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

has served my office and the people of Colorado for 14 years, and she has done so with grace and conviction. She will be leaving my office in January 2005.

Carol began her career working out of my Fort Collins Congressional office, and later, the Senate offices in Greeley and Loveland. As Area Director, she managed the office and provided dedicated service on a variety of issues, including housing and healthcare. Carol was instrumental in establishing the Fall River Visitor Center at Rocky Mountain National Park, the acquisition of Cherokee Park by the Forest Service, and many other smaller projects that have greatly benefitted our public lands and will lead to greater enjoyment by the public. She was passionate about historic preservation and worked tirelessly on behalf of many worthwhile interests, including the historic Cumbres & Toltec Scenic Railroad in Southern Colorado. Her presence on Team Allard will be missed and I know the Northern Colorado community will miss her as well. Carol was a hard working and earnest friend and employee.

My wife, Joan, joins me in thanking her for dedication and loyalty. We both wish her and her husband Jack the best in their future endeavors.●

HONORING WALTER THAYER, JR., MD, OF RHODE ISLAND HOSPITAL

● Mr. CHAFEE. Mr. President, I want to take this opportunity to recognize the retirement of an extraordinary Rhode Islander, Dr. Walter Thayer.

Walter Thayer was born in East Providence in 1929—back when there were farms in what is now an urban area. He graduated from Providence College and left for Tufts University Medical School in 1950. He returned to Rhode Island in 1965 to become the first Director of the Gastroentorology Division of Brown Medical School and Rhode Island Hospital after having worked at the National Institutes of Health, Georgetown, and Yale University School of Medicine.

Dr. Thayer's professional qualifications are outstanding. He served for 30 years as the Chief of Gastroenterology at Brown University and affiliated hospitals, and has been a professor at Brown since 1972; he was the Head of Gastroenterology at Rhode Island Hospital from 1965 to 1994 and continued as a practicing physician until this year. He has been presented with the Distinguished Clinician Award by the American Gastroenterology Association, the Humanitarian of the Year Award by both the Rhode Island and New England Chapters of the Crohns Colitis Foundation of America, and the W.W. Keene Award for Contribution to Brown Medical School. Walter has presented at the Quadrennial Lecture on Crohns Disease at the Third World Congress in Copenhagen, and served as the chairman of the NIH–NFIC Sponsored Symposium on Infectious Agents in Inflammatory Bowel Diseases and as the Governor for Rhode Island to the American College of Gastroenterology.

One of the great ironies is that Walter, who became such a fixture at Brown Medical School and trained and mentored so many fine physicians there, so desired to attend Brown University and was not admitted. Indeed, his experience in the world outside of Brown and the Ivy League was one of the factors that made him such a valuable bridge between town and gown between patient care and academic research.

This bridging between patient care and academic research is a key facet of Dr. Thayer's career. His true caring and empathy for his patients informed his extensive research. That research, where Walter sought to understand the causes of Crohn's disease and ulcerative colitis, and find effective treatments to these and other debilitating gastrointenstinal illnesses, has been remarkable and extensive, and has garnered Walter national and international renown.

To honor Dr. Thayer's service to the health and academic communities in Rhode Island, many of those whom Walter has affected, including mentors, colleagues, students and patients, gathered on October 7 to wish him well in his life in retirement, and to thank him for his service, dedication, caring, and friendship. At that time, one colleague said that Walter had earned the highest respect a doctor could earn—his colleagues would refer their family members to him. He was described as the father of gastroenterology in Rhode Island, someone who is a masterful teacher and had great love for his patients. Dr. Jose Behar said that Walter's patients trusted him so completely that when Dr. Behar would treat one of them, perhaps when Walter was on vacation, they would invariably ask him ''Do you think Dr. Thayer would agree with you?'' Dr. Behar said that as an accomplished doctor having his treatments questioned so bluntly was a little off-putting, but he came to realize that it did not stem from a lack of confidence in him as much as the patients remarkable level of trust, respect and belief in Walter.

To only speak of his professional life, however, is to miss a great deal about Walter. He is someone who is constantly curious, as is demonstrated by the fact that even now, well beyond the age of 70, he finds himself back in school pursuing an associate's degree in wildflower ecology. He has a great love of books, and is often found in his favorite chair, his glasses perched on his nose, a great book open in his hands. He is extremely active—he has run triathlons, marathons, and he spends many winter hours cross-country skiing. And he is a loving husband, father, and friend.

He sincerely cares about issues far from the realm of medicine, important social issues, and tries to address them in a real and admirable fashion. For example, as his children were growing up, he did not want them to only have knowledge of the city, so one summer he took his kids to an Amish farm and they all worked on that farm. He did not want his children to grow up isolated from questions of race, and made many efforts to bring them into close contact with families and children of different races and ethnicities.

Now, even though Dr. Thayer is officially retired, he continues his long volunteer service at the Veterans Affairs hospital and in his teaching at Brown University. He is looking forward to the opening of the new infectious bowel disease research laboratory that will open at Rhode Island Hospital—which will be named ''The Walter R. Thayer Inflammatory Bowel Disease Laboratory.'' What a fitting honor that this new, state-of-the-art research laboratory will be named for him.

Walter leaves behind a remarkable legacy. I know my colleagues join me in saluting him on his well-deserved retirement.●

TRIBUTE TO HELEN CHAMBERS HUNT

● Mr. SESSIONS. Mr. President, I wish to remember the life of one of Alabama's finest First Ladies, Helen Chambers Hunt, the wife of former Gov. Guy Hunt. Miss Helen, as she was known, was a gracious and caring woman, who carried out her duties as First Lady with charm and compassion, and she will be greatly missed by all who knew and loved her.

I was honored to get to personally know this wonderful lady. Governor Hunt told me once of a lady who had seen Mrs. Hunt walk across the stage. The lady said to him, ''I can tell she is a fine lady and you must be a fine person too.'' It was true. Her very countenance and carriage projected an aura of faith, compassion and humility. The Governor was so very proud of her and so were the people of Alabama. In all her gifts and graces she represented the highest of Alabama values.

Miss Helen grew up in the Birdsong community in Cullman County. She met Guy Hunt, the future Governor of Alabama, during high school, when they started dating. They met at church and their first date was to a drive-in movie. They were married in 1950, when Helen was only 16 years old and Guy was 17. The Hunts were blessed with four wonderful children—Pam, Sherrie, Keith and Lynn.

Miss Helen enjoyed cooking and sewing and also spending time with her husband at their Holly Pond home. She stood with him through two terms as Cullman County Probate Judge as well as his tenure as Governor from 1987–1993. Although she did not seek the spotlight, as First Lady she embraced a campaign to reduce littering along Alabama highways that resulted in the creation of the highly successful Adopt-a-Mile Program. She also was a wonderful hostess at the Governor's Mansion, organizing numerous dinners,