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# A Case Study of the Suquamish Tribe's Benefits Package

Northwest Portland Area Indian Health Board.

E. Kimball

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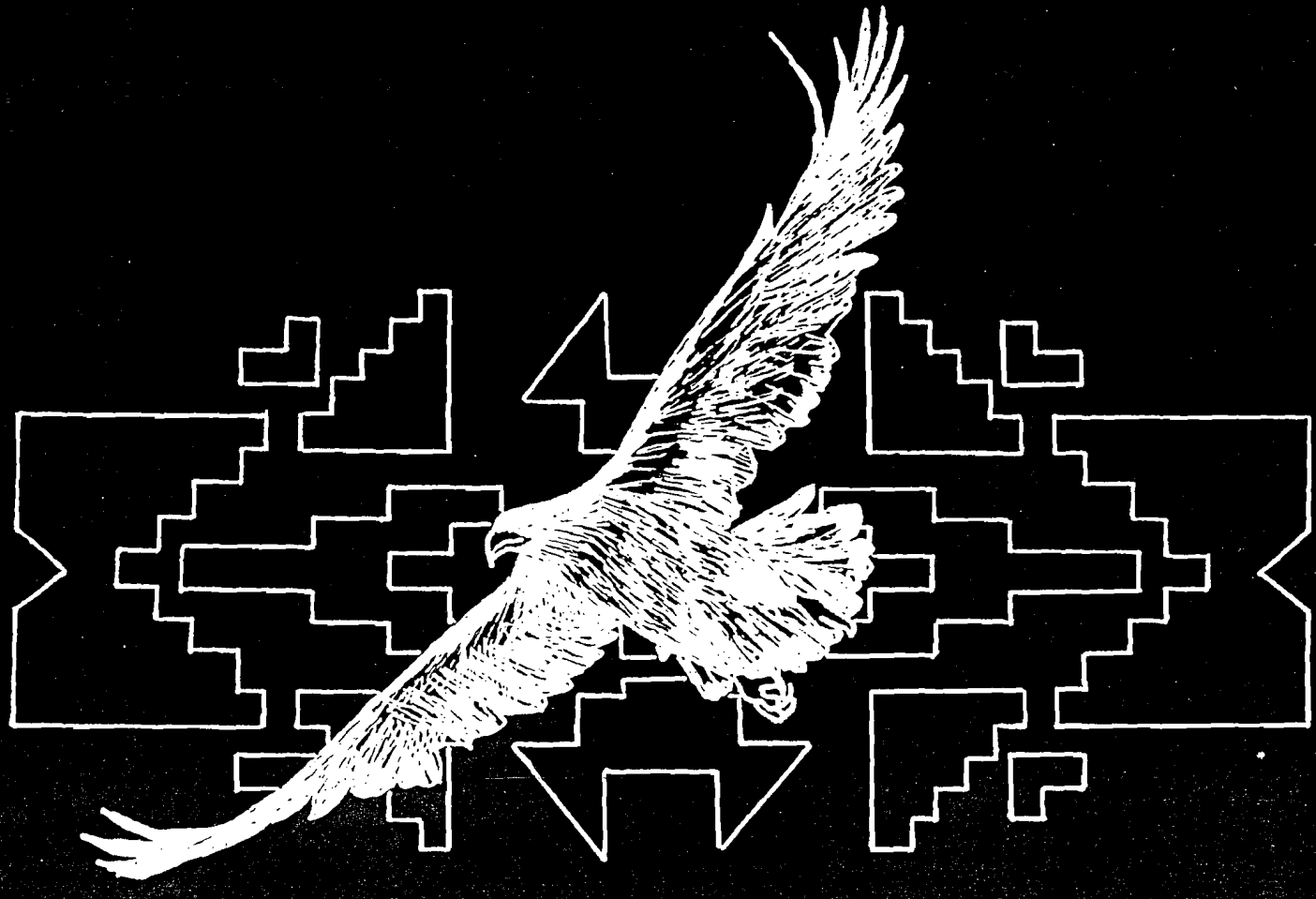

# A Case Study of the Suquamish Tribe's Benefits Package

**Submitted by:**

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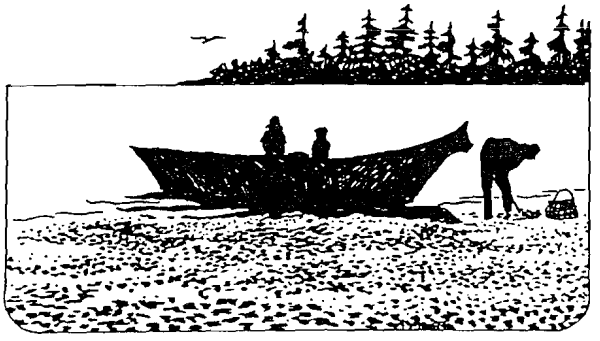
A sincere debt of gratitude and appreciation is extended to the Suquamish Tribe, Tribal Council, and Health and Social Services Department for their support and courtesy throughout the study. We would especially like to acknowledge Chuck Deam, Health and Social Services Director, and Lisa Giles, Tribal Social Worker, for their continuing assistance and support. The drawings used in the report were provided by Pegie Ahvakana of Suquamish, to whom we also extend our personal thanks. It is hoped that this study will benefit the Suquamish Tribe and IHS and demonstrate to others that innovation is always possible when the best interest of a tribe's membership is placed first.

# Foreword

The following case study was completed after extensive field work in March and April of 1988. A May 1989 publication date occurred after editing and review of the study by appropriate tribal and IHS staff.



Suquamish Benefits Package Case Study

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# Case Study

## I. Introduction

This case study describes the Suquamish Tribe's Contract Health Services (CHS) alternative delivery demonstration project. Services under this project are provided through an administrative services contract with a local third party insurance administrator. Under the terms of this agreement, Suquamish tribal members residing in Kitsap County, Washington receive a predetermined benefits package of health care services. The Tribe administers the plan by engaging the services of an administrator who defines and coordinates benefits, adjudicates claims, and pays vendors for services provided.

The Tribe's benefits package began in May 1985 when the Tribe entered into an administrative services contract with Blue Cross of Washington and Alaska. Funding for the project was provided by the Indian Health Service (IHS) under provisions of Public Law 93-638 (the Indian Self-Determination and Educational Assistance Act). This law enables tribes to directly manage services provided to their members through contracts with the Indian Health Service.

The first year of the project was May 1985 to April 1986 with 323 members enrolled at a total annual operating cost of $147,000, or $455 per capita. Under the Tribe's 1988 contract with Network Management, Inc., there were 339 enrollees and total costs were expected to approach $153,000, or $451 per capita for Fiscal Year 1988. The cost of the plan is comparable with Contract Health Services (CHS), which is the system of care used nationally by many tribes under which IHS directly purchases medical service not provided in its own or tribally managed health care facilities. During the period from October 1, 1986 to May 1, 1987, costs averaged $455 per Suquamish enrollee compared with $639 per person for each Northwest Indian receiving IHS direct and contract health services in that same year.[1] These costs were about 30%, or $200, per person less than IHS incurred in providing contract health services and other medical (or direct) care on Northwest reservations or in applicable service areas. Use of alternate resources (medical resources available to Indians other than IHS) was also higher for Suquamish, which was a major factor in reducing costs under the benefits package.

The Suquamish demonstration project has met with considerable user satisfaction. A survey of enrollees indicates that 96% favor the program over traditional Contract Health Services. The Suquamish Tribal Council has consistently supported the program and expressed their satisfaction with the project at a meeting in July 1988. Vendors (providers of care) also strongly endorse this delivery

mechanism, because it has resulted in faster payment of bills. Although the program was originally envisioned to be a prepaid-benefits package, it has not yet evolved to that stage. However, it has provided Suquamish members with defined services, improved availability and accessibility to care, and has demonstrated that a health benefits package is a viable concept for some Indian tribes. The Tribe has also gained considerable managerial expertise through administration of this health care system.

## II. Background and History

The Indian Health Service is the federal agency within the Public Health Service responsible for providing health care services to American Indians and Alaska Natives. It carries out this mission in one of two ways or a combination of both. Direct care services are those clinical, hospital, and ancillary services (including dental and pharmacy) directly provided through the agency (or by tribes) on or near Indian reservations across the country. These services are usually only provided on or near reservations with large populations. However, many smaller tribes also operate Nurse Practitioner or Physician's Assistant clinics, as is the case with 7 of the 10 tribes in the Puget Sound area. When direct services are not economically feasible or Contract Health Services are preferred by the tribe, these services are purchased locally. These usually include hospital care, physician services, patient transportation, dental care, and pharmacy (et al.) which are variable to funding availability.

Until this demonstration project was started, the Suquamish Tribe received most of its health care through CHS. Under federal requirements for this program, each service (except an emergency) had to have prior authorization from IHS and all other medical resources (including welfare) had to be accessed if the patient were eligible before IHS assumed responsibility for payment. Since funding for CHS is limited directly to Congressional appropriations, medical priorities are established to ensure that funds are available throughout the year. These priorities often change as utilization of services increase or decrease. Also, slow payment of bills by IHS is of concern to Northwest tribes and to many vendors who provide services.

With passage of the Indian Health Care Improvement Act in 1976 (Public Law 94-437) each tribal government was asked to develop a comprehensive Tribal Specific Health Plan. These plans were to be used as the basis for additional Congressional funding to assist tribes in overcoming identified unmet needs. As a result of this process, Suquamish, like many other tribes, began to focus upon available service delivery options. In 1980, the Supreme Court[2] required IHS to more equitably distribute its program resources. The result was the establishment of an Equity Health Care Fund whereby additional funds ap-

propriated by Congress were targeted to tribes having the greatest need based on calculations made by IHS from individual tribal health plans.

Suquamish, like other Puget Sound tribes, had serious deficiencies. Additional funds were provided to the Tribe beginning in Fiscal Year 1981. At this time, interest in a benefits package was expressed by the Tribe. The Tribe's Health and Social Services Director had explored the idea of a benefits package beginning in 1978 and with the availability of additional funds, the Tribe and Puget Sound Service Unit of IHS began to further consider implementing such a program.

Administratively, IHS was prohibited by law (42 USC 2001 et seg) from purchasing insurance. However, a legal opinion (see Appendix F) from the Department of Health and Human Services concluded that the Tribe could contract for services from a health maintenance organization or prepaid group practice. Group Health Cooperative of Seattle, Blue Cross of Washington and Alaska, and Kitsap Physicians Service (KPS) of Bremerton, Washington, were deemed to be acceptable service contractors and were contacted by the Tribe. Kitsap Physicians Service was the only administrator that expressed any interest in a contract with the Tribe.

After numerous meetings a proposed benefits package evolved. KPS requested demographic information on members of the four tribes residing in Mason and Kitsap counties. This task took almost one year to complete. A draft of the proposed benefits package was circulated, revised, and finally approved by the Portland Area Office of Indian Health Service. Funding for the benefits package was based on available Contract Health Services and Equity Health Care funds provided by Congress.

KPS raised concerns that it did not have actuarial experience with Native Americans, and because of the younger age of this group with higher numbers of child bearing females than the general population, costs might be excessive. KPS also expressed doubts about becoming the primary payor of services. These related to the number of members with limited amounts of health coverage, high unemployment, and high risk occupations. Subsequently, KPS refused to enter into any contract involving risks, but instead offered the Tribe an administrative services contract. Under this plan, KPS would serve as an intermediary until utilization and cost information on the Tribe could be derived to allow for a future risk contract. The administration of the program would be shared. The Tribe would receive defined health care benefits with services paid for by KPS. The Tribe and KPS would jointly coordinate alternate resources. Eligibility and authorization of services would be tribal responsibilities. As utilization and cost experience were gained, the administrative services contract would evolve into a shared risk arrangement and ultimately to a prepaid health benefits package.

During 1984, the proposed contract received approval from Portland Area Office, IHS Headquarters, and the Suquamish Tribal Council. However, a newly elected Board of Directors of Kitsap Physicians Service voted against the agreement as proposed by their actuarial staff. Using its experience, the Tribe again contacted Blue Cross of Washington and Alaska and this time they expressed interest in the contract as written with KPS. Negotiations with Blue Cross were quickly completed and the contract began in May 1985.

The Blue Cross administrative services contract with the Suquamish Tribe remained in place from May 1985 to September 1987. During that time, the Tribe experienced some problems in coordination of benefits with Blue Cross, primarily in the area of pharmacy services. In October 1987 the Tribe negotiated a new administrative services contract with Network Management Inc. of Mercer Island, Washington, a regional third-party administrator. This contract also covered administrative services only and did not require the administrator to bear financial risks. Network Management's proposal was accepted by the Tribe because its administrative costs were lower than Blue Cross and because it provided improved reporting of services.

The establishment of the benefits package at Suquamish was a lengthy process. IHS's and the Tribe's limited experience in prepaid packages and the refusal of Kitsap Physicians Service to accept the first contract proposed delayed start-up. Other factors relating to the length of this process were the time to collect census data and interest of other Puget Sound tribes in the program, who eventually dropped out. However, overall, much was learned from the process. This experience served the Tribe well when it came time to provide services to its members under the agreement.

## III. Description of the Population Served

The Suquamish Tribe has always resided in and around the western bays and inlets of Puget Sound. The Tribe's eight thousand acre Port Madison Reservation was established by Executive Order in 1864. Like many other Washington State tribes, much of this land is now held by non-tribal members. Most tribal members reside in several geographically separate communities that exist within the original boundaries of the reservation.

The Suquamish Tribe currently has 665 enrolled members, 400 of whom reside in Kitsap County, Washington. Suquamish is one of ten tribes served by the Puget Sound Service Unit. The Port Gamble/Klallam Tribe is also located in Kitsap County and this population uses many of the same medical providers as does Suquamish. The IHS service population for Kitsap County based on registered patients is 1400, of which 633 are members of the Suquamish Tribe (see Appendix E) or maintain socio-economic ties to the Tribe.

The Port Madison Reservation is located on the eastern shores of the Kitsap Peninsula, separated from the City of Seattle by Elliot Bay. The reservation is seven miles east of Poulsbo, Washington (population 5,000) (see Appendix C for Maps of Service Area). The area's largest employer is the U.S. Navy, which maintains three bases in Kitsap County.

Outpatient medical care is available to members of the Tribe in Poulsbo and Winslow Washington, fifteen minutes or less driving time from most tribal homes. Hospital care is available in Bremerton (30 to 40 minutes away) or Seattle (45 to 60 minutes away by ferry boat). North Kitsap Medical Center of Poulsbo, Washington is the largest provider of outpatient services to the Tribe. This facility includes twelve solo practitioners who share contracted radiology, lab, nursing, and administrative services. An independently contracted pharmacy is also part of this group. Other medical clinics used by the Tribe are located in Winslow (1), Bremerton (5), Silverdale (2), and Kingston (1). Pharmacies used are located in Poulsbo (3), Silverdale (2), and Bremerton (3). Medical support and specialty care is drawn from the entire region, including Seattle.

The Suquamish Tribe is demographically similar to other tribes in the Portland Area. However, it has a larger population of children under the age of 10 (25.7% of Suquamish members versus 23.9% for all Portland Area tribes) which could account for higher utilization of clinical versus hospital services. The tribe has fewer females of child bearing age than other tribes. This group comprised 18.0% of the Suquamish Tribe's service population versus 20.3% for Portland Area, an 11.4% difference. As Table 1 indicates, Suquamish has a larger population of members age 60 and over, but a smaller percent of members in the 20 to 29 age group (22% less than the Portland Area). This information is based on enrollees of the Suquamish benefits package at the time of the study (see Appendix E for population comparisons).

**Table 1**
**Comparison of Age Distribution**
**Suquamish Tribe versus Portland Area versus Indian Health Service**

| Age Group | Suquamish Tribe | Portland Area Tribes | IHS Wide |
|---|---|---|---|
| 0-10 | 25.7 | 23.9 | 21.2 |
| 10-19 | 21.3 | 20.5 | 23.8 |
| 20-29 | 15.6 | 20.0 | 19.0 |
| 30-39 | 15.2 | 15.0 | 12.5 |
| 40-49 | 7.9 | 8.2 | 8.5 |
| 50-59 | 5.8 | 5.8 | 7.5 |
| 60+ | 8.5 | 6.7 | 7.5 |

Sources: Network Management Enrollee Listing of April, 1988
Portland Area Office Planning Data, Updated 1988
IHS Chart Series, FY 1986

The health status of the Suquamish Tribe is difficult to assess, but it appears to be similar to other Puget Sound tribes. Since mortality data for the Suquamish Tribe is aggregated with all other Indians within Puget Sound, comparisons between individual tribes cannot be made. Also, because the Tribe is small, mortality rates vary greatly from year to year making it difficult to draw conclusions.

Viewing mortality rates as an aggregate, it appears that Puget Sound Indians experience lower death rates than do other Northwest tribes. Between 1981 and 1985, the death rates among Puget Sound Indians were lower than for other Portland Area tribes (see Appendix D). In FY 1985, the death rate per 1000 Puget Sound Indians was 3.9 versus a Portland Area rate of 4.8.[3] Also, the average age at death of Puget Sound Indians was more favorable (50.4 in Puget Sound vs 46.6 for Portland Area in 1985).[4] Infant mortality rates have been consistently lower among the tribes of Puget Sound (10.2 deaths per 1000 births in Puget Sound,[5] 1982-1986, vs 12.6 for Portland Area vs 10.6 in 1985 for U.S. all races). Causes of death are similar to those of other Indians in the Portland Area, however some rates vary. Puget Sound Indians have not experienced the high numbers of death due to automobile accidents but have a higher percentage of deaths due to homicide (see Appendix D).

The Suquamish Tribe has experienced slightly higher use of alternate resources than have other Puget Sound tribes. As of April 1988, 57% of Suquamish Tribal members were receiving all or part of their health care from sources either outside or supplemental to the benefits package. This compares with an estimated 50% of eligible American Indians and Alaska Natives in Puget Sound Service Unit who were covered by an alternate resource. During 1988, 230 of the 400 enrolled Suquamish members who reside in Kitap County had a medical resource in addition to the benefits package. These were: private insurance (153 or 38%); Title XIX or welfare (44 or 11%); Medicaid Assistance (21 or 5%) and Medicare (12 or 3%).

The availability of physician and hospital services to the Tribe is less than state and national averages. In 1984 Kitsap County had 1.6 physicians per 1000 population.[6] The national and Washington State averages for physicians for the same year were both 2.2 per 1000.[7] Kitsap County was also below national and statewide averages for hospital beds (2.1 per 1000 in Kitsap County vs 5.7 nationally vs 3.2 in Washington) and dentists in 1984 per 1000 population (.52 in Kitsap county vs .56 nationally vs .74 for Washington State).[8] Seattle is, however, a major medical referral and care center that affords the Tribe a high level of tertiary care with 3.6 physicians per 1000 population in 1984.[9] No evidence was found that the Tribe experienced any problem in acquiring services other than transportation.

## IV. Project Description

The Suquamish benefits package is very similar to insurance and prepaid health care plans being purchased by other groups in Western Washington as well as nationally. The patient accesses care through his or her membership card at the participating provider of their choice. Services are not preauthorized as required by CHS except for non-routine hospitalizations, and alcohol and mental health related treatments. The Tribe also requires its members to use well-child and foot-care clinics that are provided by the Kitsap County Health Department and funded by IHS. Approval is required from the Tribe for any medical equipment costing over $200.

The service categories available under the Suquamish plan generally parallel those available through Contract Health Services. However, not all CHS services are consistently available from year to year due to a lack of funding. A listing of services provided under the Suquamish Tribe's benefits plan compared with those provided by CHS is displayed in Table 2.

**Table 2**
**Services Covered by the Suquamish Plan Versus Contract Health Services**

| Benefits or Service | Suquamish | CHS |
|---|---|---|
| Inpatient Hospital Care | Yes | Yes |
| Outpatient Hospital Care | Yes | Yes |
| Physician Services | Yes | Yes |
| Outpatient and Inpatient Mental Health Services | Yes | Yes |
| Lab and Radiology | Yes | Yes |
| Home Health Care | Yes | Yes |
| Skilled Nursing Home Care | Yes | Yes |
| Optometry[1] | No | Yes |
| Dental Care[2] | No | Yes |
| Rehabilitative Services | Yes | Yes |
| Prescription Drugs | Yes | Yes |
| Chiropractic Services | Yes | Yes |
| Prosthetic Devices | Yes | Yes |
| Ambulances | Yes | Yes |
| Sterilizations | Yes | Yes |
| Alcohol Treatment[3] | No | Yes |

[1] *Optometry is provided to Suquamish by IHS through contracts relative to CHS priorities.*

[2] *Dental care is provided by IHS at Port Gamble (30 minutes or less driving time from Suquamish).*

[3] *Provided through Portland Area Office relative to service priorities.*

Source: Network Management & Blue Cross Schedules of Benefits
Portland Area Office Contract Health Service Regulations

Requirements for procurement of services are similar under the Suquamish Benefits Package and Contract Health Services. The key difference between these programs relate to requirements for 72 hours notice and enforcement of medical priorities under CHS. Table 3 is a comparison of the Suquamish plan with CHS. (All CHS requirements listed are based on applicable federal regulations).

## Table 3
## Comparison of Program Requirements
## Suquamish Plan versus CHS

| Requirements | Suquamish Plan | Contract Health Care |
|---|---|---|
| Eligibility | Applications are verified based on membership in the tribe and residency in Kitsap County (Indian spouses also receive benefits) | Eligibility is verified by IHS based on Indian descendency, tribal membership, and residence in a service area |
| Priorities | None--Benefits package is provided as long as funding is available | Four levels of service based on funding availability |
| Alternate Resources | First use of services of other resources is a requirement | Same |
| 72-Hour Notice | Not required under the benefits package | An ongoing requirement for emergency care |
| Preauthorization | Only required for hospital care | Required for all services except emergencies |
| Choice of Vendors | Left to Patient | Left to Patient |
| Requirements to use other IHS facilities | None | If accessible within 30 minutes driving time |
| Second Opinion for surgeries | Mandatory | Not Required |
| Outpatient Surgery | Required if Available | Not Required |
| Catastrophic Coverage | Cases above $15,000 are paid by Area Office | Area Office has responsibility for all cases over $15,000 |

Source: Network Management & Blue Cross Schedules of Benefits
Portland Area Office Contract Health Service Regulations

Finally, under provisions of the Suquamish Benefits Package, certain services are excluded and others remain the responsibility of the Indian Health Service. These services are listed below:

| Services Excluded From Benefits Package | How Provided |
|---|---|
| Well-Child Care | County/Tribal Program |
| Footcare | County/Tribal Program |
| Alcoholism Counseling | Tribal Program |
| Alcoholism Treatment* | IHS provides |
| Audiology and Hearing Aids* | IHS provides |
| Dental Care | IHS provides |
| Optometry* | IHS provides |
| Cosmetic Surgery* | IHS provides |
| Public Health Nursing | Kitsap County/IHS provides |
| Environmental Health | IHS provides |

* *Service availability directly relates to Contract Health Service priorities which determines if a given service will be provided*

Both the Suquamish benefits package and Contract Health Services pay usual and customary fees of providers. However, in some cases Blue Cross rates were less than the fee-for-service charges of CHS. Administrative costs of the Suquamish contract were $6.75 per enrollee per month under the first contract. In May of 1986, Blue Cross of Washington reduced these costs to $5.25. Under the Tribe's current Network Management contract, it pays $4.35 per month for each adult enrollee and $2.15 for each child.

## V. Administration of the Program

Since 1978, when the Tribe first became interested in a benefits package, it has been steadfast in the belief that local administration over the program was essential. This is especially true in areas relating to eligibility, enrollment, use of alternate resources, and coordination of benefits and payments. Local control over these areas was emphasized because these were the areas in which IHS was seen as most deficient in administering CHS.

The establishment of an administrative services contract with Blue Cross of Washington and Alaska was based upon previous procedures and requirements of that organization. Blue Cross designed the benefits program based upon a request for proposal and scope of work designed by IHS and the Tribe and through negotiations with the Tribe. Under the terms of the contract, Blue Cross provided identification cards and had responsibilities for coordination of benefits, alternate resources, and all claims processing. The Tribe provided Blue Cross with a list of members researched from enrollment records to be covered under the program. All vendors in the county were informed by letter of the change in services before the program began in May 1985. A benefits booklet detailing services of the program was also provided to all enrollees during the first ninety days of the program.

Similar procedures are followed under the Network Management Contract which began in October 1987. The administrator, through an assigned claims examiner works with the Tribe to define benefits, complete claims processing, coordinate benefits and furnish reports. All work activities of this organization are fully computerized.

Program management procedures are carried out jointly by the Tribe and its health care services contractor with oversight and contract monitoring by IHS. Eligibility is determined by the Tribe using the standard IHS Contract Health Service Individual Application for Health Care Services (PAO Form-21). Monthly, a corrected printout of eligible enrollees is provided to the contractor by the Tribe. This list includes all known alternate resources. The contractor uses this information to coordinate benefits and ensure all possible alternate resources are used.

Claims payment follows a similar approach. A printout of all bills to be paid by the contractor is provided to the Tribe bi-monthly. The Tribe's Social Worker and Health Director review these charges, verify eligibility and alternate resources, and mail the printout back to the insurer. A check is provided to Network Management monthly for all services and charges to be paid under the program. The Tribe maintains files on all enrollees in the program. Since the community is small, it relies on its own knowledge of the status of enrollees. Tribal staffing limitations sometimes hamper the speed with which information is provided to the contractor. To date, no enrollee has moved out of the county and asked for coverage under the 180 day rule of IHS.[10] The Tribe's policy would be to follow this requirement were it requested.

The Tribe receives extensive payment and patient care reports from the contractor. Under the Network Management agreement, reports generated are: bi-weekly status of claims, monthly and year to date expenditures, semi-annual charges by provider, and semi-annual hospitalization reports (which include diagnostic and utilization data). This information is the basis for tracking of expen-

ditures and reporting to IHS. During the sixteen month Blue Cross contract, similar but less extensive reports were provided.

Close-out procedures for the Tribe's contract follow established regulations of the Indian Self-Determination Act. By regulation, the Tribe has 90 days to make payment on all outstanding claims at the end of each fiscal year (September 30) and complete a close-out voucher for submission to the project officer. In actuality, this process sometimes extends beyond 90 days because alternate resource payments often take longer. New contracts are negotiated by the Tribe prior to the start of each fiscal year. These must be approved by the Portland Area Office prior to providing services.

Since the program began, only minor changes have been made in procedures. Tribal members receiving welfare were deleted from the Network Management contract. Even though Aid to Families with Dependent Children (Welfare) was their primary source of care, they were originally included in the Blue Cross contract. The number of pharmacy vendors was limited under the Network Management contract. Coordination of welfare and private insurance is carried out jointly by the Tribe's Social Worker and the contractor. All patients requiring non-emergency hospital care are screened by the social worker for alternate resource eligibility. This results in numerous cases being funded fully or in part from resources other than the benefits package.

## VI. Utilization and Cost Analysis

During the two years that the Suquamish benefits package has been administered by the Tribe, there have been significant changes in utilization and cost of services. During the first year of the benefits package, total claims were $91,160 (excluding administration). These costs increased to $119,000 during the second year of the project; an increase of 31%. Expenditures during the first six months of the Network Management Contract indicate costs will decline significantly during the third year of the project. Only $23,000 was spent during this period of time.

Without a doubt there have been major shifts in utilization of the program during its two years. The Tribe recorded a 4.7 utilization rate for outpatient services, meaning each enrollee visited a physician (or other provider) four times or more, during the first year of the plan. During the second year, enrollee use of outpatient services declined to 4.2 visits per enrollee. As shown on the following page, the Tribe's use of the outpatient services is comparable to other IHS populations.

**Table 4**
**Health Care Utilization**
**Comparison of Use of Outpatient Service**

| Population | 1985 | 1986 | 1987 |
|---|---|---|---|
| Suquamish Tribe (Benefit Package) | --- | 4.7 | 4.8 |
| Puget Sound Service Unit* | 3.3 | 3.1 | 3.4 |
| IHS Nationally | 4.6 | 4.8 | 4.8 |
| HMO's Nationally | 5.0 | 5.1 | 5.1 |
| U.S. as a Whole | 4.6 | 4.8 | 4.8 |

* *Excludes Contract Health Service Outpatient visits*

Source: Blue Cross Profiles, Dates Indicated
Portland Area Ambulatory Care Reports, Years Indicated
IHS Chart Series, FY 1986

Table 4 shows that the Suquamish Tribe experienced equal utilization of outpatient services from May 1985 to April 1987 to the general population, and to Indians nationally. HMO members received slightly higher numbers of services. This information suggests the Tribe is reaching parity with other groups nationally in utilization of ambulatory care services.

Use of hospital services by the Tribe has also varied throughout the life of the project. Under the first contract with Blue Cross, the Tribe experienced 68 admissions per 1000 enrollees.[11] During this same period of time, Puget Sound Service Unit experienced 47 admissions per 1000 patients eligible for CHS.[12] The Portland area total for admissions was 90 per 1000 population.[13]

Average length of hospital stays were shorter at Suquamish than for Portland Area but slightly longer than for Puget Sound Service Unit. During the first year of the Suquamish project, lengths of stay averaged 4.2 days. This declined to 3.5 during the second year. During Fiscal Year 1986 Portland Area experienced a 4.4 average length of stay and Puget Sound Service Unit averaged 3.8.[14] A comparison of Suquamish's hospital utilization to these other groups is shown in Table 5.

**Table 5**
**Comparison of Hospital Utilization**
**FY 1986**

| | Eligible Population | Discharges | Days | Admission ALOS | Rate |
|---|---|---|---|---|---|
| Suquamish | 339 | 23 | 97 | 4.2 | 68 |
| Puget Sound Service Unit | 6872 | 322 | 1,123 | 3.8 | 47 |
| Portland Area Indian Health Service | 40,290 | 3,592 | 15,805 | 4.4 | 90 |
| IHS Reservation States | 989,251 | 109,181 | 502,233 | 4.6 | 110 |

*NOTE: Population estimates for Puget Sound and Portland Area are based on FY 1987 Indian Registrants x 79 percent to determine estimated active users. A deduction of 339 was made for the Suquamish population multiplied by 75 percent to arrive at the eligible CHS population.*

Source: Blue Cross Profiles
Portland Area Ambulatory Care Reports
IHS Chart Series, FY 1986

The Suquamish Tribe is using hospital services at a lower level than other Indian populations in the Portland Area, but at a higher level than other Puget Sound tribes.

Services being purchased under the Suquamish benefits package vary considerably in price and quantity from those of the Indian Health Service. Breakdowns showing categorical expenditures are provided in Table 6 and Appendix D. As this information shows, the Suquamish Tribe has considerably lower expenditures for hospital care than has Puget Sound Service Unit or the Indian Health Service. Also, the Tribe has been able to make better use of alternative resources under its benefits package for hospital care than has Portland Area.

The Suquamish Tribe's expenditures for health care are similar to Puget Sound Service Unit's utilization of Contract Health Services when direct services are excluded.[15] Expenditures by the Tribe during the past two years of the benefits package are comparable to those of Puget Sound Service Unit (FY '85 & '86) for inpatient physician services, pharmacy, and diagnostic care, as shown in Table 6 on the following page. Suquamish had lower inpatient costs--21% vs 23%--and higher costs in the "all other" category--6% vs 1%. (Graphs summarizing this comparative information are provided in Appendix D of this document.)

**Table 6**
**Comparison of Puget Sound Service Unit CHS and Suquamish Benefit Package Expenditures**
**FY 1985 and 1986**

| | PSSU | % | Suquamish | % |
|---|---|---|---|---|
| Inpatient | 756,060 | 22.7 | 44,405 | 20.6 |
| Inpatient Physician | 318,013 | 9.5 | 17,357 | 8.0 |
| Outpatient Physician | 937,532 | 28.1 | 87,108 | 40.3 |
| Emergency Room | 527,552 | 15.8 | 2,116 | 1.0 |
| Diagnostic | 152,019 | 4.6 | 12,724 | 5.9 |
| Pharmacy | 607,415 | 18.2 | 38,781 | 17.9 |
| All Other | 33,546 | 1.0 | 13,682 | 6.3 |
| **Total** | **3,332,137** | **100.0** | **216,173** | **100.0** |

Source: Blue Cross Profiles
Portland Area CHS Reports

The major difference between Suquamish and the Puget Sound Service Unit relates to the use of emergency rooms. Emergency room use at Suquamish was 1% of total expenditures versus 16% for the service unit. Outpatient physician costs at Suquamish were 12% higher than the service unit. It appears that the Tribe receives a much larger proportion of its outpatient care in physician's offices than do patients of the service unit who utilize emergency rooms more frequently. Further analysis is necessary to validate this contention when additional years of tribal cost experience are available.

During the first year of its benefits package the Tribe was required to pay only 19% of all hospital charges, the balance was covered by alternate resources. Puget Sound Service Unit paid 34% of all hospital charges during a comparable period of time (Fiscal Year 1985). Alternate resources accounted for only 36% of all hospital charges in the Portland Area, during Fiscal Year 1986, with the area paying 64% of all charges. Thus, the Suquamish Tribe's use of alternate resource for hospital care was considerably higher than Portland Area as a whole.

Higher use of alternative resources by the Suquamish Tribe combined with lower utilization rates and lengths of stay has translated into lower overall costs for hospital care by the Tribe. During fiscal year 1986 the Tribe paid an average of $227 per hospital day and $958 per admission. This is approximately 33% lower than

was paid per day by Puget Sound Service Unit and 42% lower than the average for Portland Area ($340 and $399 respectively).[16] Average payments per admission for Suquamish were 54% of that paid by the Portland Area ($958 vs $1,773).[17]

The Suquamish Tribe's use of medical services has varied during the two years the project has been in operation. Expenditures have declined significantly in some expense categories. Under the first Blue Cross contract, the Tribe expended approximately 22% of all funds on prescriptions ($20,198). This declined to $18,583, or 16%, during the second year. Outpatient services declined as a percentage of total expenditure (43% to 40%) during these same two years while hospital charges increased.

The administrative costs associated with the carrier of the program have also declined. During the first year, Blue Cross' costs were $18,000. These declined to $15,500 in the second year and are expected not to exceed approximately $15,000 under the current Network Management Contract. Tribal administrative costs incurred by the tribe have remained steady at $28,900 per year. These can be expected to increase or decrease as changes in tribal indirect costs occur.

Per capita costs of the Suquamish program are equal to or lower than national and statewide averages, but slightly higher than the Indian Health Service, and particularly the Puget Sound Service Unit. From May 1985 to April 1986, the total cost of the Suquamish Benefits Package was $91,161, a per capita cost of $282 per enrollee excluding administration. This compares to per capita CHS cost in the Portland Area of $322 (which also excludes administration).[18] During the second year of the program, total costs were $119,012 or $368 per capita. Thus, costs for Contract Health Services and the Suquamish Benefits Package are comparable.

The costs of the Suquamish project are higher than those of Puget Sound Service Unit but lower than for the general population. In Fiscal Year 1986, $349 was spent per capita for Contract Health Services in Portland Area.[19] The cost of the Suquamish benefits package was $351. However, Contract Health Service costs in Puget Sound of $150 were considerably lower.[20] As indicated earlier, when direct care costs are considered, the cost of the Suquamish Benefits Package is almost 30% less than area wide per capita costs. The costs of the Suquamish program are also significantly below per capita expenditures for Kitsap County and the State of Washington ($1,127 and $1,245 respectively).[21]

The Suquamish Benefits Package is more costly from an administrative standpoint than are comparable CHS programs in the Portland Area. During the first two years of the program, administrative costs of the Suquamish benefits package averaged 28.7% of all expenditures ($91,285 of $318,120). Area expenditures for administration of CHS have averaged 12% or less over the past five years. Obviously, the size of the program is a major factor in its high administrative costs. Payments to the insurer made up 37% of all administrative costs with the remain-

ing 63% the costs of tribal staff and administration. Administrative costs are expected to decline by 12% (from the original contract) under the Tribe's current Network Management Contract.

There are several conclusions to be drawn concerning the cost effectiveness of the Suquamish benefits package.

1. The plan appears to have significantly lowered hospital costs through better coordination of alternate resources and use of outpatient surgeries and second opinions as has occurred with the Tribe's current contract.
2. Use of outpatient and inpatient services among Suquamish members is equal to other Indians and the general population. Thus, it appears patients are getting the care needed.
3. Administrative costs of the program are higher than CHS administrative costs of IHS but per capita expenditures for services are comparable or equal to that of other Tribes in the Portland Area.

This information suggests that benefit packages may be very cost effective for larger groups which would have reduced administrative costs. However, such groups may have differing hospital utilization and less availability to alternate resources and providers than Suquamish. In this case, the Suquamish benefits package has proven to be a cost effective alternative to Contract Health Services. It has yet to be determined what costs and utilization would occur in a capitated shared risk benefits package in which all services would be provided by the contractor for a flat fee.

## VII. Program Acceptance

In 1982, the Suquamish Tribal Council approved the establishment of a benefits package. Three issues were of central importance to the tribal council in considering this alternative system of care. The first concerned expanding the level of services available to members. Second, the council wished to improve accessibility of health care. Lastly, the council hoped the alternative delivery system would alleviate billing problems and slow payment complaints from providers or vendors under the IHS Contract Health Services program. All indications are that the three original goals set by the Suquamish Tribal Council were achieved in the first 24 months of the project. The Suquamish Council expressed considerable satisfaction with the program at a July 1988 meeting.

Patient satisfaction with the project is best illustrated by the results of a survey conducted by the Tribe in February of 1986. A total of 85 respondents completed the survey, representing one-fourth of all enrollees in the plan. The most significant findings of the survey were:

--96% of respondents felt the benefits package was an improvement over Contract Health Services;

--97% felt their family had received at least adequate health care over the past twelve months;

--93% were satisfied with the quality of care provided to them over the past year;

--94% felt that the provider they used had convenient hours that met their needs.

In sum, nine out of ten surveyed participants were well satisfied with the benefits package within one year of its operation.

Interviews with the Tribe's five primary providers of medical services indicate that the project has resolved billing problems and that bill payments have been speeded up considerably. Accessibility has also improved since all available providers participate in the plan. Staff and Suquamish Tribal Council members have expressed the need for additional services such as optometry and dental care if the plan is to fully meet the community's needs on a long term basis.

## VIII. Conclusions

The Suquamish Tribe's benefits package is a cost-effective alternative to contract health services. Through this system the Tribe has achieved greater local control over services resulting in a higher use of alternate resources, faster payment of bills, and improved patient knowledge of the system. The Suquamish program has proven a health benefits package is a viable alternative to Contract Health Services.

The benefits package has been successful at Suquamish because this system resolved many problems that exist with Contract Health Services. These include priorities for care, slow payment of bills, and lack of local control. If the use of a benefits package is desirable on other reservations, then the need to resolve these same issues must be a high priority of the Tribe.

The Suquamish benefits package exists in an atypical environment where the Tribe has access to a multitude of service providers unlike other rural areas. The Tribe's relationship with the medical community and the community at large has historically been good. The Tribe is small enough that it can meet the needs of its members on an individual basis. It is also geographically situated so that care can be structured around a limited number of providers that all tribal members in the service area can access. It should be reiterated that Suquamish has an administrative benefits package, not one that involves risk to the insurers. How well a package involving risks for the insurers would function cannot be speculated upon

without actual experience. However, tribes having employee insurance packages might be able to establish baseline costs and utilization.

Whether or not a benefits package can be replicated in other parts of the country cannot be completely answered through the experience of the Suquamish Tribe. Certainly, any tribe could enter into an administrative services contract and reap the positive rewards of this type of service delivery as demonstrated at Suquamish. However, it is doubtful a benefits package involving possible risks for the health services contractor would be available unless a tribe had several years of cost or actuarial experience. Suquamish had the availability of a well established health care delivery system and acquired the management capability (through a Master's level social worker) to successfully operate its program. These are important variables for other tribes to consider should they wish to replicate this system of care.

The success or failure of using benefits packages as a viable alternative to Contract Health Services rests with the Indian Health Service and the Federal Government. For such programs to be successful, the following issues need to be addressed and resolved:

1. A system for monitoring services and controlling utilization and costs needs to be in place;
2. A means of identifying and using all available alternate resources needs to be developed;
3. Adequate and ongoing funding support for such programs needs to exist;
4. Initiation of risk sharing arrangements with insurers and providers must be a goal.

IHS and tribes must work creatively together to achieve successful benefits package programs. Mutual efforts are especially important for exploring alternative service delivery options and developing workable financing arrangements. Both parties must be flexible and willing to accept fluctuations that are bound to occur in service populations and utilization as the program evolves. If the benefits package is only available part of the year or if the services available are periodically curbed due to lack of funding then the concept will never be viable as an alternative to CHS.

# Footnotes

[1] This calculation is based upon total Contract Health Service expenditures for Portland Area and Benefits Package costs of Blue Cross. Population denominators used are contained in Appendix E and calculation of per capita CHS costs in Appendix G.

[2] Rincon Band of Mission Indians vs California 464F Supp. 934 (N.D. Cal. 1979); aff'd., 618F 2d 569 (9th Cir., 1980)

[3] Department of Health and Human Services, *Vital Statistics - Portland Area Indian Health Service FY 1986*, (Portland, OR, Indian Health Service 1987), pages E 1 & 2

[4] Ibid (or same reference as shown above)

[5] Ibid, page 74

[6] Washington State Health Coordinating Council, *Health Data Book*, 1985 (Olympia, Washington Department of Health and Social Services, 1987) page 32

[7] Ibid, page 8

[8] U.S. Department of Commerce, *Statistical Abstracts of the U.S.* (Washington D.C.: Government Printing Office, 1986) page 90, (also Washington Health Data Book)

[9] Washington State Health Data Book, Op. Cit, page 141

[10] Under regulations, IHS must provide CHS to any eligible Indian for 180 days after leaving a Service Area.

[11] Blue Cross of Washington and Alaska, *Profile of the Suquamish Tribe 5/86 to 4/87* (Seattle, Washington, Blue Cross of Washington) page 86

[12] Department of Health and Human Services, *Statistical Summary Portland Area, Contract Health Services, Fiscal Year 1986* (Portland, OR, Indian Health Services, 1987), page 113

[13] Ibid (population estimates are contained in Appendix E)

[14] Ibid, pages 113-114

[15] Blue Cross Profile of Suquamish Tribe, Op. Cit. page 86

[16] Blue Cross Profile vs Statistical Summary, Fiscal Year 1986 Op. Cit.

[17] Ibid

[18] Based on Total Portland CHS hospital expenditures of $11,410,096 as reported in FY 1986 statistical summary

[19] Department of Health and Human Services, Contract Health Services, Piggyback Reports, Fiscal Year 1986 (Portland, OR, Indian Health Service, 1987) page 6

[20] Ibid, page 18

[21] Washington State Health Data Book, Op. Cit. page 141

# Appendix A

*Plan Description and Process of Application and Payment*

# THE SUQUAMISH TRIBE'S HEALTH CARE CONTRACT WITH NETWORK MANAGEMENT, INC.

WHO IS ELIGIBLE? All Suquamish Tribal members and their Federally-recognized Indian spouses and children living in Kitsap County are eligible. The Suquamish Tribe has approx. 335 Tribal members and families enrolled with Network Management, a company which administers our payments for health care. (The Suquamish Tribe's tribal enrollment is 647). Families on AFDC through the Washington State Department of Social & Health Services or individuals on SSI through Social Security are not included in the Network Management program (approx. 45 people).

ENROLLMENT PROCEDURE: We use the PAO-21 forms to enroll all members of the Tribe with Network Management.

BENEFITS: The benefits were developed through meeting with Indian Health Service and with Blue Cross, our former subcontractor. The benefits are similar to those provided by IHS, and are printed in a benefits booklet for each family. Some services (such as mental health) are preauthorized by Lisa Giles, Medical Social Worker, at the Tribal level. Others, such as chiropractors, need referrals from M.D.'s. Network also has a Second Surgical Opinion Program and an Outpatient Surgery Program for certain medical procedures. This program doesn't duplicate existing services, such as dental, alcohol treatment, or well child care.

WHAT HAPPENS WITH BILLING: All adults over 18 have a Network Management card which they show at the doctor's office. If there is health insurance involved through employment, Network Management is billed second. Most doctors' offices will bill Network. If they won't, we have claim forms and envelopes so the patient can bill directly. Sometimes the patient will have to send their Explanation of Benefits from their primary insurance to Network so they can coordinate benefits.

PHARMACY: We have 9 Participating Pharmacies in our 6 communities in Kitsap County. They bill Network directly.

THE TRIBE'S RESPONSIBILITIES: Lisa Giles, manager of the Suquamish Tribe's health care program, handles the following components:

(1) ALTERNATE RESOURCES: in case of hospitalizations, coordinates applications for DSHS when no other health insurance is available. It is important for Tribal members to keep her and the CHR's up to date on this. Lisa has a good rapport with the credit office in the local hospital--very important. Lisa also informs Network at the time of hospitalization when DSHS is involved so they can hold bills until DSHS status is determined.
(2) RECORDKEEPING: keeps up to date PAO-21's, including changes with employment insurance and changes of address, and notifies Network.
(3) BILLING: Every 2 weeks, Lisa reviews the billing list of claims to be paid by Network to make sure payments are coordinated by Network, then authorizes payment to Network. She also updates the monthly enrollment list from Network.

2/11/88

# Flow Chart of Patient Services
# Suquamish Benefits Package

## Eligibility and Service Delivery

Tribal member applies for services.

PAO Form 21 is completed; residency, enrollment and alternate resources are verified.

Form verifying eligibility is mailed to Service Unit and Network Management (Administrator).

To receive outpatient care, family doctor is seen; pharmacy and other services are then provided.

If doctor hospitalizes patient during emergency, social worker is contacted and coordinates alternate resources.

Social worker informs administrator of all hospital care, coordinates alternate resources and provides determinations when received.

## Billing and Payment

Providers bill patient's insurance or administrator. Patient may submit claims on forms provided to them.

Administrator verifies bills for payment, determines part-pays based on insurance or coordinates medical assistance with social worker.

Administrator sends tribe bi-monthly invoice of claims outstanding and administrative charges.

Social worker verifies all claims, checks alternate resources and upon approval of Director sends purchase order to accounting.

Invoice is paid by tribal accounting department, usually within 10 days.

Upon receipt of payment, administrator pays all claims on invoice.

HERE IS YOUR NEW HEALTHCARE IDENTIFICATION CARD.
Please check your name, address and member number to verify that they are correct.
Please detach and carry this card with you for ready identification.

THE SUQUAMISH TRIBE

MEMBER NAME

MEMBER NUMBER EFFECTIVE DATE

PLAN TYPE PLAN NO DEPENDENT COVERAGE

PLEASE DESTROY ANY OLD CARD YOU MIGHT HAVE.
REFER TO THE BACK OF THIS FORM FOR IMPORTANT INFORMATIO

**CLAIM FILING INSTRUCTIONS**

TO THE EMPLOYEE: This is your only medical coverage card in effect. Carry it with you at all times and present it whenever you or one of your eligible dependents receive medical services. See your plan booklet for a list of services your coverage provides

You or your doctor or provider of medical care must file a completed claim to:

Network Management Inc.
P.O. Box 9004, Mercer Island, WA 98040-9004

This card is intended for identification and not a guarantee of benefits. For coverage verification please call Network Management, Inc.:

(206) 236-2205
1-800-367-0600 Washington WATS
1-800-647-6400 United States WATS

+NETWORK
Management Inc.

## PLEASE NOTIFY US IMMEDIATELY IF:

- There is a change in your marital status or in the number of eligible dependents in your family.
- You change your address.

## 7 STEPS TO GOOD HEALTH

- Don't eat between meals.
- Don't smoke cigarettes.
- Stay within 10% of your proper weight.
- Exercise regularly.
- Don't drink to excess.
- Sleep seven to eight hours a night.
- Eat breakfast.

The beneficial effects of the practices are additive. That is, someone who follows all seven is likely to be healthier than someone who follows six and so forth.

# Appendix B

*Project Scope of Work*

# Scope of Work

## Administrative Services

The Sub-Contractor will provide the Tribe with the following services for the administration and operation of the Benefit Program:

*A. GENERAL ADMINISTRATION SERVICES*

Services provided by the Sub-Contractor include:

(1) Administration of a Benefit Program, both initially and in connection with benefit revisions.

(2) Assistance with the enrollment of eligible persons.

(3) Maintenance of eligibility files based on information provided by the Group.

(4) Issuance of Subscriber Identification Cards to the Group.

(5) Supply of appropriate claim forms.

(6) Claims processing and payment.

(7) Preparation of accounting reports for use by the Group in the financial management and administrative control of the Benefit Program. These reports will be furnished for the benefit structure adopted for the Benefit Program and will include:

(a) Initial and renewal expected unit cost and total expected cost estimates for the Benefit Program:

(b) Monthly billings, listing benefit payments and administration charges.

*B. BENEFIT PAYMENTS*

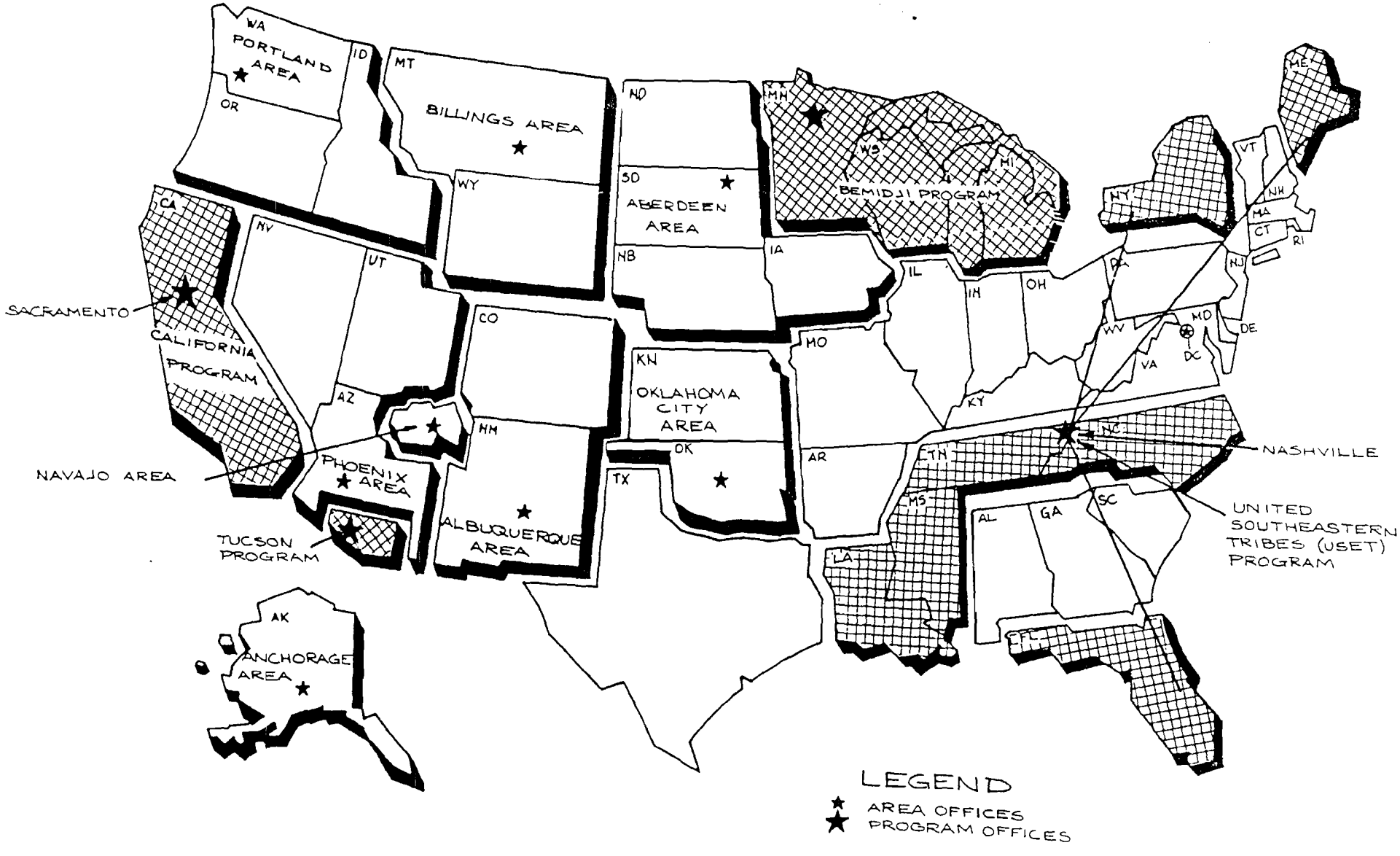
The Sub-Contractor shall make payment of benefits in accordance with the Benefit Program from the funds available, and in making such payments, the Sub-Contractor shall determine the validity of each request for benefit payment presented and make, as may be necessary, appropriate investigations.

# Appendix C

*Maps of Service Area/History of Tribe*

figure 1

# INDIAN HEALTH SERVICE AREAS



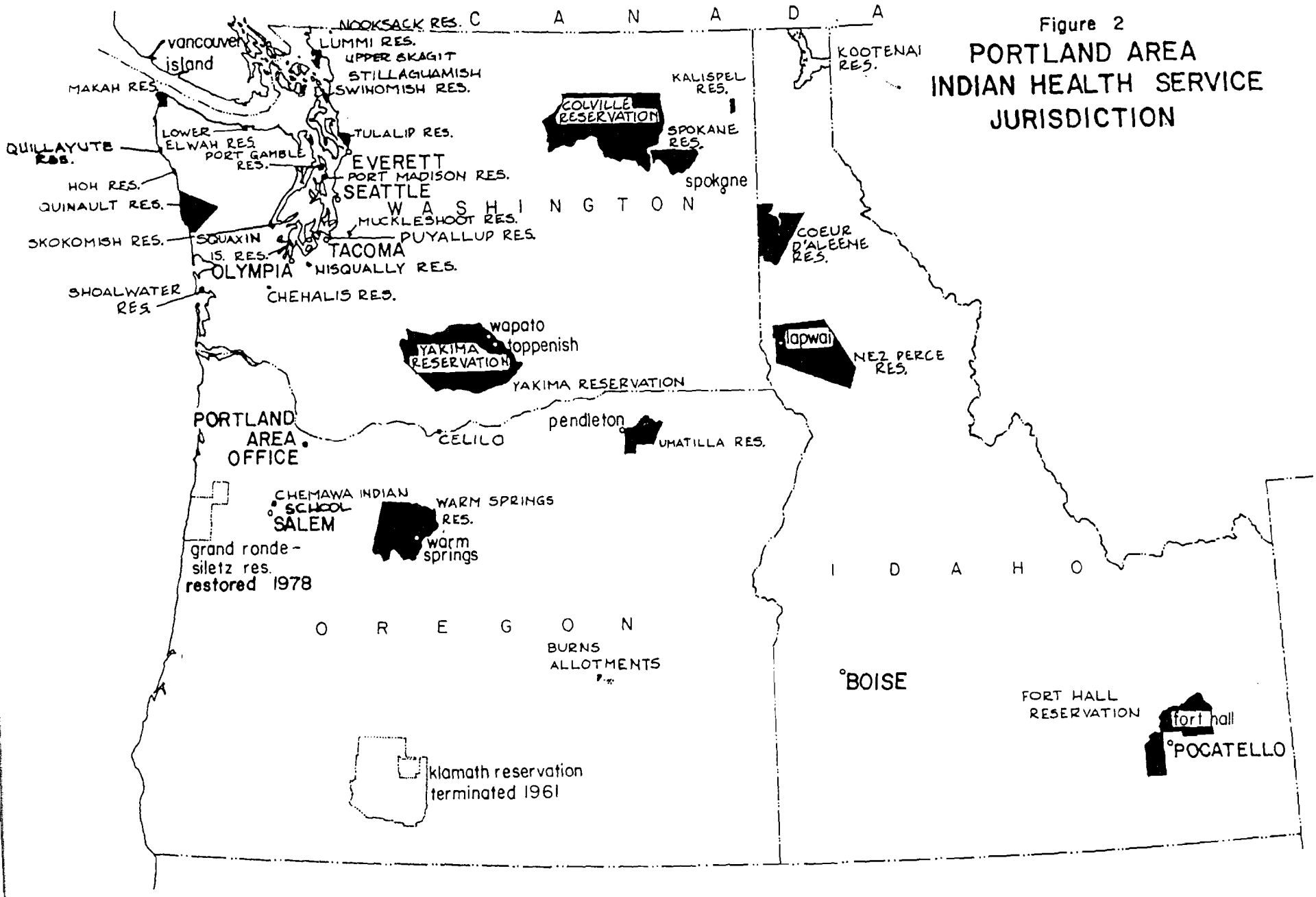


Figure 2
PORTLAND AREA
INDIAN HEALTH SERVICE
JURISDICTION
C A N A D A
NOOKSACK RES.
LUMMI RES.
UPPER SKAGIT
STILLAGUAMISH
SWINOMISH RES.
vancouver island
MAKAH RES.
QUILLAYUTE RES.
LOWER ELWAH RES
PORT GAMBLE RES.
TULALIP RES.
EVERETT
PORT MADISON RES.
SEATTLE
HOH RES.
QUINAULT RES.
W A S H I N G T O N
SKOKOMISH RES.
SQUAXIN IS. RES.
MUCKLESHOOT RES.
PUYALLUP RES.
TACOMA
OLYMPIA
NISQUALLY RES.
SHOALWATER RES.
CHEHALIS RES.
COLVILLE RESERVATION
KALISPEL RES.
SPOKANE RES.
spokane
KOOTENAI RES.
COEUR D'ALEENE RES.
wapato
toppenish
YAKIMA RESERVATION
YAKIMA RESERVATION
lapwai
NEZ PERCE RES.
PORTLAND AREA OFFICE
CELILO
pendleton
UMATILLA RES.
CHEMAWA INDIAN SCHOOL
SALEM
WARM SPRINGS RES.
warm springs
grand ronde - siletz res. restored 1978
I D A H O
O R E G O N
BURNS ALLOTMENTS
BOISE
FORT HALL RESERVATION
fort hall
POCATELLO
klamath reservation terminated 1961

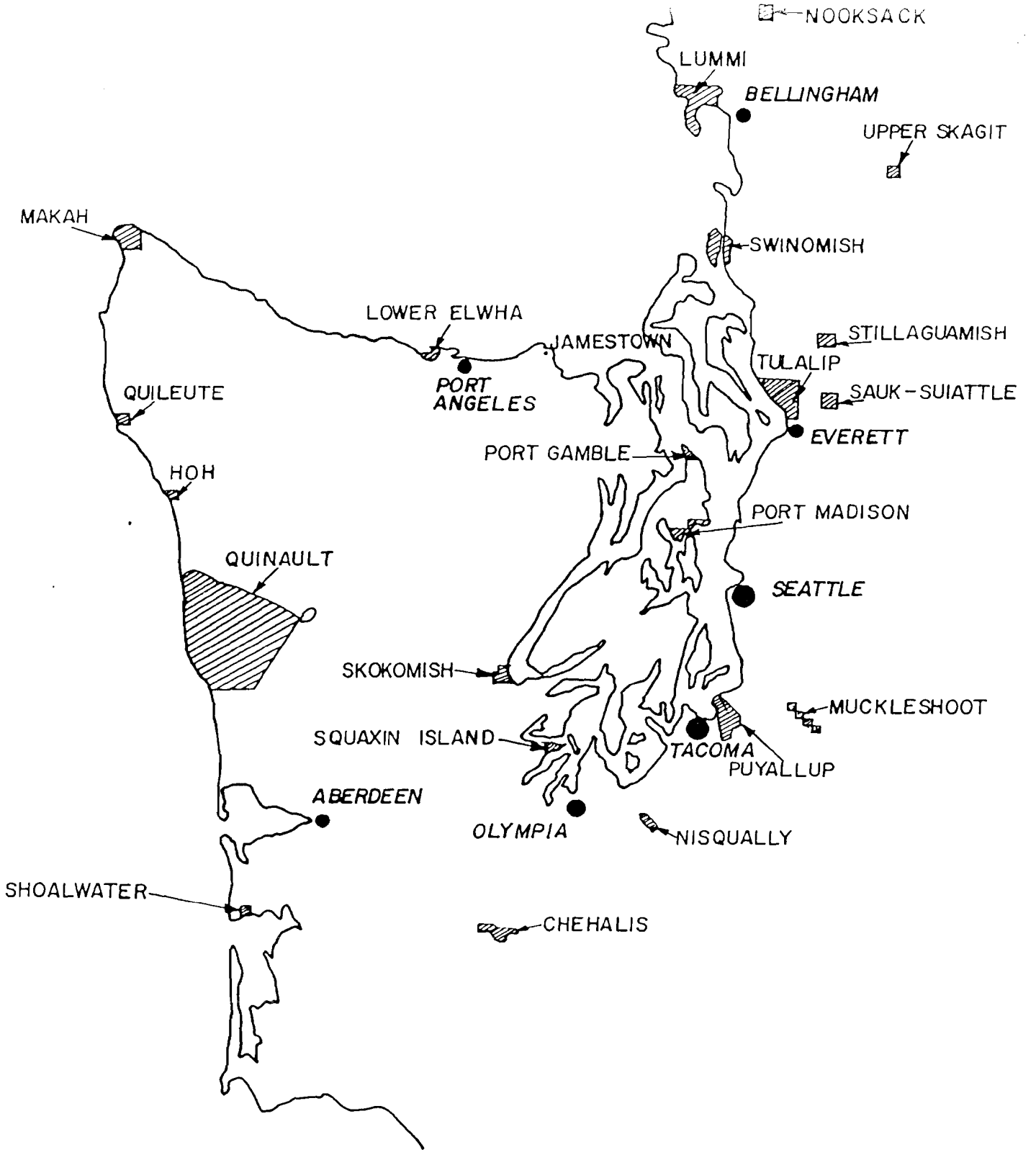



figure 3

WESTERN WASHINGTON
DISTRICT SERVICE AREA

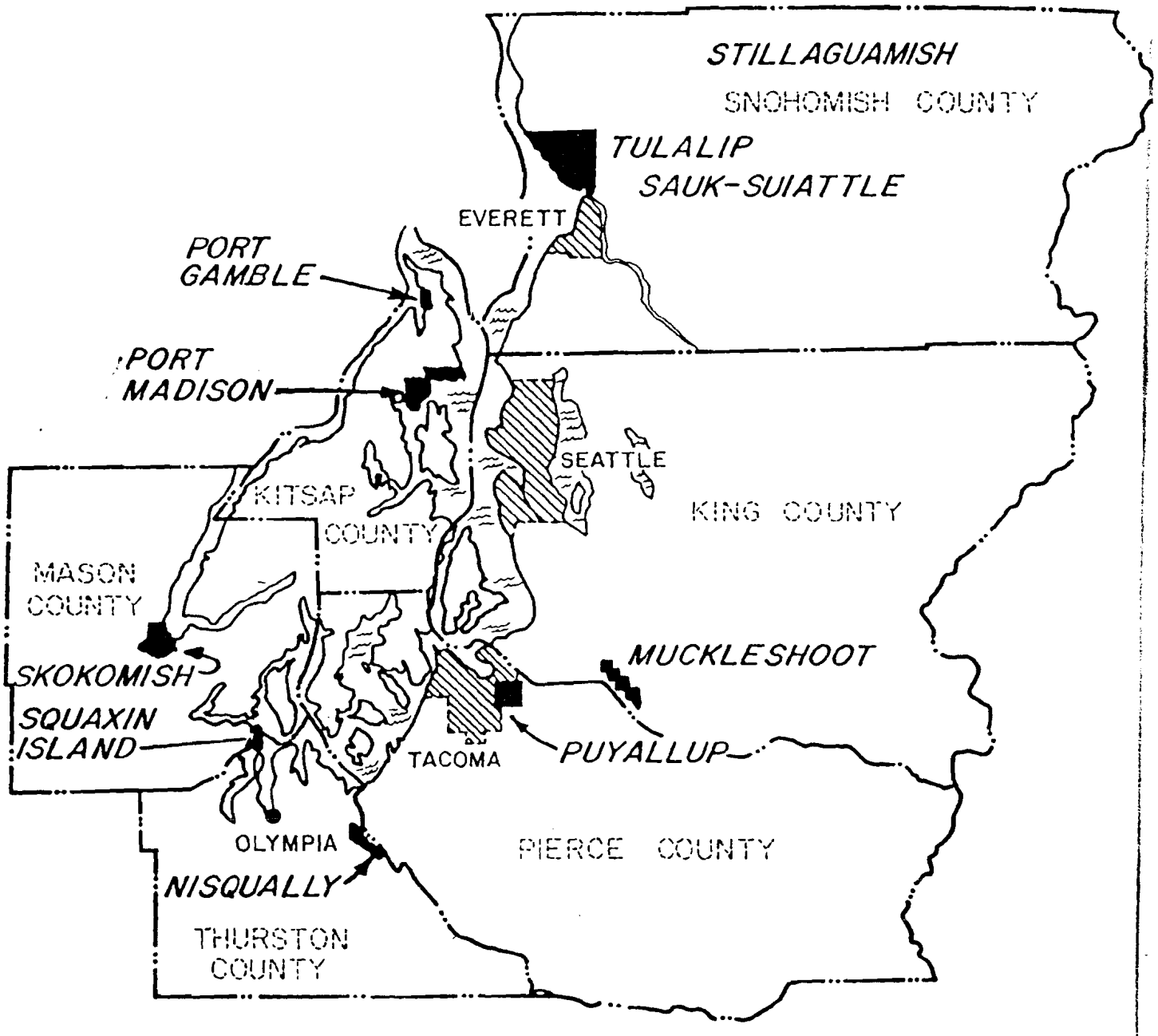



figure 4

# PUGET SOUND SERVICE UNIT

# INDIAN HEALTH SERVICE

# History of the Suquamish Tribe

The Suquamish Tribe and its members are the cultural and political descendants of Chief Seattle, who with other local tribes have inhabited Puget Sound since time immemorial. Suquamish was one of the 21 tribes and bands who were signers of the Point Elliot Treaty which was approved by the U.S. Senate on March 8, 1858 (12 Stat 972). Under the terms of this treaty, funds were to be directly appropriated to the Bureau of Indian Affairs to provide for schools, health care, Indian agents, and to meet the specialized financial needs of the signatory tribes. However, due to recurrent administrative abuses, tribes reaped few benefits from the 65 years of appropriations made by the Congress to the Point Elliot Treaty tribes.

The Suquamish reservation was originally established in the treaty as two sections of land (1,280 acres) at the head of Port Madison. This land base, however, proved inadequate to support the tribe's economy which centered around fishing, gathering, and farming. At the request of Chief Seattle, the reservation was expanded to 8,000 acres in 1864 by then Governor Stevens. In 1886, the Port Madison reservation was allotted to individual tribal families.

During the early treaty years, encroachment by white settlers often ended in the deaths of tribal members. Alcohol was often used as a means of enticing tribal members to relinquish land holdings. In 1870, the BIA destroyed O-Le-Man House, which was one of the largest longhouses in Puget Sound, This 1,000 foot long dwelling served as the central meeting place and spiritual center of the tribe. The destruction of O-Le-Man House was one of many examples of government policies affected to change the social, cultural, and economic lifestyles of Indian tribes during the period 1870 to 1900.

In the early 1900's much of the Suquamish reservation was sold to non-Indians with the support and encouragement of the BIA. As large numbers of non-Indians moved on the reservation, tribal access to fishing, hunting, and gathering was denied. This created severe economic hardships for the Suquamish people. Despite a successful lawsuit against the government in 1925, the tribe received no compensation for its loss of lands and resources. In 1946, with the creation of the Indian Claims Commission, the tribe again successfully sued the federal government, but was awarded only 90 cents per acre for its lands taken, or a total of $73,000.

The 1950's were a period of major change for the Suquamish Tribe. Termination of tribes in Oregon, California, and other states was planned for every tribe in Washington, but never occurred. In 1953, Congress passed Public Law 83-280, which gave state governments criminal and police jurisdiction over most reservations including those in Washington state. Also, in 1955 Congress established the

Indian Health Service as a separate governmental agency to provide health care services to Indian people under provisions of the Transfer Act (P.L. 83-568).

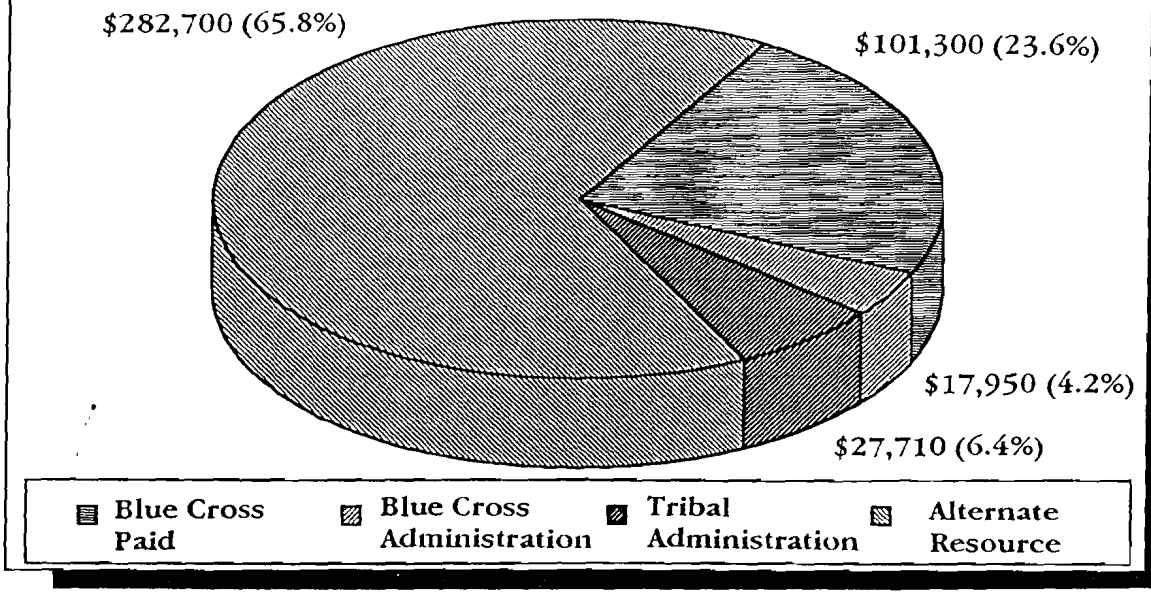
Health care at Suquamish was always very limited. This changed in 1934 with the establishment of Cushman Indian Hospital on the Puyallup Reservation in Tacoma. The hospital, which served all tribes of western Washington and Alaska, was one of the most modern facilities of its time. Employing large numbers of Puget Sound Indians, the hospital was a source of pride to many tribes in the region. During the 1950's the government closed the hospital and converted it to a tuberculosis center. The Suquamish Tribe and others in the region once again became dependent upon contract health service for the majority of its health care.

In 1966, the Suquamish Tribe adopted its present constitution. The seven member tribal council is elected every three years. Since that time the tribe has experienced considerable growth in its membership. Employment and economic development of the reservation have increased steadily. Health care has also improved as more services have become available. The Suquamish benefits package has been a significant improvement for the tribe in meeting its present and future health needs.

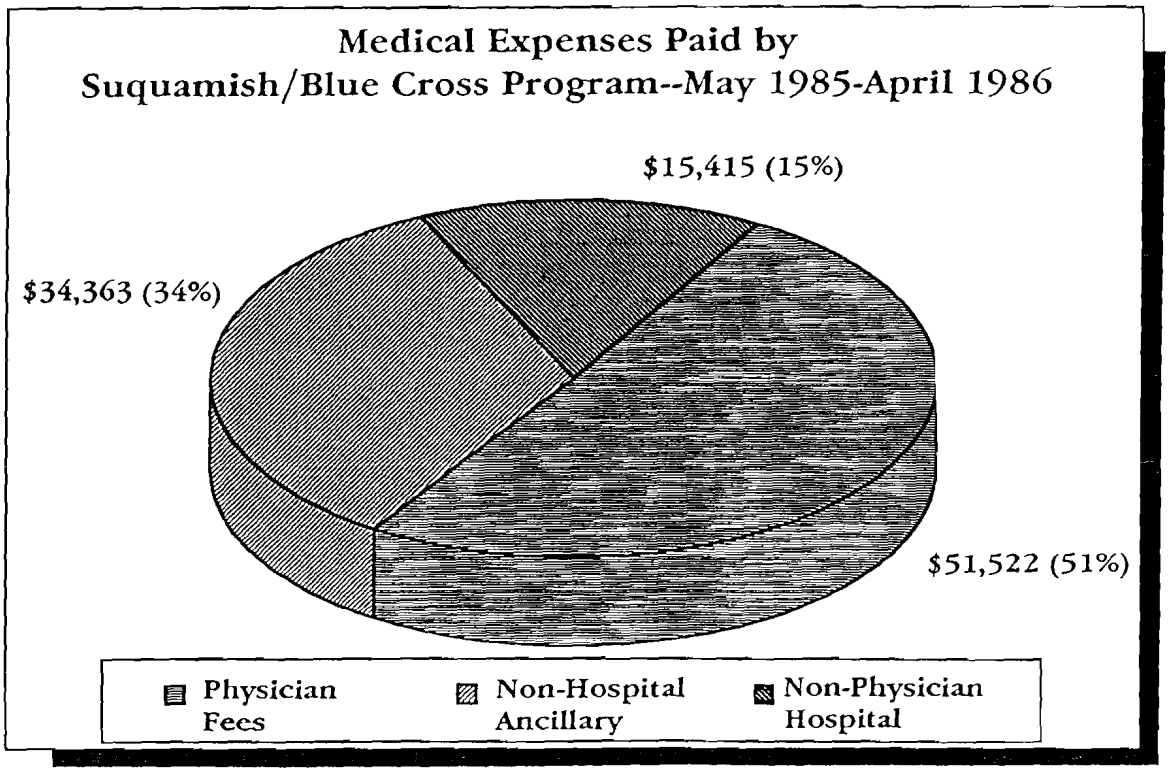
# Appendix D

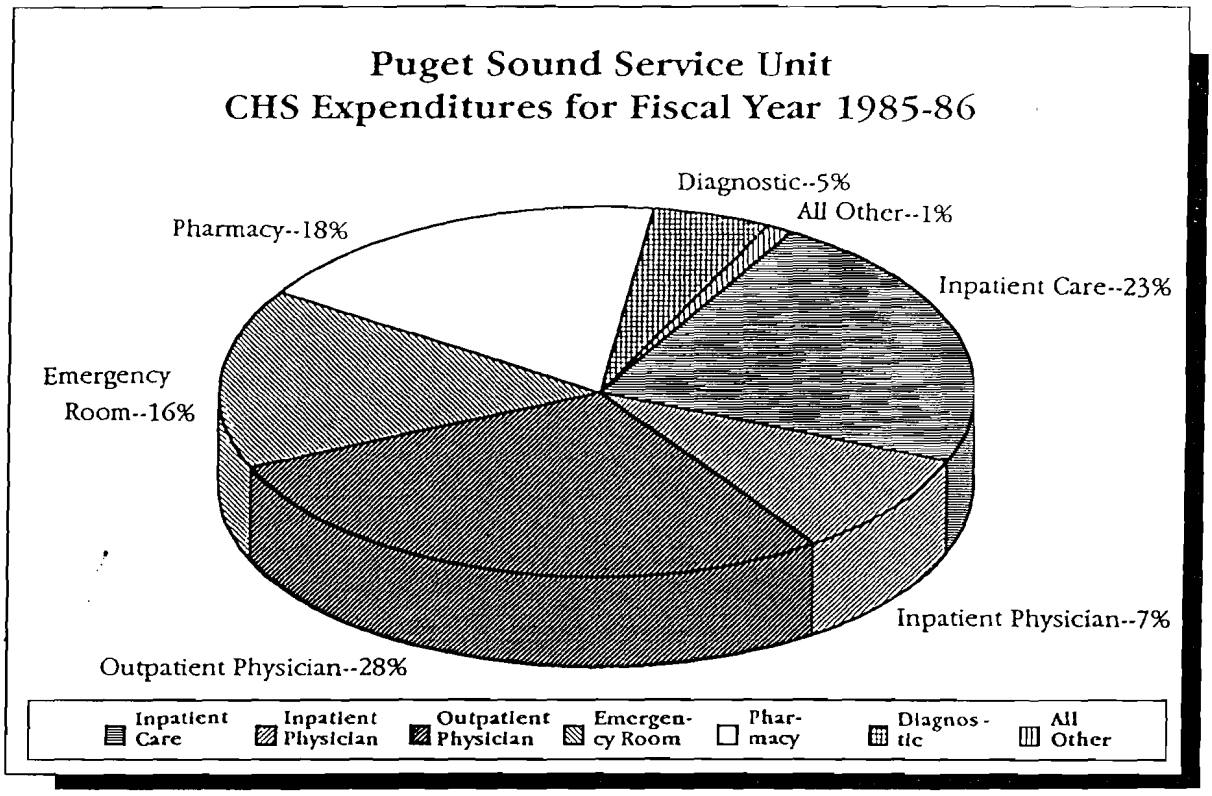
*Utilization, Cost and Mortality Statistics*

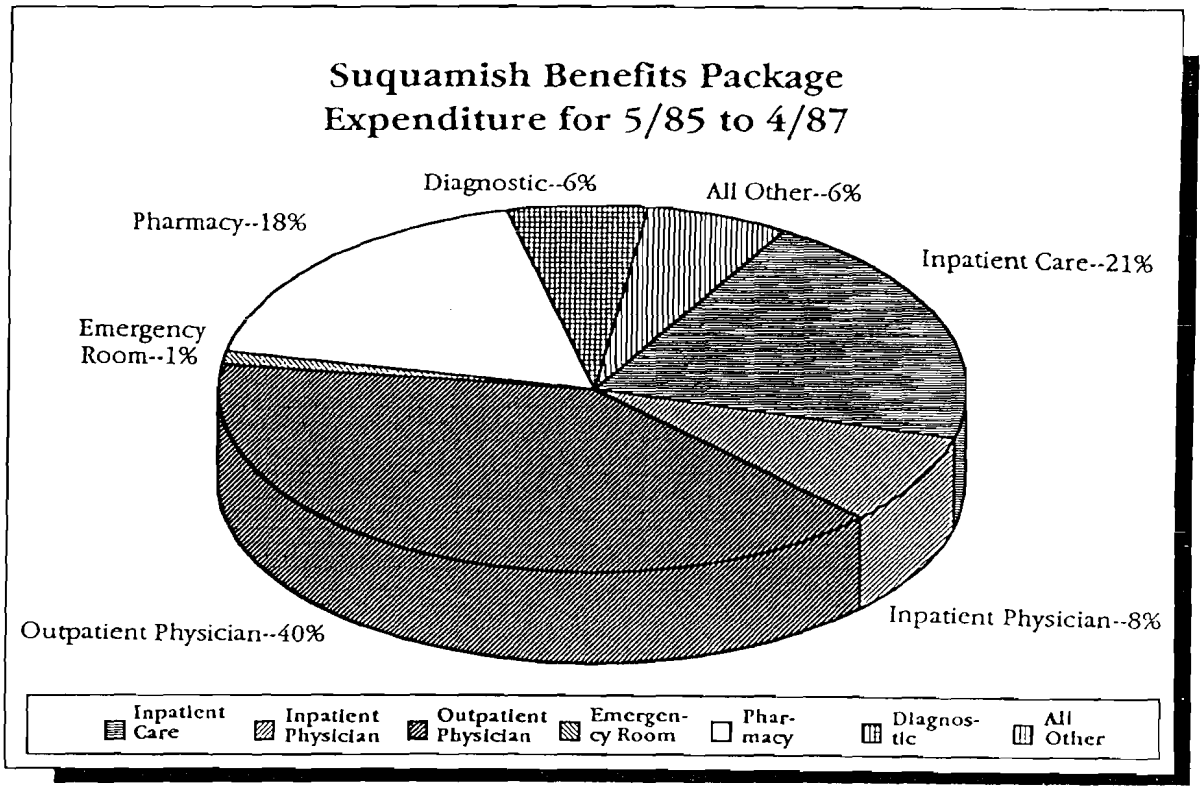
## Total Cost of Care for Members of Suquamish/Blue Cross Program--May 1985-April 1986




## Medical Expenses Paid by Suquamish/Blue Cross Program--May 1985-April 1986




Puget Sound Service Unit
CHS Expenditures for Fiscal Year 1985-86
Diagnostic--5%
All Other--1%
Pharmacy--18%
Inpatient Care--23%
Emergency Room--16%
Inpatient Physician--7%
Outpatient Physician--28%
Inpatient Care
Inpatient Physician
Outpatient Physician
Emergency Room
Pharmacy
Diagnostic
All Other


Suquamish Benefits Package
Expenditure for 5/85 to 4/87
Diagnostic--6%
All Other--6%
Pharmacy--18%
Inpatient Care--21%
Emergency Room--1%
Outpatient Physician--40%
Inpatient Physician--8%
Inpatient Care
Inpatient Physician
Outpatient Physician
Emergency Room
Pharmacy
Diagnostic
All Other

SUMMARY OF DEATHS BY HEALTH CLASSIFICATION BY CALENDAR YEAR'S 1981 - 1985
(USUAL RESIDENCE OF DECEDENT)
PORTLAND AREA AND PUGET SOUND SERVICE UNIT

| HEALTH CLASSIFICATION | PORTLAND AREA | | PUGET SOUND | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| TOTAL DEATHS | 2311 | 100 | 607 | 100 |
| Infective & Parasitic Diseases | 33 | 1.4 | 8 | 1.3 |
| Neoplasms | 232 | 10.0 | 64 | 10.5 |
| Endocrine, Nutritional & Metabolic Dis., Immunity Dis. | 73 | 3.2 | 9 | 1.5 |
| Blood & Blood forming Organs | 6 | 0.3 | 3 | 0.5 |
| Mental Disorders | 43 | 1.9 | 15 | 2.5 |
| Nervous System & Sense Organs | 35 | 1.5 | 13 | 2.1 |
| Circulatory System | 661 | 28.6 | 167 | 27.5 |
| Respiratory System | 152 | 6.6 | 48 | 7.9 |
| Digestive System | 240 | 10.4 | 61 | 10.0 |
| Genitourinary System | 43 | 1.9 | 14 | 2.3 |
| Pregnancy, Childbirth & Puerperium | 3 | 0.1 | 1 | 0.2 |
| Skin & Subcutaneous Tissue | 2 | 0.1 | 0 | 0 |
| Musculoskeletal System & Connective Tissue | 16 | 0.7 | 3 | 0.5 |
| Congenital Anomalies | 28 | 1.2 | 6 | 1.0 |
| Certain Conditions of Perinatal Period | 41 | 1.8 | 9 | 1.5 |
| Symptoms, Signs & Ill-defined Conditions | 93 | 4.0 | 24 | 4.0 |
| Injury & Poisonings (External Cause of Injury) | 610 | 26.4 | 162 | 26.7 |
| OTHER ITEMS OF SPECIAL INTEREST | | | | |
| Sudden Infant Death Syndrome | 73 | 3.2 | 22 | 3.6 |
| Automobile Accidents | 213 | 9.2 | 36 | 5.9 |
| Suicide or Self-Inflicted | 85 | 3.7 | 21 | 3.5 |
| Homicide | 80 | 3.5 | 30 | 4.9 |

SOURCE: Death Tabulations received from State Health Departments of Idaho, Oregon and Washington and tabulated on a county basis.

PROVISIONAL

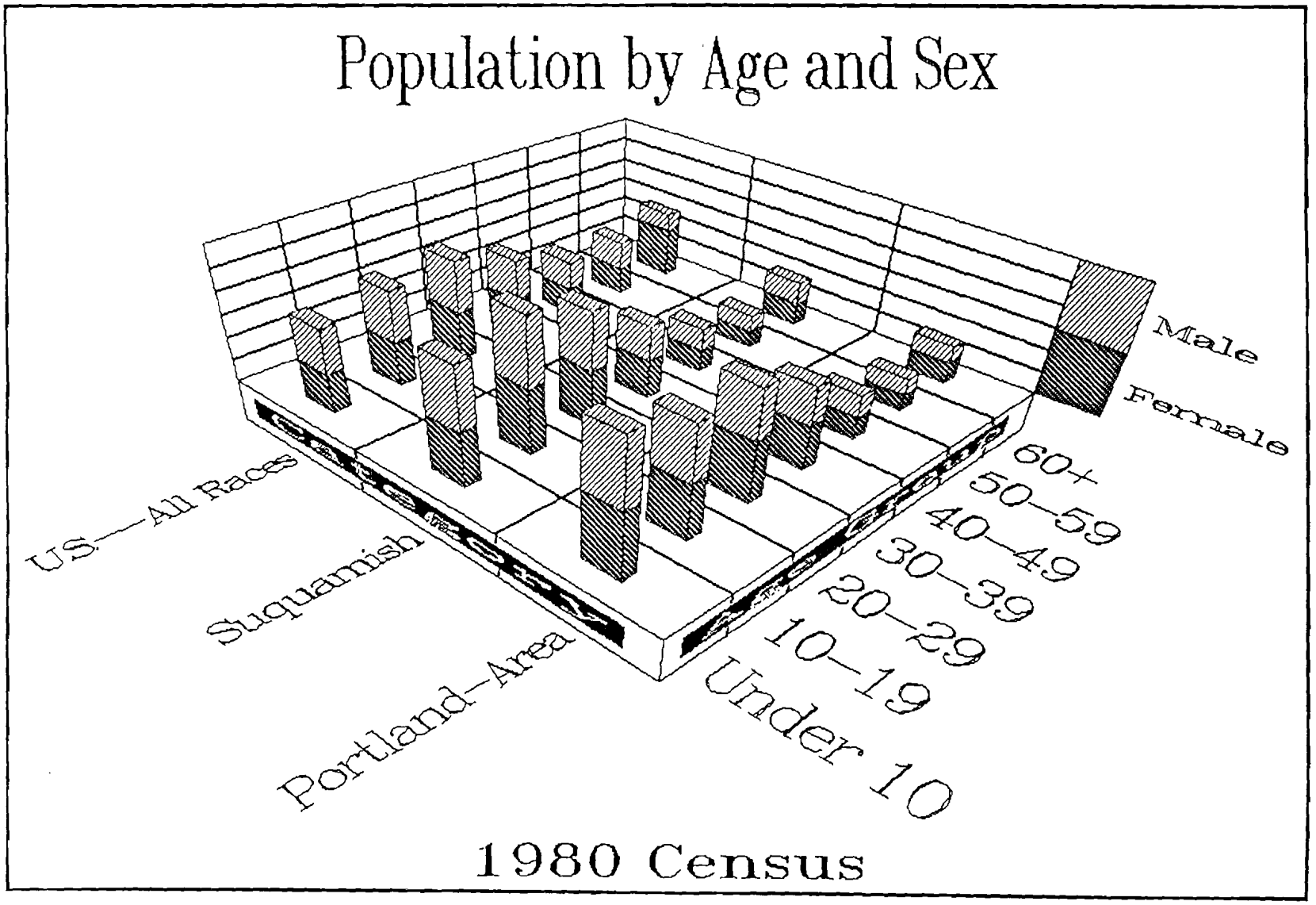
Mortality Rates For American Indians and Alaska Natives in Puget Sound Service Unit, Portland Area, Washington State, and 24 Reservation States, Calendar Years 1981 - 1985, Comparable U.S. All Races Rates, Mortality Rates Per 1,000 Population, Infant Mortality Rates Per 1,000 Live Births.

| CRUDE DEATH RATE[1] | 1981 | 1982 | 1983 | 1984 | 1985 |
|---|---|---|---|---|---|
| Puget Sound Service Unit | 4.5 | 4.1 | 4.0 | 4.5 | 3.9 |
| Portland Area | 6.1 | 6.7 | 6.9 | 5.2 | 4.8 |
| U.S. All Races | 8.8 | 8.5 | 8.6 | 8.6 | 8.7 |
| INFANT MORTALITY RATE | | | | | |
| Puget Sound Service Unit | 23.0 | 5.8 | 12.0 | 9.4 | 4.9 |
| Washington State | 10.5 | 10.7 | 9.5 | - | - |
| Portland Area | 16.8 | 15.3 | 12.8 | 9.6 | 10.9 |
| 24 Reservation States | 11.9 | 11.0 | 10.2 | 9.8 | - |
| U.S. All Races | 11.9 | 11.5 | 11.2 | 10.8 | 10.6 |
| AVERAGE AGE AT DEATH | | | | | |
| Includes Infants | | | | | |
| Puget Sound Service Unit | 42.7 | 52.3 | 52.9 | 50.9 | 50.4 |
| Portland Area | 47.6 | 50.1 | 53.4 | 51.7 | 46.6 |
| Excludes Infants | | | | | |
| Puget Sound Service Unit | 48.6 | 54.1 | 57.3 | 53.7 | 55.2 |
| Portland Area | 52.0 | 53.9 | 57.3 | 54.3 | 51.2 |

[1]NOTE: The lower death rates for the Puget Sound Service Unit and Portland Area compared with U.S. All Races may be a consequence of a younger population rather than a more favorable mortality. Because deaths occur more frequently among aged persons, you would expect areas with a large aged population to show higher crude death rates than younger population groups, even though the aged population group has better health conditions overall. The Indian population residing in Reservation States (the states in which IHS has responsibilities) is younger than the U.S. All Races population, based on the 1980 Census. For Indians, 32 percent of the population was younger than 15 years, and 5 percent was older than 64 years. For the U.S. All Races population, the corresponding values were 23 and 11 percents respectively. The Indian median age was 22.6 years compared to 30.0 years for U.S. All Races.

# Appendix E

*Population Estimates*


Population by Age and Sex
Male
Female
60+
50–59
40–49
30–39
20–29
10–19
Under 10
US.—All Races
Suquamish
Portland-Area
1980 Census

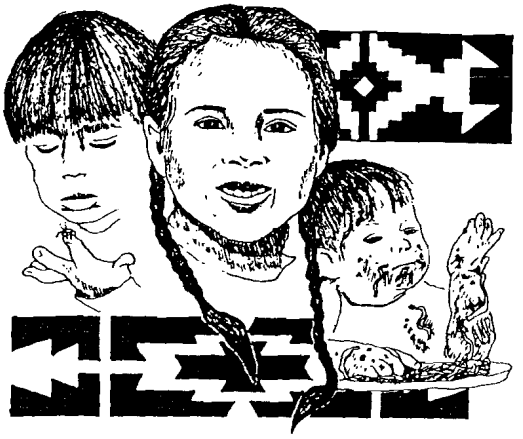
# Official User Population

## Portland Area Indian Health Service
## FY 1987 Planning Year

| Service Unit | Tribal Population | Service Unit Population |
|---|---|---|
| **AREA TOTAL** | **62,770** | **62,770** |
| COLVILLE | | 5,448 |
| Colville | 5,445 | |
| FORT HALL | | 5,299 |
| Shoshone/Bannock | 5,299 | |
| NEAH BAY | | 2,222 |
| Makah | 1,128 | |
| Lower Elwha | 497 | |
| Quileute | 511 | |
| Jamestown | 86 | |
| NORTHERN IDAHO | | 4,734 |
| Coeur d'Alene | 1,307 | |
| Kootenai | 109 | |
| Nez Perce | 3,318 | |
| NW WASHINGTON | | 4,237 |
| Lummi | 2,797 | |
| Nooksack | 636 | |
| Swinomish | 550 | |
| Upper Skagit | 254 | |
| PUGET SOUND | | 12,600 |
| Muckleshoot | 1,440 | |
| Nisqually | 689 | |
| Puyallup | 5,127 | |
| Skokomish | 791 | |
| Squaxin Island | 664 | |
| Tulalip | 1,890 | |
| Suquamish | 633 | |
| Port Gamble | 767 | |
| Sauk Suiattle | 332 | |
| Stillaguamish | 267 | |

| Service Unit | Tribal Population | Service Unit Population |
|---|---|---|
| TAHOLAH | | 2,957 |
| Chehalis | 389 | |
| Hoh | 85 | |
| Quinault | 2,299 | |
| Shoalwater Bay | 184 | |
| UMATILLA | | 2,518 |
| Umatilla | 2,518 | |
| WARM SPRINGS | | 4,918 |
| Burns Paiute | 237 | |
| Warm Springs | 3,263 | |
| Klamath | 1,418 | |
| WELLPINIT | | 3,137 |
| Kalispel | 346 | |
| Spokane | 2,791 | |
| WESTERN OREGON | | 6,602 |
| Siletz | 1,455 | |
| Cow Creek | 392 | |
| Grand Ronde | 1,255 | |
| Coos | 671 | |
| School | 471 | |
| All Others (Direct Care) | 2,352 | |
| YAKIMA | | 8,098 |
| Yakima | 8,098 | |

Prepared by Office of Planning and Evaluation
January 1987



# IHS USER POPULATION ESTIMATES

## By Area and Service Unit

## FY 1987

| | 1987 Service Population Estimates | Indian Registrants | Active Indian Registrants | Indian User Population Estimates |
|---|---|---|---|---|
| **PORTLAND AREA TOTAL** | **103,084** | **68,499** | **36,763** | **54,059** |
| Colville | 5,949 | 6,055 | 3,362 | 4,783[1] |
| Fort Hall | 4,201 | 5,491 | 4,433 | 4,433 |
| Neah Bay | 2,485 | 2,672 | 1,482 | 2,111[1] |
| Northern Idaho | 8,851 | 5,760 | 3,058 | 4,550[1] |
| Northwest Washington | 5,108 | 5,435 | 3,326 | 4,294[1] |
| Puget Sound | 31,622 | 12,028 | 489 | 9,502[1] |
| Taholah | 3,634 | 2,912 | 1,738 | 2,300[1] |
| Umatilla | 1,857 | 2,383 | 1,693 | 1,693 |
| Warm Springs | 7,105 | 4,938 | 3,412 | 3,901[1] |
| Wellpinit | 2,082 | 3,226 | 1,995 | 2,549[1] |
| Western Oregon | 20,963 | 7,484 | 3,744 | 5,912[1] |
| Yakima | 9,227 | 10,115 | 8,031 | 8,031 |

[1] Estimated by using percent active factor (79) determined based on data from other Area service units.

# Appendix F

*Legal Opinion of Use of Insurance*

DATE: April 15, 1981

FROM: Assistant Regional Attorney
Office of General Counsel, Region X

SUBJECT: P.L. 93 220/Tribal Participation in Prepaid Health Plan

TO: William Knestis, Indian Health Service Rep., PHS

You have asked our opinion on whether IHS can legally fund the Swinomish Tribe's participation in a prepaid health plan. It is our opinion that your question must be answered in the affirmative.

As you are aware, the Act of August 5, 1954 (42 U.S.C. S 2001 et seq.) does not authorize IHS to purchase health insurance on behalf of Indian beneficiaries. That act, as amended by Section 6 of P.L. 93-220 (the HMO Act), does authorize the Secretary of Health and Human Services, with the consent of the Indian people served, to contract with an HMO, or health agency, or organization for the provision of health services; provided that payment for those services is made on a fee for service, on a prepayment, or other similar basis. See 42 U.S.C. S 2001 (b).

We believe the terms health agency and/or health organization can be applied to any agency, group, individual or organization whose business is the delivery of health care services. Within the state of Washington, HMOs and Health Care Service Contractors meet that standard.

Health Care Services Contractors are defined at RCW 48.44.010 (3):

> (3) "Health care service contractor" means any corporation, cooperative group, or association, which corporation, cooperative group, or associations is sponsored by or otherwise intimately connected with a group of doctors licensed by the state of Washington or by a group of hospitals licensed by the state of Washington; or doctor licensed by the state of Washington: or group of doctors licensed by the state of Washington, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups as consideration for providing such persons with any health care services. The term also includes any corporation, cooperative group, or association, sponsored by or otherwise intimately connected with a group of pharmacists registered by the state of Washington; or any pharmacist, or group of pharmacists, registered by the state of Washington: who or which not otherwise being engaged in the insurance business, accept prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services. (emphasis added)

Attached, is a list, supplied to us by the Washington State Insurance Commissioner, of HMOs and Health Care Service Contractors currently licensed to do business within the state of Washington. It is our opinion that pursuant to Section 6 of P.L. 93-220, IHS can contract with any provider on that list.

Ernest J. Ishem, Jr.

Attachment
cc: C. S. Stitt, Jr., D.D.S.,
Director, Portland Area Indian Health Service

# Appendix G

*Calculation of Per Capita Costs*

# Calculation of Per Capita IHS Costs

An assumption was made based on previous utilization that 75% of all registered Indian patients were eligible for Contract Health Services (CHS). The remaining 25% were eligible for and using IHS direct care facilities. Based on this assumption, the following per capita costs were derived for Fiscal Years 1986 and 1987:

1. Total Portland Area expenditures for health care were calculated for the 75% CHS eligible population.

| | Fiscal Year 1986 | Fiscal Year 1987 |
|---|---|---|
| A. Recurring | $13,675,940 | $16,169,300 |
| B. Non-Recurring | 795,100 | 1,333,250 |
| | $14,471,040 | $17,502,550 |
| | x .75 | x .75 |
| | $10,853,280 | $13,127,000 |

2. These funds were added to recurring and non recurring CHS expenditures for the Portland Area for the same years. CHS funds for dental care ($1,500,000 per year), optometry ($500,000 per year) and the Suquamish Benefits Package were excluded in making this calculation.

| | Fiscal Year 1986 | Fiscal Year 1987 |
|---|---|---|
| A. Recurring | $18,638,000 | $19,303,000 |
| B. Non-Recurring | 212,000 | 419,000 |
| | $18,850,000 | $19,722,000 |
| + Direct Expenditures | $10,853,280 | $13,127,00 |
| | $29,703,280 | $32,849,000 |

3. The CHS eligible population for Portland Area was derived by multiplying registered patients by 75%

| Fiscal Year 1986 | Fiscal Year 1987 |
|---|---|
| 62,770 | 68,499 |
| x .75 | x .75 |
| 47,078 | 51,374 |

4. Per Capita costs were derived by dividing the number of patients registered by total expenditures as shown below:

| | |
|---|---|
| Fiscal Year 1986 | $29,703,280 / 47,078 = $630 |
| Fiscal Year 1987 | $32,849,000 / 51,374 = $639 |

# Appendix H

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