



**CONGRESSIONAL BUDGET OFFICE  
COST ESTIMATE**

July 10, 2006

**S. 3524  
Medicare, Medicaid, and SCHIP  
Indian Health Care Improvement Act of 2006**

*As reported by the Senate Committee on Finance on June 15, 2006*

**SUMMARY**

S. 3524 would make several changes to Medicaid and the State Children's Health Insurance Program (SCHIP) that would affect both Indians who are enrolled in those programs 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 S. 3524 would increase direct spending by \$8 million in 2007, by \$65 million over the 2007-2011 period, and by \$159 million over the 2007-2016 period. Enacting the bill would have no effect on revenues.

S. 3524 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). Some provisions of the bill, however, would result in additional spending by states to comply with new conditions for participating in the Medicaid and SCHIP programs. CBO estimates that state spending for Medicaid and SCHIP would increase by about \$93 million over the 2007-2016 period to comply with those new requirements. The bill contains no private-sector mandates as defined in UMRA.

**ESTIMATED COST TO THE FEDERAL GOVERNMENT**

The estimated budgetary impact of S. 3524 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By Fiscal Year, in Millions of Dollars									
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
<b>CHANGES IN DIRECT SPENDING</b>										
Exclude Outreach Spending from Limit on Administrative Costs										
Budget Authority	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	*	*	*	*	*	*	*	*	*	*
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
Total Changes in Direct Spending										
Estimated Budget Authority	7	13	14	15	15	15	16	21	21	22
Estimated Outlays	8	14	13	14	15	15	16	20	21	22

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

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

## BASIS OF ESTIMATE

For the purpose of this estimate, CBO assumes that S. 3524 will be enacted near the start of fiscal year 2007.

Health programs funded by the Indian Health Service 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.

## **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 4 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 capped, 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.

## **Exemption from Cost Sharing and Premiums**

Section 5 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 providers 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 7 would encourage state Medicaid administrators to consult regularly the administrators of 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 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 participating 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.

## **ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS**

S. 3524 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act. Some provisions of the bill, however, would result in additional spending by states to comply with new conditions for participating in the Medicaid and SCHIP programs. CBO estimates that state spending for Medicaid and SCHIP would increase by about \$93 million over the 2007-2016 period to comply with those new requirements.

## **ESTIMATED IMPACT ON THE PRIVATE SECTOR**

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

## **PREVIOUS CBO ESTIMATE**

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 very similar to those in S. 3524; 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 S. 3524 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).

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