Oklahoma City Area Inter-Tribal Health Board

Health Care for American Indians and Alaskan Natives & U.S Health Care Reform

June 9, 2009

Background

The provision of health care to American Indian and Alaskan Native (AI/AN) people has been guaranteed through treaties and federal law. Health care for AI/AN people was permanently authorized in the Snyder Act of 1921 (25 U.S.C. § 13).

Indian Health Care Improvement Act (P.L. 94-437), as amended, is a cornerstone to the health care delivery system for AI/AN people. The IHCIA has provided numerous benefits to the AI/AN delivery system by creating provisions to increase manpower and infrastructure capacity, participate in federal entitlement programs, enhance behavioral health services and provide care for AI/AN people located in the major urban centers throughout the U.S. However, this law has expired, and reauthorization efforts have languished in Congress. Some current proposals in Congress even suggest to dismantle the IHCIA by severing various provisions and incorporating them into a comprehensive national health care reform bill. The 44 tribes that comprise the Oklahoma City Area Inter-Tribal Health Board (OCAITHB) oppose any such effort, and insist that the IHCIA be reauthorized expeditiously by the 111th Congress.

On June 5, 2009, the OCAITHB hosted a meeting to discuss national health care reform and supports the majority of the proposals of offered by the joint effort of the National Congress of American Indians/National Indian Health Board, including selected provisions of previous Indian Health Care Improvement Act reauthorization legislation. However, provisions that affect and expand the authority of Urban Indian health programs must be carefully examined in order to have a full understanding of the implications on the unique legal and political status of Tribes.

U.S. Indian Health Service

The U.S Indian Health Service (IHS) has been the primary provider of health care to AI/AN people since 1955. Much has been accomplished since then in terms of improvements in public health and health care delivery, but much more improvements are still needed. The AI/AN population still suffers vast disparities in overall health status, and

the funding appropriated to the IHS is abysmal relative to the per capita health care amount provided to other federally-funded population groups (e.g., federal employees, Medicaid beneficiaries and even federal prisoners).

Moreover, the IHS has been characterized over the past decade as a "broken" system. The truth is that the IHS system is not so much broken, as it is "starved." The IHS has been grossly underfunded for the past several decades, and as such, cannot be expected to perform optimally. Such inadequate funding has created the perception that the system is broken.

The IHS has recently announced an initiative calling for a "Renewal of the IHS," wherein core benefits packages are determined and eligibility for services is revised. While the concept of a core benefits package is ideal, without the necessary funding, it is not realistic. The disparity is size of the tribes throughout the U.S., ranging from a few dozen citizens in some to over 300,000 citizens in the largest tribes, makes such benefits packages unattainable at current appropriations levels. Correspondingly, eligibility for service benefits must not be changed.

Eligibility for Services

General:

Current eligibility regulations clearly define who may receive services within the scope of IHS-funded health care programs. Any change in eligibility without dramatically increased funding, and a corresponding change in funding allocation methodologies, as well as changes in the type and volume of services offered at each local delivery program would result in catastrophe. Patients would naturally choose to seek care wherever the most comprehensive level of care is provided, thereby taxing the capacity and resources of a select few local delivery systems, while rendering the deserted systems unnecessary. Additionally, an examination of eligibility criteria for the purpose of limiting the number of beneficiaries to individuals that the federal government deems to be an acceptable American Indian/Alaska Native blood quantum is unacceptable. Rather than examining methods to reduce the number of IHS eligible beneficiaries, Congress has a real opportunity to better utilize the Indian health system, which has demonstrated the ability to provide efficient and effective health care, even with inadequate resources.

Services to Non-Beneficiaries:

Some, but not all, Tribes have been able to implement expansions of capacity in their local health care delivery system through economies of scale and supplemental funding mechanisms. Others still, have sought to improve their local systems through the provision of excess capacity and/or select services in short supply in their communities by extending services to others in the general public (i.e., non-beneficiaries of existing IHS health programs). A significant barrier to such initiatives is malpractice insurance. While tribal health programs are generally covered by Federal Tort Claims Act (FTCA) for their AI/AN patients, there is controversy over whether this protection extends to non-beneficiaries. By allowing FTCA to cover non-beneficiaries seen by tribal health programs, the IHS could provide additional capacity that will be needed after health reform is enacted.

Tribal programs must have the decision making authority on whether to serve non-beneficiaries or not. For those tribes who choose to serve non-beneficiaries, FTCA coverage must be extended to any non-beneficiary whose service is publically funded through grants, insurance or other public subsidy.

AI/AN Participation in U.S. Entitlement Programs

1. If an AI/AN is in an I/T/U service area then they should be eligible for voluntary enrollment if they are otherwise eligible in any of the new plans and they shall be eligible for any subsidies to which they would otherwise be eligible.
2. AI/AN beneficiaries eligible for new programs or expansion of programs shall have no time limitation on enrollment to allow freedom of choice for beneficiaries and tribes.
3. Tribes and AI/AN beneficiaries shall be exempt from taxation on health benefits and premiums.
4. Provisions shall be added to any reform legislation for tribes to be able to pay premiums for insurance and Medicare on behalf of tribal members.
5. All managed care protections in the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) must extend to health care reform legislation.
6. Tribes shall be exempted from employer mandates and financial penalties included in the mandate.
7. Should a mandatory participation for individuals be included in health care reform legislation, allowing the (AI/AN) population to "opt-out" of mandatory participation solely based on an individual's status as a Tribal citizen must be carefully examined. While the Indian health system should meet all of the health needs of AI/ANs, the reality is that it does not. The lack of adequate funding, sparsely located facilities, and limited services have created a situation where AI/ANs do not have access to health care. For this reason, the U.S. Census Bureau's Current Population Survey (CPS) has determined that individuals who report Indian Health Services (IHS) and no other coverage are classified as uninsured. Therefore an exemption from mandatory participation without addressing the funding and accessibility deficiencies within the Indian health system will have a negative affect on the health of AI/ANs.
8. Clarification of IHS eligibility as "creditable coverage". An IHS eligible AI/AN should not be barred from qualifying for a subsidized premium through an "exchange," "connector," or "gateway" which offers public subsidies for individuals without actual insurance coverage, and should not be assessed a penalty if he/she does not acquire such insurance coverage. Additionally, IHS eligibility should be considered creditable coverage in order to protect an AI/AN from penalties in the form of added cost (such as a late enrollment penalty) if the AI/AN does not immediately acquire insurance coverage.

Funding

The IHS is currently funded at approximately 54% of the identified need. Until the IHS is fully-funded (i.e., 100% of need), the extent to which this system is truly broken, and therefore, in need of reform, cannot be determined.

Conclusion

While advocating for adequate resources to carry out the federal government's trust responsibility, Tribes have often been placed in a precarious position of highlighting the deficiencies within the Indian health system while promoting the positive aspects. OCAITHB Tribes have reached the conclusion that the framework for a strong system exists to meet the health needs of AI/ANs, many positive things are happening, and with adequate funding the Indian health system could be a model for a health care delivery system that emphasizes primary care services.

Out of necessity, the Indian health system has demonstrated the ability to provide a high level of care with miniscule resources. A shining example of realizing cost efficiencies with federal resources is the Special Diabetes Program for Indians (SDPI). Through the SDPI, numerous activities have been initiated including the hiring of health professionals, education programs, nutrition counseling, exercise programs, medical supplies, health screenings, school grants, specialty care, and a host of other services designed to address the diabetes epidemic in Indian Country. While it has required a financial investment, the SDPI has realized substantial cost savings through decreases in pharmaceutical use, amputations, kidney failure , etc.