution on the Budget, Fiscal Year 2006), CBO estimates that enacting H.R. 5312 would not cause an increase in direct spending greater than $5 billion in any of the 10-year periods from 2016 to 2055.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

H.R. 5312 would preempt state licensing laws in cases where a health care professional is licensed in one state but is performing services in another state under a contract or compact with a tribal health program. This preemption would be an intergovernmental mandate as defined in the UMRA; however, CBO estimates that the loss of any licensing fees resulting from the mandate would be small and would not approach the threshold established in UMRA ($64 million in 2006, adjusted annually for inflation).

Other Impacts

H.R. 5312 would reauthorize and expand grant and assistance programs available to Indian tribes, tribal organizations, and urban Indian organizations for a range of health care programs, including prevention, treatment, and ongoing care. The bill also would allow IHS and tribal entities to share facilities, and it would authorize joint ventures between IHS and Indian tribes or tribal organizations for the construction and operation of health facilities. The bill would authorize funding for a variety of health services including hospice care, long-term care, public health services, and home and community-based services.

The bill would prohibit states from charging cost sharing or premiums in the Medicaid or SCHIP programs to Indians who receive services or benefits through an Indian health program. CBO estimates that the new requirements in the bill would result in additional spending by states of about $93 million over the 2007-2016 period. Some tribal entities, particularly those operating managed care systems, may realize some savings as a result of these provisions.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

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

PREVIOUS CBO ESTIMATES

On April 26, 2006, CBO transmitted a cost estimate for S. 1057, the Indian Health Care Improvement Act Amendments of 2005, as reported by the Senate Committee on Indian Affairs on March 16, 2006. That bill contains provisions that would affect direct spending that are similar to those in H.R. 5312; we estimated that enacting S. 1057 would increase direct spending by $27 million in 2007 and by $398 million over the 2007-2016 period. The estimated costs for S. 1057 are higher largely because that bill would exempt all Indians enrolled in Medicaid or SCHIP from any cost sharing or premiums. By comparison, the exemption in H.R. 5312 would apply to fewer individuals (Medicaid or SCHIP recipients who also use IHS) and to a narrower range of services (those provided directly or upon referral by Indian health programs).

On July 10, 2006, CBO transmitted a cost estimate for S. 3524, the Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006, as reported by the Senate Committee on Finance on June 15, 2006. The provisions in H.R. 5312 that would affect Medicaid and SCHIP spending are identical to S. 3524, and CBO's estimates of their budgetary effects are the same.

ESTIMATE PREPARED BY:

Federal Costs: Eric Rollins
Impact on State, Local, and Tribal Governments: Leo Lex
Impact on the Private Sector: Paige Shevlin

ESTIMATE APPROVED BY:

Peter H. Fontaine
Deputy Assistant Director for Budget Analysis