

Malcolm Wiener Center for Social Policy

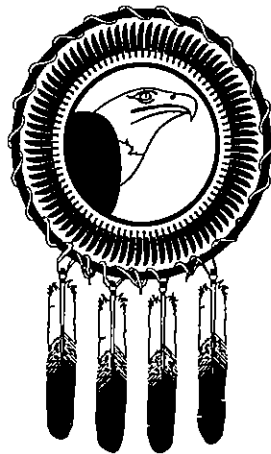
*The Impact of the American Health Security Act on Native Americans:
A Report to the Grand Traverse Band
of Ottawa and Chippewa Indians*

by

Alyce Adams and Martin Marciniak

PRS 94-1

April 1994



Harvard Project on
American Indian Economic Development

John F. Kennedy School of Government
Harvard University

The views expressed in this paper are those of the author(s) and do not necessarily reflect those of past and present sponsors of the Harvard Project on American Indian Economic Development, the Malcolm Wiener Center for Social Policy, the John F. Kennedy School of Government, or Harvard University. Reports to tribes in this series are currently supported by the Christian A. Johnson Endeavor Foundation. The Harvard Project is directed by Professors Stephen Cornell (Udall Center for Studies in Public Policy, University of Arizona), Joseph P. Kalt (John F. Kennedy School of Government, Harvard University) and Dr. Manley Begay (John F. Kennedy School of Government, Harvard University. For further information and reproduction permission, contact Dr. Begay at (617) 495-1338.

TABLE of CONTENTS

EXECUTIVE SUMMARY	iii
I. INTRODUCTION	
A. PURPOSE	1
B. INDIAN HEALTH SERVICE	2
II. RESEARCH METHODOLOGY	
A. REVIEW of LITERATURE	3
B. SOURCES of INFORMATION	4
1. INTERVIEWS	4
2. NEW MEXICO CONFERENCE of the SOUTHWESTERN TRIBES	5
C. LIMITATIONS of RESEARCH METHODS	5
III. UNDERSTANDING the HEALTH CARE FUNDING PROCESS	
A. FEDERAL FUNDING SOURCES	6
1. IHS FUNDING PROCESS	6
2. ADDITIONAL FEDERAL FUNDING SOURCES	7
B. TRIBE/INDIVIDUAL FUNDING	8
C. UNDERSTANDING FUNDING TRENDS	8
IV. UNDERSTANDING HEALTH SERVICE DELIVERY	
A. ISSUES	9
1. ACCESS	9
2. QUALITY	11
3. CULTURAL SENSITIVITY	11
4. LONG-TERM CARE	12
B. REASONS for DEFICIENCIES in SERVICE	12
C. CONCLUSIONS and RECOMMENDATIONS: FUNDING and SERVICE DELIVERY	13
D. SERVICE UNDER HEALTH CARE REFORM	14

E. THE AMERICAN HEALTH SECURITY ACT	14
F. EVALUATION of the IMPACT of AHSA	15
G. ALTERNATIVE PLANS for REFORM	18
H. The EFFECT of RESTRUCTURING GOVERNMENT: FTE REDUCTIONS	18
V. UNDERSTANDING ELIGIBILITY and ENROLLMENT	
A. ELIGIBILITY	20
B. ENROLLMENT	22
1. ELECTION	22
2. ENROLLMENT	23
C. CONCLUSIONS and RECOMMENDATIONS with REGARD to ELIGIBILITY and ENROLLMENT	25
VI. UNDERSTANDING REGIONAL HEALTH ALLIANCES	
A. MANAGED CARE	27
B. ALLIANCES	29
C. CONCERNS with REGIONAL HEALTH ALLIANCES	30
D. SHOULD REGIONAL HEALTH ALLIANCES CARE about NA/AN NEEDS?	31
E. CONCLUSIONS and RECOMMENDATIONS with REGARD to REGIONAL HEALTH ALLIANCES	32
VII. SUMMARY and CONCLUSION	34
APPENDIX A. GLOSSARY	
APPENDIX B. BIBLIOGRAPHY	
APPENDIX C. TITLE VIII, SUBTITLE D of THE AMERICAN HEALTH SECURITY ACT	
APPENDIX D. PRESENTATION SLIDES	

Executive Summary

There are six major health care reform plans weaving their way through Congressional committees. Yet, despite these legislative efforts, no plan adequately addresses the needs of Native Americans and Alaskan Natives (NA/AN). In fact, several of these plans devote only a line or two to NA/AN health care, and basically affirm their desire to continue supporting the Indian Health Service (IHS). The American Health Security Act (AHSA), while devoting an entire section to NA/AN health care, faces the same problems as those plans offering only token statements. Health care reform, in NA/AN communities, is fundamentally different from national health care reform. **NA/AN health care reform is not about providing a comprehensive core benefit package, it is about funding and resources.**

Despite legislative efforts to improve the health of NA/AN, the overall health conditions of these populations remain below the national average. Health care reform, rising to a position of prominence on the national agenda in 1993, provides an opportunity to address those health issues specific to NA/AN communities. With numerous health care reform proposals on the table, only the AHSA, specifically addresses the health issues of these communities in some detail. **In addition, issues of funding, service delivery, eligibility and enrollment, and private sector participation create further concerns about how to transform health care reform in these communities into a reality.**

The primary source of health care for NA/AN is the IHS. Created in 1955, the IHS arose out of a patch work series of health services provided by the Bureau of Indian Affairs (BIA). Pursuant to the Transfer Act of 1954, all BIA staff, hospitals, and infirmaries associated with NA/AN health care were moved to the Public Health Service (USPHS) where they are administered by the U.S. Surgeon General. This shift reinforced the government's desire to play an active role in the health care of NA/AN. However, increasing health problems among NA/AN prompted the Federal government to pass the Indian Health Care Improvement Act of 1976. While this act appears to

have improved NA/AN health, the health conditions found in these communities remain lower than those in the rest of the country.

Escalating health care costs, publicity surrounding the uninsured, and the inefficiency of the Medicaid and Medicare programs have created a crisis environment that is stimulating the development of health care reform proposals. In NA/AN communities, the health care crisis consists of inaccessibility to health care facilities, the lack of medical staff and equipment, and the scarcity of facilities for the elderly and chemically dependent. For NA/AN, the national health care reform movement has created a window of opportunity through which tribal leaders may have the ability to secure improvements in the quality of care delivered within their communities. The continued support of Dr. Philip Lee, the Assistant Secretary for Health at the Department of Health and Human Services (DHHS), and First Lady Hillary Rodham Clinton will prove instrumental in this process. Both individuals have worked as advocates of NA/AN health issues, and have elevated it to a place of prominence in the national health care reform debate.

NA/AN may pursue several strategies in their effort to participate in the reform of the health care system. However, NA/AN must address the following issues in any health care reform policy they choose.

- The IHS Funding Process: While the offices of the Indian Health Service have been under the auspices of the DHHS since 1954, the appropriations process for this agency remains located in the Committee on the Interior. Therefore, the IHS must compete with the National Park Service and other agencies for committee consideration. Also, a recurring base system and spending plans of the area directors determine allocation of the funds to the area offices. Under this system, NA/AN can only indirectly influence the allocation of funding through the area office directors.
- Service Delivery: High rates of substance abuse, a growing elderly population, cultural issues and distance to IHS facilities complicate service delivery to NA/AN. Among

those services provided by the IHS, specialized care services (e.g. nursing homes and drug treatment centers) are scarce. For many NA/AN living on rural reservations, primary care services are inaccessible due to travel distances. 55 miles represents the average travel distance to a non IHS facility, according to the USPHS. In addition, many private care providers are unaware of the cultural factors that influence health care for NA/AN, thereby further hindering their access to non-IHS facilities.

•Eligibility and Enrollment: Given that NA/AN tribes have different requirements for membership, basing access to health care service on tribal membership would cause some NA/AN to go without care. For instance, if an NA/AN marries into a tribe, but does not have the blood quantum level required for membership in any one tribe, they will be ineligible for services under such a system. Also, isolation and cultural issues may prevent some NA/AN from enrolling in a health care system. Therefore, in addition to membership requirements, mandatory individual enrollment may also leave some individuals without health care.

•Regional Health Care Alliances: The AHSA proposes the use of regional health care alliances for obtaining health care insurance coverage. Should a tribe or member thereof choose to opt out of the Federal system and choose private care, the tribe or the individual may become a member of a health alliance. The nature of an alliance is such that the social position of the local community will help define its strength as an alliance. Given the poor health conditions prevalent on some reservations, the alliance may experience difficulty providing affordable insurance for reservation members.

The strategy for NA/AN in extending health care reform to "Indian Country" will happen in two areas, inter-tribal coordination and support of national legislation. First, tribes must decide to

what degree they want to coordinate with one another to become national players in health care reform. Options include each tribe pursuing an agenda of its own with Dr. Lee and other policy makers, or create an inter-tribal group to pursue such tasks. Secondly, NA/AN leaders must decide to what extent they should support current legislative proposals. They can support the AHSA, one of the alternative plans, or not support any of the initiatives. Regardless of the decision, tribes must develop criteria which any plan must pass in order to receive mass support.

Recognizing that the aforementioned issues complicate health care reform in NA/AN communities, any plan chosen by tribal leaders should:

- **Employ the support of Dr. Lee and other national leaders.**
- **Set well defined goals regarding the improvement of health conditions.**
- **Increase the participation of NA/AN leaders in the funding and planning processes.**
- **Recognize that the windows of opportunity may close before the issues of Indian Country have been adequately addressed unless time constraints are included in the plan.**

While initiatives by one tribe may lend themselves to well defined goals, they may detract from the overall goal to improve health care for all NA/AN. In addition, individual tribal lobbying efforts may tax the time of influential policy makers and extend the period of policy development. As a result, the window of opportunity may close before all tribal issues are addressed. Also, the tribes which have the greatest barriers to service delivery may not have the money to support an individual lobbying effort.

Inter-tribal coordination would reduce the amount of time spent lobbying legislators and policy makers. However, the goals may become less clear, the concern of smaller or less politically active tribes may be lost in the discussion, and the coordination between nations may take more time than the window of opportunity will allow. Regional discussion groups, such as those formed at the Regional Conference on Native American Health Care Reform (RCNAHCR) sponsored by the DHHS, may resolve these issues so that smaller or less politically active tribes

will not be overwhelmed and the broad goals will remain clear while emphasizing the diversity among tribes.

In deciding which plan to support if any, two strong advantages for supporting the AHSA exist. The plan already has a section devoted to NA/AN health issues and the DHHS is developing recommendations for the plan from the RCNAHCR. However, the AHSA may not pass through Congress in its current form. The AHSA may be subject to numerous revisions, before it is voted on by Congress. Furthermore, even with revisions, it still might not pass. If NA/AN do not work with the sponsors of other plans, which do not thoroughly address NA/AN issues, reform in NA/AN communities will not occur. Support of alternative plans provides an opportunity to shape changes in service delivery and funding. However, the legislative language in alternative plans remains limited. Therefore, structuring the legislation may take too much time. Also, once NA/AN leaders decide which plan to support, it may not pass Congress either.

The adoption of a standard criteria which any plan must meet in order to receive support of tribal nations presents the most viable option. This criteria should remain flexible so that it can be applied to any health care legislation. This allows time to focus on developing relationships with legislators and building political support, instead of developing legislation.

In order to become national players in the health care reform debate, NA/AN leaders must act quickly. We recommend that in the next three months tribes take the following steps:

Recommendations

- **Maintain and Expand the role of Regional Focus Groups:**

The tribes should **maintain and expand the regional discussion groups** developed as a result of the RCNAHCR. The positions papers provided to the DHHS should establish what problems need to be addressed immediately in order to improve health conditions in each region. **This group should develop a**

criteria to evaluate health care reform proposals, set short and long-term goals, and designate a representative to attend a national meeting on NA/AN health care reform. This group should coordinate with the National Congress of American Indians, the Indian Health Board and the Council on Native American Health to develop a strategy for achieving those goals. The regional focus/discussion groups are not meetings to air health care delivery grievances. They are proactive discussion groups that not only address and discuss health care reform issues, but develop and shape policy alternatives.

- **Develop Criteria:**

Do not support any of the health care reform plans exclusively. Instead, develop a set of criteria which can be applied to any health care reform package. These criteria must address the four key issues that are essential to any NA/AN health care reform package. These issues are:

- **Funding:**
IHS is currently funded at 70% of actual need. In order to improve the health status of these communities, **funding levels must increase.**
- **Service Delivery:**
IHS service infrastructure is antiquated. In order to improve the health status of these communities, **hospitals and clinics must be adequately staffed, have the appropriate equipment, and be located nearer to their service population.** IHS has attempted to improve cultural sensitivity within facilities by providing scholarships for NA/AN youth to attend medical school. However, **in order for this program to continue and for overall service to improve, IHS funding levels must increase to reflect the true cost of providing these services.**
- **Eligibility and Enrollment:**
Tribal membership qualifications and inaccurate census data make the active enrollment of NA/AN difficult. In order to maximize the number of NA/AN enrolled, **it will be necessary for tribes to develop universal membership criteria based on their nations respective Constitutions.** These lists, once developed, can be used to passively enroll NA/AN into an IHS health plan. **Funding depends on membership rolls, if lists are inaccurately developed and undercounting occurs, IHS programs will lack the necessary funds to service their true population.**

- **Regional Health Alliances:** Regional health alliances represent a viable option for some NA/AN communities. Because the IHS plan under the AHSA will not take effect until 1999, tribes need to evaluate the relative merits of moving to a health plan offered by a regional health alliance. The draw backs associated with committing to one of these plans is as follows: First, NA/AN will be expected to bear the full cost of the health plan; and second, a negative dynamic within the community may result in NA/AN groups being politically impotent and having little bargaining power with the insurance industry. **Therefore, tribes must make individual assessments based on their financial situation whether or not they will participate in a plan offered through a regional health alliance.**

The primary problems facing NA/AN health are a crisis in funding resources, and limited time with which to prepare and push for NA/AN health care reform. NA/AN leaders need to deal with these issues immediately. For specific recommendations on how to address these problems, please see table one. In the near future, Tribal Leaders will have to expand their focus to address other health related issues. For instance, should tribes concentrate efforts on establishing their own medical facilities? Should funding for the IHS be moved out of the Committee on the Interior? These questions are crucial to the future of health care in NA/AN communities. However, the challenge before NA/AN leaders is to act in the existing window of opportunity presented by the national movement to reform the American health care system.

Table One Recommendations

Recommendation for the Funding Process

- Increase the number of consultations between Area Office Directors and Tribal Leaders;
- Address the issue of the IHS appropriation process being located in the Committee on the Interior instead of the Department of Health and Human Service appropriation process.

Recommendations for Health Service Delivery

- Increase accessibility through decreased travel distances and increased funding for staff, facility construction and equipment;
- Continue to expand the supplemental services provided by the IHS, including preventative health and educational programs;
- Address issues of cultural sensitivity by using the native language of the tribe, and using traditional healers within the community;
- Provide community based long-term health care facilities, and drug and alcohol treatment centers.

Recommendations for Eligibility and Enrollment

- Tribes need to establish a minimum universal membership criteria, based on their respective Constitutions, in order to insure that full blooded Indians are not excluded from health care;
- Tribes should make this minimum membership criteria retroactive to 1990;
- The IHS and tribes need to use this minimum universal membership criteria to develop membership lists that will allow for passive enrollment of NA/AN.

Recommendations for Regional Health Alliances

- Tribes will need to set well defined goals regarding the exploration of plans offered through regional health alliances;
- Tribes should develop discussion groups that will examine the plans offered through the regional health alliance. Issues of particular importance are:
 - How tribal members will pay for health plans that are not offered through the IHS;
 - Will the health plans offered through regional health alliances cover those preventative and long-term health services that are necessary in NA/AN communities.

**The Impact of the American Health Security Act
on Native Americans**

**A Report to the Grand Traverse Band of
Ottawa and Chippewa Indians**

I. Introduction

A. Purpose

In 1993, President Clinton developed and formally presented the AHSA to Congress. However, while the AHSA has received the majority of press attention, it is only one of six major plans before Congress. These alternative plans advocate a number of different methodologies for health care reform, from single payor organizations to a free market system. Although an important piece of the health care puzzle, the AHSA will dominate these plans in the health care debate for the near future. The primary focus of this paper is Native American Health as it is defined in Title VIII, Subtitle D of AHSA.

Of critical importance to NA/AN is the treatment the AHSA gives to the IHS, Indian health programs, and the obligation of the United States to provide health care to Indian tribes. This paper will examine four key issues, critical to NA/AN: funding, health care service delivery, eligibility and enrollment, and the possible role of regional health alliances (RHA) in NA/AN health. Prior to discussing these issues in detail, we will provide a brief summary of our findings, background information on the IHS, and the methodology used in developing our conclusions.

In order to become a national player in the health care reform debate, NA/AN leaders must act quickly. We recommend that in the next three months tribes establish regional discussion groups that both explore and define the short and long term goals of health care reform for NA/AN. In addition, these discussion groups should not be used as a forum to air grievances about the current state of NA/AN health care delivery. These discussion groups should be used to explore, develop, and evaluate reform options as they relate to: funding, service delivery, eligibility and enrollment, and the role of regional health alliances in NA/AN communities.

B. Indian Health Service

The involvement of the USPHS in Indian health programs started in 1926, and was based on the Indian programs' need for medical personnel and health services.¹ While the initial thrust of this effort was the prevention of communicable diseases, the USPHS became the physicians and health care providers of NA/AN. Not until 1954 were Indian health programs moved from the Bureau of Indian Affairs, to the USPHS where they are administered by the U. S. Surgeon General. Now, the IHS runs Indian health programs. The goal of IHS is simple: elevate the health status of NA/AN to their highest possible level. To ensure equity, availability and accessibility to a comprehensive, high quality health care delivery system comprises the goal of the IHS. Programs developed through IHS and tribal governments encourage NA/AN involvement in defining their health care needs, setting health priorities for their local areas, and managing and controlling their health programs.²

As a result of their broad mandate, the IHS has developed an integrated program for the dissemination of health services to the NA/AN community. This system attempts to provide clinical services as well as promote public health programs and educational initiatives. Within their budgetary limitations, the IHS attempts to improve and increase the services their delivery system provides. This system includes:

- **comprehensive, curative, preventative and rehabilitative health care;**
- **supplemental services to improve access and appropriate utilization;**
- **public health, community and population based programs;**
- **traditional NA/AN beliefs and approaches to personal, spiritual and community health.³**

¹ U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Position Papers on Health Care Reform: Section 3: Background Issues for the IHS, (Washington: IHS, 1994) p. 1.

² U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Trends in Indian Health 1992. (Washington: IHS, 1992), p. 1.

³ Ibid. 1, p. 1.

This system attempts to meet the needs of an IHS service population which includes approximately 1.3 million NA/AN spread across 33 states.⁴ In Fiscal Year 1993 alone, the discretionary appropriation for IHS was \$1.537 billion for Indian health services and \$336 million for Indian health facilities, including domestic and community sanitation facilities.⁵

Discretionary appropriations are used to meet the diverse needs of over 500 Federally recognized tribes and 34 urban Indian organizations. This effects both the quality and quantity of services because funding levels vary on a yearly basis. Currently, IHS operates 50 hospitals, 140 service units, 164 health centers, 7 school health centers, 112 health stations, 172 Alaskan village clinics, and 28 urban clinics. Services within the urban areas range from the provision of outreach and referral services to delivery of comprehensive ambulatory health care.⁶ However, much of the service infrastructure is antiquated. For example, Jim Cournoyer, Director of the Sioux San Hospital stated in the November 24, 1993 "Indian Country Today" that his facility, built in 1938, and some of it in 1905, was never designed for the services offered now. Given the current resource limitations of IHS, and antiquated infrastructure, one can reasonably assume that other methods of program financing will play an increasingly important role in providing services to this community.

II. Research Methodology

A. Review of Literature

Our initial research focused on establishing a historical reference for Indian health care. Much of the necessary statistical information came from IHS and DHHS reports regarding trends in Indian health. Law journals, law reviews, and health care journals provided background information concerning the relationship between NA/AN and the services provided to them by the Federal Government. Also, information concerning the specifics of the AHSA came from summaries, analyses of the proposal and the public documents released earlier in the fall of 1993.

⁴ Ibid. 1, p. 1.

⁵ Ibid. 1, p. 2.

⁶ Ibid. 1, p. 2.

The second part of our search consisted of reviews of previous studies of NA/AN health care issue and related topics. Earlier studies provided background information, including the names of experts in this field. In order to develop an historical perspective, we consulted past policy analysis exercises (PAEs), reports conducted by members of the Harvard Project on Economic Development and the IHS.

B. Sources of Information

1. Interviews

During our research into the AHSA, we conducted phone interviews with Congressional committee staff members, IHS administrative officials, members of the Clinton administration's health care reform task force groups, Congressional legislative assistants and health organizations devoted to NA/AN issues. Upon the suggestion of Professor Joseph Kalt, we contacted staff members of Senate subcommittees as well as Mr. Justin Latus, who conducted a PAE on a similar issue one year ago. Initial interviews with Mr. Latus and Professor Kalt provided us with the names of task force participants and Congressional staff who assisted us in developing the background and framework for our analysis. These persons also informed us of ongoing deliberations concerning changes to the AHSA.

Contacts with the Indian Health Care Board (IHCB) and the National Congress of Native Americans served to connect us to NA/AN involved in health care reform, as well as to inform us of meetings conducted by the DHHS and other government agencies. During these interviews, we obtained the position papers of these organizations that detailed their concerns regarding the effect of the AHSA on NA/AN. Finally, the IHCB informed us of the New Mexico Conference, conducted by the DHHS in February of this year.

Interviews with IHS employees filled many gaps in our information regarding the philosophy, duties and structure of IHS. Cliff Wiggins, Keith Longie and the finance division of IHS proved particularly helpful in providing information concerning the IHS structure, local implemen-

tation structures and financing respectively. Their assessment of the AHSAs impact provided the groundwork for our own analysis.

2. New Mexico Conference of the Southwestern Tribes

The Albuquerque, New Mexico Conference on Health Care Reform in Indian Country, February 2-4, 1994, provided us with the opportunity to collect information from a diverse group of tribes regarding their health care concerns. DHHS held the conference in an effort to assess the quality of health care in NA/AN communities, and determine what changes in Federal policy were necessary to improve those conditions. In attendance were tribal leaders, the Assistant Secretary for Health and the Acting Director of the IHS revealed the main issue is the current status of health and health care in NA/AN communities. Panel discussion participants addressed many of the key issues characterizing the impact of health care reform on NA/AN. Overall, the conference served as a means to obtain a diverse array of information concerning NA/AN health care reform.

C. Limitations of Research Methods:

The manner in which the research was conducted created two important limitations for our analysis. First, the concerns expressed by tribal leaders at the New Mexico conference are not generalizable to all tribes across the nation. Data from the DHHS was used to supplement the conference information so that the issues identified could be generalized to tribes in other areas of the country. For example, data on travel distances and hospital resources confirmed that these issues were common to many tribes, not just those who attended the Albuquerque conference. Secondly, due to the vagueness and variability of the health care reform legislation we were unable to describe all of the components in detail. We do not believe that any alternate method of information gathering would have remedied this problem within this time period available. As a result of this uncertainty, we have recommended that tribes develop criteria which any health care reform legislation must pass in order to gain the political support of NA/AN leaders.

III. Understanding the Health Care Funding Process

Issues

- Appropriations for the IHS are considered by the same Congressional committee which oversees both the Department of Parks and Wildlife and Fisheries Department;
- Influence of Area Office Directors on the appropriation process and disbursement of funds to Indian Tribes;
- The macroeconomic impact of increasing health care costs on funding health care services in NA/AN communities.

Recommendations for the Funding Process

- Increase the number of consultations between Area Office Directors and Tribal Leaders;
- Address the issue of the IHS appropriation process being located in the Committee on the Interior.

III. Understanding the Health Care Funding Process

Trends in quality of service and capacity for reform greatly depend upon the nature of the funding process. The IHS, tribes, Medicaid/Medicare, and other government programs (to include Veteran's Assistance Programs), private insurance and individuals make up the primary sources of funding for Indian health. For a visual representation of this, please see chart 1. All of the Federal sources depend on Congressional appropriations, while the remaining sources depend on the economic well being of the tribes and their members.

A. Federal Funding Sources

1. IHS Funding Process

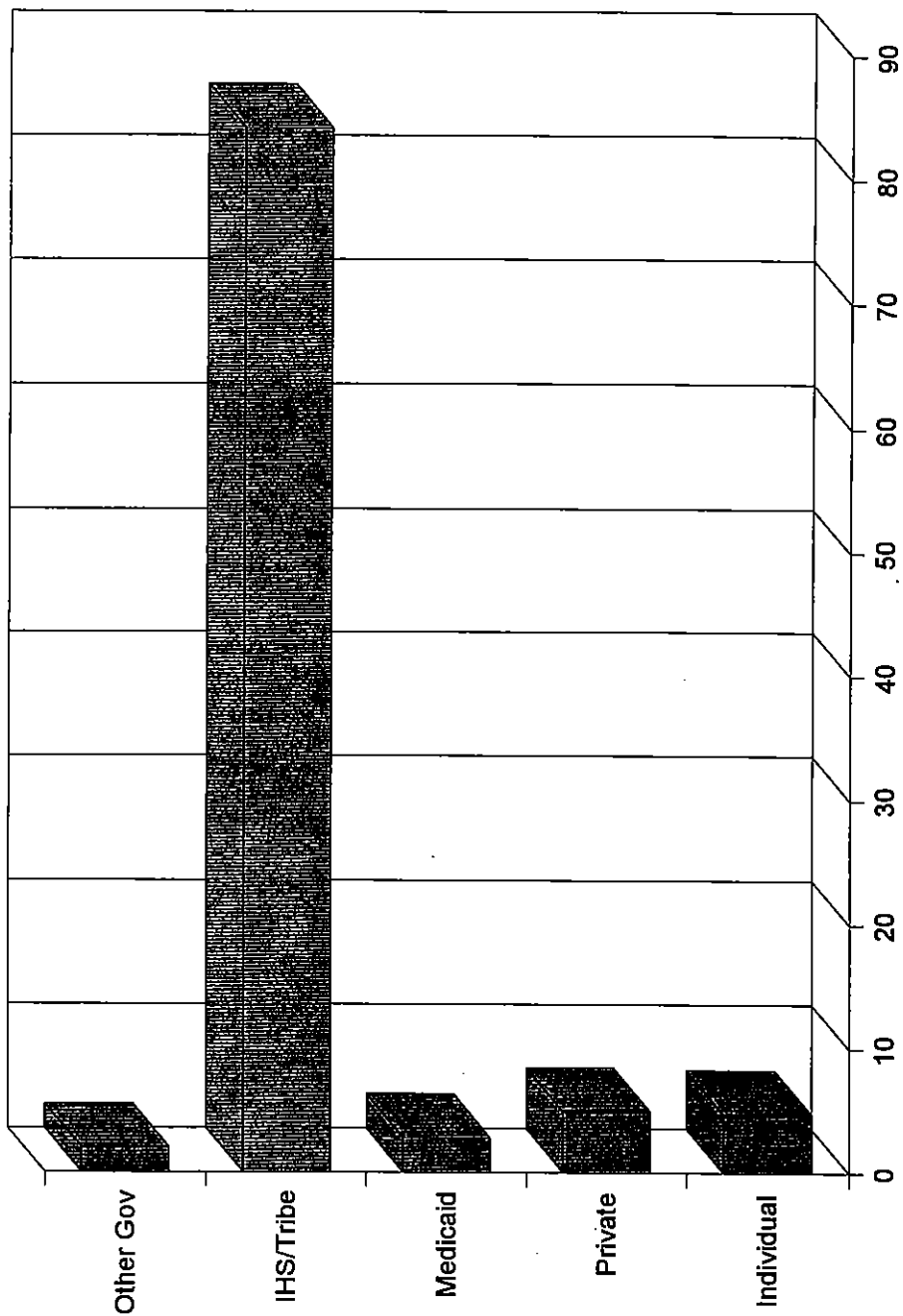
Appropriations for the Indian Health Service are considered by the same Congressional committee which oversees both the Department of Parks and Wildlife and the Fisheries Department. This standard operating procedure remained unchanged when the IHS was moved to the DHHS in compliance with the Transfer Act of 1955.⁷ The significance of this procedure lies in the fact that the above agencies are well established politically and efforts at reduced government spending has increased competition between agencies for funding. This may prevent the IHS from obtaining needed funds for its programs. Once money is appropriated, the IHS must submit an estimated distribution which proposes how the money will be spent (an apportionment) to the Office of Management and Budget. A recurring base system is used to allocate money between the 12 area offices. In other words, each office must receive a certain amount of money for operation and direct services each year. This money encompasses the majority of the appropriations. The Program Manager must distribute the balance by August first. In order to equate expected costs with allocations, area office directors create spending plans based on their appropriation costs, facilities and services.⁸

⁷ Conference on Health Care Reform for Native Americans, DHHS, February 2-4, 1994.

⁸ Interview with Jean Gatling, Indian Health Service, Division of Resources Management, March 15, 1994.

Chart 1

Funding Sources for Health Care



As currently constructed, the IHS divides its budget into three categories: primary/direct services, construction/facility maintenance, and supplemental services. Primary/direct services include clinical and preventative health services. Supplemental services include training programs, scholarship funds for Indian youths, and other non primary care services. Appropriations are divided into direct services and facilities categories and totaled 1.85 billion dollars in 1993, as compared to 1.5 billion dollars in 1992. Of the 1.85 billion dollars, over 80% was budgeted for clinical services, preventative health, urban health, tribal management, direct operations, self governance, contract support costs and other direct services. The remaining 333.64 million dollars was appropriated for construction and facility maintenance.⁹

2. Additional Federal Funding Sources

The Veterans Administration (VA) and Medicaid programs combined account for less than 10% of funding for Indian health care. Therefore, the main funding trends can be attributed to IHS appropriations and tribal/individual financing sources. Still, as of 1986, 700,000 Native Americans were Medicaid recipients. In that same year, over 4,000 Native Americans used VA hospitals. The majority of those served by the VA are World War II veterans in their 60's or older.¹⁰

Medicaid/Medicare funds and obligations make evaluation of funding trends difficult. In the mid 1980's, IHS began receiving Medicaid/Medicare funds directly. This funding procedure hinders comparisons of expenditures to appropriations. Also, outstanding bills or obligations further cloud the picture.¹¹ However, estimates state that the IHS is funded at only 70% of need.¹² Therefore, while overall funding for IHS has increased, any enhancements of the current package of service and/or continued growth of the service population will require sharp increases in resources for the agency.

⁹ Budget of the U.S. Government, FY 1994, Government Printing Office, Appendix-609.

¹⁰ Statistical Record of Native North Americans, U.S. Bureau of the Census, pp. 762-765.

¹¹ Ibid. 8.

¹² Ibid. 7.

B. Tribe/Individual Funding

Public Law 638 permitted Indian tribes to contract out for their health care services.

Congress appropriates funding for P. L. 638 contracts to IHS, which allocates it to tribes.

However, some rural and/or poor tribes report difficulty in attracting physicians to their areas.

Our inpatient services are provided through contract care facilities. In 1986, our...hospital was closed without Congressional approval, without planning, staffing, or equipping of tribal health centers to replace our hospital. Our tribes have had to develop our own system through the 638 contracts. Distances to contract health facilities range from 100 miles to 450 miles.

Patrician Hicks
Chairperson
Walker River, Peyote Tribe

Another source of funding for tribes to supplement appropriations shortfalls are tribal industries.

Nevada tribes emphasized tobacco sales as one source of additional funding. Given the DHHS public opposition to the use of tobacco products, it is ironic that this industry would produce revenue for the improvement of Indian health.

C. Understanding Funding Trends

All federal programs which fund health care services in NA/AN communities are subject to budget cuts, political conflicts and appropriation procedures. The IHS, Medicaid/Medicare, and other government programs that fund health care fall under the jurisdiction of the DHHS. As stated previously, the Committee on the Interior determines funding for the IHS, the primary funding source for the health care of NA/AN. Speculation that the funding process for the IHS may negatively affect appropriations to the IHS is supported by current assessments. Currently, Indian health care is funded at only 70% of need, and at half that of health care premium users.¹³

¹³ Ibid. 7.

IV. Understanding Health Service Delivery

Issues

Access

- Excessive travel distances to medical facilities;
- Lack of staff and equipment for facilities.

Quality

- Failure to provide appropriate health care services;
- The prolonged use of temporary facilities.

Cultural Sensitivity

- Linguistic and cultural differences influence the delivery of health care.

Long-Term Care

- There is lack of long-term health care facilities and drug and alcohol treatment centers in NA/AN communities.

Recommendations for Health Service Delivery

- Increase accessibility through decreased travel distances and increased funding for staff, facility construction and equipment;
- Continue to expand the supplemental services provided by the IHS, including preventative health and educational programs;
- Address issues of cultural sensitivity by using the native language of the tribe, and using traditional healers within the community;
- Provide community based long-term health care facilities.

IV. Understanding Health Service Delivery

A. Issues

In their presentations to the Assistant Secretary for Health at the New Mexico conference on Health Care Reform in Indian Country, the Southwest tribes identified access, quality, cultural sensitivity and long-term care as primary concerns regarding service delivery. Data from the DHHS suggest that these issues are not specific to the Southwest region.

1. Access

Despite the existence of IHS and tribal health facilities, consistent primary care remains inaccessible for some NA/AN. Tribes identified travel distances to facilities and reduced clinic capacity as their greatest barriers to accessing health care services. For those reservations located outside of metropolitan areas and lacking on site facilities, primary and emergency health care providers may be in excess of 1/2 hour driving distance. Reduced clinic hours and staff due to insufficient funding have made health care inaccessible to others according to the conference attendees.

To illustrate this point, DHHS data from the 1980's (the most recent available) show that for 20 reservations over 70% of medical visits were to facilities 1/2 to 1 hour away. The Saboba Reservation in California had the highest percent at 100% of visits.¹⁴ This data is misleading in that it does not include trips in excess of 1 hour. The USPHS states that the average distance to the nearest non-IHS facility is 55 miles. Furthermore, lack of space and resources characterize IHS facilities. In addition to the 50 hospitals and 283 outpatient clinics, four additional facilities are scheduled to open this year.¹⁵ Tribes expressed concern over the increasing patient loads at already above capacity clinics from the Urban Indian and/or non-Indian population. Furthermore, resources for these clinics in the form of equipment and personnel continue to decline despite increases in the service population. For example, the Phoenix Indian Medical Center, a 200 bed hospital which serves a four state area, currently operates at 74% of capacity because of budget and

¹⁴ Ibid. 10, pp. 731-735.

¹⁵ FTE Fact Sheet, Public Health Service, p. 2.

personnel constraints.¹⁶ All together, excessive travel distances, lack of resources and personnel shortages create significant barriers to the delivery of health services to NA/AN.

Perhaps as a consequence of deficient clinic capacity and travel distances, visits to preventative care specialists make up a small percentage of total outpatient visits. For example, visits to the optometrist account for only 2.5% of total outpatient visits. At the same time, 30% of Indian reservation adolescents in a 1992 non-random study reported having vision problems.¹⁷ Furthermore, dental care services are currently funded at 44% of need nation wide.¹⁸ These statistics appear to further support the concerns of Southwestern tribes who stressed the importance of continuing programs which perform preventative health services in the presence of inaccessibility.

On some reservations, Community Health Representatives (CHR) provide the type of intervention which characterizes preventive medical services. For the Pueblos of New Mexico, use of the CHR program has become an established procedure to compensate for reduced clinic access. This reduction occurred because of a reduction in staff hours and an increase in patient workloads.

The CHR's provide direct services, such as making home visits to all age groups in the community. Services include taking vital signs, changing dressings, provide health education, case identification, screening, health promotion and disease prevention coordination, and making referral to the IHS providers, BIA providers, and all outside health related resources (State and Federal Programs).

Sandia Pueblo
Health Advisory Committee¹⁹

Others who cite distance as their main barrier have come to depend upon the Emergency Medical Services (EMS) in their area and emergency medical training for emergency health care needs.²⁰ Therefore, the consequence of reduced access include additional strains on the EMS system and in-

16 Ibid. 7.

17 Ibid. 10, pp. 720, 759.

18 Ibid. 7.

19 Position Paper of the Sandia Pueblo Concerning Health Care Reform, presented to the Assistant Secretary of Health and Human Services, February 3, 1994, p. 2.

20 Ibid. 7.

creased dependence upon the CHR program. Lack of access produces inconsistent care which may contribute to the rise in preventable health problems.

2. Quality

For the purposes of this analysis, quality is defined as the degree to which services match the needs of the service population. Failure to provide appropriate services may impede IHS' overall goal to improve the health status of NA/AN. Among those procedures identified as inadequate at the New Mexico conference included the use of temporary facilities for health care delivery and the lack of drug and alcohol treatment facilities. Some areas received trailer homes for the delivery of health care until permanent facilities could be built. However, for some, the trailer homes have remained in use for 10 years and have become permanent features of health care delivery in these areas.²¹ In addition, the high incidence of alcohol and drug abuse on reservations have not been adequately addressed by the IHS. For example, conference attendees expressed concern over the lack of drug and alcohol treatment centers provided by IHS. These inadequacies demonstrate that the quality of health care delivery for NA/AN is poor.

3. Cultural Sensitivity

Cultural sensitivity is important in the delivery of health care services. "While medicine benefits from a certain amount of scientific input, culture intervenes at every step of the way."²² Cultural sensitivity poses a particularly important and complex issue in Indian Country. Its influence may materialize in a number of ways including linguistic differences and the use of traditional healers.

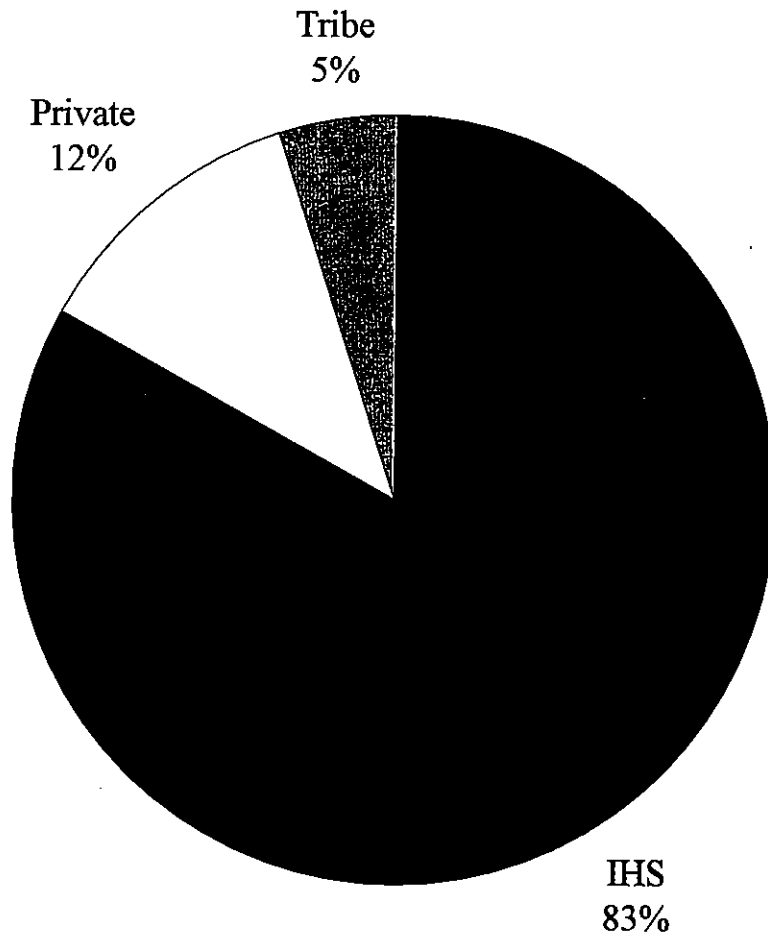
IHS employs members of the service community in its efforts to improve cultural awareness within its facilities. While Indian physicians currently account for only 5.8% of IHS physicians, scholarships have been established for Indian youth to attend medical school so that they

²¹ Ibid. 7.

²² Payer, L., Medicine and Culture, NY, 1988, pp. 15-34.

Chart 2

Methods of Health Care



may return to practice within their communities²³. It appears that such efforts at cultural integration on the part of IHS, which are absent in the private sector, are one reason why many P.L. 638 tribes primarily use IHS rather than contract out for services. "There is a strong opposition for Indian health people to go outside the IHS service units for health care provisions because of cultural relevance concerns."²⁴ Please see chart two for a statistical breakdown of service providers.

4. Long-Term Care

The demographic trends within a population provide essential information toward the development of appropriate services. In Indian Country, as in other parts of the nation, a growing elderly population creates problems for those communities unequipped to deal with long-term care. In 1993, Indian elders in six states identified "improved home and community care" as their primary concern.²⁵ The Census Bureau reported in 1990 that 34,461 Native Americans were living in nursing homes.²⁶ Given concerns over cultural sensitivity, and the fact that poverty on reservations precludes nursing home care for the elderly of many communities, the lack of long-term care provided by IHS is receiving increased attention. Indian councils on aging are lobbying tribal and political leaders in an effort to draw attention to this issue.

B. Reasons for Deficiencies in Service

Trends in funding and lack of communication between the federal government and tribes during the planning stages may have led to deficiencies in service. As a result of the continued placement of the IHS appropriation process in the Committee on the Interior, the IHS must compete with a variety of other departments for the committees attention. Perhaps as a consequence of this procedure, "the level of need funded for the Indian Health Service on a nationwide basis now is about 75% ...".²⁷

²³ Ibid. 10, p. 749.

²⁴ Ibid. 19, p. 2.

²⁵ Health Care Reform: Long Term Care for Indian Country, The National Council on Aging, January 1994, p. 1.

²⁶ Ibid. 10.

²⁷ Ibid. 7.

Furthermore, many of the conference participants complained that they received little information from the local IHS headquarters regarding policy implementation. Overall, they expressed a feeling of disenfranchisement from the health care development process. Given the attendance of IHS representatives at the meeting and the close ties between the Acting Director of IHS and the tribes, this problem does not appear to be the result of an IHS policy, or a characteristic of the organizations' administrator. There may exist organizational and tribal characteristics which explain this perceived lack of communication. These characteristics may include lack of communication within government agencies and tribal apprehension in dealing with the federal government. Comments from the Southwestern tribes focused on their distrust of the federal government due to past conflicts further support this hypothesis. Also, tribes and area directors may at times have conflicting goals. For instance, while a willingness to downsize staff may label an area office as efficient, NA/AN tribes may view it as a threat to service delivery. NA/AN leaders should investigate these issues in an effort to improve communication with the IHS at the regional level.

C. Conclusions and Recommendation: Funding and Service Delivery:²⁸

As funding and service delivery are interdependent issues, the conclusions to their respective sections have been combined. Despite legislative efforts to improve the quality of NA/AN health, health problems continue to plague NA/AN communities at disproportional rates. Policies directed at NA/AN health issues have been relatively unsuccessful due to lack of funding, lack of access to health care facilities, and insufficient specialized services. The appropriations procedure for the IHS complicates the funding process. Rural areas have too few clinics, and the lack of staff and equipment are forcing some hospitals to operate below capacity. The quality of care is diminished by the use of temporary edifices and lack of specialized care for the elderly and the chemically dependent. Also, the cultural insensitivity of some non-IHS providers hinders efforts to access alternative health care providers. In light of these funding and service delivery issues and the

²⁸ Because funding and service delivery are interdependent issues, the conclusions to their respective sections have been combined. This is the only location that this occurs in this paper.

prominence of IHS as the primary health care provider to NA/AN, the IHS has become the focal point of health care reform in Indian Country.

Given the current status of funding and service delivery, any policy which proposes to reform health care in Indian Country should address the following issues:

- **The funding procedure for the IHS;**
- **Inaccessibility to facilities (lack of facilities in rural areas and staffing shortages);**
- **Local procedures for the transfer of health policy information to the tribes and the distrust of Federal motives on the part of NA/AN;**
- **The importance of outreach and community health projects;**
- **The lack of long term care and drug treatment facilities.**

D. SERVICE UNDER HEALTH CARE REFORM

Regardless of the nature of health care reform, the services provided by the Indian Health Service (IHS) cannot easily be replaced. IHS plays a prominent role within the Indian community by providing comprehensive health coverage to its eligible population. This eligible population was 1.16 million in 1990 and is projected to grow to over 1.49 million by the year 2000.²⁹ Eligibility is the key to insuring access to IHS service programs that offer the possibility of improving the health status of the NA/AN communities.

E. The American Health Security Act³⁰

The goals of the AHSA concerning service are consistent with those of the IHS and the Indian Health Care Improvement Act. AHSA emphasizes choice, quality, and autonomy in specific reference to Native American health. "Tribal governments will exercise their full autonomy to

²⁹ Ibid. 2, p. 20.

³⁰ All of the information concerning the AHSA was obtained from that document and Indian Health Under Clinton Health Reform Bill, Ducheneaux, Taylor and Associates, November 19, 1993.

devise health care delivery that works for them."³¹ Furthermore, the plan proposes to increase community health, home health care and preventive services. These services speak directly to cultural sensitivity, emergency term care, and preventative health.

Improvements to current services are projected over a short, 5 year time span. Within this time, IHS must upgrade its services to match those in the comprehensive benefits package (CBP) guaranteed under the AHSA. These services are delineated in table two. Services of particular interest in NA/AN communities are bolded.

Table One Comprehensive Benefits Package	
1.	HOSPITAL SERVICES
2.	SERVICES OF HEALTH CARE PROFESSIONALS
3.	EMERGENCY & AMBULATORY MEDICAL & SURGICAL SERVICES
4.	CLINICAL PREVENTIVE SERVICES
5.	MENTAL HEALTH & SUBSTANCE ABUSE SERVICES
6.	FAMILY PLANNING & SERVICES FOR PREGNANT WOMEN
7.	HOSPICE CARE
8.	HOME HEALTH CARE
9.	EXTENDED CARE SERVICES
10.	AMBULANCE SERVICES
11.	OUTPATIENT LABORATORY, RADIOLOGY, & DIAGNOSTIC SERVICES
12.	OUTPATIENT PRESCRIPTION DRUGS & BIOLOGICALS
13.	OUTPATIENT REHABILITATION SERVICES
14.	DURABLE MEDICAL EQUIPMENT, PROSTHETIC & ORTHOTIC DEVICES
15.	VISION CARE
16.	DENTAL CARE
17.	HEALTH EDUCATION CLASSES
18.	INVESTIGATIONAL TREATMENTS

F. Evaluation of the Impact of AHSA

Failure to adequately address issues of access and funding reduce the probability the AHSA will improve service delivery for NA/AN. The plan is vague in defining how tribes and IHS will pay for the expanded services. The primary sources for funding will be employer/employee pre-

³¹ Ibid. 7.

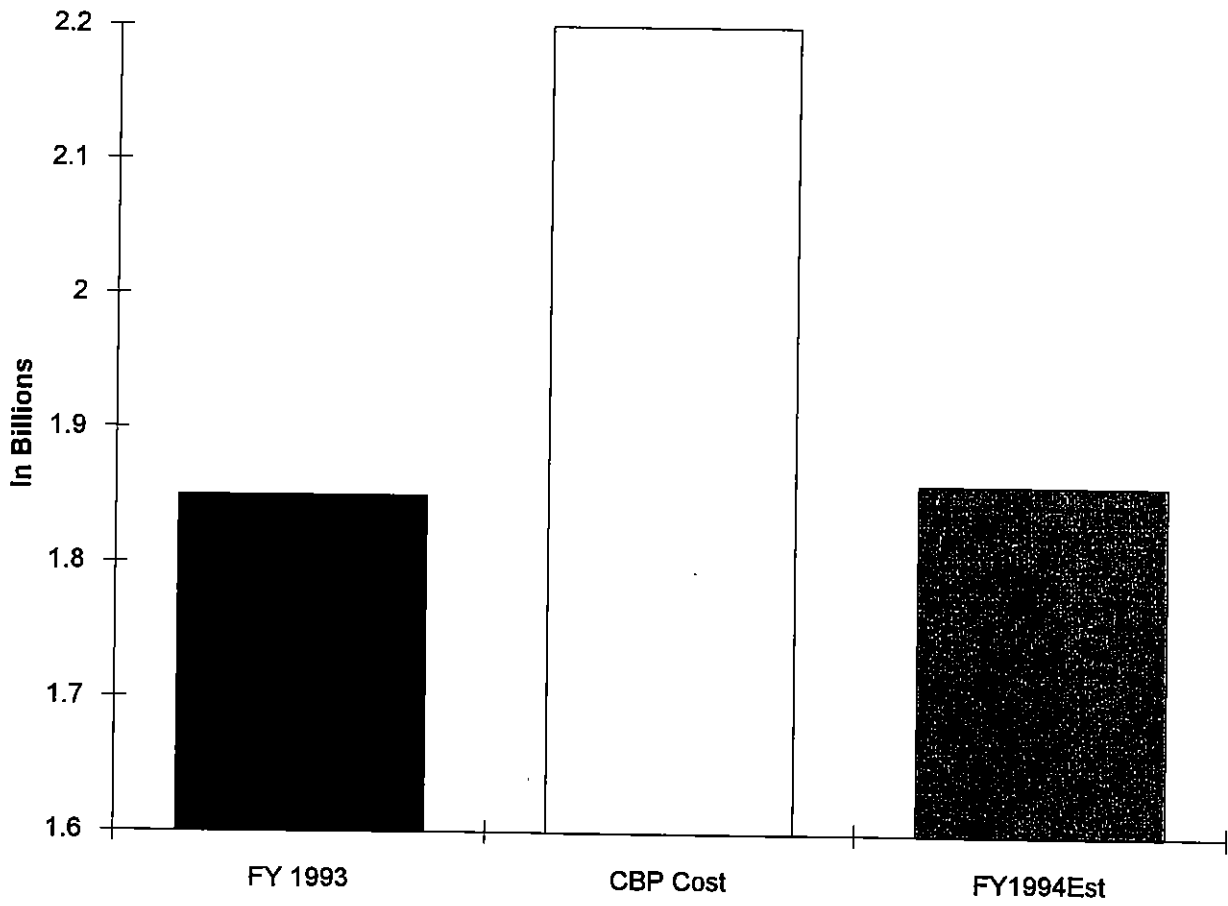
miums and Congressional appropriations. However, tribal governments and organizations are exempt from employer premiums. Also, IHS eligible Indians do not have to pay premiums or any other health costs. The ineligible family members of eligibles can receive IHS services, but must pay for services and their premiums must be paid through an employer. Again, AHSA exempts tribal employers from such payments. In addition, given the high percentage of tribes which operate as primary employers, and high rates of unemployment on many reservations, employer/employee payments will probably prove inadequate to support the services mandated by the AHSA. Also, trends in appropriations indicate that costs for the CBP will greatly exceed the amounts typically appropriated through Congress. Please see chart three for a comparison between appropriations received, cost projections for the CBP, and estimated funding projections. The AHSA does include a provision for revolving loans for providers to improve facilities and provide expanded services. However, the AHSA does not detail who will repay these loans.

Furthermore, no provisions to prevent funding reserved for specific services to be used for other purposes exist in the plan. This is particularly important for the issue of improved accessibility through construction of new facilities. The AHSA makes 40 million dollars available from the Public Health Service Initiatives Fund for construction. However, if funding falls short of need in the area of primary care, the AHSA does not prevent construction funds from being used for primary care purposes. Ideally, Congressional appropriations would address such shortages. However, given the history of underfunding by Congress, use of construction funds may prove more expedient and certain during a funding crisis. Increased funding through changes in procedures and restrictions to prevent the movement of funds from one purpose to another may increase the availability of resources for both direct services and construction.

In addition, the AHSA fails to adequately address the issues of policy consultation with tribes. The legislation requires only annual consultations between the Secretary of Health for DHHS and tribal leaders. Establishing measures of communication both at the Federal and local level would insure that NA/AN are aware of their choices of health plans under health care reform

Chart 3

Cost Estimates vs. Funding Projections



and can contribute to the planning process. This communication may help lead to more appropriate health policies.

Also, AHSA does not address the issue of community outreach services. Community outreach workers have formed a link between IHS and tribes in some areas. Further support of these organizations would facilitate efforts at improved communications at the local level, enhanced community health, and cultural sensitivity. For example, community based services seem an ideal vehicle through which to promote health education issues in a culturally sensitive manner. In addition, the Secretary of Health for DHHS has emphasized the importance of this issue, to include recommending the inclusion of a specific provision addressing the use of traditional healers.³²

A final concern brought up at the RCNAHCR was the lack of detail concerning who would control which part of the funds. The Peyote Tribe asked that the Health Secretaries act not compromise the "advantages of tribal administration in control of program operations. Because if the sources are controlled at the tribal level...[tribal administrators] are more responsive to the grass roots needs of the people."³³ Also, the question of who will control the allocation of the funds once they are available is a crucial autonomy issue for tribes. The AHSA would establish a CBP fund to hold the employer and family premium payments as well as appropriated amounts and all other additional funding sources. The IHS health program will manage the funds. Under the Plan, an IHS program would include not only IHS local programs, but tribal programs as well. The Assistant Secretary of DHHS interprets this inclusion as a signal that there exists "a great deal of local control envisioned" in the AHSA.³⁴ However, the AHSA does not specify how the money will be allocated. Whether management includes the allocation, or if the allocation will be based upon the apportionment submitted by IHS to the OMB, or by the spending plans developed by the local IHS directors remains unclear. These questions must be clarified before Indian tribes

32 Ibid. 7.

33 Ibid. 7.

34 Ibid. 7.

can make an informed decision regarding which plan they will support and what provider they will chose if the AHSA passes.

G. Alternative Plans for Reform

Of all the health care reform bills, only the AHSA discusses in detail the effect of the plan on the IHS or on the options of NA/AN. For instance, the plans of Senators McDermott (D-WA) and Chaffee (R-RI) both ask for the continued support of the IHS and other Public Health Programs, but the language of reform does not extend to these agencies. The McDermott single payor system is federally financed, but the program is administered by the individual states. The benefits package under this plan would be established by a health security board, which also has the responsibility to set pricing standards. Under Senator Chaffee's plan, individuals would be required to purchase insurance packages, for a specified list of benefits, from their employer or a health alliance. In addition, a voucher system will be used to assist low income individuals in purchasing insurance. While other plans explore different payment mechanisms, the AHSA is the only plan that outlines a specific program for NA/AN health.

H. The Effect of Restructuring Government: FTE Reductions

Government administrative cutbacks have the potential to significantly alter health care delivery. The President has called for federal agencies to reduce their workforce (FTEs) by 100,000 employees by the end of FY 1995. As a result, the OMB has set reductions for the IHS at 7.1% in a three year period. The IHS has been asked to take an above-average reduction (the total target is a 4% reduction) due to its exemption from cuts in 1993 and the ability of tribes to contract out for services.³⁵ Given the issues surrounding access that exist even in the presence of contracting abilities, the cuts will have potentially unfavorable consequences for service delivery. To prevent loss of capacity in service delivery, the Assistant Secretary of Health has exempted "staffing associated with essential patient care responsibilities" from the FTE cuts. However, the Public Health

³⁵ Ibid. 15, p. 2.

Service did not specify what constitutes essential patient care responsibilities in its fact sheet regarding FTEs.³⁶

In order to avoid the FTE reduction, Secretary Shalala of DHHS has submitted a waiver to the OMB for exemption of the IHS. This waiver request was denied earlier this year. DHHS Assistant Secretary Lee stated at the conference that the information he gained from the tribes will be used to initiate another request for a waiver from FTE reductions.

³⁶ Ibid. 15.

V. Understanding Eligibility and Enrollment

Issues

Eligibility

- Undercounting the eligible service population is a constant concern for both the IHS and Tribal Leaders because the discretionary appropriation process is based in part on accurate population figures;
- As Indian tribes are federally recognized, membership lists that are developed may be incomplete as individuals are invariably missed in the initial count. Without tribal membership, these individuals are not eligible for tribal or federal benefits, including those services provided by IHS.
- Differences in tribal membership requirements may reduce the number of NA/AN who are eligible to receive health care.

Enrollment

- Those NA/AN living close to urban population centers have the opportunity to enroll in health plans provided through Regional Health Alliances. Which plan should those NA/AN enroll in?
- If the AHSA is enacted, a considerable amount of confusion will result in a number of persons being missed in the initial enrollment period;
- Cultural and geographical isolation may make it difficult to enroll in health plans.

Recommendations for Eligibility and Enrollment

- Tribes need to establish a minimum universal membership criteria, based on their respective Constitutions, in order to insure that full blooded Indians are not excluded from health care;
- Tribes should make this minimum membership criteria retroactive to 1990;
- The IHS and tribes need to use this minimum universal membership criteria to develop membership lists that will allow for passive enrollment of NA/AN.

V. Understanding Eligibility and Enrollment

A. Eligibility

The goal of the AHSA is to ensure that all Americans, including NA/AN, enroll in their choice of high quality health plans that provide the nationally guaranteed comprehensive benefits package.³⁷ This choice will allow NA/AN the opportunity to choose the provider of their comprehensive benefit package from IHS, tribal health programs, or RHAs. The AHSA provides relatively open language with respect to NA/AN. However, in order to secure health coverage through IHS, eligibility is required. While the IHS does not limit its services to the reservation-based Indians, IHS clinical facilities have traditionally been placed close to reservations. As a result, most of the funding appropriated for IHS goes to services for those Indians who live on or near a reservation.

The AHSA defines eligibility in section 8302, Eligibility and Health Service Coverage of Indians.(Appendix C) In it, a descendent of a member of an Indian Tribe, is regarded as a Indian by the Indian Community if she possesses the following characteristics: the individual lives on or near a reservation or in a geographical area designated by statute as meeting the requirement of being on or near an Indian reservation notwithstanding the lack of an Indian Reservation; an Urban Indian; or an Indian described in section 809(b) of the Indian Health Care Improvement Act (25 U.S.C. 1679(b)). However, eligibility is not restricted to federally recognized tribes for two reasons. First, Indian tribes vary in how they determine their membership. Some rely on blood quantum, while others rely on a consistent line of descendency. Second, tribal membership rolls may be opened infrequently making it difficult for Indians to prove their eligibility for IHS services. As a result, tribal membership is not the sole criteria for eligibility in IHS programs.

Undercounting of the eligible service population presents a constant concern for the IHS and Native American Communities. While IHS has endeavored to be more accurate since 1980,

³⁷ The Health Securities Act: Health Alliances. Washington: The White House, 1994.

with a new improved method of census data collection, disputes still exist concerning the actual population number and tribal membership rolls. This is important because funding for the IHS is a discretionary appropriation process based in part on accurate population figures. Undercounting may have the disastrous effect of causing budgetary shortfalls halfway through the fiscal year.

Two opportunities exist as possible methods of excluding eligible Indians from health care services, tribal blood quantum requirements and changes in federal Indian policy. The first, tribal blood quantum requirements, arises out of the possibility of exclusion from tribal membership lists. These lists may include full-fledged members and other enrollees who do not have the full privileges of members such as voting rights or the right to share in tribal benefits.³⁸ With a 1/4 blood quantum requirement, there is the possibility of excluding full blooded Indians from IHS services because they lack tribal membership. For example, mother (x) is a member of tribe (aa) and elects to marry husband (y), a member of tribe (bb). They elect to live on the reservation of tribe (aa), and are therefore subject to the membership requirement which mandates a 1/4 blood quantum requirement of tribe (aa) to be eligible for benefits. Eventually they produce an off-spring that is $1/2x1/2y$. While this off-spring is eligible for services, if the next two generations elect to marry outside tribe (aa), their off-spring will have a blood quantum less than 1/4 (aa) and will therefore be ineligible for IHS services. As a result, an effort must be made to insure that all individuals who fall into this situation have an opportunity to participate in IHS programs. One method would be to establish a membership roll based on descendency that would document their lineage and avert the possibility of exclusion.

The second concern is changing Federal Indian policies. As a result of past inequities, the Federal government has been reluctant to enact policies that would restrict NA/AN participation in government programs. Therefore, it is easy to understand why the U.S. Congress would be reluctant to make the provision of IHS services incumbent on the Federal recognition of an Indian tribe.

³⁸ United States Congress. Office of Technology Assessment. Indian Health Care. Washington: GPO, 1986. p. 6.

However, as the Federal Government recognizes tribes, difficulties do arise. Membership lists that are developed may be incomplete as individuals are invariably missed in the initial count. Without tribal membership, these individuals are not eligible for tribal or federal benefits, including those services provided through IHS. Overlooked individuals must wait for enrollment expansion before tribes will formally recognize them as members. In the interim, they are not considered members of the Indian community, and are not eligible to receive the health services provided by IHS.

How many eligible Indians will the Federal Government miss when the IHS component of the AHSA is implemented in 1999? With the diversity in eligibility requirements, disputes about population estimates, and the difficulties experienced during tribal recognition, it is reasonable to assume that some percentage of the population will be overlooked. Policy initiatives must be taken to insure that the initial start up of the AHSA is as inclusive as possible, and that all eligible NA/AN have an opportunity to be covered.

B. Enrollment

1. Election

The AHSA provides that all Americans will have the opportunity to enroll in the health plan of their choice. Choice is the key component of the AHSA. While this will mean that the majority of Americans will have to make a decision about the health plans offered within the RHA, NA/AN will have to make a decision at a more fundamental level. Who will provide the health care services? NA/AN will have to choose between IHS or RHA. This decision should not be made in haste, as each program has advantages and disadvantages.

NA/AN have three points of entry into the Indian Health System. They are traditional IHS programs; Tribal Self Determination Act Programs; and Urban Indian Health Programs. Despite the numerous points of access to IHS programs, Section VIII, Subtitle D of the AHSA will not take effect until 1999. This is one full calendar year later than the enactment of the rest of the

AHSA in 1998. So, while an eligible individual can elect to participate in the IHS program, they will have to wait an additional year for complete access to the comprehensive benefits package.

This causes a dilemma for NA/AN, especially those living close to urban population centers where the opportunity exists to participate in plans offered through RHA. What are the advantages of staying with programs offered through IHS? A NA/AN who enrolls in the Indian Health System will not be subject to any charge for health insurance premiums, deductible, co-payments etc. This is significantly different from the health plans offered through an RHA. Indians, eligible for coverage through IHS, but exercising their power to opt out of the program will find themselves completely on their own. If an eligible Indian, who would otherwise be eligible for the Indian Health Plan decides to enroll in a RHA health plan, or some other plan, the Indian Health Service is not responsible to make payments to that individual for the premiums charged for the alternate plan, nor is IHS responsible to pay for any other cost which the individual would be required to pay under the alternate plan, such as the co-payment.³⁹ The bottom line is that those persons who elect to choose an alternative plan offered through a RHA will have to absorb the entire financial costs. What provision will be made for those individuals unable to meet the premium requirement as a result of insufficient income or unemployment remains unclear. It can be assumed in these situations that such an individual could qualify for reduced premium enrollment in RHA, or state programs as provided for under other sections of the AHSA.⁴⁰

2. Enrollment

At the core of the AHSA is its inclusivity, and its goal of providing universal health care to all Americans. This plan will require individuals to be conscious consumers of health plans, and then take the initiative to enroll themselves in the plan of their choice. For some, their geographic location will limit their choice of plans. For others, access to urban centers will offer the pos-

³⁹ Kaufmann and Associates, Incorporated. Round Table Conference on Health Care Reform, The Health Security Act, and Indian Health Care: A Briefing Book. (Washington: Kauffman and Associates, Incorporated, 1994) p. 19.

⁴⁰ Ibid. 39, p. 20.

sibility of choice. In both instances, a number of Americans may be overlooked in the initial registration for health care services, including NA/AN.

It can be assumed that if the plan is enacted, a considerable amount of confusion will result in a number of persons being missed in the initial enrollment period. The AHSA attempts to address this concern by making provisions for point of service enrollment. Point of service enrollment is analogous to the "Motor Voter" legislation that was proposed several years ago as a method of improving voter turnout. Point of service enrollment allows any American not enrolled during the initial enrollment period to access health care services. In addition to receiving health services, they will be provided with plan information, and offered the opportunity to enroll in the particular site they are using if it is part of a health plan. The opportunity to enroll does not remove their option of choice. The opportunity still remains for the individual to choose other plans that may be more compatible with their needs and geographic location. Clifton Wiggins, Senior Analyst with IHS, stated that there is the possibility that a number of Indian people, particularly those in rural areas, might not make an effort to actively enroll until they actually need health care.⁴¹

While miscounting may not pose a major problem for plans operating through RHAs, it could have a disastrous effect on the budget development process for IHS. The National Congress of American Indians (NCAI) believes that the current process of active enrollment advanced in the AHSA may miss thousands of NA/AN.⁴² Because the IHS budgetary process involves using estimations of its service base, there is the possibility of precipitously low budget projections if undercounting of NA/AN occurs. As a result, a mechanism must be in place that makes as accurate as possible accounting of NA/AN from the start. An alternative would be to shift the enrollment from an active to a passive process. The difference between the two is an active processes would require tribal members to personally enroll themselves in a plan, while a passive process would use tribal lists to enroll members within IHS.

⁴¹ Clifton Wiggins, Senior Analyst, IHS; personal interview, 21 January, 1994.

⁴² Ibid. 39, p. 20.

One method of accomplishing this would be to use tribal lists as a method of mass enrollment. The element of choice would still exist, but it would require the individual to opt out of the IHS program. This method would provide the IHS with a better estimation of its service base, but would still cause problems because both IHS and NA/AN communities have two different methods of estimating population size. The IHS prefers census data, while NA/AN prefer tribal lists which include both full-fledged members, as well as those ineligible for privileges, such as voting or the right to share tribal benefits.⁴³ The use of tribal lists opens the possibility of over counting. The key to accurate budgeting is an accurate estimation of the NA/AN population. Therefore, one possible solution to this would be a hybrid of tribal rolls and census information.

C. Conclusions and Recommendations with Regard to Eligibility and Enrollment

Despite legislative efforts to improve the quality of NA/AN health and health problems, issues involving eligibility and enrollment remain unresolved. The central issues are:

- **Differences in tribal membership requirements may reduce the number of NA/AN who are eligible to receive health care;**
- **Cultural and geographical isolation may make it difficult to enroll in health plans.**

While the AHSA makes provisions for point of service enrollment, there is still the opportunity for a significant number of NA/AN to be missed. In order to resolve this situation, a two fold approach requiring both tribal and IHS participation is necessary. This approach will require:

- **Tribes need to establish a minimum universal membership criteria, based on their respective Constitutions, in order to insure that full blooded Indians are not excluded from health care;**
- **Tribes should make this minimum membership criteria retroactive to 1990;**
- **The IHS and tribes need to use this minimum universal membership criteria to develop membership lists that will allow for passive enrollment of NA/AN.**

In order to address these complicated inter-tribal/IHS issues, it will be necessary to set well defined goals regarding eligibility and enrollment requirements. The development of regional discussion

⁴³ Ibid. 38, p. 6.

groups that would allow the dissemination of ideas between tribes and IHS would facilitate this process. Through these discussion groups, criteria should be developed that will maximize the participation of NA/AN in health programs.

VI. Understanding Regional Health Alliances

Issues

- The nature of the RHA is such that the social position of the local community will define the relative strengths of the alliance, and the premium paid for health plans by its membership.
- The nature of the RHA allows the potential for “gerrymandering” RHAs around disadvantaged communities because of the desire to provide low cost plans by selecting for adverse risk.
- Given the structure of RHAs and the poor health of NA/AN communities, there may be difficulties acquiring affordable insurance for reservation members.

Concerns

- If NA/AN communities buy into RHAs, tribal members will be expected to bear the entire cost of the health plan.
- A negative dynamic within the community may result in NA/AN groups being politically impotent and having little bargaining power with the insurance industry.

Recommendations for Regional Health Alliances

- Tribes will need to set well defined goals regarding the exploration of plans offered through regional health alliances.
- Tribes should develop discussion groups that will examine the plans offered through the regional health alliance. Issues of particular importance:
 - How tribal members will pay for health plans that are not offered through the IHS;
 - Will the health plans offered through regional health alliances cover those preventative and long-term health services that are necessary in NA/AN communities.

VI. Understanding Regional Health Alliances

The AHSA places considerable emphasis on the role and function of the RHA. The purpose of the alliance is to ensure that consumers have the opportunity to enroll in high quality health plans with a defined benefit package at an affordable cost. In generic terms, the alliances can be described as a state sponsored insurance cooperative designed to serve as a mechanism for keeping the growth of spending for the comprehensive benefit package within the budgeted level.^{44,45} It will accomplish this through the following mechanisms. First, the RHA will serve as an organization that accepts bids from approved health care plans, and negotiates and contracts with the health plans that it approves. Second, the alliance will serve as a clearing house for consumer information, allowing consumers to make decisions based on the access, quality, and price of the plan. Third, it will serve as a mechanism of premium collection. Fourth, the RHA will represent both the interests of the employers and employees by serving as a mechanism for the distribution of funds to alliances for the provision of care within a geographical region. Fifth, the alliance serves as a market regulator, not only by controlling the plans it approves, but by serving as a mechanism for controlling the growth and cost of the comprehensive benefits package. The Clinton Administration argues that this mechanism for health coverage will reduce administrative costs and offer consumers the opportunity to realize cost savings and more affordable health insurance plans.

A. Managed Care

Health care in the 1990s has three essential ingredients, access, quality and price. These three components are interlinked. For example, an increase in access may have a negative impact on the quality or price of the program. Therefore, while the broadly defined goal of any health care system is to insure adequate access to quality health care at a reasonable price, it is important to realize that this is a tenuous relationship. (As a prelude to any discussion of RHAs, a discussion of managed health care is necessary.) Managed care specifically addresses issues of access, price

⁴⁴ Robert E. Moffit, A Checklist of Vital National Issues, A Guide to the Clinton Health Plan, (Washington: The Heritage Foundation, 1993) p. 15.

⁴⁵ Ibid. 37.

and quality. It uses a purchasing strategy specifically targeted at the level of health care financing and delivery as a method to maximize the dollar value spent per employee or individual enrolled within the plan. At the heart of this program is the microeconomic principal of competition, in this case price competition. Health plans are rewarded for their ability to improve access, quality and cut costs. In essence, they are rewarded for doing the "best job" of satisfying their patient population, and this reward is in the form of a larger subscription pool. However, the "best job" is a subjective and difficult criteria to quantify.⁴⁶ Therefore, rewards based on this criteria may lead to plans that select for a particular level of risk or attempt to fragment the market into favorable sections.

Since, the key to this system is a microeconomic argument of competition, to work successfully, providers must be divided into competing economic units that use market forces to encourage the development of efficient health care delivery systems.⁴⁷ In order for this argument to hold, there must be numerous providers and consumers, the goods and services must be homogeneous with the consumers having perfect or nearly perfect information and no major externalities in production of consumption. At its core, managed care is price competition, but only at the level of premiums, not individual services. Therefore when individuals look at the premiums associated with their plan, there exists the incentive to shop for the lowest price, especially among those individuals who are sick. Unfortunately, those who are ill have the most difficulty obtaining the information necessary to make an informed decision.

The natural question to ask is, if HMOs use price competition to produce a level of efficiency, why are we debating the merits of the AHSA? The problem is that while price competition should produce efficient outcomes with the lowest price, the demands of employers and employees

⁴⁶ Alain C. Enthoven, "The History and Principles of Managed Competition," *Health Affairs*, (1993): Supplement, Managed Competition, Health Reform American Style, p. 29.

⁴⁷ *Ibid.* 46, p. 29.

must be contended with.⁴⁸ Therefore, while it was reasonable to assume that managed care would attenuate the problems associated with cost, in reality they have not.

B. Alliances

Today's health insurance market is fragmented and overly bureaucratic, filled with different companies, agents, marketers and underwriters selling different plans with different benefits, exclusions, co-pays and deductibles.⁴⁹ Insurance companies control the process--and they compete by selecting the healthiest people.⁵⁰ Small groups and marginalized populations have been historically disadvantaged in this situation because they have very little opportunity to bargain for plans that address their needs. Therefore, certain sectors of the population (low income, unemployed, and marginalized persons) pay high insurance premium prices, or are entirely priced out of this market. This negative power dynamic results from these politically impotent groups having little bargaining power with the insurance industry. The Clinton Administration designed the AHSA to restructure the health insurance market by consolidating buying power and increasing the amount of choice for consumers.

The AHSA proposes to restructure the health insurance market so that health plans can compete on price and service rather than risk selection. It proposes to do this through the consolidation of small and mid-sized employers and their employees into large pools to purchase health coverage in order to spread risks, reduce administrative costs, expand choices, and increase market leverage.⁵¹ The goal of the plan is to protect the consumer and place the consumer in the driver seat by allowing them to choose the plan in which they wish to enroll.

Under the AHSA, by January 1, 1998, each state must be a participant in a National Health Care Reform Plan. This may include the formation of one or more Regional Health Alliances, or

48 Ibid. 46, p. 30

49 Ibid. 37.

50 Ibid. 37.

51 Ibid. 37.

plans offered by the state government. The National Health Board is responsible for administering and regulating the plan at the national level. This board also acts as a mechanism designed to prevent untoward influence by pharmaceutical, physician and insurance lobbying groups. It accomplishes this by restricting board membership to equal numbers of consumers and employers. There is no room for representation by health care providers who may have alternative motives, but there is a provision for a health provider board. The purpose of this board is to insure the fulfillment of the health care needs of the community. However, while various boards look out for the consumers best interest, the state, under the AHSA, must insure that their citizens are enrolled within a health plan. The question is, should NA/AN shift their health care coverage to plans provided by a RHA, or stay with the services provided by IHS?

C. Concerns with Regional Health Alliances

While states will be legally obligated to insure the equitable development of health alliance boundaries and that these will not lead to discrimination, our recent history leads one to believe otherwise. Every ten years new census data is compiled, and when the new population figures are tabulated, Congressional District maps are re drawn. This activity is subject to considerable political pressure as political parties attempt to draw district maps favoring the election of their candidates. When faced with political pressure, community leaders may exclude certain groups from the RHA. This system has the potential to pit black against white, poor against rich, and city against suburb.⁵² If a NA/AN were to buy into a system of RHA, they would become another ethnic minority that has very little opportunity to exert the political force necessary to protect their rights.

Why would this occur? Individuals want low health insurance premiums. One method to accomplish this is to exclude the elderly, those individuals who have a higher incidence of disease, or have a higher crime rate or incidence of violence. As a result, voters in areas with these characteristics will want them excluded from their RHA. Will Native Americans be subject to this situation? Many Native Americans live under harsh environmental, economic, and social conditions

⁵² Ibid. 44, p. 12.

that predispose them to a disproportionately higher risk for injury compared to the general population.⁵³ While IHS has helped this population achieve a better health status, it still lags behind the rest of the United States.

The health status of Native Americans when compared with the rest of the population remains poor. The leading cause of death for NA/AN residing in IHS service areas was heart disease and accidents.⁵⁴ Mortality and morbidity within this group is also higher than that of the general population. Incidence of tuberculosis and pneumonia are 480% and 42% higher than the general population respectively.⁵⁵ This means that the cost to treat this population will generally be higher than that of the general public. The issue is risk pooling. Many plans operate under a strategy of maximizing the premium cost to those persons enrolling in their plan. Generally, this means that in order for premium costs to be kept low, the plans must select out those individuals who may use a disproportionate amount of the services relative to what they pay in. That way, those persons with few health risks will get more value for their dollar.

D. Should Regional Health Alliances Care about NA/AN needs?

Opting into a RHA assures choice a full year earlier than the IHS counter part, but does it insure happiness? Examining this question from employer/employee context, the answer becomes apparent. The employer of a company has an incentive to insure that his workers are happy, if they are not happy, business suffers. If the American public is unhappy, who watches out for their interests? There is no built in incentive structure to insure that a substantial number of individuals are happy with their plan. The fiduciary relationship gives the corporation a unique responsibility to its employees, and this responsibility makes it incumbent upon the corporation to insure their employees satisfaction.

53 Ibid. 1, p. 3.

54 Ibid. 2, p. 3.

55 Ibid. 2, p. 3-4.

If a tribe decides to buy into this system, where would the accountability be found within the RHA? An example of the potential problems can be seen by looking at the Massachusetts Bay Transportation Authority (MBTA). The MBTA runs an integrated regional rapid transit system in Boston and its surrounding communities. This is the only rapid transit found in the city as a result of a legal monopoly and economies of scale. If you purchase a token, you receive a fixed level of service. MBTA makes no guarantees regarding the quality or timeliness of the service. The ride doesn't have to be in a clean, comfortable or safe train car or bus. It merely has to be there because a substantial amount of the population must rely on it. There is little accountability to the general public because responsibility for the system is diffuse. If the trains or buses are late, the rider pays the price of being late to their destination. The authors believe that this lack of accountability is present in the design of the AHSA. While there are provider boards and a National Health Board, who does one contact when something goes wrong? Where does one turn when they have difficulties with their policy? Finally, if there is some person there to answer your concern, what incentive structure has been built in to insure that the system meets the needs of the consumer? Of special concern are those groups that do not possess political clout.

It is reasonable to state that there is the potential for discrimination within the AHSA. RHAs have the possibility of becoming a political battleground where only the strong will survive. Traditional minority groups that lack organization will have difficulty interacting within this environment. Well-funded organizations can exert the necessary political pressure to insure that the system satisfies their agenda. As a result, the goals and initiatives of other groups, such as NA/AN, may be swept under the table.

E. Conclusions and Recommendations with Regard to Regional Health Alliances

The use of RHAs as a clearing house for obtaining health care insurance is the focal point of the AHSA. However, while an option for NA/AN in urban areas, the RHA has potential problems. These potential problems are:

- **The nature of the RHA is such that the social position of the local community will define the relative strength of the alliance, and the premium paid for health plans by its membership.**
- **The nature of the RHA allows the potential for "gerrymandering" RHAs around disadvantaged communities because of the desire to provide low cost plans by selecting for adverse risks.**
- **Given the structure of RHAs and the poor health of NA/AN communities, there may be difficulties acquiring affordable insurance for reservation members.**

RHAs represent an option for NA/AN, not a necessity. The appeal of this option is the fact that it will be available one full year ahead of the IHS component of the AHSA. The disadvantages of RHAs for NA/AN communities are as follows:

- **If NA/AN communities buy into RHAs, tribal members will be expected to bear the full cost of the health plan.**
- **A negative dynamic within the community may result in NA/AN groups being politically impotent and having little bargaining power with the insurance industry.**

In order to address these complicated tribal issues, it will be necessary to set well-defined goals regarding the exploration of RHAs. This approach will require:

- **Tribes will need to set well defined goals regarding the exploration of plans offered through regional health alliances;**
- **Tribes should develop discussion groups that will examine the plans offered through the regional health alliance. Issues of particular importance are:**
 - **How tribal members will pay for health plans that are not offered through the IHS;**
 - **Will the health plans offered through regional health alliances cover those preventative and long-term health services that are necessary in NA/AN communities.**

These discussion groups will enable tribes to develop criteria that will maximize their participation in plans designed to improve their health status. In addition, these discussion groups are not to serve as meetings to air tribal grievances about health care delivery on their reservations. They are to be proactive groups that not only engage their respective NA/AN communities, but also include the surrounding non-Indian communities.

VII. Summary and Conclusion

General Recommendations

- **Maintain and Expand regional discussion groups:** The tribes should maintain and expand the regional discussion groups developed as a result of the RCNAHCR. The position papers provided by the DHHS should establish what need to be addressed immediately in order to improve health conditions in each region. This groups should develop a criteria to evaluate health care reform proposals, set short and long-term goals, and designate a representative to attend a national meeting on NA/AN health care reform. This group should be in contact with the National Congress of American Indians, the Indian Health Board and the Council on Native American Health to develop strategy for achieving those goals. The regional focus/discussion groups are not meetings to air health care delivery grievances. They are proactive discussion groups that not only address and discuss health care reform issues, but develop and shape policy alternatives.
- **Develop Criteria:** Do not support any of the health care reform plans exclusively. Instead, develop a set of criteria which can be applied to any health care reform package. These criteria must address the four key issues that are essential to any NA/AN health care reform package. These issues are:
 - **Funding:** IHS is currently funded at 70% of actual need. In order to improve the health status of these communities, funding levels must increase.
 - **Service Delivery:** IHS service infrastructure is antiquated. In order to improve the health status of these communities, hospitals and clinics must be adequately staffed, have the appropriate equipment, and be located nearer to their service population. IHS has attempted to improve cultural sensitivity within facilities by providing scholarships for NA/AN youth to attend medical school. However, in order for this program to continue and for overall service to improve, IHS funding levels must increase to reflect the true cost of providing these services.
 - **Eligibility and Enrollment:** Tribal membership qualifications and inaccurate census data make the active enrollment of NA/AN difficult. In order to maximize the number of NA/AN enrolled, it will be necessary for tribes to develop universal membership criteria based on their nations respective Constitutions. These lists, once developed, can be used to passively enroll NA/AN into an IHS health plan. Funding depends on membership rolls, if lists are inaccurately developed and undercounting occurs, IHS programs will lack the necessary funds to service their true population.
 - **Regional Health Alliances:** Regional health alliances represent a viable option for NA/AN communities. Because the IHS plan under the AHSA will not take effect until 1999, tribes need to evaluate the relative merits of moving to a health plan offered by a regional health alliance. The draw backs associated with committing to one of these plans is as follows: First, NA/AN will be expected to bear the full cost of the health plan; and second, a negative dynamic within the community may result in NA/AN groups being politically impotent and having little bargaining power with the insurance industry. Therefore, tribes must make individual assessments based on their financial situation whether or not they will participate in a regional health alliance.

VII. Summary and Conclusion

Escalating health care costs, publicity surrounding the uninsured and the inefficiency of the Medicaid and Medicare programs have created the crisis environment currently stimulating the development of health care reform proposals. Despite legislative efforts to improve the health of NA/AN, the overall health conditions of these communities remain below the average for the rest of the nation. While policy makers will advance many proposals in the coming months, four issues must be addressed in order to insure effective health care reform in NA/AN communities: the IHS funding process, service delivery, eligibility and enrollment, and the role of regional health care alliances in NA/AN communities.

Despite legislative efforts to improve the quality of NA/AN health, health problems continue to plague NA/AN communities at disproportional rates. Policies directed at NA/AN health issues have been relatively unsuccessful due to a lack of funding, lack of access to health care facilities, and insufficient specialized services. Funding is complicated by the appropriations procedure for the IHS. Too few clinics in rural areas and the lack of staff and equipment force some hospitals to operate below capacity. The quality of care is diminished by the use of temporary edifices and the lack of specialized care for the elderly and the chemically dependent. Efforts to access alternative health care providers are hindered by cultural ignorance and insensitivity on the part of outside providers of care.

Given the current status of funding and service delivery, any policy which proposes to reform health care in NA/AN communities should address the following issues:

- **The funding procedure for IHS;**
- **Inaccessibility to facilities-the lack of facilities in rural areas and staffing shortages;**
- **Local procedures for the transfer of health policy information to the tribes and the distrust of Federal motives on the part of NA/AN;**
- **The importance of community outreaches and community health projects;**
- **The lack of long-term care and drug treatment facilities.**

Tribes determine membership requirements for service eligibility in different ways. Care must be taken to insure that inter-tribal variations do not exclude citizens from access to health care. For instance, if someone marries within tribes, but does not have the blood quantum level required for membership in any one tribe, they will be ineligible for services under such a system. Also, due to isolation and cultural reasons, some NA/AN will not enroll themselves in a health care system. In order to resolve this situation, a two fold approach requiring both tribal and IHS participation is necessary. This approach will require:

- **Tribes to examine their membership requirements in order to insure that full blooded NA/AN are not excluded from health care.**
- **The IHS and tribes need to develop membership lists that will allow for passive enrollment of NA/AN.**

In order to address these complicated inter-tribal/IHS issues, it will be necessary to set well-defined goals regarding eligibility and enrollment requirements.

The AHSA proposes the use of regional health care alliances for obtaining health care insurance coverage. Should a tribe or member thereof choose to opt out of the Federal system and choose private care, it or the individual may become a member of a RHA. The nature of the RHA is such that the position of the local community will define the strength of the alliance. The appeal of this option is the fact that it will be available one full year ahead of the IHS component of the AHSA. The disadvantages for NA/AN communities are as follows:

- **If NA/AN communities buy into RHAs, tribal members will be expected to bear the full cost of the health plan.**
- **NA/AN groups may be politically impotent and have little bargaining power with the insurance industry.**

In order to address these complicated tribal issues, it will be necessary to set well defined goals regarding the exploration of RHAs. This can be facilitated through the development of tribal discussion groups that could explore the proper role of alliances within these communities.

In deciding which plan to support if any, the AHSA has two strong advantages. The plan already has a section devoted to NA/AN health issues and the DHHS is developing recommenda-

tion for the plan from the RCNAHCR. However, the AHSA may not pass through Congress. If NA/AN do not work with the sponsors of other plans, which do not thoroughly address NA/AN issues, reform in NA/AN communities will not occur. Support of alternative plans provides an opportunity to shape changes in service delivery and funding. However, the legislative language in alternative plans remains limited. Therefore, structuring the legislation may take more time than is available. Also, once NA/AN leaders decide which plan to support, it may not pass Congress either.

The adoption of a standard criteria which any plan must meet in order to receive support of tribal nations presents the most viable option. This criteria should be flexible so that it can be applied to any health care legislation. This allows time to focus on developing relationships with legislators and building political support, instead of developing legislation.

In order to become national players in the health care reform debate, NA/AN leaders must act quickly. We recommend that in the next three months tribes take the following steps:

Recommendations

- **Maintain and Expand the role of Regional Focus Groups:**

The tribes should **maintain and expand the regional discussion groups** developed as a result of the RCNAHCR. The positions papers provided to the DHHS should establish what problems need to be addressed immediately in order to improve health conditions in each region. **This group should develop a criteria to evaluate health care reform proposals, set short and long-term goals, and designate a representative to attend a national meeting on NA/AN health care reform. This group should coordinate with the National Congress of American Indians, the Indian Health Board and the Council on Native American Health to develop a strategy for achieving those goals.** The regional focus/discussion groups are not

meetings to air health care delivery grievances. They are proactive discussion groups that not only **address and discuss health care reform issues**, but **develop and shape policy alternatives**.

- **Develop Criteria:**

Do not support any of the health care reform plans exclusively.

Instead, develop a set of criteria which can be applied to any health care reform package. These criteria must address the four key issues that are essential to any NA/AN health care reform package. These issues are:

- **Funding:**

IHS is currently funded at 70% of actual need. In order to improve the health status of these communities, **funding levels must increase**.

- **Service Delivery:**

IHS service infrastructure is antiquated. In order to improve the health status of these communities, **hospitals and clinics must be adequately staffed, have the appropriate equipment, and be located nearer to their service population**. IHS has attempted to improve cultural sensitivity within facilities by providing scholarships for NA/AN youth to attend medical school. However, **in order for this program to continue and for overall service to improve, IHS funding levels must increase to reflect the true cost of providing these services**.

- **Eligibility and Enrollment:**

Tribal membership qualifications and inaccurate census data make the active enrollment of NA/AN difficult. In order to maximize the number of NA/AN enrolled, **it will be necessary for tribes to develop universal membership criteria based on their nations respective Constitutions**. These lists, once developed, can be used to passively enroll NA/AN into an IHS health plan. **Funding depends on membership rolls, if lists are inaccurately developed and undercounting occurs, IHS programs will lack the necessary funds to service their true population**.

- **Regional Health Alliances:**

Regional health alliances represent a viable option for NA/AN communities. Because the IHS plan under the AHSA will not take effect until 1999, tribes need to evaluate the relative merits of moving to a health plan offered by a regional health alliance. The draw backs associated with committing to one of these plans is as follows: First, NA/AN will be expected to bear the full cost of the health plan; and second, a negative dynamic within the community may result in NA/AN groups being politically impotent and having little bargaining power with the insurance industry. **Therefore, tribes must make individual assessments based on their financial situation whether or not they will participate in a regional health alliance**.

Table Two Recommendations

Recommendation for the Funding Process

- Increase the number of consultations between Area Office Directors and Tribal Leaders;
- Address the issue of the IHS appropriation process being located in the Committee on the Interior instead of the Department of Health and Human Service appropriation process.

Recommendations for Health Service Delivery

- Increase accessibility through decreased travel distances and increased funding for staff, facility construction and equipment;
- Continue to expand the supplemental services provided by the IHS, including preventative health and educational programs;
- Address issues of cultural sensitivity by using the native language of the tribe, and using traditional healers within the community;
- Provide community based long-term health care facilities, and drug and alcohol treatment centers.

Recommendations for Eligibility and Enrollment

- Tribes need to establish a minimum universal membership criteria, based on their respective Constitutions, in order to insure that full blooded Indians are not excluded from health care;
- Tribes should make this minimum membership criteria retroactive to 1990;
- The IHS and tribes need to use this minimum universal membership criteria to develop membership lists that will allow for passive enrollment of NA/AN.

Recommendations for Regional Health Alliances

- Tribes will need to set well defined goals regarding the exploration of plans offered through regional health alliances;
- Tribes should develop discussion groups that will examine the plans offered through the regional health alliance. Issues of particular importance are:
 - How tribal members will pay for health plans that are not offered through the IHS;
 - Will the health plans offered through regional health alliances cover those preventative and long-term health services that are necessary in NA/AN communities.

The primary problems facing NA/AN health are a crisis in funding resources, and limited time with which to prepare and push for NA/AN health care reform. NA/AN leaders need to deal with these issues immediately. For specific recommendations on how to address these problems, please see table two. In the near future, Tribal Leaders will have to expand their focus to address other health related issues. For instance, should tribes concentrate efforts on establishing their own medical facilities? Should funding for the IHS be moved out of the Committee on the Interior? These questions are crucial to the future of health care in NA/AN communities. However, the challenge before NA/AN leaders is to act in the existing window of opportunity presented by the national movement to reform the American health care system.

If one steps back from this analysis, it is clear NA/AN health care reform is fundamentally different from national health care reform. NA/AN health care reform is not about providing a comprehensive core benefit package to a group of people, it is about funding and resources. A theme that has been explored throughout this work.

APPENDICES

APPENDIX A. GLOSSARY

APPENDIX B. BIBLIOGRAPHY

APPENDIX C. TITLE VIII, SUBTITLE D of
THE AMERICAN HEALTH SECURITY ACT

APPENDIX D. PRESENTATION SLIDES

Appendix A. Glossary

AHSA	American Health Security Act
BIA	Bureau of Indian Affairs
CHR	Community Health Representatives
CBP	Comprehensive Benefit Package
DHHS	Department of Health and Human Services
EMS	Emergency Medical Services
IHCB	Indian Health Care Board
IHS	Indian Health Service
MBTA	Massachusetts Bay Transportation Authority
NA/AN	Native American and Alaskan Native
NAHCR	Native American Health Care Reform
OMB	Office of Management and Budget
P.L.	Public Law
RCNAHCR	Regional Conference on Native American Health Care Reform
RHA	Regional Health Alliance
USPHS	United States Public Health Service
VA	Veterans Administration

Appendix B. Bibliography

- Allen, Randy. Telephone interview. 24 Nov. 1993.
- Anquoe, Bunty. "Health Reform Gives Indians a Choice." Indian Country Today. 29 Sept. 1993, A1-2.
- Belcourt, Gordon. Telephone interview. 18 Jan. 1994.
- Chaffee, Senator Richard (R-NJ). "The Health Equity and Reform Today Act of 1993." S. 1770; H.R. 3704.
- De Coteau, Jerilyn. "Access of Urban Indians to Health Care." Vol. 20 of Clearinghouse Review. (Summer 1986): 402-409.
- Ducheneaux, Taylor and Associates. "Indian Health Care Under Clinton Health Reform Bill." Client Memorandum, 19 Nov. 1993.
- Enthoven, Alain. "The History and Principles of Managed Competition." in Health Affairs. Supplement: Managed Competition, Health Reform American Style. (1993): 2.
- Gatz, Carolyn. Telephone Interview. 15 Nov. 1993.
- Getches, David H. et al. "Indians and Indian Law." in Federal Indian Law. Westlaw Publications. Minneapolis, (1978): 10-11.
- Joseph, Yvette. Telephone interview. 13 Nov. 1993.
- Kauffman, Joanne. Telephone interview. 12 Jan. 1994.
- Kauffman, Joanne and Associates, Inc. Round Conference on Health Care Reform, The Health Securities Act, and Indian Health Care: A Briefing Book. Washington, q D.C. 1993.
- Latus, Justin. Telephone interview. 15 Nov. 1993.
- Loungie, Keith. Telephone interview. 18 Jan. 1994.
- Mankiller, Wilma. "Native Americans: Protecting a Long Standing Right to Government Provide Care." in The League of Women Voters. (December/January 1994): 12.
- Moffit, Robert E., A Checklist of Vital National Issues, A Guide to the Clinton Health Plan, Washington: The Heritage Foundation, 1993.
- National Summit on Indian Health Care Reform. American Indian Resources Institute, Washington, D.C. March 1993.
- New York Times. "Health Care: Clinton's Plan and the Alternatives." 17 Oct. 1993.
- Payer, L. Medicine and Culture. New York: Henry Holt and Co., (1988): 15-34.
- Pevar, Steven. The Rights of the Indian Tribes. American Civil Liberties Union Guide. 2nd. ed. United States: Newheaf Studio, 1992.

- Public Health Service. FTE Fact Sheet. 2. 1994.
- Regional Forum on Indian Health Care Reform. Department of Health and Human Services. 2-4 Feb. 1994.
- Sandia Pueblo. Position Paper. Presented to the Assistant Secretary of Health. 3 Feb. 1994.
- Slagle, Al Logan. "Current Government Proposals Affecting Health Care Services for Native Americans." in Vol. 9. of Whittier Law Review. (Summer 1987): 201-230.
- United States Bureau of the Census. Statistical Record of Native North Americans. (1993): 720, 731-735, 749, 759, 762-765.
- United States Congress. Office of Technology Assessment. Indian Health Care. Washington, D.C.: Government Printing Office, 1986.
- United States Congress. "The American Health Security Act." 103rd Cong., 1st sess. H. Res. 3600. Washington: GPO, 1993.
- United States Government Printing Office . Budget of the United States Government. (FY 1994): Appendix 609.
- United States Department of Health and Human Services. Fact Sheet: "The Health Securities Act and the Indian Health Service." Indian Health Service and the Public Health Service. Oct. 1993.
- United States Department of Health and Human Services. "Indian Women's Health Care: Consensus Statement." Indian Health Service and the Public Health Service. Washington, D.C.: Jan. 1991.
- United States Department of Health and Human Services. "Position Papers on Health Care Reform." Washington, D.C.: Indian Health Service, 1994.
- United States Department of Health and Human Services. "Trends in Indian Health." Washington, D.C.: Indian Health Service, 1992.
- The White House. The Health Securities Act: Health Alliances. Washington, D.C.: 1994.
- The White House. "Health Security: The President's Report to the American People." Washington, D.C.: Oct. 1993.

Calendar No. 335

103^D CONGRESS
1ST SESSION**S. 1757**

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 20 (legislative day, NOVEMBER 2), 1993

Mr. MITCHELL (for himself, Mr. MOYNIHAN, Mr. KENNEDY, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. RIEGLE, Mr. AKAKA, Mr. BAUCUS, Mrs. BOXER, Mr. BUMPERS, Mr. CAMPBELL, Mr. CONRAD, Mr. DODD, Mrs. FEINSTEIN, Mr. GLENN, Mr. GRAHAM, Mr. HARKIN, Mr. INOUE, Mr. JEFFORDS, Mr. LEAHY, Mr. LEVIN, Mr. MATHEWS, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mrs. MURRAY, Mr. PELL, Mr. PRYOR, Mr. REID, Mr. SIMON, and Mr. WOFFORD) (by request) introduced the following bill; which was read the first time

NOVEMBER 22, 1993

Read the second time and placed on the calendar

1 authority responsible for the administration of such provi-
2 sion.

3 (c) OMNIBUS BUDGET RECONCILIATION ACT OF
4 1993.—Effective as of the date of the enactment of this
5 Act, section 11101(b)(3) of the Omnibus Budget Rec-
6 onciliation Act of 1993 (Public Law 103-66; 107 Stat.
7 413) is amended by striking “September 30, 1998” and
8 inserting “December 31, 1997”.

9 (d) EFFECTIVE DATE.—Except as provided in sub-
10 section (c), this section and the amendments made by this
11 section shall take effect on the day after the FEHBP ter-
12 mination date.

13 **Subtitle D—Indian Health Service**

14 **SEC. 8301. DEFINITIONS.**

15 For the purposes of this subtitle—

16 (1) the term “health program of the Indian
17 Health Service” means a program which provides
18 health services under this Act through a facility of
19 the Indian Health Service, a tribal organization
20 under the authority of the Indian Self-Determination
21 Act or a self-governance compact, or an urban In-
22 dian program;

23 (2) the term “reservation” means the reserva-
24 tion of any federally recognized Indian tribe, former
25 Indian reservations in Oklahoma, and lands held by

1 incorporated Native groups, regional corporations,
2 and village corporations under the provisions of the
3 Alaska Native Claims Settlement Act (43 U.S.C.
4 1601 et seq.);

5 (3) the term "urban Indian program" means
6 any program operated pursuant to title V of the In-
7 dian Health Care Improvement Act; and

8 (4) the terms "Indian", "Indian tribe", "tribal
9 organization", "urban Indian", "urban Indian orga-
10 nization", and "service unit" have the same meaning
11 as when used in the Indian Health Care Improve-
12 ment Act (25 U.S.C. 1601 et seq.).

13 **SEC. 8302. ELIGIBILITY AND HEALTH SERVICE COVERAGE**
14 **OF INDIANS.**

15 (a) **ELIGIBILITY.**—An eligible individual, as defined
16 in section 1001(c), is eligible to enroll in a health program
17 of the Indian Health Service if the individual is—

18 (1) an Indian, or a descendent of a member of
19 an Indian tribe who belongs to and is regarded as
20 an Indian by the Indian community in which the in-
21 dividual lives, who resides on or near an Indian res-
22 ervation or in a geographical area designated by
23 statute as meeting the requirements of being on or
24 near an Indian reservation notwithstanding the lack
25 of an Indian reservation;

1 (2) an urban Indian; or

2 (3) an Indian described in section 809(b) of the
3 Indian Health Care Improvement Act (25 U.S.C.
4 1679(b)).

5 (b) ELECTION.—An individual described in sub-
6 section (a) may elect a health program of the Indian
7 Health Service instead of a health plan.

8 (c) ENROLLMENT FOR BENEFITS.—An individual
9 who elects a health program of the Indian Health Service
10 under subsection (b) shall enroll in such program through
11 a service unit, tribal organization, or urban Indian pro-
12 gram. An individual who enrolls in such program is not
13 subject to any charge for health insurance premiums,
14 deductibles, copayments, coinsurance, or any other cost
15 for health services provided under such program.

16 (d) PAYMENTS BY INDIVIDUALS WHO DO NOT EN-
17 ROLL.—If an individual described in subsection (a) does
18 not enroll in a health program of the Indian Health Serv-
19 ice, no payment shall be made by the Indian Health Serv-
20 ice to the individual (or on behalf of the individual) with
21 respect to premiums charged for enrollment in an applica-
22 ble health plan or any other cost of health services under
23 the applicable health plan which the individual is required
24 to pay.

1 **SEC. 8303. SUPPLEMENTAL INDIAN HEALTH CARE BENE-**
2 **FITS.**

3 (a) **IN GENERAL.**—All individuals described in sec-
4 tions 8302(a) remain eligible for such benefits under the
5 laws administered by the Indian Health Service as supple-
6 ment the comprehensive benefit package. The individual
7 shall not be subject to any charge or any other cost for
8 such benefits.

9 (b) **AUTHORIZATION OF APPROPRIATIONS.**—In addi-
10 tion to amounts otherwise authorized to be appropriated,
11 there is authorized to be appropriated to carry out this
12 section \$180,000,000 for fiscal year 1995, \$200,000,000
13 for each of the fiscal years 1996 through 1999, and such
14 sums as may be necessary for fiscal year 2000 and each
15 fiscal year thereafter.

16 **SEC. 8304. HEALTH PLAN AND HEALTH ALLIANCE RE-**
17 **QUIREMENTS.**

18 (a) **COMPREHENSIVE BENEFIT PACKAGE.**—The Sec-
19 retary shall ensure that the comprehensive benefit package
20 is provided by all health programs of the Indian Health
21 Service effective January 1, 1999, notwithstanding section
22 1001(a).

23 (b) **APPLICABLE REQUIREMENTS OF HEALTH**
24 **PLANS.**—In addition to subsection (a), the Secretary shall
25 determine which other requirements relating to health

1 plans apply to health programs of the Indian Health Serv-
2 ice.

3 (c) CERTIFICATION.—Effective January 1, 1999, all
4 health programs of the Indian Health Service must meet
5 the certification requirements for health plans, as required
6 by the Secretary under this section, as certified from time
7 to time by the Secretary. Before January 1, 1999, all such
8 health programs shall, to the extent practicable, meet such
9 certification requirements.

10 (d) HEALTH ALLIANCE REQUIREMENTS.—The Sec-
11 retary shall determine which requirements relating to
12 health alliances apply to the Indian Health Service.

13 **SEC. 8305. EXEMPTION OF TRIBAL GOVERNMENTS AND**
14 **TRIBAL ORGANIZATIONS FROM EMPLOYER**
15 **PAYMENTS.**

16 A tribal government and a tribal organization under
17 the Indian Self-Determination and Educational Assistance
18 Act or a self-governance compact shall be exempt from
19 making employer premium payments as an employer
20 under section 6121.

21 **SEC. 8306. PROVISION OF HEALTH SERVICES TO NON-EN-**
22 **ROLLEES AND NON-INDIANS.**

23 (a) CONTRACTS WITH HEALTH PLANS.—

24 (1) IN GENERAL.—A health program of the In-
25 dian Health Service, a service unit, a tribal organi-

1 zation, or an urban Indian organization operating
2 within a health program may enter into a contract
3 with a health plan for the provision of health care
4 services to individuals enrolled in such health plan if
5 the program, unit, or organization determines that
6 the provision of such health services will not result
7 in a denial or diminution of health services to any
8 individual described in section 8302(a) who is en-
9 rolled for health services provided by such program,
10 unit, or organization.

11 (2) REIMBURSEMENT.—Any contract entered
12 into pursuant to paragraph (1) shall provide for re-
13 imbursement to such program, unit, or organization
14 in accordance with the essential community provider
15 provisions of section 1431(c), as determined by the
16 Secretary.

17 (b) FAMILY TREATMENT.—

18 (1) DETERMINATION TO OPEN ENROLLMENT.—
19 A health program of the Indian Health Service may
20 open enrollment to family members of individuals
21 described in section 8302(a).

22 (2) ELECTION.—If a health program of the In-
23 dian Health Service opens enrollment to family
24 members of individuals described in section 8302(a),
25 an individual described in that section may elect

1 family enrollment in the health program instead of
2 in a health plan.

3 (3) ENROLLMENT.—

4 (A) IN GENERAL.—An individual who
5 elects family enrollment under paragraph (2) in
6 a health program of the Indian Health Service
7 shall enroll in such program.

8 (B) APPLICABLE INDIVIDUAL CHARGES.—
9 The individual who enrolls in such program
10 under subparagraph (A) is not subject to any
11 charge for health insurance premiums,
12 deductibles, copayments, coinsurance, or any
13 other cost for health services provided under
14 such program attributable to the individual, but
15 the family members who are not eligible for a
16 health program of the Indian Health Service
17 under section 8302(a) are subject to all such
18 charges.

19 (C) APPLICABLE EMPLOYER CHARGES.—
20 Employers, other than tribal governments and
21 tribal organizations exempt under section 8305,
22 are liable for making employer premium pay-
23 ments as an employer under section 6121 in the
24 case of any family member enrolled under this
25 subsection who is not eligible for a health pro-

1 gram of the Indian Health Service under sec-
2 tion 8302(a).

3 (4) PREMIUM.—

4 (A) ESTABLISHMENT AND COLLECTION.—

5 The Secretary shall establish premiums for all
6 family members enrolled in a health program of
7 the Indian Health Service under this paragraph
8 who are not eligible for a health program of the
9 Indian Health Service under section 8302(a).
10 The Secretary shall collect each premium pay-
11 ment owed under this paragraph.

12 (B) REDUCTION.—The Secretary shall pro-
13 vide for a process for premium reduction which
14 is the same as the process, and uses the same
15 standards, used by regional alliances for the
16 areas in which individuals described in subpara-
17 graph (A) reside, except that in computing the
18 family share of the premiums the Secretary
19 shall use the lower of the premium quoted or
20 the reduced weighted average accepted bid for
21 the reference regional alliance.

22 (C) PAYMENT BY SECRETARY.—The Sec-
23 retary shall provide for payment to each health
24 program of the Indian Health Service, in the
25 same manner as payments under section 6201,

1 amounts equivalent to the amount of payments
2 that would have been made to a regional alli-
3 ance if the individuals described in subpara-
4 graph (A) were enrolled in a regional alliance
5 health plan (with a final accepted bid equal to
6 the reduced weighted average accepted bid pre-
7 mium for the regional alliance).

8 (c) ESSENTIAL COMMUNITY PROVIDER.—

9 (1) HEALTH SERVICES.—If a health program of
10 the Indian Health Service, a service unit, a tribal or-
11 ganization, or an urban Indian organization operat-
12 ing within a health program elects to be an essential
13 community provider under section 1431, an individ-
14 ual described in paragraph (2) enrolled in a health
15 plan other than a health program of the Indian
16 Health Service may receive health services from that
17 essential community provider.

18 (2) INDIVIDUAL COVERED.—An individual re-
19 ferred to in paragraph (1) is an individual who—

20 (A) is described in section 8302(a); or

21 (B) is a family member described in sub-
22 section (b) who does not enroll in a health pro-
23 gram of the Indian Health Service.

1 **SEC. 8307. PAYMENT BY OTHER PAYERS.**

2 (a) **PAYMENT FOR SERVICES PROVIDED BY INDIAN**
3 **HEALTH SERVICE PROGRAMS.**—Nothing in this subtitle
4 shall be construed as amending section 206, 401, or 402
5 of the Indian Health Care Improvement Act (relating to
6 payments on behalf of Indians for health services from
7 other Federal programs or from other third party payers).

8 (b) **PAYMENT FOR SERVICES PROVIDED BY CON-**
9 **TRACTORS.**—Nothing in this subtitle shall be construed as
10 affecting any other provision of law, regulation, or judicial
11 or administrative interpretation of law or policy concern-
12 ing the status of the Indian Health Service as the payer
13 of last resort for Indians eligible for contract health serv-
14 ices under a health program of the Indian Health Service.

15 **SEC. 8308. CONTRACTING AUTHORITY.**

16 Section 601(d)(1)(B) of the Indian Health Care Im-
17 provement Act (25 U.S.C. 1661(d)(1)(B)) is amended by
18 inserting “(including personal services for the provision of
19 direct health care services)” after “goods and services”.

20 **SEC. 8309. CONSULTATION.**

21 The Secretary shall consult with representatives of
22 Indian tribes, tribal organizations, and urban Indian orga-
23 nizations annually concerning health care reform initia-
24 tives that affect Indian communities.

1 SEC. 8310. INFRASTRUCTURE.

2 (a) FACILITIES.—The Secretary, acting through the
3 Indian Health Service, may expend amounts appropriated
4 pursuant to section 8313 for the construction and renova-
5 tion of hospitals, health centers, health stations, and other
6 facilities for the purpose of improving and expanding such
7 facilities to enable the delivery of the full array of items
8 and services guaranteed in the comprehensive benefit
9 package.

10 (b) CAPITAL FINANCING.—There is established in the
11 Indian Health Service a revolving loan program. Under
12 the program, the Secretary, acting through the Indian
13 Health Service, shall provide guaranteed loans under such
14 terms and conditions as the Secretary may prescribe to
15 providers within the Indian Health Service system to im-
16 prove and expand health care facilities to enable the deliv-
17 ery of the full array of items and services guaranteed in
18 the comprehensive benefit package.

19 SEC. 8311. FINANCING.

20 (a) ESTABLISHMENT OF FUND.—Each health pro-
21 gram of the Indian Health Service shall establish a com-
22 prehensive benefit package fund (hereafter in this section
23 referred to as the “fund”).

24 (b) DEPOSITS.—There shall be deposited into the
25 fund the following:

1 (1) All amounts received as employer premium
2 payments pursuant to section 1351(e)(3).

3 (2) All amounts received as family premium
4 payments and premium discount payments pursuant
5 to section 8306(b)(4).

6 (3) All amounts appropriated for the fund for
7 the purpose of providing the comprehensive benefit
8 package to individuals enrolled in a health program
9 of the Indian Health Service.

10 (4) Any other amount received with respect to
11 health services for the comprehensive benefit pack-
12 age.

13 (c) ADMINISTRATION AND EXPENDITURES.—

14 (1) MANAGEMENT.—The fund shall be man-
15 aged by the health program of the Indian Health
16 Service.

17 (2) EXPENDITURES.—Expenditures may be
18 made from the fund to provide for the delivery of
19 the items and services of the comprehensive benefit
20 package under the health program of the Indian
21 Health Service.

22 (3) AVAILABILITY OF FUNDS.—Amounts in the
23 fund established by a service unit of the Indian
24 Health Service under this section shall be available
25 without further appropriation and shall remain

Understanding the Health Care Funding Process

Issues

- Appropriations for the IHS are considered by the same Congressional committee which oversees both the Department of Parks and Wildlife and Fisheries Department;
- Influence of the Area Office Directors on the appropriations and disbursement of funds to Indian Tribes;
- The macroeconomic impact of increasing health care costs on funding health care services in NA/AN communities.

Understanding the Health Care Funding Process

Recommendations for the Funding Process

- Increase the number of consultations between Area Office Directors and Tribal Leaders;
- Address the issue of the IHS appropriation process being located in the Committee on the Interior.

Understanding Health Service Delivery

Issues

Access

- Excessive travel distances to medical facilities;
- Lack of staff and equipment for facilities.

Quality

- Failure to provide appropriate health care services;
- The prolonged use of temporary facilities.

Cultural Sensitivity

- Linguistic and cultural differences influence the delivery of health care.

Long-Term Care

- There is lack of long-term health care facilities and drug and alcohol treatment centers in NA/AN communities.

Understanding Health Service Delivery

Recommendations for Health Service Delivery

- Increase accessibility through decreased travel distances and increased funding for staff, facility construction and equipment;
- Continue to expand the supplemental services provided by the IHS, including preventative health and educational programs;
- Address issues of cultural sensitivity by using the native language of the tribe, and using traditional healers within the community;
- Provide community based long-term health care facilities.

Understanding Eligibility and Enrollment

Issues

Eligibility

- Undercounting the eligible service population is a constant concern for both the IHS and Tribal Leaders because the discretionary appropriation process is based in part on accurate population figures;
- As Indian tribes are federally recognized, membership lists that are developed may be incomplete as individuals are invariably missed in the initial count. Without tribal membership, these individuals are not eligible for tribal or federal benefits, including those services provided by IHS.
- Differences in tribal membership requirements may reduce the number of NA/AN who are eligible to receive health care.

Understanding Eligibility and Enrollment

Issues

Enrollment

- Those NA/AN living close to urban population centers have the opportunity to enroll in health plans provided through Regional Health Alliances. Which plan should those NA/AN enroll in?
- If the AHSA is enacted, a considerable amount of confusion will result in a number of persons being missed in the initial enrollment period;
- Cultural and geographical isolation may make it difficult to enroll in health plans.

Understanding Eligibility and Enrollment

Recommendations for Eligibility and Enrollment

- Tribes need to establish a minimum universal membership criteria, based on their respective Constitutions, in order to insure that full blooded Indians are not excluded from health care;
- Tribes should make this minimum membership criteria retroactive to 1990;
- The IHS and tribes need to use this minimum universal membership criteria to develop membership lists that will allow for passive enrollment of NA/AN.

Understanding Regional Health Alliances

Issues

- The nature of the RHA is such that the social position of the local community will define the relative strengths of the alliance, and the premium paid for health plans by its membership.
- The nature of the RHA allows the potential for “gerrymandering” RHAs around disadvantaged communities because of the desire to provide low cost plans by selecting for adverse risk.
- Given the structure of RHAs and the poor health of NA/AN communities, there may be difficulties acquiring affordable insurance for reservation members.

Understanding Regional Health Alliances

Concerns

- If NA/AN communities buy into RHAs, tribal members will be expected to bear the entire cost of the health plan.
- A negative dynamic within the community may result in NA/AN groups being politically impotent and having little bargaining power with the insurance industry.

Understanding Regional Health Alliances

Recommendations for Regional Health Alliances

- Tribes will need to set well defined goals regarding the exploration of plans offered through regional health alliances.
- Tribes should develop discussion groups that will examine the plans offered through the regional health alliance. Issues of particular importance:
 - How tribal members will pay for health plans that are not offered through the IHS;
 - Will the health plans offered through regional health alliances cover those preventative and long-term health services that are necessary in NA/AN communities.

Understanding the AHSA

General Recommendations

- **Maintain and Expand the role of Regional Focus Groups:**

The tribes should maintain and expand the regional discussion groups developed as a result of the RCNAHCR. The positions papers provided to the DHHS should establish what problems need to be addressed immediately in order to improve health conditions in each region. This group should develop a criteria to evaluate health care reform proposals, set short and long-term goals, and designate a representative to attend a national meeting on NA/AN health care reform. This group should coordinate with the National Congress of American Indians, the Indian Health Board and the Council on Native American Health to develop a strategy for achieving those goals. The regional focus/discussion groups are not meetings to air health care delivery grievances. They are proactive discussion groups that not only address and discuss health care reform issues, but develop and shape policy alternatives.

Understanding the AHSA

General Recommendations

- **Develop Criteria:**

Do not support any of the health care reform plans exclusively. Instead, develop a set of criteria which can be applied to any health care reform package. These criteria must address the four key issues that are essential to any NA/AN health care reform package. These issues are:

Understanding the AHSA

General Recommendations

- **Funding:** IHS is currently funded at 70% of actual need. In order to improve the health status of these communities, funding levels must increase.

Understanding the AHSA

General Recommendations

- **Service Delivery:**

IHS service infrastructure is antiquated. In order to improve the health status of these communities, hospitals and clinics must be adequately staffed, have the appropriate equipment, and be located nearer to their service population. IHS has attempted to improve cultural sensitivity within facilities by providing scholarships for NA/AN youth to attend medical school. However, in order for this program to continue and for overall service to improve, IHS funding levels must increase to reflect the true cost of providing these services.

Understanding the AHSA

General Recommendations

- **Eligibility and Enrollment:**

Tribal membership qualifications and inaccurate census data make the active enrollment of NA/AN difficult. In order to maximize the number of NA/AN enrolled, it will be necessary for tribes to develop universal membership criteria based on their nations respective Constitutions. These lists, once developed, can be used to passively enroll NA/AN into an IHS health plan. Funding depends on membership rolls, if lists are inaccurately developed and undercounting occurs, IHS programs will lack the necessary funds to service their true population.

Understanding the AHSA

General Recommendations

- **Regional Health Alliances:**

Regional health alliances represent a viable option for NA/AN communities. Because the IHS plan under the AHSA will not take effect until 1999, tribes need to evaluate the relative merits of moving to a health plan offered by a regional health alliance. The draw backs associated with committing to one of these plans is as follows: First, NA/AN will be expected to bear the full cost of the health plan; and second, a negative dynamic within the community may result in NA/AN groups being politically impotent and having little bargaining power with the insurance industry. Therefore, tribes must make individual assessments based on their financial situation whether or not they will participate in a regional health alliance.