CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

October 10, 2007

Medicare, Medicaid, and SCHIP
Indian Health Care Improvement Act of 2007

As ordered reported by the Senate Committee on Finance on September 12, 2007

SUMMARY

This legislation would make several changes to Medicaid that would affect Indians who are enrolled in both the Medicaid program and the Indian Health Service (IHS). Those changes would include exempting Indians from paying cost sharing or premiums for certain services and making it easier for IHS and related health programs to receive Medicaid payments for services provided through managed care arrangements.

CBO estimates that enacting this legislation would increase direct spending by $9 million in 2008, by $52 million over the 2008-2012 period, and by $126 million over the 2008-2017 period. Enacting the bill would have no effect on revenues.

The legislation contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). CBO estimates that the new requirements in the bill would result in additional Medicaid spending by states of about $78 million over the 2008-2017 period. This legislation contains no private-sector mandates as defined in UMRA.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

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

	By Fiscal Year, in Millions of Dollars											
	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
CHANGES IN DIRECT SPENDING												
Exemption from Medicaid Cost Sharing and Premiums												
Estimated Budget Authority	5	6	6	7	7	8	8	9	9	10	31	74
Estimated Outlays	5	6	6	7	7	8	8	9	9	10	31	74
Consultation with Indian Health Programs												
Estimated Budget Authority	*	*	1	1	1	1	1	1	1	1	3	7
Estimated Outlays	*	*	1	1	1	1	1	1	1	1	3	7
Medicaid Managed Care Provisions												
Estimated Budget Authority	3	3	4	4	4	5	5	5	6	6	18	45
Estimated Outlays	3	3	4	4	4	5	5	5	6	6	18	45
Total Changes												
Estimated Budget Authority	9	9	11	11	12	13	14	14	16	17	52	126
Estimated Outlays	9	9	11	11	12	13	14	14	16	17	52	126

Notes: Components may not sum to totals because of rounding.

* = less than $500,000.

BASIS OF ESTIMATE

For the purpose of this estimate, CBO assumes that this legislation will be enacted near the start of fiscal year 2008.

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 Medicaid Cost Sharing and Premiums

Section 5 would prohibit Medicaid programs from charging premiums or other cost-sharing payments 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.

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 280,000 Indians are Medicaid recipients who also use IHS, and that federal Medicaid spending on affected services would be about $225 per person annually in 2008. 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 payments by individuals equal 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 2008 and by $74 million over the 2008-2017 period.

Consultation with Indian Health Programs

Section 7 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 2008 and by $7 million over the 2008-2017 period.

Medicaid Managed Care Provisions

Section 9 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 non-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 $3 million in 2008 and $45 million over the 2008-2017 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.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The legislation contains no intergovernmental mandates as defined in UMRA. The bill would impose new rules on state Medicaid programs and prohibit states from imposing cost-sharing requirements or charging premiums to Indians who receive services or benefits through an Indian health program. Some tribal entities, particularly those operating managed care systems, may realize some savings as a result of these provisions. CBO estimates that the new requirements in the bill would result in additional spending by states of about $78 million over the 2008-2017 period.

Those requirements, however, would not be intergovernmental mandates as defined by UMRA because Medicaid provides states with significant flexibility to make programmatic adjustments to accommodate the changes. UMRA makes special provision for identifying intergovernmental mandates in legislation affecting large entitlement grant programs (those that provide more than $500 million annually to state, local, or tribal governments), including Medicaid. If a legislative proposal would increase the stringency of conditions of assistance, or cap or decrease the amount of federal funding for the program, such a change would be considered an intergovernmental mandate only if the state, local, or tribal government lacks

authority to amend its financial or programmatic responsibilities to continue providing required services.

The legislation 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. Finally, 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 that would benefit tribal governments.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

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

PREVIOUS CBO ESTIMATE

On September 11, 2007, CBO issued revised cost estimates for S. 1200, the Indian Health Care Improvement Act Amendments of 2007, as ordered reported by the Senate Committee on Indian Affairs on May 10, 2007, and H.R. 1328, the Indian Health Care Improvement Act Amendments of 2007, as ordered reported by the House Committee on Natural Resources on April 25, 2007. Those bills contain the same Medicaid provisions as the Finance Committee's legislation, and CBO's estimates for them are identical.

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