



OFFICE OF THE GOVERNOR

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BILL ANOATUBBY
GOVERNOR

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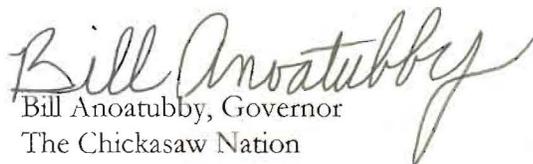
Honorable Byron Dorgan, Chairman
U.S. Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Dorgan:

Enclosed is a white paper from the Chickasaw Nation regarding the national health care reform efforts currently underway in Congress. Your consideration of these ideas and comments is appreciated.

If you have questions or need more information, please contact Mr. Thomas John, administrator of self governance, at (580) 436-7214.

Sincerely,


Bill Anoatubby, Governor
The Chickasaw Nation

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cc: Senator Tom Coburn
Senator James M. Inhofe
Representative John Sullivan
Representative Tom Cole
Representative Dan Boren
Representative Frank Lucas
Representative Mary Fallin



Health Care Reform in Indian Country

- **American Indian and Alaskan Native (AI/AN) tribes are unique.**
- **The relationship between the U.S. federal government and AI/AN tribes is unique.**
- **The health care delivery system for AI/AN tribes is unique.**
- **AI/AN tribes do not want to be assimilated into the mainstream of U.S. society.**
- **Nor do AI/AN tribes want their health care system assimilated into the mainstream.**
- **The AI/AN health care delivery system (i.e., U.S. Indian Health Service [IHS]) has been wrongfully characterized as “broken.”**
- **The IHS health care delivery system has been drastically and chronically underfunded.**
- **The extent to which the IHS is truly “broken” cannot be determined without full funding first.**
- **Incorporating only those pieces of the IHS deemed not to be broken in national health care reform will fragment the AI/AN health care delivery system and harm the health status of AI/AN people.**
- **Comprehensive reforms that honor and augment the uniqueness of AI/AN tribes and their health care delivery system will be more successful than a piecemeal assimilation approach.**

Background

First and foremost, the provision of health care to American Indian and Alaskan Native (AI/AN) tribes is founded on a sovereign government-to-government relationship between the United States and tribes. As such, the provision of health care to AI/AN people is based on a unique political relationship, and is not based on race.

This provision of health care is formalized as a federal trust responsibility to AI/AN people that has been guaranteed through numerous treaties and federal law. Health care for AI/AN people was permanently authorized in the Snyder Act of 1921 (25 U.S.C. § 13).

The Indian Health Care Improvement Act (IHCIA), (P.L. 94-437, as amended), is another cornerstone to the health care delivery system for AI/AN people. The IHCIA has provided numerous benefits to the AI/AN delivery system by creating provisions to increase manpower and infrastructure capacity, participate in federal entitlement programs, and enhance behavioral health services, to name a few. However, this law has expired, and reauthorization efforts have languished in Congress.

Despite over a decade of effort to reauthorize the IHCIA to affect the modernization of health care for AI/AN people, some current proposals in Congress go so far as to suggest the dismantling of the IHCIA now that national health care reform has become popular. Severing select provisions of the IHCIA and assimilating them into a comprehensive national health care reform bill will create more harm than benefit to the AI/AN health care system. The Chickasaw Nation opposes any such efforts, and insists that the IHCIA be reauthorized expeditiously by the 111th Congress.

U.S. Indian Health Service

The U.S. Indian Health Service (IHS) has been the primary provider of health care to AI/AN people since 1955. Much has been accomplished since then in terms of improvements in public health and health care delivery, but much more improvement is still needed. The AI/AN population still suffers vast disparities in overall health status, and the funding appropriated to the IHS is abysmal relative to the per capita health care amount provided to other federally-funded population groups (e.g., federal employees, Medicaid beneficiaries and even federal prisoners).

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

The IHS is currently funded at approximately 54% of the identified need. Until the IHS is fully-funded (i.e., 100% of need), the extent to which this system is truly broken, and therefore, in need of reform, cannot be determined. The Chickasaw Nation urges the 111th Congress to fully fund the IHS first, prior to any efforts to fragment the IHS system through assimilation initiatives in national health care reform.

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

Correspondingly, eligibility for service benefits must not be changed. Current eligibility regulations clearly define who may receive services within the scope of IHS-funded health care programs (see 42 C.F.R. §§ 36.12, 36.14 and 36.23). Any change in eligibility without dramatically increased funding and a corresponding change in funding allocation methodologies, coupled with changes in the type and volume of services offered at each local delivery program, would result in catastrophe. Patients would naturally choose to seek care wherever the most comprehensive level of care is provided, thereby overburdening the capacity and resources of a select few local delivery systems, while rendering the deserted systems unnecessary.

Services to Non-Beneficiaries:

Some, but not all, AI/AN tribes have been able to implement expansions of capacity in their local health care delivery system through economies of scale and supplemental funding mechanisms. Others still, have sought to improve their local systems through the provision of excess capacity and/or select services in short supply in their communities by extending services to others in the general public (i.e., non-beneficiaries of existing IHS health programs). A significant barrier to such initiatives is malpractice insurance.

While tribal health programs are generally covered by Federal Tort Claims Act (FTCA) for their AI/AN patients, there is controversy over whether this protection extends to non-beneficiaries. By allowing FTCA to cover non-beneficiaries seen by tribal health programs, the IHS could provide additional capacity that will be needed after health reform is enacted.

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

The Value of Health Services as Taxable Income

Recent concerns have been raised regarding the U.S. Internal Revenue Service seeking to tax the value of health care services provided to individual tribal citizens that are tribally-funded. As stated, the IHS is grossly underfunded. Therefore, supplemental funding to the IHS health care delivery system is drastically needed, and regardless of whether such supplemental funding comes from tribally-generated revenue sources or other sources, such funding cannot justifiably be presumed as the personal income of individual tribal citizens. All attempts to tax the value of health care services provided to tribal citizens should be abandoned.

AI/AN Participation in U.S. Entitlement Programs

Under the authorities of Title IV of the IHCA, tribes have been allowed to participate in the U.S. Medicare, Medicaid and State Children's Health Insurance Program entitlements through the enrollment of AI/AN people and billing for reimbursement of covered services. Such authorities must be maintained through the permanent reauthorization of the IHCA, or through national health care reform legislation, but in a way that solidifies the AI/AN health care delivery system.

To date in the health care reform initiative, national Indian organizations have distributed position papers that focus on making targeted changes to AI/AN participation in entitlement programs. Such papers contain recommendations that address enrollment and opt-out provisions, negotiation of reimbursement rates, tribal inclusion in networks, cost-sharing and the like. While these recommendations are important to the current structure of the health care delivery system, they do not address the fundamental uniqueness of AI/AN tribes and the AI/AN health care delivery system.

Such approaches can be characterized as assimilation approaches into the mainstream health care system. A path for AI/AN participation in entitlement programs must be found that honors tribal sovereignty and the government-to-government relationship. Carving-out AI/AN resources of entitlement programs and reallocating them directly to the IHS would do just that.

Per capita expenditures for entitlements at the national level can be easily calculated, as can the user population figures and workload data of the IHS. Therefore, it would follow that an aggregate amount of entitlement funding provided to AI/AN beneficiaries could be easily calculated and reallocated directly to the IHS. Not only would such an approach be an enormous cost savings in the administration of entitlements for AI/ANs at the federal and state levels, it would drastically reduce the administrative costs for tribal health care programs associated with third-party collections.

Many tribes already perform various functions related to the application, documentation and verification processes to determine individual eligibility and enrollment in entitlement programs. However, tribes do not currently have the final authority to certify eligibility. Furthermore, most tribes have a long history of conducting compliance and audit functions, as well as case management and reporting. In any health care reform proposals, tribes must be granted final certification authority for individual enrollment and participation in entitlement programs.

Tribes are fully capable of determining eligibility, facilitating enrollment, managing case work, billing for reimbursement and reconciling aggregate financial information. In consideration of these capabilities, providing a direct entitlement carve-out to the Indian health system would not only simplify the flow of resources, it would do vastly more to cover the uninsured AI/AN population than fragmenting the current system through individual or employer insurance mandates. Furthermore, any proposed expansions in current entitlement programs would simply be an extension of carve-out authority and resources.

Such an approach would be an innovative method of providing a unique and comprehensive set of entitlement services to tribes nationwide, under a single set of guidelines, rather than negotiating, seeking individual approval for, and managing changes for specific issues in 36 separate state plans for AI/AN beneficiaries.

Treatment of Non-Profit and Other Incorporated Organizations:

Additional concerns have been raised about health care provided to AI/AN people that reside in urban centers. The Chickasaw Nation believes that such urban AI/AN people deserve health care just as much as the AI/AN people that reside in Indian country. However, urban Indian organizations (UIOs) or other tribal organizations (TOs) that serve as the delivery system of health care to AI/AN people are not tribes. Therefore, such UIOs and TOs should not be granted similar status as tribes, either through law, regulation or federal policy.

Granting UIOs and TOs similar status as tribes through the government-to-government relationship diminishes and devalues tribal sovereignty. Any authorities granted or funding allocated to UIOs and TOs must be specific and separate from those afforded to tribes, and further emphasize that such authorities and funding are not based on a government-to-government relationship, but rather as a trust responsibility to the individual AI/AN people that such organizations serve.

Summary of Recommendations:

- **Reauthorize the Indian Health Care Improvement Act as the health care reform legislation for the Indian health system.**
- **Fully fund the IHS based on 100% of the identified level of need for health care.**
- **Abandon any proposal to change existing IHS eligibility regulations.**
- **Authorize Federal Tort Claims Act coverage of all health care services provided through the Indian health system, regardless of funding source or category of beneficiary.**
- **Abandon any proposal to tax individuals for the value of health care services provided within the Indian health system.**
- **Authorize tribes to certify eligibility, enrollment and participation in U.S. entitlement programs.**
- **Authorize a nationwide entitlement carve-out for AI/AN beneficiaries, and reallocate such resources directly to the Indian health system.**
- **Abandon any proposal that would grant urban Indian organizations or tribal organizations authority or status on the same basis as tribes.**