

National Indian Health Board



THE INDIAN HEALTH PERSPECTIVE IN HEALTH CARE REFORM

The National Indian Health Board (NIHB) has established a health care reform workgroup to review and analyze health care reform concept papers, proposals, and legislation. This document identifies key points and guiding principles, and supplies factual information regarding the Indian health care delivery system for use by the Obama Administration and Congress in the development of any health care reform legislation.

INDIAN HEALTH SPECIFIC KEY POINTS FOR DEVELOPMENT OF HEALTH CARE REFORM LEGISLATION:

- Health care reform legislation must retain the current Indian health care delivery system, a comprehensive system that provides culturally competent health care to 1.9 million American Indians and Alaska Natives (AI/ANs), especially those in remote areas not served by the mainstream health care.
- Such legislation must include Indian-specific provisions to assure that reform options can work in the unique Indian health delivery system.
- Health care reform legislation must take into account the multiple roles of Indian Tribes as providers, payors, employers, and governmental entities.
- Any expansion of Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) must preserve the authority of Indian health programs to be fully participating providers in both the existing and enhanced programs.
- Any new public program created to cover the uninsured must be equally available to AI/ANs who use the Indian health system, and, where necessary, contain Indian-specific language and funding to assure that AI/AN enrollees can fully utilize the benefits covered by such program.
- Health care reform legislation must address the chronic underfunding of the Indian health system and must include full funding and/or mechanisms to achieve full funding.
- Health care reform legislation that proposes premiums or cost sharing requirements should include an exemption or 100% subsidy for AI/ANs.

INDIAN HEALTH SYSTEM GUIDING PRINCIPLES:

Indian Country has articulated guiding principles for the new Administration and Congress to follow in the development of any health care reform:

- **Trust Responsibility:** Health care reform initiatives must be consistent with the federal government's trust responsibility to Indian Tribes acknowledged in treaties, statutes, court decisions and Executive Orders.
- **Government-to-Government Relationship:** Indian Tribes are not simply another interest group. They are recognized in law as sovereign entities that have the power to govern their internal affairs. Based on the government-to-government relationship with the federal government, Tribes need to be at the table in any discussions on health care reform initiatives that affect the delivery of health services to AI/AN people.
- **Special Legal Obligations:** It is the policy of the United States, in fulfillment of its legal obligation to Tribes, to meet the national goal of achieving the highest possible health status for AI/ANs to provide the resources necessary for the existing health services to affect that policy.
- **Tribal Control and Management:** The legal authority of Tribal governments to determine their own health care delivery systems, whether through the Indian Health Service (IHS) or Tribally-operated programs, must be honored.
- **Distinctive Needs of AI/AN People:** A community-based and culturally appropriate approach to health care is essential to preserve Indian cultures and eliminate health disparities. The extremely poor health status of Indian



people demands specific legislative provisions to increased funding to break the cycle of illness and addiction that began with the destruction of a balanced Tribal lifestyle.

- **Access to Care:** Indian health care services are not simply an extension of the mainstream health system in America. Through the IHS, the federal government has developed a unique system based on a public health model that is designed to serve Indian people in remote reservation communities. The Indian health delivery system must be supported and strengthened to enhance access to health care for AI/ANs.

FACTUAL INFORMATION ON THE INDIAN HEALTH DELIVERY SYSTEM:

The Federal Government has a trust responsibility to provide health care to AI/ANs, based on the Indian Commerce Clause of the U.S. Constitution, and confirmed through treaties, federal law, and federal court decisions. In treaties negotiated during the 18th and 19th centuries, Indian Tribes ceded over 400 million acres of land in exchange for health care for their people. The Indian Health Care Improvement Act (IHCIA), (Pub. L. 94-437), along with the Snyder Act of 1921 (25 U.S.C. 13), form the statutory basis for the delivery of federally-funded health care to AI/ANs.

The IHS, an agency within the Department of Health and Human Services (HHS), provides comprehensive health care services – using a public health model – to 1.9 million AI/ANs residing in tribal communities located in 35 States. The IHS directly operates 31 hospitals, 52 health centers, 2 school health centers, and 31 health stations. In addition, Tribes and Tribal organizations, through contracts and compacts under the Indian Self-Determination and Education Assistance Act (ISDEAA), operate almost 50% of the IHS system and provide health care in 15 hospitals, 256 health centers, 9 school health centers, and 282 health stations (including 166 Alaska Native village clinics). The IHS or Tribes/Tribal organizations also operate 11 regional youth substance abuse treatment centers and 2,241 units of staff quarters. In addition, IHS provides funding for Indian health centers located in 34 urban areas.

The IHS and tribal programs are authorized to bill Medicare, Medicaid and State Children’s Health Insurance Programs for services provided in their facilities. State Medicaid Programs are reimbursed at 100% Federal medical assistance percentage for services provided to AI/ANs in these facilities. To the extent that needed direct care cannot be provided by the IHS or Tribes, services are purchased from private and public sector providers under a contract health services (CHS) program. Private and public Medicare participating hospitals providing CHS services to AI/ANs are paid at reimbursement rates similar to Medicare payment rates. The IHS and tribal programs are residual payors to other federal health programs and private insurance.

The IHS is a discretionary funded program with annual appropriations of \$3.3 billion (FY 2008) for health program operations, preventive health programs, facility construction, maintenance and improvement, and construction and operation of sanitation facilities. Additional funding is supplied from Medicare and Medicaid collections estimated at \$780 million/year, diabetes funding of \$150 million/year, and \$6 million in staff quarters rental collections. The IHS system has a total operating budget of \$4.3 billion. Even so, the IHS system is funded at only approximately 50% of the level of need in comparison to services available to the general population. In some parts of Indian Country, health care is limited to “life or death” emergencies. As a result, AI/ANs suffer lower life expectancies, disproportionate health disparities, and die at higher rates from alcoholism (550% higher), diabetes (190% higher), and suicide (70% higher) than the general U.S. population.