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Final report on an assessment of private insurance coverage and medicare/medicaid reimbursement among American Indians eligible for health care provided by the Indian Health Service.

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FINAL REPORT OF AN ASSESSMENT OF PRIVATE INSURANCE COVERAGE AND MEDICARE/ MEDICAID REIMBURSEMENT AMONG INDIANS ELIGIBLE FOR HEALTH CARE PROVIDED BY THE INDIAN HEALTH SERVICE

Submitted to:

Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation

Prepared by:

Lanny J. Morrison
Suzanne Kitchen
J. Scott Goodman
Kerry Zimmerman

Macro Systems, Inc. August 1984
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- C. BASIS FOR FIRST-CUT PROJECTED MEDICARE AND MEDICAID COLLECTIONS
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</tbody>
</table>
L SUMMARY
SUMMARY

Over the past several years there has been considerable debate within the Administration as to the appropriate level of reimbursement which the Indian Health Service could be expected to generate from third-party payors.

In the Administration's Fiscal Year 1984 budget request, it was estimated that IHS would be able to collect a total of $70 million from third-party payors—$40 million and $30 million from Medicare/Medicaid and private insurance, respectively. In the Fiscal Year 1985 budget request, it was estimated that IHS could collect $59.4 million—$4 million from private insurance and $55.4 million from Medicare/Medicaid. IHS had collected $25 million in Medicare/Medicaid reimbursements in Fiscal Year 1983 and had experience in comprehensive billing of private insurance companies. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with Macro Systems, Inc., to forecast the reimbursements that IHS could reasonably expect to obtain over the next several fiscal years. The study was designed to:

- Provide estimates of potential IHS reimbursements from Medicaid, Medicare, and private health insurance
- Identify factors that may impact upon IHS third-party reimbursements

The following tables provide estimates of potential Medicaid and Medicare reimbursements for Fiscal Years 1984, 1985, 1986, and 1987; private insurance reimbursements for Fiscal Year 1984; and private insurance billings for Fiscal Years 1984, 1985, 1986, and 1987 for facilities directly operated by IHS.

<table>
<thead>
<tr>
<th>Total Medicare And Medicaid Reimbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 1984        - $29,180,935 - $30,484,778</td>
</tr>
<tr>
<td>FY 1985        - $36,801,305 - $38,605,139</td>
</tr>
<tr>
<td>FY 1986        - $47,392,257 - $51,408,991</td>
</tr>
<tr>
<td>FY 1987        - $64,059,159 - $72,513,320</td>
</tr>
</tbody>
</table>
### Estimated Reimbursements

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 1984</strong></td>
<td>$11,734,583 - $13,038,425</td>
<td>$17,446,352</td>
</tr>
<tr>
<td><strong>FY 1985</strong></td>
<td>$16,234,510 - $18,038,344</td>
<td>$20,566,795</td>
</tr>
<tr>
<td><strong>FY 1986</strong></td>
<td>$22,761,490 - $26,778,224</td>
<td>$24,630,767</td>
</tr>
<tr>
<td><strong>FY 1987</strong></td>
<td>$34,216,643 - $42,770,804</td>
<td>$29,842,516</td>
</tr>
</tbody>
</table>

### Estimated Private Insurance Billings

<table>
<thead>
<tr>
<th></th>
<th>50% Utilization</th>
<th>25% Utilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 1984</strong></td>
<td>$8,031,593</td>
<td>$4,016,476</td>
</tr>
<tr>
<td><strong>FY 1985</strong></td>
<td>$8,230,341</td>
<td>$4,116,236</td>
</tr>
<tr>
<td><strong>FY 1986</strong></td>
<td>$8,435,073</td>
<td>$4,218,372</td>
</tr>
<tr>
<td><strong>FY 1987</strong></td>
<td>$8,645,078</td>
<td>$4,323,480</td>
</tr>
</tbody>
</table>

### Estimated Private Insurance Reimbursements

<table>
<thead>
<tr>
<th></th>
<th>FY 1984</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FY 1984</strong></td>
<td>$75,000</td>
</tr>
</tbody>
</table>

In sum, these estimates show that the IHS can increase substantially the amounts of third-party reimbursement over the next several fiscal years, especially from Medicaid and Medicare. However, the rate of increase will be more gradual than previously estimated.

A detailed documentation of the study methodology is contained in Appendix A.

There are several factors, not all of which are directly quantifiable, that may potentially affect the IHS third-party billing and collection effort. Some of these factors are specific to the IHS organization itself, such as its organizational and operational structure, its unique status as a provider of health care, and its legal authority to seek reimbursement for services provided. Others involve the nature and availability of the third-party payment programs (Medicaid, Medicare, private health insurance) and the payment program-specific requirements and processes. All of these combine to create a constantly changing third-party payment environment, influencing billings and collections.
Five major factors that have contributed to the variation in IHS historical billing and collection performance and, presumptively, to the estimated levels of future billings and collections are presented below, and are discussed in detail in Chapters III-V. Some of these factors are under the direct control of IHS, but some are not.

**Factors Impacting Upon Third-Party Reimbursements**

- Inconsistent billing policies and procedures among IHS Areas and Service Units limit the potential for IHS third-party revenue billings and collections.
- Prompt billing and projected third-party reimbursement depend largely upon IHS' capability to automate its billing and collection functions.
- Area Office methods of distributing third-party revenues act as both an incentive or disincentive for third-party revenue generation.
- IHS third-party revenues tend to decrease in cases where there is increased availability and accessibility to private health care providers on the part of Indians who have third-party coverage.
- The degree of difficulty in third-party eligibility, identification, and enrollment tends to inhibit IHS recovery of third-party revenues.
- Present legislation prohibits IHS from recovering reimbursement for services provided in a number of its facilities.
- A variety of cost containment approaches at both the Federal and State levels tend to limit the potential for IHS recovery of third-party monies.
- There are inherent barriers in private health insurance policies that preclude IHS from recovering significant reimbursement.
II. PROJECTIONS FOR THIRD-PARTY REIMBURSEMENTS
II. PROJECTIONS FOR THIRD-PARTY REIMBURSEMENTS

This chapter presents our estimates of IHS Medicaid and Medicare reimbursements for Fiscal Years 1984, 1985, 1986, and 1987. It also presents our estimates for IHS private insurance billings for the same fiscal years and collections for Fiscal Year 1984.

Our approach in estimating Medicaid and Medicare reimbursement has been based upon IHS historical performance. Estimates were developed using a bottoms-up approach. Past performance at each of the IHS Service Units was examined and used to predict future reimbursement potential. In the short term, it was assumed that growth could continue at a steady rate because the IHS ability to accurately bill and collect would continue to improve and that all eligible Indians had not yet been identified and enrolled in the Medicaid and Medicare programs.

These estimates were then adjusted to reflect factors which might decrease IHS' reimbursement potential. For example, Alaska cut its Medicaid program by some 30 percent, and Mississippi has proposed a similar cut. Although the Federal government reimburses States 100 percent for their costs in reimbursing IHS facilities. State cost containment activities will effect the IHS in the same way any other qualified provider is effected. Other factors which decrease IHS reimbursement potential require changes in authorizing legislation or State policies. These may or may not be amenable to changes over the next several fiscal years.

We have estimated potential private insurance billings, but not collections, because of the widespread existence of clauses in insurance policies excluding reimbursement for services rendered in Federal facilities. The billings estimates are tantamount to a simulation, with clearly stated assumptions regarding the proportion of IHS service population having private health insurance, their expected use of IHS services, and their basis for being charged for services by IHS.
The IHS service population having private insurance is composed of two basic groups: Federally employed Indians and non-Federally employed Indians. This distinction is important as data on the private health insurance status of Federally employed Indians are available through the Federal government and these Indians represent a substantial proportion of the privately-insured Indian population as a whole. Non-Federally employed Indians appear less likely to carry private health insurance. The majority of non-Federally employed Indians having private health insurance are most likely employed by the tribal government. A detailed description of our methodology for Medicare, Medicaid and private insurance can be found in Appendix A.

1. THE ESTIMATED MEDICARE AND MEDICAID REIMBURSEMENTS FOR IHS

Estimated Medicare and Medicaid reimbursements to IHS are presented below.

<table>
<thead>
<tr>
<th>Total Medicare And Medicaid Reimbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 1984 - $29,180,935 - $30,484,778</td>
</tr>
<tr>
<td>FY 1985 - $36,801,305 - $38,605,139</td>
</tr>
<tr>
<td>FY 1986 - $47,392,257 - $51,408,991</td>
</tr>
<tr>
<td>FY 1987 - $64,059,159 - $72,813,320</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Estimated Reimbursements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
</tr>
<tr>
<td>FY 1984 $11,734,583 - $13,038,426</td>
</tr>
<tr>
<td>FY 1985 $18,234,510 - $18,038,344</td>
</tr>
<tr>
<td>FY 1986 $22,761,490 - $26,778,224</td>
</tr>
<tr>
<td>FY 1987 $34,216,643 - $42,770,804</td>
</tr>
</tbody>
</table>

Estimates for Medicare and Medicaid billings and collections were based upon historical performance using a "bottoms up" approach. Data were collected using the Service Unit as a base; however, the data obtained were not uniform across Service Units. Initial estimates were made using an average percentage change for each Service Unit, from year to year. We attempted to refine these initial estimates using more advanced analytical techniques, including linear trends and stepwise regression. We rejected these techniques because the large number of variables, the number of empty data cells, and the few years of data increased the error of the estimates substantially.
As a result, the average percentage change technique proved to be the most reliable, and subjective adjustments were made to these estimates to incorporate Area and program changes. For example, where a Service Unit had been eliminated, no projections were made. In addition, we attempted to take into account State Medicaid cost containment efforts by assuming a 10 percent reduction in projected amounts for Fiscal Years 1984 and 1985, 15 percent reduction for Fiscal Year 1986, and 20 percent reduction for Fiscal Year 1987. We also made a contingency for termination of the Arizona Health Care Cost Containment System, affecting the Navajo, Phoenix, and Tucson Service Units. Finally, we made no assumptions regarding the effects of DRGs or any other program changes on the Medicare estimates.

Exhibit II-1 shows the actual and projected growth in IHS Medicaid and Medicare reimbursements in graphic form. The estimated growth in Medicaid and Medicare reimbursements by Area are presented in Appendix B.

We project a larger growth rate in Medicaid reimbursements than in Medicare reimbursements. Currently, IHS efforts to identify, enroll and bill for services to Medicare eligible Indians have been more successful than comparable efforts regarding Medicaid eligible Indians. Additionally, the demographics and economic conditions of the IHS eligible Indian population indicate that the elderly population will grow at a slower rate than households with young children and high rates of unemployment.

It should be noted that we estimate that each Area will increase its collection from Medicaid and Medicare. An exception is the United Southeastern Tribes (USET) Program in terms of Medicaid, where we project a reduction due principally to two factors: the Choctaw facility has changed from an IHS direct operated facility to a facility "operated by the Tribe under contract" (a 638-contracted facility), and Mississippi has cut its Medicaid program substantially. Another exception to the projected increase can be found in the Portland Area, which has no Medicare hospital—a prerequisite for IHS participation in the Medicare program.
2. THE ESTIMATED PRIVATE INSURANCE BILLINGS AND COLLECTIONS

Based upon IHS experience to date, we estimate that IHS will collect approximately $75,000 in private insurance reimbursements in Fiscal Year 1984, mostly for the Navajo Area.

Exhibit II-2 shows the estimated billings for private health insurance by Area. This level of billings assumes that IHS would identify all Indian patients having private health insurance and that insurance companies would be billed in an efficient manner for services provided by IHS to these Indians. These figures include both Federally employed, privately-insured Indians having access to IHS facilities, and non-Federally employed privately-insured Indians. We show the estimated billings under two varying assumptions: (1) that privately-insured Indians receive one-half of their health care from IHS, or (2) that privately-insured Indians receive one-fourth of all their health care from IHS.

<table>
<thead>
<tr>
<th></th>
<th>Estimated Private Insurance Billings By IHS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50% Utilization</td>
</tr>
<tr>
<td>FY 1984</td>
<td>$8,031,593</td>
</tr>
<tr>
<td>FY 1985</td>
<td>$8,230,341</td>
</tr>
<tr>
<td>FY 1986</td>
<td>$8,435,073</td>
</tr>
<tr>
<td>FY 1987</td>
<td>$8,645,073</td>
</tr>
</tbody>
</table>

Two separate methods were employed for the private insurance billing and collection estimates. IHS private insurance collections for Fiscal Year 1984 were based on historical performance to date. These estimates are based primarily on the Navajo Area, which has a special insurance policy allowing reimbursement. Some additional reimbursement is expected from Alaska where the IHS is authorized to treat non-Indians and required to bill for those services.

Assuming that data available through IHS Data Processing Services Center (DPSC) were an underrepresentation of the actual number of privately-insured Indians, we opted for a simulation technique to estimate private insurance billings for Fiscal Years 1984-1987. Using personnel data supplied by the Federal government on the private health insurance coverage of Federally employed Indians having access to IHS facilities, we
**ESTIMATED IHS PRIVATE INSURANCE BILLINGS**

<table>
<thead>
<tr>
<th>Area</th>
<th>1984</th>
<th>1985</th>
<th>1986</th>
<th>1987</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Assuming 50 Percent Utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aberdeen</td>
<td>650,429</td>
<td>666,643</td>
<td>682,710</td>
<td>699,571</td>
</tr>
<tr>
<td>Alaska</td>
<td>602,477</td>
<td>616,541</td>
<td>631,293</td>
<td>645,693</td>
</tr>
<tr>
<td>Albuquerque</td>
<td>364,202</td>
<td>372,403</td>
<td>380,646</td>
<td>388,973</td>
</tr>
<tr>
<td>Bemidji</td>
<td>82,195</td>
<td>84,323</td>
<td>86,493</td>
<td>88,704</td>
</tr>
<tr>
<td>Billings</td>
<td>125,920</td>
<td>129,574</td>
<td>133,270</td>
<td>137,322</td>
</tr>
<tr>
<td>Navajo</td>
<td>1,120,022</td>
<td>1,148,291</td>
<td>1,177,395</td>
<td>1,206,624</td>
</tr>
<tr>
<td>Oklahoma City</td>
<td>795,968</td>
<td>812,141</td>
<td>829,066</td>
<td>846,240</td>
</tr>
<tr>
<td>Phoenix</td>
<td>907,222</td>
<td>926,451</td>
<td>946,474</td>
<td>966,579</td>
</tr>
<tr>
<td>Portland</td>
<td>202,966</td>
<td>207,293</td>
<td>211,744</td>
<td>216,362</td>
</tr>
<tr>
<td>Tucson</td>
<td>102,611</td>
<td>104,678</td>
<td>106,787</td>
<td>109,210</td>
</tr>
<tr>
<td>USET</td>
<td>141,050</td>
<td>143,094</td>
<td>145,181</td>
<td>147,226</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,095,062</td>
<td>5,211,432</td>
<td>5,331,059</td>
<td>5,452,504</td>
</tr>
<tr>
<td></td>
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<td></td>
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</tr>
<tr>
<td>2. Assuming 25 Percent Utilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aberdeen</td>
<td>325,194</td>
<td>333,206</td>
<td>341,491</td>
<td>349,901</td>
</tr>
<tr>
<td>Alaska</td>
<td>301,238</td>
<td>308,406</td>
<td>316,326</td>
<td>322,826</td>
</tr>
<tr>
<td>Albuquerque</td>
<td>182,122</td>
<td>186,086</td>
<td>190,323</td>
<td>194,371</td>
</tr>
<tr>
<td>Bemidji</td>
<td>41,098</td>
<td>42,182</td>
<td>43,226</td>
<td>44,352</td>
</tr>
<tr>
<td>Billings</td>
<td>62,960</td>
<td>64,672</td>
<td>66,656</td>
<td>68,640</td>
</tr>
<tr>
<td>Navajo</td>
<td>559,990</td>
<td>574,166</td>
<td>588,698</td>
<td>603,312</td>
</tr>
<tr>
<td>Oklahoma City</td>
<td>397,984</td>
<td>406,186</td>
<td>414,554</td>
<td>423,235</td>
</tr>
<tr>
<td>Phoenix</td>
<td>453,477</td>
<td>463,226</td>
<td>473,373</td>
<td>483,290</td>
</tr>
<tr>
<td>Portland</td>
<td>101,462</td>
<td>103,626</td>
<td>105,872</td>
<td>108,160</td>
</tr>
<tr>
<td>Tucson</td>
<td>51,306</td>
<td>52,224</td>
<td>53,414</td>
<td>54,605</td>
</tr>
<tr>
<td>USET</td>
<td>70,525</td>
<td>71,568</td>
<td>72,570</td>
<td>73,613</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,547,626</td>
<td>2,605,548</td>
<td>2,666,503</td>
<td>2,726,305</td>
</tr>
</tbody>
</table>
were able to estimate the total number of Indians (Federal and non-Federal employees and dependents) with private health insurance. These data were then adjusted upward to account for tribal employment. Assumptions were made regarding IHS service utilization and these utilization figures were then multiplied by current IHS reimbursement amounts for inpatient/outpatient services. The resulting figures represent estimated IHS private insurance billings.

* * * * *

Although the estimated reimbursements from third-party payors show substantial increases, they are significantly lower than previous estimates used in the budgets for IHS. The estimates of third-party reimbursements for the years 1984-1987 rely heavily upon IHS historical performance. It should be noted that these estimates can and will vary because of the onset of rapid and tumultuous change in methods of calculating reimbursements, as well as budget pressures that result in reduction of State Medicaid programs. The next chapter describes the major factors that impact upon IHS third-party reimbursements.
III. FACTORS IMPACTING UPON MEDICARE, MEDICAID, AND PRIVATE INSURANCE REIMBURSEMENTS
III. FACTORS IMPACTING UPON MEDICARE, MEDICAID, AND PRIVATE INSURANCE REIMBURSEMENTS

There are four elements basic to the generation of third-party reimbursements. First, the individual or facility providing services must attain status as a qualified provider of services under a given third-party payment program. Second, there are eligibility factors. Patient eligibility under the criteria of the program must be determined. If the recipient is deemed eligible under the program criteria, he or she must then be enrolled in that program. The third set of factors relate to reimbursement, such as rates or methods of reimbursement. Fourth, there are IHS policies and procedures which effect reimbursement potential.

Within these elements we have identified five specific factors that have contributed to variations in IHS Medicare, Medicaid, and private insurance billing and collection performance to date:

1. Billing Policy and Procedural Inconsistencies
2. Varying Levels of Automation
3. Third-Party Billing Incentives and Disincentives
4. Provider Availability and Accessibility
5. Identification and Enrollment of Third-Party Program Eligibles

Other factors specific to either the Medicare and Medicaid programs or private health insurance are discussed in Chapters IV and V, respectively.

1. BILLING POLICY AND PROCEDURAL INCONSISTENCIES

Inconsistent billing policies and procedures, among IHS Areas and Service Units, limit the potential for IHS third-party revenue billings and collections.
The direct care health delivery system of IHS is largely decentralized. However, at the Area level, the degree of centralization in billing and collection functions varies. Different Area Offices prefer varying levels of centralization for the enhancement of their recovery of third-party funds. For example, the Oklahoma Area Office maintains centralized billing and collection processes to assure quality control and verify enrollment and covered services. Conversely, the Portland Area Office prefers decentralized billing because it believes that decentralization results in:

- More timely billings
- More accurate and timely information provided by the Service Units
- More realistic expenditure planning by the Service Units - based on a knowledge of current reimbursements
- A decrease in the number of bills rejected by third-party programs

Although it is not conclusive that Area centralized billing and collection processes are more effective than decentralized processes, the centralized system is more conducive to the implementation of an automated medical management and cost accounting information system. An automated system would increase both the accuracy and timeliness of bill generation. The feasibility of such a system is currently being examined.

In addition, the Area Offices play a varied role in billing and collection processes. Some Area Offices delay billing third-party programs until the third or fourth quarter of a given fiscal year. In this way, reimbursements are low in the beginning of the fiscal year and increase at the end of the year. This may also result in a large carryover balance at the end of the fiscal year.

Area Office staff also make the determination as to whether billing certain payors is economically viable. For example, the Oklahoma Area Office had originally billed the Kansas State Department of Social and Rehabilitation Services (Kansas's Medical Assistance Program) for covered services provided to enrolled Indians at the IHS Holton, Kansas facility. After one year of billing, the revenues were deemed insufficient to cover the administrative costs of billing the State, and billing ceased. In another instance, the Billings Area Office determined that in the absence of coverage for health
center outpatient care in the Wyoming State Medicaid plan, there is an insufficient number of Medicaid eligible Indians in the State to warrant negotiations with the Wyoming State Medicaid program for inpatient care coverage only.

There are also instances where the Area Offices provide no overall monitoring of Service Unit billings. This results in inconsistent billings and potential loss of revenue.

Billing and enrollment variations also arise from differences in organization and use of personnel or training. A number of IHS facilities are plagued with high levels of physician turnover. Bills for services provided to Indian beneficiaries will not be reimbursed if a facility does not have a doctor. Although temporary physicians may be employed to alleviate gaps in the provision of health care, temporary physicians often do not have the time to complete billing paperwork and bills are not generated. As a result, many services provided by IHS physicians are not reimbursed. In several of the larger Albuquerque Area facilities (not including the Albuquerque Indian Hospital), the billing clerks are under the direct supervision of nursing personnel, and are acting as ward clerks. Consequently, patient care takes priority over billing. Billing third-party payors in these instances is either not done at all or is done sporadically as time permits. In the Navajo Area, at the Gallup Hospital which has approximately a 650-visit outpatient volume per day, billing clerks are inundated with the identification and registration of all IHS eligibles. As a result, the clerks focus on identifying those individuals using specific revenue-producing clinics, such as obstetrics and medicine, in order to maximize the reimbursement per claim. Thus, potential revenues from other clinics may be lost. There are also some instances of clerks not knowing how to bill. This results in little or no billings, and little or no reimbursement for covered services.

2. VARYING LEVELS OF AUTOMATION

Prompt billing and projected third-party reimbursement depend largely upon IHS's capability to automate its billing and collection functions.

The degree of automation of the processes for billing and collection vary among IHS Areas. Some Areas, such as Oklahoma City, are entirely automated. This allows increased efficiency, accuracy, and the capability of timely bill (and report) generation.
However, this automation is Area-specific, designed only to meet the needs of that Area. In contrast, those Areas employing manual bill processing, such as Albuquerque, have a greater probability of error and involve significantly more time to generate bills.

In a recent ASPE study conducted by Macro Systems, which examined the feasibility of IHS contracting with a fiscal agent to process its contract health care (the contract health service program is designed to supplement IHS direct care) claims, automation of IHS systems was determined to be a chief factor in increasing third-party resources. It was also concluded that, although IHS needs to address further the issues surrounding its in-house processing of contract care claims, there was no substantial benefit identified in employing a fiscal agent.

Currently, an ASPE study is underway to determine the requirements and specifications of an automated IHS medical management and cost accounting information system. Such an integrated information system is critical to improving IHS management and reimbursement capabilities. While the impact of such a system on our findings cannot be specifically determined, our projections of continued increases in reimbursement from third-party payors assume such improvement will be made in the near future.

3. THIRD-PARTY BILLING INCENTIVES AND DISINCENTIVES

The manner in which Area Offices allocate third-party reimbursements to the Service Units can affect future reimbursements by acting as an incentive or a disincentive. There are primarily two distribution methods in use currently—needs allocation and source allocation. All Area Offices require the Service Units in the Area to submit a fiscal year plan for the use of third-party funds. The items listed on the plan are usually actions planned to meet Joint Commission on Accreditation of Hospitals (JCAH) or Medicare certification deficiencies. Area Office personnel evaluate these plans and then allocate the monies where needed. Some Service Units view this as a positive action, because facilities whose deficiencies have been corrected may then bill, and increase the overall level of reimbursement. Other Service Units view this as a
revenue loss to their particular Service Unit that would be better used to enhance services offered Indian patients in that Service Unit.

In contrast, there are Areas, such as Portland and Navajo, that channel revenues back proportionately to the Service Units that generate the funds. This provides a powerful incentive to identify eligibles more aggressively and to bill both more regularly and in a more consistent manner. The findings of the Grace Commission also identified an increase in time spent on third-party collections by IHS personnel when extra monies are utilized on new equipment and additional personnel. This distribution method also promotes self-identification by enrolled Indians because the patient can see the benefits of monies returned to the Service Unit in a tangible manner, such as new or improved services. In Areas where there is no specific relationship between revenues generated by a Service Unit and the amounts returned to that Service Unit, there may be no visible or positive incentives at play. Generating revenue that does not return to one's own Service Unit may not be viewed as a particularly valuable endeavor.

4. PROVIDER AVAILABILITY AND ACCESSIBILITY

IHS third-party revenues tend to decrease in cases where there is increased availability and accessibility to private health care providers on the part of Indians who have third-party coverage.

The availability of qualified providers (both IHS and non-IHS) also affects the dollar volume of reimbursements to IHS. In many locations, the Indian Health Service is the sole provider of care. This is especially true in the case of reservations and in the State of Alaska. Often, non-IHS facilities, if available, are located off the reservation and require travel over a substantial distance. If non-IHS providers exist, they are often-times reluctant to accept Indian patients, especially the assignment for Indian Medicare or Medicaid patients. Because these providers are generally not dependent on the business of their Indian patients, they do not feel compelled to accept assignment or lower than standard fee charges. For example, in the State of Oklahoma, physician specialists refuse to accept Medicare assignment, forcing Indian Medicare beneficiaries to use IHS facilities for their speciality care. Non-IHS physicians in the area have also begun to charge their Medicare patients (Indian and non-Indian) a fee for filling out the required forms. The result has been a shifting of Indian Medicare patients away from the
private physicians to IHS. Consequently, we anticipate an increase in IHS Medicare reimbursements in this Area. It should be noted that physicians willing to accept assignment of benefits for both Medicare and Medicaid has declined nationally, over time.

In Areas where non-IHS physicians are accessible to the Indian patient, two results are seen. First, individuals having a third-party payor source often opt to seek services outside of the Indian Health Service, because the quality of care is perceived to be better. There is a pervasive feeling that services that are "paid for" in some sense are better than free services. However, the use of a non-IHS provider is not always a matter of choice. For example, in Sisseton, South Dakota, the IHS hospital has been under reconstruction. Consequently, the majority of patients have been referred to the nearby community hospital, placing a strain on the IHS contract care budget and significantly decreasing third-party reimbursement.

Second, there are isolated cases of individuals preferring IHS services to those offered by rural primary care providers. This preference is due to IHS offering at least four basic specialty services in these areas, including pediatrics and obstetrics. For example, individuals with a third-party payor relationship choose to drive 90 miles to an IHS facility in an area of Oklahoma that has a number of non-IHS providers. However, individuals generally, if given the choice, choose non-IHS providers.

5. IDENTIFICATION AND ENROLLMENT OF THIRD-PARTY PROGRAM ELIGIBLES

| Difficulty in third-party eligibility, identification, and enrollment tends to inhibit IHS recovery of third-party revenues. |

(1) General Identification Problems

In general, the identification of individuals eligible for third-party payment programs in a given population is extremely difficult. Identification of patients with alternate resources underlies the entire ability to bill. Program eligibility criteria change periodically, and Medicaid and private insurance eligibility status are on a month-to-month basis. In those Areas with relatively closed communities
Identification is easier because the Service Unit staff consists of individuals from the local populace. However, there are areas and times where the Indian population is highly mobile and identification is difficult. For example, Oklahoma and Phoenix have transient populations hindering identification efforts. It should be noted that individual Indians have no legal obligation to provide the IHS with information on their third-party resources in order to receive services in a direct care facility. The IHS must depend on the voluntary cooperation of the Indian people.

(2) **Impact of Patient Volume**

The probability of identifying all eligibles varies inversely with patient volume; in effect, the number of visits made to a facility in a specific period of time. The greater the volume of patients in a facility, the less likely all enrollees can be identified by the billing clerks. Therefore, clerks concentrate on identifying patients who visit specific revenue-producing clinics to maximize the reimbursement per bill. In high volume Oklahoma facilities, clerks concentrate on identifying outpatients, and in the evenings, the hospital nursing staff supplement the process by identifying inpatient third-party enrollees.

(3) **Registration System Side Effects**

In recent months, the Indian Health Service has begun implementation of an IHS-wide patient registration system. As a response to an inadequate records management system, the registration system is designed to identify the IHS user population and their alternate resources, if any. While providing much needed information to maximize third-party reimbursements, the process has resulted in waiting area congestion, increased waiting times, and patient unresponsiveness in providing information. This is primarily found in large, high patient volume facilities, and undermines efforts to identify third-party resources. As implementation of the system progresses, the negative effects should be minimized and reimbursements increased.
(4) Third-Party Program Identification And Enrollment Activities

Several specific groups and activities aid in the identification and enrollment of eligible Indians. First, although at reduced levels, the Community Health Representatives (CHRs) are still active in a number of Areas and provide assistance in identification and enrollment, in addition to providing transportation to patients. Although the Administration's Fiscal Year 1985 Budget Amendments have proposed elimination of this service, congressional action is still pending. Second, a more active role is played by the Area Office Social Service personnel, whose functions include outreach enrollment in the community and determination of program eligibility. Third, in many facilities, the charts of patients having a third-party relationship are flagged to alert the billing staff. At the time of the site visits, an Ambulatory Patient Care Report (APC) with an alert in the form of a green stripe was being implemented in several IHS Areas. Currently, this is being instituted IHS-wide. Thus, more records are identified, more services are billed, and reimbursements increase. A fourth aid in the identification of enrollees are the information-sharing capabilities between facilities (or Area Offices) and payors. This increases the number and accuracy of patient identifications and decreases the number of bills denied by payors because of changes in eligibility.

(5) Identification And Enrollment Difficulties Specific To Medicare

Many think of the Medicare program as solely an age-related benefit program. However, as Appendix F shows, individuals with sufficient quarters of coverage, disabled persons under the age of 65, or individuals of any age with End-Stage Renal Disease (ESRD) may be enrolled. The staffs at a number of IHS facilities question people who appear to be over the age of 45 regarding their Medicare enrollment status. Often, patients are enrolled in the program and do not know it. In some Oklahoma Area Service Units, letters are sent to individuals over the age of 65 suggesting they make application for Medicare and then seek enrollment. Although these age-oriented approaches may be somewhat effective, they do limit identification of possible enrollees or eligibles by concentrating all identification efforts on the aged.
The Medicare program assists IHS Area Offices and facilities in the identification process prior to the submission of bills. Some Area Office and Service Unit personnel make use of this assistance; others continue to submit bills for ineligible patients only to have them rejected.

(6) Identification And Enrollment Difficulties Specific To Medicaid

There are a number of factors regarding Medicaid eligibility that affect IHS's ability to generate Medicaid revenue:

- The eligibility requirements for each State Medicaid program are determined by and unique to the State (see Appendix G).

- There is a belief that many Indians eligible for Medicaid are not enrolled because of the perceived stigma or for other reasons; currently, there are no data by which to estimate the number of Indians for whom this would be true.

- Some States appear to have created specific barriers to Indian participation in Medicaid. For example, IHS field staff reported that in Montana and Oklahoma, the State Medicaid Agencies, as a matter of policy, are including the individual Indian applicant's proportionate share of trust lands as a resource in eligibility determinations. This policy is contrary to Federal law and virtually assures that Indians are denied eligibility because their resources are above allowable State standards. Currently, there is active litigation on this issue involving BIA and North and South Dakota.

- Under Section 1915(a) of the Social Security Act, States may "lock-in" or require Medicaid recipients who continually overuse care and services to use the services of designated providers (as in Oregon), or "lock-out" providers who significantly abuse the program. The Arizona Health Care Cost Containment System (AHCCCS) is a general "lock-in" program based upon the recipient's county of residence. Under this program, county welfare offices determine eligibility. Because Indian residents are not tax liable, many welfare agencies have turned away Indians making application to the program. Enrolled Indians living off the reservation wishing medical services must go to a designated provider (the result of provider bidding) and have prepaid a monthly fee. In this case, they cannot use IHS facilities for their care, if they wish to be reimbursed under AHCCCS. On-reservation Indians may use either the IHS facilities or the county AHCCCS provider. Should they choose the county provider, the capitation is waived and care is provided on a fee-for-service basis. There is concern over the loss of freedom of choice, quality of care, turning away of eligibles, and the "dumping" of individuals into AHCCCS's beds.
Most rejected Medicaid bills submitted by IHS have been due to changes in Medicaid eligibility (which is month-to-month), or because of incorrect determination of eligibility status. A number of States, including those where IHS acts as its own fiscal intermediary, provide the Area Office and/or Service Unit with an updated list of Medicaid enrollees or access to such a list. These States are not legally required to provide this information, but often act in terms of a reciprocal agreement, with IHS providing enrollment tapes as well. For example, the Arizona Health Care Cost Containment System provides a computer-generated listing of Indian Medicaid eligibles to the Navajo Area Office. This saves time, decreases rejected billings, and may help in the initial identification of patients. This is especially important because patients in some locations prefer not to identify themselves as being on the Medicaid roles.

Although IHS could deal with 20 State Medicaid programs, it currently negotiates with only 18. There are two fundamental reasons for this. First, with respect to Kansas and Wyoming, IHS determined that the administrative costs involved in billing outweighed the potential revenues because of small target populations. With respect to Colorado and Iowa, IHS is currently negotiating with the States for participation.

Most State programs are currently incorporating cost containment measures into their Medicaid programs. These measures vary from general eligibility roll cuts (as threatened a year ago in North and South Dakota) and program cuts (a 30 percent cut in Alaska in 1983), to more stringent income qualifications. For example, individuals on North Dakota General Assistance may be ineligible for Medicaid. General Assistance is discontinued if IHS pays recipient liability (i.e., deductibles, co-insurance, copayments, etc.) as this is deemed income.

Minnesota requires that specific eligibility determination be made for a newborn, after birth. Many mothers are unaware of this requirement and assume that the child is automatically covered by Medicaid. As a result, the child is not enrolled and IHS loses reimbursement for postnatal care.
IV. FACTORS IMPACTING PRIMARILY UPON MEDICARE AND MEDICAID REIMBURSEMENTS
IV. FACTORS IMPACTING PRIMARILY UPON MEDICARE AND MEDICAID REIMBURSEMENTS

There are two factors that impact solely upon Medicare and Medicaid reimbursements. The first of these involves the program requirements for facilities and individual providers. Although the general requirements of both the Medicare and Medicaid programs are similar, there are requirements that are specific to each program. The second factor surrounds reimbursement issues—more specifically, cost containment efforts at the Federal and State levels. The ultimate goal of all such efforts is the same, the means used in curtailing costs vary.

1. FACILITY AND PROVIDER REQUIREMENTS

Present legislation prohibits IHS from recovering reimbursement for services provided in a number of its facilities.

(1) Medicare Facility Requirements

Section 1880(a) of the Social Security Act allows reimbursement to IHS for services provided to enrollees in a hospital or skilled nursing facility. All hospitals must meet the standards and criteria set forth by the Joint Commission on Accreditation of Hospitals (JCAH) or the Health Care Financing Administration (HCFA). Currently, 33 of the 47 hospitals operated by IHS and all 5 hospitals operated by Tribes are JCAH-accredited. The remaining 9 IHS hospitals are certified by HCFA for Medicare participation, as are some freestanding clinics. The freestanding clinics of the Indian Health Service receive their designation by maintaining a tie-in with an accredited or certified facility. An example of this arrangement is the tie-in of a Southern Colorado health center with the Santa Fe Hospital. Under current law, IHS may receive Medicare reimbursement only for its hospitals and skilled nursing facilities. Therefore, most health centers and other facilities of IHS are not able to meet Medicare facility requirements. For example, the Portland Area cannot legally receive Medicare reimbursement because there is no IHS hospital in the Area.
(2) **Medicaid Facility Requirements**

As with Medicare, an IHS facility seeking reimbursement must be approved as a hospital by an officially designated State standard-setting authority. It must meet the requirements for participation in the Medicare program. IHS may theoretically seek reimbursement from a Medicaid program for freestanding clinics under Section 1905(a)(9) of the Social Security Act (see also Action Transmittal, HCFA-AT-81-3 (BPP)), but this is idiosyncratic to each State. Reimbursement for these facilities occurs on an ad hoc basis and has not been routinely pursued. IHS, however, has recently received approval from the State of Alaska to bill for three major clinics in the Mt. Edgecumbe Service Unit. In contrast, Aberdeen has several large freestanding clinics, but the State of South Dakota does not permit billing by IHS for these facilities.

(3) **Medicaid Physician Requirements**

Each State varies as to its requirements regarding physician licensure. Section 1905(a)(5) of the Social Security Act states that a physician's services "must be provided by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy." The issues involved are twofold and may best be illustrated by examples. In Oklahoma, the State requires physicians seeking reimbursement to be licensed by the State of Oklahoma. Therefore, for these IHS physicians without Oklahoma licenses, IHS receives no reimbursement.

The second issue involves those physicians actually licensed in a State, in this case Oklahoma. Although IHS may bill for the services of these individuals, reimbursement is made by the State directly to the physician. The IHS physicians have chosen not to seek reimbursement because any reimbursement would be reported to the Internal Revenue Service as income to the physician, creating tax concerns for the physician. Although this could be resolved through relatively simple accounting procedures, physicians are still reluctant to bill. States also control the services for which they will allow physicians to bill. For example, South Dakota only allows IHS to bill for outpatient physician services, not inpatient physician services. In contrast, IHS may bill other States for inpatient physician services.
2. REIMBURSEMENT ISSUES

A variety of cost containment approaches at the Federal and State levels tend to limit the potential for IHS recovery of third-party revenues. This is further enhanced by problems with IHS adjustment to cost containment methods.

(1) Medicare Prospective Payment

As of October 1, 1983, accredited or certified Medicare providers were to begin receiving reimbursement for inpatient services under the Prospective Payment System (PPS). Under this approach, hospital payment is related to the treatment provided to each patient, not to the cost incurred by the hospital. Therefore, the hospitals will have an incentive to provide care more efficiently and inexpensively.

Currently, the prospective payment rates are based on a national representative Medicare cost per discharge for each Medicare patient Diagnosis Related Group (DRG), adjusted for different wage rates throughout the country and for each facility. As an example of the uniqueness of IHS health delivery operations, IHS has two wage indices—one for Alaska and one for the lower 48 States. In addition, the State of Alaska has a cost-of-living adjustment that impacts upon reimbursement. Therefore, an understanding of PPS must take into account the idiosyncrasies of IHS operations and third-party recovery potential.

In the past, IHS Medicare billings and collections were based upon a flat per diem rate for inpatient services, a flat rate for physician services, and a per visit outpatient rate, as provided yearly in the Federal Register. Now, however, amounts collected have no relationship to amounts billed, because IHS facilities have neither the case mix (grouper) or pricer programming, nor the equipment necessary to bill accurately by DRGs. This also makes it difficult to forecast reimbursements with precision.

It is the opinion of New Mexico Blue Cross/Blue Shield (the IHS Medicare fiscal intermediary) that IHS will not be a cost-outlier (an atypical hospital case that has an extremely high cost relative to most cases in the same diagnosis-related group) due to its all-inclusive rates; rather, they anticipate that IHS may be a day-outlier.
(an atypical hospital case that has an extremely long or short length of stay relative to most cases in the same diagnosis-related group). If this proves out, reimbursements may be lower per diagnosis due to the uniqueness of the IHS delivery system. For example, the Gallup Indian Hospital retains total hip replacement and cataract patients for a longer time period than other health delivery systems because of the poor living conditions of the Navajo. These are the stated explanations by IHS staff for the discrepancy of billings exceeding collections. Similarly, the Oklahoma Area Office has thus far concluded that for shorter stays (under five to six days), the collections exceed billings; for those stays over five to six days, billings were greater than collections. If this tendency continues, the provision of care may alter, as IHS attempts to pattern its health delivery to that of the private sector providers.

Inherent to PPS is an emphasis on principal diagnosis: that diagnosis resulting in the hospital admission. There have been reports of disagreements between billing personnel and physicians as to what the principal diagnosis should be. There are two primary reasons for this. The first relates to differences in definition between primary and principal diagnosis. The second is a realization by either the clerk or the physician that certain diagnoses result in higher levels of reimbursement. In addition, the focus of Professional Standards Review Organization (PSRO) reviews has shifted from the length of stay and necessity of admission to DRG assignment, which is the determinant for reimbursement.

(2) The Role Of PSROs

With respect to Medicare and Medicaid, PSROs monitor inpatient admissions and reasons for continued length of stay. In some States, such as in Minnesota, they also give prior approval for inpatient admissions, including emergency admissions. The approval calls for Medicaid paying for the inpatient stay. There are an increasing number of reports from IHS field staff regarding denials of Medicaid admissions and questioning of the necessity for Medicare admissions, DRG classification, and length of stay. Many of these may be the result of cost containment approaches, resulting in greater stringency of review.
(3) Limits On Medicaid Reimbursements

As part of Medicaid cost containment efforts, many States have established reimbursement ceilings on certain services. For example, South Dakota allows a maximum reimbursement of $5,000 per year for renal dialysis. IHS estimates, however, that renal dialysis alone costs IHS $1,000 per month to provide to an end-stage renal disease patient in the Aberdeen Area.

(4) State-Specific Medicaid Nuances

Each State Medicaid Agency may establish a variety of unique requirements in defining its Medicaid program. Some requirements specifically influence the amount or use of Medicaid reimbursement IHS may receive. Illustrations of these requirements are indicated below:

- In Minnesota, if durable medical equipment (DME) is to be reimbursed by Medicaid, it must be purchased from local suppliers on a patient-specific basis. Because IHS typically makes bulk DME purchases (not specific to any given patient), these supplies provided by IHS are generally not reimbursable.

- Nebraska requires that Medicaid reimbursements made by the State remain in the State; this constrains Oklahoma Area Office distribution plans.
V. FACTORS IMPACTING PRIMARILY UPON PRIVATE INSURANCE REIMBURSEMENT
V. FACTORS IMPACTING PRIMARILY UPON PRIVATE INSURANCE REIMBURSEMENT

On October 1, 1983, the Indian Health Service began collecting information to bill private insurance companies for services provided to covered Indians. Previously, private insurance reimbursements were only received in the Navajo and Alaska Areas. The Navajo Tribe had negotiated special, low premium rates for its employees. The Alaska Area IHS hospitals are literally the sole community providers and, therefore, serve several non-Indians, a number of whom have private health insurance coverage - IHS has routinely submitted bills to the insurance companies for these individuals and has received reimbursement.

The current process involves the identification of Indians enrolled in private insurance plans, the provision of services to these individuals in an IHS facility, the submission of billing information to the IHS Data Processing Services Center (DPSC) in Albuquerque, and the formulation of a universal billing form (UB-82) at DPSC. These bills are then returned to the facility for patient signatures and the name and address of the private insurance carrier to be entered on the bill.

However, there are several concerns surrounding the billing of private insurers by IHS: exclusionary clauses, lack of itemized bills, perceived lack of authority to submit clinical information, and tribal concerns. Currently, there are also several factors under IHS control that directly influence private insurance billings. Each of these factors is discussed below.

There are significant barriers contained in private health insurance policies and practices that preclude IHS from recovering significant reimbursement.

1. EXCLUSIONARY CLAUSES

Most insurance policies prohibit (exclusionary clauses) payment for services rendered in a Federal facility because the policy owner is not charged for the service (has no liability). This is true of Tribal insurance policies reviewed, as well as of the policies
available to Federal employees. These exclusionary clauses would have to be overcome to collect significant revenues.

The exclusionary clauses contained in the private health insurance policy of the Leech Lake Band of the Minnesota Chippewa and the Federal Employee Health Benefit Plan of Aetna Life Insurance Company typify both the language and content of policies that IHS would have to overcome to collect any reimbursement. Respectively, these plans state:

"no benefits are payable under this plan for expenses incurred:...
...2. for service or supplies furnished by a hospital owned or operated by the United States Government or an agency thereof; ..." 1 /

"The following charges are not covered...Charges for services and supplies—paid for under a plan provided by law or paid for directly or indirectly by a government except (1) under a plan specifically established for a government for its own civilian employees and their dependents, and (2) the benefits provided under Medicare." 2 /

2. LACK OF ITEMIZED BILLS

IHS would have to develop itemized bills or attain acceptance of a per diem rate by the insurance companies. Currently, IHS bills all third-party payors by using a flat rate (per diem for inpatient, per visit for outpatient). However, this is not consistent with private health insurance standards. There are examples in the Bemidji Program Area of reimbursements being denied because IHS charges were not itemized.

3. LACK OF AUTHORITY TO SEND CLINICAL INFORMATION

Some Area Office personnel are concerned that they do not have the authority to send appropriate and necessary clinical information to the private health insurance companies. If such information is not forthcoming, the insurers will deny claims.

1/ Leech Lake Reservation Business Committee - Employee Benefit Plan, p. 20.
4. TRIBAL CONCERNS

The Tribes have additional concerns. Tribes, such as the Greater Leech Lake Band of the Minnesota Chippewa, stated that they would drop their private health insurance coverage if IHS billing were to result in increased premiums and increased administrative costs. Many Tribes have negotiated lower premiums with carriers, based on the understanding that IHS would be the primary provider of care for which the insurance company would not be liable. For others, the billing could result in stricter eligibility guidelines for both the Tribe and the carrier, such as health status. For example, the Pima Tribe of the Gila River Indian Reservation has one of the highest incidences of diabetes in the world. The Tribe is concerned that it would have to impose more stringent health status qualifications on Tribal employees if insurance costs were increased. There is also concern that IHS might have to shift privately-insured Pima out of IHS beds to make room for uninsured Tribal members.

The necessity to purchase a private health insurance policy may be an issue depending upon access to IHS services. In the Oklahoma Area, for instance, it was pointed out that many of the elderly in the Ada area dropped their private insurance coverage when the IHS hospital was built. There is a perception that if IHS provides services, there is no need for private health insurance, and there appears to be little desire to furnish the cash outlay. Often those most interested in obtaining private health insurance are non-Indian spouses. This occurs because they are denied care in IHS facilities. For example, the Sisseton-Wahpeton Sioux Tribe in South Dakota surveyed tribal employees, both Indian and non-Indian. It was only the non-Indians, most of whom were spouses, who desired a private health insurance policy. As a result, the Tribe did not take out a policy.

5. FACTORS UNDER IHS CONTROL

Varied reactions have occurred among IHS field staff since the IHS private insurance initiative began. In Oklahoma, IHS facility staff have taken a long range perspective and are encouraging people to take out coverage so the Service Units generate more revenue. Conversely, some of the staff at the Gallup Indian Hospital are warning people against providing any information on their alternate
resources, particularly private health insurance. The Indians in this region, largely the Navajo, view the process as a step toward termination or service reduction at best. This may be attributed in part to a Public Health Service facility being closed in the region and the removal of National Health Service Corps personnel.

Currently, there are several factors that are directly influencing private insurance billings; these include differences in billing approach, lack of motivation, difficulty in obtaining patient signatures, and concern over who will receive the receipt.

Area Offices differ in their approach to billing. Oklahoma plans to submit every universal billing form (UB-82) generated by DPSC. Conversely, Bemidji is billing selectively, attempting to obtain a representative sample of insurance industry responses.

There is a lowered motivation toward billing private insurers because of the necessity of creating a suspense fund. The fund was created because private insurers may exercise the exclusionary clauses and seek recovery. Consequently, billing clerks are less motivated to bill private insurers, and this is exacerbated by inconsistent billing instructions emanating from Areas and Headquarters.

A number of bills may not be submitted after processing at DPSC. This may occur because the patients are usually gone when the bills are returned to the facilities, so required signatures are difficult to obtain.

Facility staff, tribal representatives, and patients have expressed the need for assurances that once these monies are received, they will be used to supplement, not supplant, appropriations. If reimbursements are used to supplant appropriations, no benefit to identifying one's resource status would appear to exist.