CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 1, 2000

S. 406
Alaska Native and American Indian Direct Reimbursement Act of 1999

As ordered reported by the House Committee on Resources on April 5, 2000

SUMMARY

S. 406 would extend indefinitely an Indian Health Service (IHS) demonstration project that allows four tribally operated IHS facilities to bill the Medicare and Medicaid programs directly, rather than submitting their claims through the IHS. The act also would allow all other tribally operated IHS facilities to bill Medicare and Medicaid directly. CBO estimates that S. 406 would raise federal outlays by $8 million to $9 million in each of fiscal years 2001 through 2005. (Federal Medicare outlays would be higher by about $2 million a year, and federal Medicaid outlays would be higher by about $6 million a year.) Because the act would affect direct spending, pay-as-you-go procedures would apply.

S. 406 contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). Participation in the direct billing program would improve the cash-flow of health facilities operated by tribal governments and increase their total Medicaid funding.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 406 is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

	Outlays, by Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
CHANGES IN DIRECT SPENDING						
Medicare	0	3	2	2	2	2
Medicaid	0	6	6	5	5	6
Total	0	9	8	8	8	8

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

BASIS OF ESTIMATE

Under current law, four tribally operated Indian Health Service demonstration sites are authorized to bill the Medicare and Medicaid programs directly rather than submitting their claims through the IHS. The demonstration authority expires on September 30, 2000. S. 406 would allow all tribally operated IHS facilities to bill Medicare and Medicaid directly.

According to IHS, seven hospitals are tribally operated and would likely choose to bill Medicare and Medicaid directly. In 1999, Medicare and Medicaid collections totaled $56 million in these facilities. In addition, more than 150 health stations, health centers, and clinics would be eligible to bill directly under the legislation. CBO assumes that all of the hospitals would choose to bill directly over the next several years but that only a few of the largest of the other facilities would develop the infrastructure necessary to adopt direct billing. CBO further assumes that a few additional hospitals would become tribally operated and begin to bill directly.

Based on information from the IHS on the experiences in the demonstration sites, CBO expects that direct billing would increase Medicare and Medicaid payments for two reasons. First, the demonstration sites report a reduction in the amount of time between filing reimbursement claims and receiving payment. CBO therefore assumes that in the first year a facility participated in direct billing, it would receive one to two extra months worth of Medicare and Medicaid payments. The legislation would also accelerate federal spending for the four existing demonstration sites because under current law they are required to return to billing Medicare and Medicaid through IHS and will therefore experience a one- to two-month slow-down in Medicare and Medicaid collections. Of the $41 million in estimated Medicare and Medicaid costs over the 2001-2005 period, $10 million is attributable to the one-time acceleration of payments.

Second, demonstration sites also reported increased Medicare and Medicaid payments under direct billing because of improved claims processing. The sites reported that they were better able to track their claims and correct errors under direct billing than when they filed their claims through the IHS. Medicare and Medicaid payments have grown dramatically in both demonstration sites and nondemonstration IHS facilities in the 11 years since the demonstration was authorized. Much of the growth stems from higher Medicare and Medicaid reimbursement rates for IHS facilities, efforts by IHS to improve its Medicare and Medicaid collections, and general growth in medical costs and enrollment, rather than from direct billing. Nonetheless, based on the experience in the demonstration sites, CBO estimates that the improved claims processing procedures that would result from direct billing would increase Medicare and Medicaid payments by about 10 percent for the facilities that choose to undertake it.

In addition, direct billing may slightly reduce IHS administrative costs, which are subject to annual appropriation.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in the following table. (S. 406 would not affect receipts.) For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	9	8	8	8	8	9	9	10	10	11
Changes in receipts	Not applicable										

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 406 contains no intergovernmental mandates as defined in UMRA. By allowing all tribally operated IHS facilities to directly bill the Department of Health and Human Services for Medicare and Medicaid services, the act would shorten the period of time for receiving reimbursements and improve processing procedures. CBO estimates that those facilities would receive a total of between $5 million and $7 million annually in additional Medicaid

reimbursements. Since the federal medical assistance percentage is 100 percent for tribal health facilities, S. 406 would increase total funding and improve the cash-flow position of facilities that chose to participate in the direct billing program.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

S. 406 contains no private-sector mandates as defined in UMRA.

PREVIOUS CBO ESTIMATE

On August 27, 1999, CBO estimated that S. 406, as ordered reported by the Senate Committee on Indian Affairs on August 4, 1999, would increase direct spending by $37 million over the 2000-2004 period. The language in the Senate version of S. 406 is substantively the same as that in the version that was ordered reported by the House Committee on Resources. CBO has updated its earlier estimate to include more recent data on Medicare and Medicaid collections by IHS facilities (which were lower than expected) and to show the legislation's effects in 2005.

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