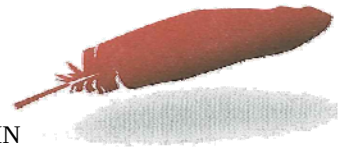
National Indian Health Board



TESTIMONY OF BUFORD ROLIN

CHAIRMAN, POARCH BAND OF CREEK INDIANS,
VICE CHAIRMAN, NATIONAL INDIAN HEALTH BOARD,
CO-CHAIRMAN, TRIBAL DIABETES LEADERS COMMITTEE &
CO-CHAIRPERSON OF THE NATIONAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
JUNE 11, 2009

Chairman Dorgan, Vice-Chairman Barrasso and distinguished Members of the Committee:

I am Buford Rolin, Chairman of the Poarch Band of Creek Indians, Vice-Chairman of the National Indian Health Board (NIHB) and Co-Chairman of the Tribal Leaders Diabetes Committee (TLDC). I also serve as the Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). In these capacities and others, I have been fortunate to work with Tribal Leaders from across the country to address issues that affect the Indian health delivery system and the health status of Indian people.

Thank you for holding this hearing and providing this opportunity to testify on reform of the Indian health care system. I am honored to provide this testimony on behalf of the National Indian Health Board (NIHB).

With Congress and the Obama Administration proposing to make sweeping reforms to the nation's health care system, Indian Country has examined reform components to evaluate their impact on the Indian health system. Our system was designed by the Federal government to carry out its trust responsibility for Indian health and to make health care accessible to Indian people, including those who reside in remote, sparsely-populated reservation and Alaska Native communities where little, if any, other health infrastructure exists. Our system is very different from the mainstream health care system; thus, we must assure that "reform" measures do not inadvertently cause harm to it. Thus, we ask you and your colleagues to –

- Evaluate all components of health care reform proposals to assure they “do not harm” the Indian health system,
- Assure that the legislation actually **supports** and **protects** the Indian health system through Indian-specific provisions where needed,
- Ensure that Indian people and Indian health programs have full opportunities to participate in and benefit from reform programs and
- Acknowledge and respect the status of Indian tribes as sovereign governments.

The National Indian Health Board (NIHB), together with the National Congress of American Indian (NCAI), and the National Council of Urban Indian Health (NCUIH), has examined reform proposals from the perspective of the Indian health system, and determined that Indian-specific policies must be included in order to assure that the Indian system is not harmed. These organizations have taken the first step and presented Congressional leaders with a joint paper titled "Health Care Reform – Indian Country Recommendations" ("Joint Paper.") See Exhibit 1. NIHB fully endorses this paper.[1]

I. PRINCIPLES FOR REFORMING THE INDIAN HEALTH CARE DELIVERY SYSTEM

Honoring the Trust Responsibility

Reform of the Indian health care system must rest on the unique trust relationship. As Tribes ceded millions of acres of land to the government, the United States, in its role as "guardian," agreed to provide a variety of services to Indian people. This federal trust responsibility forms the basis of providing health care to American Indians and Alaska Natives (AI/ANs). The unique relationship between the U.S. and federally recognized Indian Tribes is rooted in the United States Constitution and has been reaffirmed by judicial decisions, executive orders and congressional law. With every action of the drafting pen, Congress must remember the duty that the federal government owes to Indian people.

Recognizing the Importance of the Indian Health System

The Indian Health Services is responsible for providing health care to some 1.9 million American Indians and Alaska Natives in the United States. This system consists of services provided by the Indian Health Services); programs operated by Indian tribes and tribal organizations through Indian Self-Determination and Education Assistance (ISDEAA) agreements; and by urban Indian organizations who receive funding from IHS. [Collectively, these three components are referred to as the "Indian health system."]

The Indian health system is not health insurance but is Indian Country's health care home. This community-based delivery system supplies culturally appropriate health care services essential to promoting a healthy lifestyle. Existing health disparities, high rates of poverty, and the remote, rural nature of Indian communities demand a unique health care delivery system. The Indian health system was designed in large part to reach these beneficiaries in these communities.

II. REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT IS NECESSARY TO FACILITATE REFORM OF THE INDIAN HEALTH CARE SYSTEM

On behalf of the NSC and NIHB, I would like to express our appreciation for your outstanding leadership in achieving Senate approval of IHCIA reauthorization legislation last

[1] Indian Health Boards from throughout Indian Country have hosted or will soon host discussions on health care reform. A table listing the dates of these discussions are included here as Exhibit 2. We are pleased to share with the Committee reports from these gatherings.

year. We shared your disappointment that the House did not complete the job. Enacting an IHCIA reauthorization bill remains a top priority for Indian country. The IHCIA is the foundation for the delivery of health care services to AI/ANs. Today, I respectfully request Congress and the Administration to fulfill the nation's responsibility to Indian people by finally enacting an IHCIA bill this year. I also urge Congress to make this law permanent – without a sunset date – as Congress has done with other major Indian laws such as the Snyder Act, the ISDEAA and the BIA education laws.

The NSC's long-standing policy has been to seek passage of IHCIA reauthorization provisions on other legislation where possible – such as the recently enacted CHIPRA and ARRA laws, which included significant Indian health provisions. In furtherance of that strategy, the Joint Paper includes a list of IHCIA provisions, which would bring long-sought authorities and advancements to the Indian health system. We ask this Committee to advocate for their inclusion in health care reform legislation. I would like highlight a sample of these provisions that will likely be critical for Indian Country in national health care reform.

Third Party Collection: This revised provision would strength IHS and tribal program authority to collect reimbursements from third party insurers including insurance company, health maintenance organization, employee benefit plan, and third-party tortfeasor. (Sec. 403 of S. 1200)

Payor of Last Resort: This provision would codify in law the existing IHS regulation which makes IHS payor of last resort, meaning that all other available sources (e.g., Medicare, Medicaid, private insurance, other) pay for care before IHS appropriated funds are used. To assure such policies are properly implemented, legislation should require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (Sec. 407 of S. 1200)

Comprehensive Behavioral Health Programs. A major goal of the IHCIA reauthorization process has been to establish coordinated, comprehensive programs to address the myriad of behavioral health problems in Indian Country, such as substance abuse, suicide (especially among youth), and domestic violence. The resulting new Title VII in the IHCIA reauthorization bills, if properly funded, would make major strides toward addressing these chronic problems. I am hopeful this entire Title VII can be enacted on a health care reform measure.

III. APPLICATION OF INDIAN POLICIES TO NATIONAL HEALTH CARE REFORM

The Joint Paper sets forth recommendations for protecting the Indian health system and assuring that health care reform efforts will have a beneficial effect on it. These recommendations are based on honoring the trust relationship and carrying out the government-to-government relationship between the U.S. and tribes. I would like to refer you to this paper but bring additional attention to the following recommendations for which we seek your advocacy.

Application of an Individual Mandate to Beneficiaries served by the Indian Health System and the Concept of "Creditable Coverage"

A key component of health care reform is that every American has a responsibility to acquire health insurance coverage – through his/her employer; through enrollment in Medicare or Medicaid; by purchasing coverage; or by qualifying for subsidized premiums. The Joint Paper correctly notes that in one sense, the IHS system does not constitute "creditable coverage" because it is not insurance, and not all locations are able to provide a comprehensive benefits package. Nonetheless, AI/ANs need the **protections** offered by the concept of "creditable coverage" in order to shield individual Indians from any penalty imposed for failing to obtain health insurance, and from any late enrollment penalties. It would be a gross violation of the trust responsibility for the Federal government, which is responsible for providing health care to Indian people, to then penalize these beneficiaries for failing to obtain insurance coverage.

Exemption from Any Cost Sharing in a Government Subsidy

The Federal government's trust responsibility to provide health care to Indian people dictates that no cost sharing (premium, co-pay, etc.) would be imposed on an AI/AN who qualifies government subsidized insurance. An AI/AN should be expressly exempt from all such cost-sharing. This policy is consistent with the recent amendments to Title XIX (Medicaid) of the Social Security Act, which prohibit the assessment of any cost-sharing against any AI/AN enrolled in Medicaid who is served by the IHS or by a health program operated by a tribe, tribal organization or urban Indian organization.

Assure Indian health programs are Admitted to Exchange/Gateway Provider Networks

Health care reform legislation must assure that programs operated by IHS, tribes and urban Indian organizations are admitted to provider networks established by insurance plans, which market their products through the proposed insurance Exchange or Gateway. This is essential to ensure that these providers are not arbitrarily excluded from networks and thereby denied payments for services to insured patients. It is also vital that the legislation direct the Secretary to establish terms for such participation that recognize their unique treatment under Federal law, such as the law which applies the Federal Tort Claims Act to Indian health programs.

Tribal Involvement in Development of Reform Policies and Decisions

<u>Health care reform boards and commissions</u>

Tribal representatives must be included on key commissions, boards or other groups created by health care reform legislation, and the Secretary of HHS must be required to consult with tribes and tribal organizations on health reform policies and regulations. Tribal governments and tribal organizations are the experts in the implementation of services that tribes and tribal members receive, administer, and purchase. Only by engaging knowledgeable Tribal leaders, advocates and administrators in policy development can health reform promises to improve the Indian health system and the health status of AI/ANs be achieved.

<u>Opening the doors of tribal facilities to serve non-Indian patients</u>

With the increased demand for health care services, Tribes may be asked to open their doors to serve non- Indians and receive payment for such care. Indian tribes must retain the authority to decide whether to serve non-Indians at their health facilities, as they must consider capacity and resources and whether adding patients would enhance the breadth of services that can be

offered or would diminish an already limited capacity. To support tribes who are interested in expanding their patient base by serving non-Indians, legislation must –

- Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers, which receive funding from HRSA under Sec. 330 of the Public Health Services Act.)
- Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians. Sec. 813 sets out the criteria that must be applied to determine whether an Indian health facility serve non-Indians. One of those requires a determination whether reasonable alternative health services are available to the non-Indian population. Congress should consider dropping this criterion. In a reformed environment with the enormous new demand for health care services, this criterion would be obsolete and merely impede a tribe's determination to open its doors to non-Indian patients.

Exemption from Penalties under the Employer Mandate

Indian tribes should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. Tribes, who are both sovereign government and employers, must be permitted to determine for themselves the extent to which they can or will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so.

Out of State Medicaid Applicability

Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools.

Furthermore, this proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such a patient who travels out of state in order to receive culturally competent care at an Indian health facility, including care related to behavioral health needs and substance abuse treatment.

Medicare Amendment

The Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services. At present, the system for making Medicare reimbursements to IHS and tribally operated facilities provides payment at only 80%, as Medicare presumes 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. Because of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes Medicare by paying the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would infuse over $40 million more into the Indian health system annually, funds that would be used to reduce health status disparities.

Authority and Funding for Outreach and Education to Assist with Enrollment in Any Public Funded Health Program such As Medicaid or Any Government Subsidy Offered Through the Health Exchange or Connector

Indian Country needs additional mechanisms to assist with enrolling individual Indians into expanded entitlement programs and access health insurance thru the proposal of health exchange or connector. AI/AN participation in entitlement programs and services has been hindered by a number of factors, including consumer cost sharing, lack of transportation to offices where eligibility determination is made, difficulty filling out applications and documentation requirements, difficulty navigating the bureaucracy, confusion about choices regarding managed care plans, and language barriers. These barriers face many rural and remote communities were telephone and computer enrollment methods are often not readily available. Additional resources such as fast track or express lane enrollment may assist with enrollment in programs. In addition, tribal governments should be authorized as portals for accepting such applications.

Addressing the Indian Health System's Personnel Shortage

A critical component of any health care delivery system is the workforce. Indian health programs already have difficulty recruiting and retaining needed health care professionals, and competition for health care workforce personnel will intensify as millions of individuals enter the ranks of the insured. As of June 9, 2009, Indian Health Service listed on its website 1,188 job vacancies across the Indian health care system. Educational and training programs must be implemented to recruit and retain health professionals to fill these vacancies across the Indian Health system.

Some of the ideas to help Indian programs attract and retain health care personnel include:

- The legislation should enhance funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs.
- Mechanisms for assignment of National Health Service Corps personnel should be revised to facilitate participation by Indian health programs and enable these programs to access NHSC personnel based on their Indian service population.
- Expand funding to train and support alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aide therapists.
- Include the Indian health delivery system as a key focus area in the coordinated national strategy to address health care workforce shortages.

Prevention Services and Traditional Health Care Practices

NIHB applauds Congress for focusing greater attention on prevention services through such means as requiring insurance coverage for such services and perhaps barring co-pays to encourage individuals to seek them. Indian health programs have long emphasized prevention programs, often in conjunction with traditional health care practices. We would ask you to assure that where an Indian health program integrates its traditional methodologies into its prevention/wellness programs, it does not thereby lose its ability to collect reimbursements for prevention services.

IV. SOME OBSERVATIONS ABOUT THE INDIAN HEALTH SYSTEM

I believe we can all agree that the Indian health system is grossly underfunded. That is the only conclusion one can reach knowing that we are provided with only 54% of the resources needed to supply all the health care that should be supplied our people. I am very hopeful that this unacceptable situation will be end in a reform environment.

Some have suggested that the Indian health system is "broken", but I would disagree. Even though it is burdened with having to do more with less, our system has nonetheless made commendable strides toward fulfilling its mission of improving the health status of Indian people. I am particularly proud of the many innovations and improvements that have come about through hands-on involvement of tribes and tribal organizations in the exercise of Indian Self-Determination rights. For example, the Special Diabetes Program for Indians has led to a dramatic decline in blood sugar levels.[2] Just imagine the successes we could achieve if our system were fully funded.

This is not to say, however, that our system is perfect or that the only thing needed to make it perfect is more funding. There are inequities and inefficiencies in the system, which require attention. I am aware that this Committee expects to suggest some changes in IHS operations and in fundamental programs such as facilities construction and contract health services. Indian Country looks forward to hearing these ideas and to *working in partnership* with this Committee to advance those ideas that truly hold promise for a system charged with providing health care to underserved populations in remote areas. I would urge the Committee to avoid "solutions" which merely redistribute already scarce resources. Creating new winners and losers is not "reform". Instead, we should look for ways to enhance and expand the health infrastructure we have worked so hard to establish in Indian communities.

V. CONCLUSION

Indian Country will address the tough questions raised during the course of the health care reform discussion and will continue to work diligently with the Administration and Congress to ensure that the Indian health system is included in health care reform legislation. We request that the Administration and Congress honor its trust responsibility and insist that the Federal Government meaningfully consult with Tribes and tribal organizations at all stages of development of health care reform legislation and include Indian-specific provisions in the legislation where needed to protect and enhance the Indian health system.

Thank you so much for your time today, and we look forward to all of us working together on improving and starting a new legacy for the Indian health care system.

[2] The mean blood sugar level (A1C) decreased by more than 1% from 9.00% unit in 1996 (before the Special Diabetes Program for Indians) to 7.85% unit in 2007 (after the Special Diabetes Program for Indians). This decrease is a major achievement over ten years.

EXHIBIT 1

Health Care Reform – Indian Country Recommendations

by
National Indian Health Board
National Congress of American Indian
National Council of Urban Indian Health

Dated May 31, 2009

National Indian Health Board

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

EXECUTIVE SUMMARY

Tribal leaders concur with Chairman Baucus's proposal to augment funding for the Indian health system, and concur with his observation that "IHS desperately needs additional funding. It is impossible to keep America's promise to provide care to Native Americans and Alaska Natives with the current level of IHS funding."[3]

Indian Country strongly supports health care reform and seeks to ensure that the Indian health care delivery system is strengthened and improved so that Indian people and Indian health programs benefit from reformed systems.

Some key features of our recommendations include:

- Increasing the number of Indian people enrolled in Medicaid, CHIP and other publicly-funded insurance programs, including using fast track methodologies for Medicaid enrollment.
- Exempt Indian tribes from any employer mandate penalties and individual Indians from individual mandate penalties.
- Innovative ideas for addressing health care workforce shortages in the Indian health system such as pipeline incentive and utilizing alternative provider types.
- Expanding options for delivery of long term care services in Indian Country.
- Support targeted research and best practice benchmarking appropriate to American Indians and Alaska Natives.
- Achieve advancements for the Indian health system by incorporating provisions from legislative proposals to update and modernize the Indian Health Care Improvement Act.

Inquiries for this document may be directed to:

Jennifer Cooper, Legislative Director
National Indian Health Board
926 Pennsylvania Ave, SE, Washington, DC 20003
(202) 507-4070
Jcooper@nihb.org

May 31, 2009

[3] Baucus, Senator Max, *Call to Action: Health Reform 2009* (Nov. 12, 2008), at 28.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

INTRODUCTION

Foundation of Federal Obligation to Provide Health Care to Native Americans. When Indian tribes ceded certain lands – lands which now constitute the United States –agreements were made with the United States government. Among them was the establishment of a "trust" responsibility for the safety and well-being of Indian peoples in perpetuity. In addition, a number of the treaties specifically outlined the provision of education, nutrition, and health care. Since the creation of the Indian reservation system, and the subsequent federal policy of trying to move Indians to specific urban communities, the United States government has implemented that trust and treaty health care obligation through different forms of what is now the Indian Health Service.

Current Indian Heath Care Delivery Structure. The current system consists of services provided by: the Indian Health Service (IHS) (an agency of the Department of Health and Human Services); programs operated by Indian tribes and tribal organizations (through contractual agreements with IHS); and urban organizations that receive IHS grants and contracts (collectively the "Indian health system" or "I/T/U"). The I/T/U system serves approximately 1.9 million Native people and medical and dental care is delivered through more than 600 health care facilities.

Most beneficiaries served by the Indian health system live on very remote, sparsely-populated reservations and Alaska Native Villages. The Indian health system was designed in large part to reach these beneficiaries, who often have no other options. Even in more populated urban areas, where the Federal government moved Indian people during the 1950s and 60s, the Indian health system provides the most meaningful access as it is the only culturally competent provider and the only provider with a direct Federal-tribal relationship. The incentives in the Indian health system are not financial; its mission is the improvement of the health status of Indian people.

Inadequacies of Current System. Historical inadequate funding is the most substantial impediment to the current Indian health system's effectiveness. A 2008 CBO report on IHS stated that due to "staff shortages, limited facilities, and a capped budget, the IHS rarely provides benefits comparable with complete insurance coverage for the eligible population."[4] IHS expenditures per capita are roughly one-third the amount spent per capita for the general public and one-half the amount spent on federal prisoners.

RECOMMENDATIONS

Set out below are recommended systemic changes that, in concert with increased appropriations, will dramatically improve health care delivery for American Indians and Alaska Natives (AI/ANs).

Personal Responsibility Coverage Requirement (Individual Mandate)

Indian tribes do not object to the requirement that all Americans acquire a minimum level of health insurance, but would object to imposition of a penalty on an Indian individual who fails to obtain such insurance. The United States has a trust responsibility to provide health care to Indian people without cost, so assessment of any penalty for failing to acquire health insurance would violate this Federal responsibility.

[4] Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, at 127 (Dec. 2008).

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

Subsidies

1. IHS is not creditable coverage. Indian people should not be barred from qualifying for subsidies due to their eligibility for care from the Indian health delivery system. The Indian health system should not count as creditable coverage for two reasons: (i) it is not a health insurance program; and (ii) the Indian health system is unable to provide a consistent, comprehensive package of health benefits to its beneficiaries.

2. Insurance subsidies. To the extent tribal governments provide health insurance for their employees or members who would be eligible for premium subsidies, the subsidies should be made available to the tribal government to offset the cost of acquiring coverage that should be available to Indian people without cost.
   - This same support should also be extended to tribal organizations carrying out programs under the Indian Self-Determination and Education Assistance Act and the Tribally Controlled Schools Act, as well as urban Indian organizations.

3. Apply Federal law protections. The protections afforded to Indians regarding their participation in Medicaid should apply to their participation in any health insurance plan:
   - Indians should be exempted from all cost-sharing (including premiums, co-pays and deductibles), consistent with the recent amendment to the Social Security Act which exempts Indians from cost-sharing under Medicaid.
     - If the law nonetheless requires that Indians pay premiums, Indian health delivery system (I/T/Us) must have the authority to pay the premiums on behalf of their beneficiaries and administrative barriers to doing so must be removed.
   - Individual Indian income from Federally-protected sources must be excluded from the calculation of an individual AI/AN's income for purposes of determining eligibility for a subsidy. See, e.g., 25 USC §§1407, 1408; 43 USC §1626.
   - AI/ANs must not be subject to any restriction on selection of a provider. They must be permitted to obtain care from their IHS, tribal, or urban Indian organization program without any financial or other penalty. See recent amendment to Sec. 1932(h)(1) of the Social Security Act to permit an Indian enrolled in Medicaid to select an Indian health care provider as a primary care provider. Pub. L. 111-5, Sec. 5006(d) (Feb. 17, 2009).
   - A special enrollment period should apply to Indian beneficiaries in order to maximize opportunities for enrollment.

4. Allow integration of traditional health practices. Assure that prevention and wellness programs are covered services in all public programs (Medicare, Medicaid and CHIP). To the extent an Indian health program integrates traditional health care practices into its prevention/wellness programs, it should be permitted to do so with no adverse impact on its ability to receive federal support for prevention and wellness programs.

5. Outreach in Indian communities. Expressly designate Indian health delivery system as a location for outreach and enrollment activities for public programs.

Employer Mandate

Indian tribes, as employers, should be exempt from any requirement that an employer provide health insurance coverage to its employees or suffer a financial penalty. As sovereign governments, tribes must

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

be permitted to determine for themselves the extent to which they can/will provide health insurance coverage to their employees, and must not be subject to any penalty or tax for declining to do so.

Medicaid and CHIP Expansion

1. Medicaid income eligibility. Medicaid eligibility should be expanded to 150% of the Federal poverty level, and should be expanded to make childless adults eligible.

2. Cost-sharing exemption. All expansions of Medicaid and CHIP (including any waiver or demonstration programs) must expressly exempt AI/ANs served by the I/T/U system from any form of cost-sharing pursuant to the recent amendment to Title XIX made by Sec. 5006(a) of Pub.L. 111-5 (Feb. 17, 2009).

3. Out of state Medicaid applicability. Indian tribes support the proposal of the Finance Committee to require interstate coordination for child Medicaid beneficiaries to ensure that a child's home-state Medicaid program will cover the child's health care costs when he/she is out of state. Such a requirement would beneficially impact Indian children enrolled in Medicaid who leave their home states for such purposes as attending Bureau of Indian Affairs boarding schools.
   - This proposal should be expanded to require an adult Indian's home-state Medicaid program to cover the health care costs of such a patient who travels out of state in order to receive culturally competent care at an Indian health facility, including care related to behavioral health needs and substance abuse treatment.

4. Outreach and enrollment. Aggressive mechanisms are needed to increase enrollment of eligible Indians in Medicaid and CHIP. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of Medicaid and CHIP eligibility, but Indians are under-enrolled in these programs.
   - States should be authorized to rely on a finding of eligibility for Medicaid and CHIP made by an I/T/U to the same extent as they would rely on such a finding by an Express Lane agency (as defined in Sec. 203 of CHIPRA).
   - Indian health providers should be permitted to apply fast-track enrollment methods and to participate as Express Lane or other Medicaid enrollment simplification network entities.
   - States must be required to demonstrate they have employed effective outreach and enrollment activities on/near Indian reservations and in off-reservation Indian communities, with penalties attaching for failure to do so.
   - Tribal governments should be authorized as portals for accepting Medicaid applications.

Health Insurance Exchange

1. All insurance plans admitted to a health insurance exchange (including any public option) should be subject to the protections for Indian beneficiaries and Indian health system providers recently applied to Medicaid managed care programs by Sec. 5006 of Pub.L. 111-5 (Feb. 19, 2009). These include:
   - Assurance that an Indian enrolled in a plan in the exchange is permitted to obtain care from his/her Indian health program without any financial or other penalty.
   - A requirement that provider networks includes sufficient Indian health care providers to assure access for Indians.
   - A requirement that I/T/U providers be paid (whether or not enrolled in the network) at a rate negotiated with the I/T/U, or if no rate is negotiated, at the rate paid to a non-Indian network provider.
   - A requirement for prompt payment to an I/T/U provider.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

2. The legislation should include a requirement that the Secretary establish terms for I/T/U participation in provider networks that take into account their unique treatment under Federal laws that apply to the Indian health delivery system such as the Federal Tort Claims Act.
   - This recommendation builds on lessons learned during implementation of the Medicare Part D drug program where it was necessary for CMS to require specific terms for pharmacy contracts in order to assure participation opportunities for I/T/U pharmacies.

3. Outreach and enrollment. Aggressive mechanisms are needed to assure that Indians eligible for insurance subsidies can quickly obtain subsidy determinations. The AI/AN population suffers from disproportionately high poverty rates and thus has a high proportion of people who will be eligible for a subsidy. Experience demonstrates that Indians are under-enrolled in Medicaid and CHIP; thus it is expected that aggressive outreach and enrollment efforts will be needed to encourage Indian people to avail themselves of premium subsidies for which they are eligible.
   - Insurance plans for which subsidies are available should be authorized to rely on a finding of subsidy eligibility made by an I/T/U to the same extent as means-tested programs rely on eligibility findings by Express Lane agencies (as defined in Sec. 203 of CHIPRA).
   - Indian health providers should be permitted to apply expedited mechanisms (similar to fast track processes in Medicaid) to subsidy determination
   - Authorize Tribal governments to serve as portals for accepting insurance subsidy applications.

Other Safeguards Needed for Indian Health System

1. Health care workforce. Indian health programs already have difficulty recruiting and retaining needed health care professionals, and competition for health care workforce personnel will intensify as millions of individuals enter the ranks of the insured. The Indian Health Service budget must be enhanced to assure that Indian programs can attract and retain health care personnel.
   - The legislation should enhance funding for scholarship and loan programs to encourage Indian people to enter the health professions and serve in Indian health programs.
   - Mechanisms for assignment of National Health Service Corps personnel should be revised to facilitate participation by Indian health programs and enable these programs to access NHSC personnel on the basis of their Indian service population.
   - Expand funding to train and support alternative provider types who have proven records of providing quality care, such as community health representatives, community health aides, behavioral health aides, and dental health aide therapists.
   - Include the Indian health delivery system as a key focus area in the coordinated national strategy to address health care workforce shortages.

2. Medicare amendments.
   - The Medicare law should be amended to provide 100% payment to Indian health programs for covered Medicare services. At present, the system for making Medicare reimbursements to IHS and tribally-operated facilities provides payment at only 80%, as Medicare presumes a 20% patient co-pay, and expects patients to satisfy deductibles before qualifying for benefits. Because of the trust responsibility for Indian health, the IHS does not charge patient co-pays; thus, the IHS budget subsidizes Medicare by paying the remaining 20%, as well as applicable deductibles. According to 2008 data, reimbursing Indian facilities for Medicare services at 100% would infuse over $40 million more into the Indian health system annually, funds that would be used to reduce health status disparities.
   - Remove from Section 1880 of the Social Security Act the sunset date (December 31, 2009) applicable to IHS and tribal program authority to receive payment for certain Medicare covered items and services.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

3. Research. Reform legislation must support targeted research and best practice benchmarking appropriate to AI/ANs. Best practices in prevention and treatment must be grounded in evidence-informed study on the actual population involved.
   - Any Federally-funded population survey or collection of data to establish best practices, or benchmarking must ensure that AI/ANs are over-sampled to be able to generate statistically reliable estimates.
   - Conduct a comprehensive national health needs assessment for off-reservation Indian communities to measure undocumented need.
   - Funding should be provided to I/T/Us to create and maintain comprehensive data collection systems.

4. Health information technology. HIT improvements must reach all Indian health providers. The remote location of many I/T/U facilities and complex relationships with IHS lead to wide disparities in health technology capabilities. Explicit policies are needed to assure that all Indian health providers receive an equitable distribution of resources for improving health information technology and that Indian health providers are not penalized for lack of information technology.
   - Supply funding to develop and implement a system for monitoring and measuring the needs of the Indian health system to assure that budgetary resources are sufficient to support the level of need throughout the system.
   - The Secretary of HHS should be required to conduct a feasibility study to determine how the Indian health system can efficiently integrate smart card technology through which a patient's medical history can be stored on a portable microchip pocket card.

5. Payor of Last Resort. Include coordination of benefits policies which assure that, consistent with existing Federal regulations, the I/T/U program is the payor of last resort.

6. Facilities. The quality and capacity of facilities throughout the Indian health system differ widely as the IHS construction budget has never kept up with the level of need. Thus, tribes need the authority to explore innovative ideas for addressing facility needs and the flexibility to utilize existing facilities fully and efficiently. Proposals follow:
   - Establish a loan program through which Indian tribes can borrow funds to construct health care facilities.
   - Enact incentives to facilitate opportunities for IHS and tribes to develop cost-effective cooperative arrangements for sharing of facilities and staff with local non-Indian communities.
   - Facilitate tribal authority to decide whether to serve non-Indians at their health facilities. The demand for health services will greatly increase in a reformed health care environment and tribes are likely to be asked to open their doors to serve non-Indian patients and receive payment for such services. This is a challenging decision that requires consideration of capacity and resources and whether adding users will improve the breadth of services that can be offered or would diminish an already limited capacity. To support tribes who are willing to expand accessibility to health care by serving non-Indians, the legislation must –
     - Extend the Federal Tort Claims Act coverage now provided to ISDEAA contractors to include coverage for services to non-Indians. (This is consistent with the FTCA coverage extended to community health centers which receive funding from HRSA under Sec. 330 of the Public Health Service Act.)
     - Revise as necessary Sec. 813 of the Indian Health Care Improvement Act to facilitate a tribal decision to serve non-Indians.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

Long-Term Care Services and Support in Indian Country

1. Federal support. Grant funding and federal support should be made available to assist tribes and tribal organizations to develop the full range of long-term care services needed to meet their community needs, with an emphasis on culturally appropriate home and community based services, including care management services that will delay or prevent the need for nursing home care. Specifically, Indian tribes must be expressly included as entities eligible for long-term care grant programs, including: the Community Choice Act Demonstration Project, Real Choice Systems Change Grant Initiative, Aging and Disability Resource Centers (ADRC), Informal Caregivers and Green House Model.

2. State support. State Medicaid programs should be required to enter into agreements with IHS and tribal health programs under which reimbursement would be made for the range of long term care services tribal programs are able to offer, and assure covered services include care management and home health care.

Other Matters

1. Tribal involvement. Include Tribal representation on key commissions, boards and other groups created by health reform legislation, and direct the Secretary of HHS to consult with Tribes on health reform policies and regulations. Only by engaging knowledgeable Tribal leaders before policy approaches are evaluated, refined and implemented can health reform promise to improve the Indian health system and the health status of AI/ANs.
   - Tribal organizations (as defined in the ISDEAA) which operate health programs should be included in the consultation, as they are created by tribal governments expressly to perform health care delivery.
   - Consultation should occur throughout Indian Country, as Indian cultures, tribal resources and health system structures differ greatly.
   - The views of Federally-funded programs serving Indian people in urban communities should also be sought.

2. Exclusion of health benefits as income. Indian tribes, as sovereign governments, and the tribal organizations that serve them by providing health services, should have the express authority to pay the costs of providing health insurance coverage to their members and beneficiaries and the value of such coverage should not be considered to be taxable income to the AI/AN. (See Appendix A.)

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

Indian Health Care Improvement Act Amendments

Legislation to amend and reauthorize the Indian Health Care Improvement Act contains many provisions that would improve the Indian health delivery system and enable it to better perform its mission. Since the IHCIA legislation has not yet achieved enactment, Congress should consider including in Health Care Reform legislation some provision from IHCIA bills, and should make the IHCIA a permanent law of the United States. Recommendations follow.

Provisions from 110th Congress IHCIA reauthorization legislation *(S. 1200 section numbers)*

1. **Sec. 123 – HEALTH PROFESSIONAL CHRONIC SHORTAGE DEMONSTRATION PROGRAMS**. This demonstration program is intended to address the chronic shortages of health care professionals in the Indian health system.
2. **Sec. 205 – SHARED SERVICES FOR LONG-TERM CARE**. This would authorize IHS and ISDEAA tribes/tribal organizations to operate long-term care programs, and to share staff and facilities.
3. **Sec. 213 – AUTHORITY FOR PROVISION OF OTHER SERVICE**. This provision would expressly authorize IHS and tribes to offer hospice, assisted living, long-term care and home- and community-based care.
4. **Sec. 207 – MAMMOGRAPHY AND OTHER CANCER SCREENING.** This provision updates current law standards for cancer screenings.
5. **Sec. 209 – EPIDEMIOLOGY CENTERS**. This revision to current law would give epi centers access to IHS health data which they need to do their jobs. NOTE: revise text to combine Sec. (e) of S. 1200 and H.R. 1328 (110th Congress bills).
6. **Sec. 222 – LICENSING**. This provision would enable tribal health programs to employ health care professionals licensed in other states just as the IHS is currently able to do. This authority is needed to aid in recruitment and retention of needed professionals.
7. **Sec. 403 – THIRD PARTY COLLECTIONS**. This revised provision would strengthen IHS and tribal program authority to collect reimbursements from 3rd party insurers, and would make the Federal Medical Care Recovery Act applicable to tribal programs.
8. **Sec. 405 – PURCHASING HEALTH CARE COVERAGE**. This would authorize tribes and tribal organizations to use appropriated funds and Medicare/Medicaid revenue to purchase health benefits coverage for beneficiaries.
9. **Sec. 407 – PAYOR OF LAST RESORT**. This provision would codify in law the existing IHS regulation which makes IHS payor of last resort, meaning that all other available sources (e.g., Medicare, Medicaid, private insurance, other) pay for care before IHS appropriated funds are used.
    - To assure such policies are properly implemented, require the involvement of the CMS Tribal Technical Advisory Group in development of regulations, and provide funding to support the TTAG's work. (NOTE: Federal law formally recognizes the TTAG and directs the Secretary to maintain this panel within CMS. See Pub.L. 111-5, §5006(e) (Feb. 17, 2009)).
10. **Sec. 509 – FACILITIES PROGRAM FOR URBAN INDIAN ORGANIZATIONS.** Authorize funding for acquisition and construction of facilities for urban Indian organizations, and authorize feasibility study for creation of a loan fund for construction of urban Indian organization facilities.
11. **Sec. 514 – CONFERRING WITH URBAN INDIAN ORGANIZATIONS.** – Authorize the IHS to confer with urban Indian organizations.
12. **Sec. 517 – COMMUNITY HEALTH REPRESENTATIVES.** Authorize grants/contracts to urban Indian organizations to operate Community Health Representatives programs authorized by Sec. 109 of current IHCIA.
13. **Sec. 601 – ELEVATION OF IHS DIRECTOR TO ASSISTANT SECRETARY FOR INDIAN HEALTH**. This provision would revise current law to elevate the position of IHS Director to an Assistant Secretary of HHS.

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

14. **Sec. 814 – CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS**. This provision would facilitate quality assurance program reviews for IHS, tribal and urban Indian organization programs. [NOTE: The National Tribal Steering Committee recommends minor revisions to the S. 1200 text.]
15. **New Title VII on BEHAVIORAL HEALTH**. This new title broadens the existing law's title VII which focuses only on substance abuse programs. [NOTE: The National Tribal Steering Committee recommends revisions to recognize systems of care treatment for youth and families.]
16. **Bill title II, Sec. 201 – EXPANSION OF MEDICARE, MEDICAID AND CHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS AND URBAN INDIAN PROGRAMS**. This provision would amend the Social Security Act to facilitate access to payments from Medicare, Medicaid and CHIP by IHS, tribal and urban Indian organization programs.
17. **Bill title II, Sec. 209 – ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.** This provision would require HHS to collect on an on-going basis much needed data on Indian enrollment in Medicare, Medicaid and CHIP. Congress and tribal health advocates need such data to design policies to assure proper access to these programs. HHS does not now have a mechanism in place to collect this information.

Other recommendations not contained in 110th Congress IHCIA reauthorization bills:

1. **TAX EXEMPTION FOR IHS SCHOLARSHIPS AND LOANS.** [Sec. 124 from S. 211, 107th Cong.]. Make health profession scholarships and loans from IHS non-taxable to recipients.
2. **ACCESS TO FEDERAL FACILITIES AND FEDERAL SOURCES OF SUPPLY FOR URBAN INDIAN ORGANIZATIONS.** [Sec. 517 from S. 212, 107th Cong.) Authorize the Secretary to permit urban Indian Organizations to access FSS, and to acquire excess and surplus Federal property.
3. **ADDITIONAL PROGRAM AUTHORITY FOR URBAN INDIAN ORGANIZATIONS.** Authorize urban Indian organizations to operate the following types of programs authorized by IHCIA current law: mental health training (per Sec. 209); school health education (per Sec. 215); prevention of tuberculosis (per Sec. 218); and behavioral programs in proposed new IHCIA Title VII (see above): Sec. 701 (behavioral health prevention and treatment services); and Sec. 707(g) (multi-drug abuse program).

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

APPENDIX A

PROPOSAL TO CLARIFY THE EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBES FROM INCOME

Current Law

Internal Revenue Code ("Code") Section 61 provides that, except as otherwise provided, gross income includes all income from whatever source derived. The U.S. Supreme Court has ruled that Code Section 61 generally includes in-kind benefits and payments to third parties satisfying the obligations of the taxpayer.[5] Treasury Regulation Section 1.61-1(a) states that "gross income" means all income from whatever source derived unless excluded by law.

The Internal Revenue Service ("IRS") and federal courts have consistently held that payments made under legislatively provided social benefit programs for the promotion of general welfare are not includable in the recipient's gross income.[6] Revenue Ruling 76-131, 1976-1 C.B. 16 explicitly lists health as a need that promotes the general welfare. Consistent with this position, in Revenue Ruling 70-341, 1971-2 C.B. 31, the IRS ruled that government provided health care benefits for the elderly, commonly known as Medicare benefits, were nontaxable to recipients. However, in recent non-binding guidance, the IRS has required individuals participating in state-sponsored health-related assistance programs to satisfy a financial means test.[7]

Reasons for Change

A statutory exclusion is needed to clarify that health benefits and health care coverage provided by Indian tribes to their members are not subject to income taxation. The Federal government has a longstanding policy of providing tax-free medical care to Indians. To effect this policy, federal statutes have been enacted stating that a major "goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level"[8] and providing specific authorization for the Indian Health Service, a federal agency that administers funds provided by Congress for the promotion of Indian health care services.[9] However, the federal funds appropriated for Indian Health Service programs have been consistently inadequate to meet even basic health care needs,[10] and Indian tribal governments have been encouraged to use gaming revenues to provide for the health care needs of their members, including through universal coverage programs.[11]

---

[5] See Old Colony Trust Co. v. Commissioner, 279 U.S. 429 (1929).
[6] See, e.g., Rev. Rul. 57-102, 1957-1 C.B. 26 (payments to the blind); Private Letter Ruling 200845025 (November 7, 2008) (ruling that payments made by an Indian tribe to elderly tribal members who were displaced by a flood were general welfare payments); Bailey v. Commissioner, 88 T.C. 1293 (1987) (considering whether grants to restore a building façade were excludable from income as general welfare payments).
[7] See e.g., Chief Counsel Advice 200648027 (July 25, 2006).
[8] 25 U.S.C. §1601(b).
[9] 25 U.S.C. §13.
[10] See Overview of Federal Tax Provisions Relating to Native American Tribes and Their Members (JCX-61-08) (stating that "the average funding of an IHS site was found to be 40 percent less than an equivalent average health insurance plan").
[11] See NIGC Bulletin No. 05-1 (Subject: Use of Net Gaming Revenue) (January 18, 2005) (available at http://www.nigc.gov under the "Reading Room" tab and "Bulletins" sub-tab).

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

Consistent with the Federal government's policy of providing health care services to Indians, the proposal would clarify that health care benefits provided to Indians are not subject to income taxation. It would also encourage Indian tribes to provide such benefits to their members on a non-discriminatory basis.

Description of Proposal

The proposal clarifies that the value of "health services," "health benefits" or "health coverage" received by Indians, whether provided or purchased by the Indian Health Service, either directly or indirectly through grants to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service; or by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or health insurance (or through an arrangement having the effect of accident or health insurance) is excluded from gross income. It also provides for the exclusion from gross income any other benefit or service provided by an Indian tribe that supplements the programs and services provided by the federal government to Indian tribes, or other general welfare benefits or services provided by Indian tribes to their members.

The terms "accident or health insurance" and "personal injuries and sickness" have the same meaning as such terms do in Code Section 104 and, as such, are intended to include preventative health care services.

The term "Indian tribe" is defined in the proposal as any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

The term "tribal organization" follows the definition in the Indian Self-Determination and Education Assistance Act and means the recognized governing body of any Indian tribe (or consortium of Indian tribes) or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization (see 25 U.S.C. 450(*l*)).

The term "Indians" or "Indian" is based on the definition of the term "Indians" or "Indian" under the Indian Health Care Improvement Act (25 U.S.C. 1603(c)). The proposal states that "Indians" or "Indian" means any person who (A) is a member of an Indian tribe, as defined in subsection (b)(2) of this section, (B) (i) irrespective of whether the individual lives on or near a reservation, is a member of tribe, band, or other organized group terminated since 1940 and those recognized now or in the future by the State in which they reside, (ii) is a descendant, in the first or second degree, of any such member, (C) is an Eskimo, Aleut or other Alaska Native, or (D) is considered by the Secretary of the Interior to be an Indian for any purpose.

No inference is intended as to the tax treatment of governmental benefits (including, but not limited to health care benefits not covered under this proposal) provided by Indian tribes to Indians before, on, or after the date of enactment of this section.

Health Benefit Exclusion Language (Internal Revenue Code Section 61)

(a) Gross income does not include

(1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization, or grants to or other programs of third parties funded by the Indian Health Service;

HEALTH CARE REFORM
INDIAN COUNTRY RECOMMENDATIONS

(2) health services, health benefits or other amounts for health care services, including preventive care and treatment of personal injuries or sickness and other health conditions, provided by an Indian tribe or tribal organization to an Indian either directly, through purchased services, or through accident or health insurance (or through an arrangement having the effect of accident or health insurance);

(3) the value of health coverage provided or premiums paid by an Indian tribe or tribal organization to or on behalf of an Indian under an accident or health plan (or through an arrangement having the effect of accident or health insurance); or

(4) any other benefit or service provided by an Indian tribe that supplements the programs and services provided by the federal government to Indian tribes or Indians, or other general welfare benefits or services provided by Indian tribes.

(b) Definitions.

(1) The terms "accident or health insurance" and "personal injuries and sickness" shall have the same use and meaning as 26 U.S.C. 104.

(2) The term "Indian tribe" means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or regional or village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(3) The term "Indians" or "Indian" means any person who

(A) is a member of an Indian tribe, as defined in subsection (b)(2) of this section,

(B) (i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, (ii) is a descendant, in the first or second degree, of any such member,

(C) is an Eskimo or Aleut or other Alaska Native,

(D) is otherwise eligible for services provided or funded by the Indian Health Service under applicable law, or

(E) is considered by the Secretary of the Interior to be an Indian for any purpose.

(4) The term “tribal organization” means the recognized governing body of any Indian tribe (or consortium of Indian tribes) or any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization (see 25 U.S.C. 450b(*l*)).

(c) No inference is intended as to the tax treatment of governmental benefits (including, but not limited to health care benefits not covered under this section) provided by Indian tribes to Indians before, on, or after the date of enactment of this section.

Exhibit 2

Health Care Reform Discussions Hosted or Scheduled to be Held by an Indian Health Board, Tribe or Tribal Organization in the Various Indian Health Service Areas as of June 9, 2009

Indian Health Service Area	States Within IHS Area	Date of Health Care Reform Meeting
California	California	May 22
Nashville	Texas, Florida, Georgia, Alabama, Mississippi, Louisiana, Arkansas, Missouri, Illinois, Indiana, Ohio, Kentucky, Tennessee, North Carolina, South Carolina, Virginia, West Virginia, Maryland, Delaware, New Jersey, Pennsylvania, New York, Vermont, New Hampshire, Rhode Island, Connecticut, Maine, Massachusetts	June 4
Tucson	Southern Arizona	June 25
Oklahoma	Oklahoma and Kansas	June 5
Bemidji	Minnesota, Michigan and Wisconsin	June 2-3
Aberdeen	North Dakota, South Dakota, Nebraska and Iowa	
Alaska	Alaska	May 15
Albuquerque	New Mexico and Colorado	
Billings	Montana and Wyoming	June 17-18
Navajo	Arizona, New Mexico and Utah	May 28
Portland	Idaho, Oregon and Washington	June 2-3
Phoenix	Arizona, Nevada, and Utah	June 25