SENATE COMMITTEE ON INDIAN AFFAIRS

Hearing on Reforming the Indian Health Care System
June 11, 2009

NCAI HEADQUARTERS
1516 P Street, NW
Washington, DC 20005
202.466.7767
202.466.7797 fax

Chairman Dorgan, Vice Chairman Barrosso, and the members of the Committee, thank you for having me here today. My name is Jefferson Keel and I am the Lt. Governor of the Chickasaw Nation and the First Vice President of the National Congress of American Indians (NCAI), the oldest and largest national organization representing tribal governments. I am delighted to be here.

BACKGROUND

The Federal government provides health care to American Indians and Alaska Natives based on its trust responsibility found in the U.S. Constitution and affirmed by treaties, federal court decisions, and federal law. Today, health care is provided to 1.9 million to American Indians and Alaska Natives primarily residing on or near Indian reservations located in 35 states.

The health statistics for Indian Country are not new. In fact, sadly, the numbers seem to get worse with each new report. The life expectancy of American Indian and Alaska Natives is nearly six years less than any other race or ethnic group in America[1]. We are three times more likely to die from diabetes[2] and suffer from a rate of tuberculosis that is six times higher than the non-Native population[3]. Our youngest are often the most vulnerable. The American Indian and Alaska Native infant mortality rate is 40 percent higher than that of non-Natives[4], and our youth, ages 15-34, commit suicide at a rate three times the national average[5].

The U. S. Indian Health Service (IHS) has been the primary provider of health care to American Indian and Alaska Native people since 1955. Much has been accomplished since then in terms of improvements in public health care delivery, but many more improvements are still needed. The American Indian and Alaska Native population still suffer vast disparities in health status and the funding appropriated is abysmal relative to the per capita health care amount provided to other federally funded population groups such as federal employees, Medicaid beneficiaries, and even federal prisoners.

Moreover, the IHS has been characterized over the past decade as a "broken" system. The truth is that the IHS system is not so much broken as it is "starved". The IHS has

[1] National Vital Statistics Reports, U.S. States Life Tables, 2003. Available from http://www.cdc.gov/nchs/data/nvsr/nvsr54/nvsr54_14.pdf. (accessed April 2008).
[2] National Center for Health Statistics, Health, United States, 2007, With Chartbook on Trends in the Health of Americans.
[3] Trends in Indian Health 1998-1999. Indian Health Service. http://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp
[4] CDC 2008. Infant Mortality Statistics from the 2005 Period Linked Birth/Infant Death Data Set. National Vital Statistics Reports 57(2).
[5] Trends in Indian Health 1998-1999. Indian Health Service. http://www.ihs.gov/PublicInfo/Publications/trends98/trends98.asp

been grossly underfunded for decades and as such, cannot be expected to function optimally. Such inadequate funding has created the perception that the system is broken.

Despite these desperate statistics, the reauthorization of the Indian Health Care Improvement Act, the baseline authority for providing direct health care to American Indian and Alaska Natives, has not been reauthorized for ten years. The bill establishes objectives for addressing some of the basic and overwhelming health disparities confronting Indians as compared with other Americans and provides progressive approaches to health care delivery that will help move Indian health care into the 21st century. Passage of this much needed legislation is not only necessary to fulfill the Federal government's responsibility of health care to Indian people; it must happen so that Indian people are placed on parity with the majority population and able to engage meaningfully in national health care reform.

REFORMING THE INDIAN HEALTH DELIVERY SYSTEM

Perhaps nowhere in the country is the debate on health care reform more important, or will it have more of an impact, than in tribal communities. Tribal leaders and tribal health advocates have been working diligently to ensure that Indian Country and the current Indian health delivery system are being included in a meaningful way in the national plan for health care reform. As such, we are poised to consider achievable reform opportunities for the delivery of health care through the Indian health delivery system.

Attached is a copy of "Health Care Reform: Indian Country Recommendations" put forth by the National Indian Health Board, the National Council on Urban Indian Health, and NCAI. These recommendations have been shared with all committees of jurisdiction, in the House and Senate, working on health care reform. In an effort to not be repetitive in testimony, subjects and issues were divided among our organizations.

NCAI offers the following recommendations:

Tribal Consultation

Given the expeditious nature of moving health reform forward, we would like to thank the Committee for engaging and including Indian Country. It is only by speaking with knowledgeable tribal leaders, before policy approaches are evaluated and implemented, that meaningful consultation occurs. As such, there may be a need to continue the consultation process. Realizing the short time frame involved, we suggest partnering with the Department of Health and Human Services who will be conducting a consultation session on "Health Care Reform and the Indian Health Care System" in July, 2009.

Contract Health Services

Reducing the spiraling costs of health care is a priority for Indian Country. Astronomical medical inflation rates, the expense of providing services in extremely rural communities, along with an increasing Indian population and limited competitive pricing have all tremendously hindered tribe's and IHS's abilities to provide health care to Indian people.

One of the most impacted areas of the IHS system is the Contract Health Service (CHS) program. The CHS program provides funding for primary and specialty health care services that are not available at IHS or tribal health facilities to be purchased from private sector health care

providers. This includes hospital care, physician services, outpatient care, laboratory, dental, radiology, pharmacy, and transportation services.

It is estimated that CHS is currently funded at 50% of need. While the Committee has previously heard from Indian Country on this issue, we must continue to stress that anything less than full and recurring funding of CHS compromises the health and lives of those in our communities. By supporting us in these efforts, you will be ensuring that tribes have the ability to deliver the highest quality services to their tribal members.

One way to immediately and dramatically address the shortfall in CHS funding is by ensuring that all American Indians and Alaska Natives are auto-enrolled in Medicaid. Creating an Indian specific subsection or category of Medicaid would facilitate access to the comprehensive health care benefits of this program while easing the already overburdened CHS system. The joint proposal submitted by the national Indian organizations (see attached) provides the recommendation of fast-tracking Indian patients into the Medicaid system. NCAI supports this approach; however, if the Committee is serious about examining ways to improve the CHS system, we suggest that proper consideration be made to establishing a new category of eligibility under Medicaid for Indian patients.

Other suggestions to augment limited CHS funding include extending Medicare like rates (MLR) to outpatient settings and the reduction in administrative overhead within the IHS. The extension of MLR would be a cost neutral fix that would allow tribes to extend their limited CHS funding even further. We would request however that when a mechanism for applying MLR to outpatient services is devised, that it is created in a manner that does not cut off or limit the current supply of medical providers. Likewise, reducing the administrative costs of IHS would extend the already limited funding of the Indian health delivery system. Reductions should include limits on the departmental-imposed administrative paperwork, systems, programs, etc., as well as limit the dollar amount of resources that may be utilized for administrative costs versus cost to directly fund healthcare.

Expanding Services to Non-Indians

Tribal health facilities are often times located in remote, rural geographic locations – making them, in some instances, the only viable option of health care delivery. As a result, some tribes have made the decision to implement expansions of capacity in their local health care delivery system through economies of scale and supplemental funding mechanisms. Others have sought to improve their local systems through the provision of excess capacity and/or select services in short supply in their communities by extending services to others in the general public (*i.e.,* non-beneficiaries of existing IHS health programs).

With the anticipated increase in demand for health services, tribes that have not opted for such expansion recognize that they 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. As such, Indian tribes must retain the authority to decide whether or not to serve non-Indian at their health facilities.

Tribes making this decision may also be well-poised to become a preferred provider organization within the state exchange or network in which they reside. To allow for such growth and expansion of services, an update to existing legislation is needed to remedy a significant barrier to

such initiatives – malpractice insurance. While tribal health programs are generally covered by Federal Tort Claims Act (FTCA) for their Indian patients, there is controversy over whether this protection extends to non-beneficiaries. By allowing FTCA to cover non-beneficiaries seen by tribal health programs, the IHS could provide additional capacity that will be needed after health care reform is enacted. For those tribes who choose not to serve non-beneficiaries, FTCA coverage must be extended to any non-beneficiary whose service is publically funded through grants, insurance, or other public subsidy. We would also recommend that the current law, which prohibits the inclusion of non-Indians as a portion of the IHS user population, is preserved. .

Health Care Workforce

Indian Country is not alone in its concern on how to address the ever increasing health care workforce shortage. Our health facilities however face daunting challenges in recruiting and retaining health care professionals due to our often remote and isolated geographic locations. As the competition for these personnel intensifies with the influx of new patients, under the new U.S. health care system, the IHS system must also adapt to meet Indian Country's health delivery needs.

Mid-level practitioners are an underutilized resource in health care delivery. These front-line health workers, while not doctors, have been trained to diagnose and treat common health problems, to manage emergencies, to refer appropriately, and to transfer the seriously ill or injured for further care. Increasing the number of these licensed and qualified health care workers, including nurse practitioners and physicians' assistants will allow Indian health facilities to better meet the health care needs of their communities while providing a financially feasible delivery option to health care.

Dental health aid therapist (DHAT) is an example of an innovative and successful mid-level program being implemented in Indian Country that could become a model for the IHS system and throughout rural America. Indian Country faces profound oral health disparities compared to the majority population. For example, Native children face an alarming rate of tooth-decay, suffering at rates four times higher than the general population[6]. Compounding this problem, Native communities face a lack of access to dentists and consistent dental treatment and prevention, low dentist to patient ratios, identified backlogs of treatment, and grossly inadequate expenditure levels. By employing a mid-level oral health provider model, such as DHAT, tribal members will be able to receive a variety of dental care practices, such as routine exams, simple extractions, restorative procedures, as well as health promotion and disease prevention to the communities in which they reside.

A final benefit to both mid-level practitioners and the DHAT program is the ability to "grow-your-own". As mentioned above, one of the major workforce shortage issues facing the IHS is retention. Tribal health facilities can coordinate with local Tribal Colleges and Universities to recruit community members to fill these much needed positions. In addition, these community members will be better prepared to deliver the culturally appropriate and competent care needed.

Exclusion of Health Benefits as Income

Tribal governments have been trying to meet the challenge of addressing the health care needs in their communities. Some tribal governments have met this challenge by providing supplemental services above and beyond the limited IHS services while others are providing more

[6] American Indian and Alaska Native Oral Health Access Summit. American Dental Association, 2002. Retrieved June 9. 2009 from http://www.ada.org/prof/resources/topics/topics_access_alaska_summit.pdf.

comprehensive care through self insured funds or third-party plans. This type of universal health coverage for tribal citizens is similar to Medicare. However, some IRS field offices – in examining specific tribal governments for their compliance dating back to 2002 or 2003 – are asserting that this type of coverage, when provided by a tribal government, should be treated as a taxable benefit.

In order to continue to encourage tribal governments to provide such benefits to their members on a non-discretionary basis, NCAI seeks a statutory exclusion to clarify that the health care benefits and coverage provided by tribal governments to their members are not subject to income taxation. Our proposal clarifies that the health services, benefits, or coverage received by Indians is excluded from gross income, in the same manner as Medicare - another government benefit health plan that is not viewed as taxable[7].

CONCLUSION

Thank you for your ongoing commitment to Indian Country. On behalf of the Chickasaw Nation and NCAI, I thank you for the opportunity to share our health reform recommendations for the Indian health delivery system. We urge you to make a strong commitment to Indian Country by ensuring that American Indians and Alaska Native receive high quality health care through a strong Indian health care system.

[7] 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).

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."[8]

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

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

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."[9] 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.

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

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 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.

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.

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.

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.)

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 SERVIC**E. 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.

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).

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.[10] 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.[11] 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.[12]

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"[13] 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.[14] However, the federal funds appropriated for Indian Health Service programs have been consistently inadequate to meet even basic health care needs,[15] 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.[16]

---

[10] See Old Colony Trust Co. v. Commissioner, 279 U.S. 429 (1929).

[11] 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).

[12] See e.g., Chief Counsel Advice 200648027 (July 25, 2006).

[13] 25 U.S.C. §1601(b).

[14] 25 U.S.C. §13.

[15] 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").

[16] 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).

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;

(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.