David G. Sewell; David L. Sherlin; Joseph L. Smalls; Julianna Smoot; Joshua H. Stein; Michael Sullivan; Jonathan Sumrell; Adrian Talbott; Noelle Shelby Talley; Bradford T. Thompson; Cindy E. Townes; Brooke I. Turner; Ann S. Vaughn; Jannice T. Verne; Rebecca Walldorff; Jewell E. Wilson; Jessica F. Wintringham; Andrew A. Young; Lisa E. Zeidner.

COMMENDING VERGENNES FIRE CHIEF RALPH JACKMAN FOR 50 YEARS OF SERVICE

Mr. LEAHY. Mr. President, I rise today to pay tribute to Ralph Jackman of Vergennes, VT. Mr. Jackman has been reporting for duty as chief of the Vergennes Fire Department for 50 years—since December 1, 1954.

Chief Jackman started with the fire department 8 years before he took over as chief. During his tenure a new station was built, the number of firefighters doubled, the number of vehicles tripled, and the budget more than quadrupled.

Though at 80 years of age Chief Jackman has given up fighting the fires himself, he continues to respond to calls and manage the volunteer department's paperwork and affairs.

I congratulate Chief Jackman and his family for over 50 years of service to the City of Vergennes and the State of Vermont. He has selflessly given so much to his community.

I ask unanimous consent that an editorial that appeared in today's Burlington Free Press be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From the Burlington Free Press, Dec. 8, 2004]

OPINION: TRUE PUBLIC SERVANT

Rare is the modern-day employee who stays in a job throughout his adult lifetime.

In sharp contrast stands Ralph Jackman, who has committed the last 50 years to the Vergennes Fire Department. That surely makes him one of the longest serving fire chiefs in the nation.

Jackman became chief of the department on Dec. 1, 1954, eight years after joining the force. And at age 80, don't expect him to retire anytime soon. Jackman's not actually battling blazes these days, but he's still in the thick of the action by managing the volunteer department's paperwork and overseeing the changes that have brought this fire department into the 21st century.

Among those changes was construction of a new fire station and a doubling of the number of firefighters.

He has also seen destruction and death. Jackman recalls in 1948 following a fire engine on the way to a blaze, and watching the engine crash into an oncoming car, leaving firefighter Lee Schroder dead.

His most memorable blaze was the Feb. 24, 1958, fire that destroyed much of downtown Vergennes. He was an eyewitness to an event that shaped the spirit of a small Vermont city.

His devotion to his community was honored last weekend at a gathering that drew Gov. Jim Douglas and Vergennes Mayor Kitty Oxholm. .

The nation came to understand the depth of that commitment on 9/11, when so many of New York City's firefighters lost their lives trying to save victims of the terrorist attacks on the World Trade Centers. Vermont firefighters don't face that extreme scenario, but they put their lives on the line every time they roll to a scene to protect their neighbors.

Jackman recently said, ''Being chief is just a privilege and an honor.''

However, it is the people of Vergennes who have been honored by his 50 years of service to their community.

ADDITIONAL STATEMENTS

FINAL THOUGHTS ON THE INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2003

• Mr. CAMPBELL. Mr. President, I am pleased to provide for inclusion in the CONGRESSIONAL RECORD, the final cost estimate for S. 556, the Indian Health Care Improvement Act Amendments of 2003 prepared by the Congressional Budget Office.

This estimate had not been completed in time to be filed with the Senate Report No. 108–411 on S. 556 that was filed on November 17, 2004.

S. 556 would reauthorize the Indian Health Care Improvement Act which sets forth the statutory framework for the Indian health system and was first enacted in 1976. The act was reauthorized in 1992. The goal of the 1976 act, as amended, is to raise the health status of Indians to achieve parity with that of other Americans.

American Indians and Alaska Natives rank at or near the bottom of nearly every health indicator when compared to the general U.S. population. Health studies indicate disproportionately higher mortality rates of alcoholism, between 670–770%; tuberculosis, 650%; diabetes, between 318–420% accidental injuries, 280%; suicide, 190%; and homicide, 210%, than other populations.

With the basic goals of the Act unrealized, the need for reauthorization grows greater. S. 556 would have provided an additional set of improvements to the Indian health care system—most notably, for facility construction, access to care through Medicaid cost-sharing waivers, and long-term planning through the establishment of a bipartisan commission to study the Indian health care system.

The reauthorization bill has been a work in progress since the 106th Congress when I introduced a bill to reauthorize the act. I have introduced a bill to reauthorize the act in every subsequent Congress. Over the course of the past three Congresses, the Committee has held eight hearings on the reauthorization with four hearings held in the 108th Congress alone.

I was particularly pleased to have Secretary Thompson testify before the Committee on July 21, 2004, regarding the administration's views on the proposed legislation. At this hearing, the Secretary expressed enthusiastic support of the proposed legislation and his desire to see it enacted this year.

This show of support was particularly important because we had been anticipating the administration's view for several months and were fast coming to the end of the 108th Congress.

At the hearing, Secretary Thompson committed his staff to immediately begin meeting with the bill committee staff to work on the bill. Much effort to advance this legislation had already been put forth by committee staff, tribal leaders and the Indian health community. With department staff working alongside committee staff, we anticipated swift passage of the bill.

However, swift passage did not happen and I am disappointed that the reauthorization did not get enacted this year. The committee staff worked diligently along with the administration and Indian tribal leaders until the very end of this Congress to finalize the bill for passage.

I believe that, in addition to the changes made prior to July, 2004, the committee was quite responsive to the department's concerns and suggestions in revising the bill.

In particular, the provisions for Medicare and health professional shortage areas were not included in the reported bill. The committee modified the establishment of creative funding programs such as the revolving loan funds and opted for studies for this type of funding mechanism instead—at the request of the administration.

There was substantial discussions at the eleventh hour regarding provisions governing urban Indians and non-eligible individuals. I believe the Federal responsibility to provide health care applies to individual Indians living in the urban centers, especially when it is remembered that Indians reside in urban areas primarily as a result of the Federal policy of relocation during the first half of the 20th Century.

In addition, in the course of negotiations, we were made aware of concerns dealing with the Veteran's Administration drug supply schedules and services to non-eligible individuals. A limited scope of services to certain non-eligibles has been a part of the Indian Health Care Improvement Act for years. Nevertheless, the Department and some tribes have different views of the scope of services.

In any event, the matter is being addressed in the courts. Any resolution we could offer would be better served by reviewing the decision of the courts and then thoroughly examining the matter instead of fixing what has not been determined by the courts to be a problem.

Likewise, I am concerned with what may be a desire to rollback the gains tribes have made in implementing the Indian Health Care Improvement Act and the Indian Self-Determination and Education Assistance Act.

The underlying policies and plain language of the both statutes should not be ignored and the commitment to self-governance needs to be respected when enacting any Indian legislation.

I certainly appreciated President Bush's Memorandum to Department Heads on ''The Government-to-Government Relationship with Tribal Governments'' dated September 30, 2004, in which he reiterated his support for the government-to-government relationship and tribal sovereignty. President Bush continued the long-standing policy of self-governance begun in 1970 by President Nixon.

The committee has continually upheld those principles and fought for expansions in self-governance, even over the objections of previous Administrations. I believe that retreating from those principles in enacting any Indian statutes would be inconsistent with the President's commitment as well as the will of Congress.

What I am particularly disappointed in having to set aside this year is the State Children's Health Insurance Program, SCHIP, improvements that we had worked on for several months. In mid-May, 2004, we were informed that the department lacked information regarding how many Indian children qualified for the program and how many Indian children were actually being served, despite clear statutory language mandating services to Indian children. Yet again, we find the most needy must continue to suffer until there is a serious effort to address these disparities.

There were many other Senators and committees which provided substantial assistance in seeking passage of this bill. Without the commitment and support of Majority Leader Bill Frist, we certainly could not have gotten as far as we did.

Senator FRIST was constructively engaged very early on this bill and continued his support throughout the negotiations with the Administration.

Senator STEVENS was also very supportive and committed to passage of this bill. His staff worked diligently also with the committee staff until the very end of the session.

Likewise, Senator GRASSLEY also committed his staff in assisting the committee staff in developing significant improvements in the Medicaid provisions.

I cannot forget the work of Senator HATCH on this matter as well. Senator HATCH was instrumental in developing the Indian provisions in the SCHIP statute and assisted in seeking resolutions for many of the problems we found in SCHIP implementation.

I am leaving the Senate knowing that there are many issues left unresolved but I have every confidence that the Committee under the leadership of Senator MCCAIN will continue to protect tribal sovereignty and uphold principles of tribal self-governance.

I do look forward to seeing a vigorous discussion on the reauthorization next year and believe that coordinated efforts ensure its passage.

I ask that the CBO cost estimate be printed in the RECORD.

S. 556—Indian Health Care Improvement Act Amendments of 2004

Summary: S. 556 would authorize the appropriation of such sums as necessary through 2015 for the Indian Health Care Improvement Act, the primary authorizing legislation for the Indian Health Service (IHS). The bill also contains specific authorizations for loans and loan guarantees for urban Indian organizations and a commission on Indian health care. In addition, the bill also would affect direct spending, primarily through provisions that would make it easier for IHS to enter into capital leases and make changes to the Medicaid program.

CBO estimates that implementing S. 556 would cost $2.4 billion in 2005 and $31.8 billion over the 2005–2014 period, assuming appropriation of the necessary amounts. We also estimate that enacting the bill would increase direct spending by $8 million in 2005, by $69 million over the 2005–2009 period, and by $238 million over the 2005–2014 period.

S. 556 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 ($60 million in 2004, adjusted annually for inflation). Other provisions of the bill would establish new or expand existing programs for Indian health care. It also would place new requirements on Medicaid and the State Children's Health Insurance Program (SCHIP) that would result in additional spending of about $35 million over the 2005–2009 period. This bill contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 556 is shown in Table 1. The costs of this legislation fall within budget function 550 (health).

TABLE 1.—ESTIMATED BUDGETARY EFFECTS OF S. 556

	By fiscal year, in millions of dollars—									
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
CHANGES IN SPENDING SUBJECT TO APPROPRIATION										
Estimated Authorizations Level	2,977	3,026	3,093	3,165	3,243	3,321	3,401	3,484	3,569	3,657
Estimated Outlays	2,353	2,843	2,995	3,131	3,212	3,289	3,368	3,450	3,535	3,621
CHANGES IN DIRECT SPENDING										
Estimated Budget Authority	7	42	90	44	46	96	49	51	104	54
Estimated Outlays	8	12	13	15	21	24	28	36	38	43

Basis of estimate: For the purpose of this estimate, CBO assumes that S. 556 would be enacted near the start of calendar year 2005 and that the authorized amounts will be appropriated for each fiscal year.

Spending Subject to Appropriation

The estimated effects of S. 556 on spending subject to appropriation are shown in Table 2. IHS programs were authorized for 2004 by the Department of the Interior and Related Agencies Appropriations Act, 2004 (Public Law 108–108).

Existing Indian Health Service activities. S. 556 would authorize the appropriation of such sums as necessary for the Indian Health Service through 2015. The agency's responsibilities under the bill would be broadly similar to those in current law. CBO's estimate of the authorized level for IHS programs is the appropriated amount for 2004 adjusted for inflation in later years. The estimated outlays reflect CBO's current assumptions about spending patterns for IHS activities. (The pending omnibus appropriation act, H.R. 4818, would provide $2.985 billion in funding for IHS activities in fiscal year 2005).

TABLE 2.—ESTIMATED EFFECTS OF S. 556 ON DISCRETIONARY SPENDING

	By fiscal year, in millions of dollars—										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Spending Under Current Law [1]											
Budget Authority	2,921	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	2,909	605	159	71	5	0	0	0	0	0	0
Proposed Changes:											
Existing Indian Health Service Activities:											
Estimated Authorization Level	0	2,973	3,025	3,092	3,165	3,243	3,321	3,401	3,484	3,569	3,657
Estimated Outlays	0	2,352	2,841	2,994	3,131	3,212	3,289	3,368	3,450	3,535	3,621
Loan Guarantees for Urban Indian Organizations:											
Estimated Authorization Level	0	*	1	1	0	0	0	0	0	0	0
Estimated Outlays	0	*	*	*	*	*	*	0	0	0	0
Commission on Indian Health Care Entitlement:											
Authorization Level	0	4	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	1	2	1	0	0	0	0	0	0	0
Total Changes in Spending Subject to Appropriation:											
Estimated Authorization Level	0	2,977	3,026	3,093	3,165	3,243	3,321	3,401	3,484	3,569	3,657
Estimated Outlays	0	2,353	2,843	2,995	3,131	3,212	3,289	3,368	3,450	3,535	3,621
Spending Under S. 556:											
Estimated Authorization Level [1]	2,921	2,977	3,026	3,093	3,165	3,243	3,321	3,401	3,484	3,569	3,657

TABLE 2.—ESTIMATED EFFECTS OF S. 556 ON DISCRETIONARY SPENDING—Continued

	By fiscal year, in millions of dollars—										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Estimated Outlays	2,909	2,958	3,002	3,066	3,136	3,212	3,289	3,368	3,450	3,535	3,621

[1] The 2004 level is the amount appropriated for that year. The pending omnibus appropriation act (H.R. 4818) would provide $2.985 billion in funding for IHS activities in fiscal year 2005.

Note: *=Less than $500,000.

Loan Guarantees for Urban Indian Organizations. Section 509 of the bill would establish a loan guarantee program for urban Indian organizations. Under this new program, the federal government would provide loans or loan guarantees, with a term of up to 25 years, for construction or renovation by urban Indian organizations. The bill would not require any guarantee fees to be charged to the organizations and would not limit the percent of the loan that would be insured by the federal government. CBO therefore assumes that IHS would insure up to 100 percent of the loan value and that borrowers would not be charged any guarantee fees.

The new loan program would be considered a discretionary federal credit program and would require appropriation to establish a limit on the total value of outstanding loans and loan guarantees and to provide a credit subsidy for the cost of such loans and loan guarantees. Based on discussions with officials from the National Council of Urban Indian Health, CBO estimates that the total value of loans and loan guarantees would be $30 million. Using the Small Business Administration's 7(a) general business loan program as a guide, CBO assumes that, like small businesses, the default rate for loans made to urban Indian organizations would be about 10 percent and that recoveries on such loans would be about 50 percent. Using those assumptions, CBO estimates that the subsidy rate for the new loan program would be 5 percent, and that establishing the loan program would cost about $2 million over the next five years, assuming appropriation of the necessary amounts.

Commission on Indian Health Care Entitlement. Section 815 would authorize the appropriation of $4 million for a commission that would study establishing a legal entitlement for Indians to receive health care services. The members of the commission would have to be appointed within five months of the bill's enactment and would be required to submit a final report to the Congress no later than 18 months after that. Assuming the appropriation of the authorized amount, CBO estimates that implementing this provision would cost $1 million in 2005, $2 million in 2006, and $1 million in 2007.

New Hospital for Fort Berthold Indian Reservation. S. 556 contains a provision that would authorize the appropriation of $20 million for the construction of a new hospital on the Fort Berthold Indian Reservation in North Dakota. CBO estimates that this provision would have no effect on spending because it is also contained in a separate piece of legislation (S. 1146, the Three Affiliated Tribes Health Facility Compensation Act) that the Congress recently cleared.

Direct Spending

S. 556 contains several provisions, primarily related to leasing by IHS and the Medicaid program, that would affect direct spending. The bill's estimated effects on direct spending are shown in Table 3. Overall, CBO estimates that enacting the bill would inrease direct spending by $8 million in 2005 and $238 million over the 2005–2014 period.

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.

TABLE 3.—ESTIMATED EFFECTS OF S. 556 ON DIRECT SPENDING

	By fiscal year, in millions of dollars—									
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Spending on Health Facilities:										
Estimated Budget Authority	0	31	78	32	32	82	33	34	86	35
Estimated Outlays	0	0	0	2	7	9	12	18	20	23
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
Exempt Indians from Cost Sharing:										
Medicaid:										
Estimated Budget Authority	3	5	5	5	6	6	7	8	8	9
Estimated Outlays	3	5	5	5	6	6	7	8	8	9
SCHIP:										
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	1	1	1	1	*	*	*	*	*	*
Exempt Indians from Premiums:										
Medicaid:										
Estimated Budget Authority	2	3	3	3	3	3	3	3	3	3
Estimated Outlays	2	3	3	3	3	3	3	3	3	3
SCHIP:										
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	*	*	*	*	*	*	*	*	*	*
Medicaid Interaction with SCHIP:										
Estimated Budget Authority	*	*	*	*	1	1	1	1	1	1
Estimated Outlays	*	*	*	*	1	1	1	1	1	1
Medicaid Managed Care Provisions:										
Estimated Budget Authority	1	2	3	3	3	4	4	4	5	5
Estimated Outlays	1	2	3	3	3	4	4	4	5	5
Scholarship and Loan Repayment Recovery Fund:										
Estimated Budget Authority	*	*	*	*	*	*	*	*	*	*
Estimated Outlays	*	*	*	*	*	*	*	*	*	*
Total Changes in Direct Spending:										
Estimated Budget Authority	7	42	90	44	46	96	49	51	104	54
Estimated Outlays	8	12	13	15	21	24	28	36	38	43

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.

Spending on Health Facilities. IHS already has the authority to enter into leases, contracts, or other agreements with tribes or tribal organizations that have title to, a leasehold interest in, or a beneficial interest in facilities that would be used by IHS to deliver health care services. Section 308 of the bill would require that all such arrangements be treated as operating leases for the purposes of the Balanced Budget and Emergency Deficit Control Act.

Under the bill, CBO anticipates that IHS would enter into arrangements that should be treated as capital leases because those arrangements would effectively allow IHS to acquire new buildings. Consistent with government rules for accounting for obligations, the full cost of those leases should be recorded in the budget as new budget authority at the time the lease agreements are signed. That budget authority—estimated to be about $440 million over the 2005–2014 period—is determined by calculating the discounted present value of the anticipated lease payments. Spending of that budget authority would occur over the term of the various leases (that is, outlays would significantly lag behind the budget authority).

For this estimate, CBO assumed that IHS would begin signing new capital leases starting in 2006. Based on information from IHS, we anticipate that those leases would be used for a variety of construction projects, including inpatient hospitals, outpatient hospitals, and staff quarters. We assume that IHS would not begin to make lease payments until 2008; payments in that year would total $2 million and then rise gradually to $23 million by 2014. Both the level of spending that might occur under the bill and the types of projects that might be financed are uncertain, and IHS spending may be more or less than the amounts CBO has estimated.

Consultation with Indian Health Programs. Section 409 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 about $200,000 in 2005 and by $7 million over the 2005–2014 period.

Exempt Indians from Cost Sharing. Section 412 would prohibit Medicaid and SCHIP from charging cost sharing to Indians for services provided directly or upon referral by Indian health programs. The provision also would require that payments by Medicaid and SCHIP for services provided directly by those programs could not be reduced by the amount of cost sharing that Indians otherwise would pay.

Medicaid. CBO anticipates that this provision's budgetary effect would stem primarily 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.

Using Medicaid administrative data, CBO estimates that about 225,000 Indians are Medicaid recipients who also use IHS, and that federal Medicaid spending on affected services would be about $400 per person annually in 2005. 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 all services for 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 cost sharing to nominal amounts—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 $3 million in 2005 and by $62 million over the 2005–2014 period.

State Children's Health Insurance Program. SCHIP regulations already prohibit states from charging cost sharing to Indian children enrolled in the program. As a result, the provision's impact on SCHIP spending reflects higher payments to Indian health programs and the use of additional referral services by adult enrollees that some states cover in waiver programs. CBO estimates that the additional spending would total $1 million in 2005 and $5 million over the 2005–2014 period. The provision's effects would be limited in later years because total funding for the program is capped.

Exempt Indians from Premiums. Section 412 also would exempt Indians from paying any premiums under Medicaid or SCHIP. Based on information from the Government Accountability Office on the limited extent to which states charge premiums in those programs and Medicaid administrative data, CBO estimated that this provision would affect about 5,000 Medicaid recipients, and that the loss of premium payments from those individuals would raise federal Medicaid spending by $2 million in 2005 and by $29 million over the next 10 years.

CBO also estimates that this provision would affect federal SCHIP spending by less than $500,000 annually. As noted above, Indian children do not pay premiums under SCHIP, so the provision would affect only adult recipients.

Medicaid Interaction with SCHIP. The changes in SCHIP spending outlined above also would lead to slightly higher Medicaid spending. Total funding for SCHIP is limited by statute, and CBO anticipates that many states will experience funding shortfalls over the 10–year projection period. CBO also assumes that states will partly offset those funding shortfalls by expanding Medicaid eligibility, which would allow states to continue to receive federal matching funds, albeit at a less-favorable matching rate. Since S. 556 would increase spending in SCHIP, it also would increase the extent to which states use Medicaid funds to offset funding shortfalls in SCHIP. CBO estimates that this interaction would raise federal Medicaid spending by less than $500,000 in 2005 and by about $5 million over the 2005–2014 period.

Medicaid Managed Care Provisions. Section 413 contains three provisions that would affect Medicaid spending on services provided in managed care settings.

Pay Indian Health Programs at Preferred Provider Rates. States that rely on managed care organizations (MCOs) to provide care to Medicaid beneficiaries and have an IHS presence commonly require MCOs to include Indian health programs in their networks or otherwise allow access to services provided by those programs. In other instances, states pay Indian health programs directly for services provided to Indians enrolled in managed care. Although Indian health programs are generally eligible for Medicaid reimbursement from MCOs, they may not be paid at the same rates as preferred providers. S. 556 would require that managed care organizations pay Indian health programs at least the rate paid to preferred providers. As an alternative, state Medicaid programs could pay the increased amounts directly to Indian health programs.

Under current law, about 200,000 Indians on Medicaid receive health care services through MCOs. Based on Medicaid administrative data, CBO estimates that about a third of Indians in Medicaid managed care also use Indian Health providers, mainly for primary care services. Assuming that a third of those enrollees use non-preferred providers, CBO estimates that providers serving about 23,000 Indians would receive rate increases by 2009. Based on administrative spending data for Indians in managed care and assuming that rates under the bill would be 20 percent higher than under current law, CBO estimates that the bill would increase payments to providers of about $150 per year in 2009, some of which would be paid through managed care plans and the balance directly by the states. Assuming the regular Medicaid match rate for plan spending and a 100 percent match rate for direct payments to facilities operated by IHS and tribes, CBO estimates that the bill would increase federal Medicaid payments by less than $1 million in 2005 and by about $16 million over the 2005–2014 period.

Submission of Claims. The bill also would prohibit MCOs from requiring enrollees to submit claims as a condition of payment to contracting Indian health programs. CBO anticipates that Indian health programs would be able to bill more, raising federal Medicaid spending by less than $1 million in 2005 and by $5 million over the 2005–2014 period.

Require States to Contract with Indian Health Programs. Finally, S. 556 would require states to enter into agreements with MCOs that are run by an Indian health program. CBO anticipates that the provision would increase the number of Indians who receive care from MCOs. Because payments to those MCOs would be reimbursed at a 100 percent federal matching rate (instead of the regular matching rate), CBO estimates that this provision would increase federal Medicaid spending by less than $1 million in 2005 and by $13 million over the 2005–2014 period.

Scholarship and Loan Repayment Recovery Fund. Section 111 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 about $150,000 in 2005 and by $3 million over the 2005–2014 period.

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

Intergovernmental Mandates

S. 556 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 funding agreement in a tribal health program. This preemption would be an intergovernmental mandate as defined in 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 ($60 million in 2004, adjusted annually for inflation).

Other Impacts

S. 556 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, traditional Indian health care, and home and community-based services.

The bill would prohibit states from charging cost sharing or premiums in the Medicaid or SCRIP programs to Indians who receive services or benefits through an Indian health program. The bill also would require states that operate managed care systems within their Medicaid programs to enter into agreements with Indian health programs that operate managed care systems. CBO estimates that these requirements would result in additional spending by states of about $35 million over the 2005–2009 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 estimate. On November 30, 2004, CBO transmitted a cost estimate for H.R. 2440, the Indian Health Care Improvement Act Amendments of 2004, as reported by the House Committee on Resources on November 19, 2004. The language in the two bills is almost identical, and CBO estimates that their budgetary effects would be the same.

Estimate Prepared by: Federal Costs: Eric Rollins; Impact on State, Local, and Tribal Governments: Leo Lex; Impact on the Private Sector: Stuart Hagen.

Estimate approved by: Peter H. Fontaine; Deputy Assistant Director for Budget Analysis.●

TRIBUTE TO CAROL SALISBURY

● Mr. ALLARD. Mr. President, on this occasion I pay tribute to a dear friend and employee, Carol Salisbury. Carol joined my office in January of 1991, when I was first elected to Congress from the Fourth Congressional District. One of my original staffers, Carol