Testimony of

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Regarding the Reauthorization of the Indian Health Care Improvement Act
H.R. 2440 and S. 556
Title IV and Amendments to the Social Security Act
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Chairman Campbell, members of the Committee, thank you for the opportunity to testify regarding the reauthorization of the Indian Health Care Improvement Act (IHCIA). The last time I had the privilege of testifying before this Committee was in the late 1980s when I was serving as Commissioner of the Department of Health and Social Services for the State of Alaska. In 1990 I left that post and since have had the honor of representing tribes and tribal organizations as a member of the Sonosky, Chambers Law Firm.

Since the formation of the National Steering Committee (NSC) I have worked with its members, on behalf of the Alaska Native Health Board (ANHB) and the Alaska Native Tribal Health Consortium (ANTHC), to develop and advocate for the reauthorization of the Indian Health Care Improvement Act. Although I have worked on all parts of the bill, due to my experience with Medicaid, Medicare and other third-party recovery, I worked most closely with the members of the National Steering Committee whose task it was to examine the provisions of the Act relating to access to health services – a euphemism for provisions related to financing.

Throughout its work on the Indian Health Care Improvement Act, the National Steering Committee recognized that the IHCIA addresses authorization, not appropriations. The IHCIA, in other words, provides the opportunity, but not necessarily the means. Title IV and the two amendments to the Social Security Act, sections 4 and 5 of H.R. 2440 and Title II of S. 556, are the exception. They actually address mechanisms by which the Indian Health Service (IHS), tribal health programs, and urban Indian organizations can receive reimbursement for the services they provide and thereby reduce the chronic underfunding for Indian health services.

Background

In 1976 during the first authorization of the Indian Health Care Improvement Act, Congress authorized the Indian Health Service and tribal health programs operating through IHS facilities to bill Medicaid and Medicare. This was controversial then and is still. The United States owes a duty to American Indians and Alaska Natives to provide them with health care. Until 1976 that duty had been carried out, however inadequately, through direct appropriations. Since then, some part of each year's budget for the Indian Health Service and for tribal health programs has been assumed by Congress to be

available from third-party revenues generated by billing Medicaid, Medicare, and other third-party insurance.

This was not a choice embraced easily by tribes. For many, it appears as an abrogation of the duty by the United States to provide health care, or at least a step in that direction. Many American Indians and Alaska Natives resented being required to apply for Medicaid, a needs-based program equated with welfare. They found it humiliating to have to reveal private information about themselves in order to have access to services to which they they had been promised access. This view is one held especially by the elders, who also fear that reliance on Medicaid will result in the loss of trust assets that would otherwise be passed down to their children.

Tribes and the Indian Health Service have worked hard to overcome these concerns. Pragmatically, there was simply no other choice. Appropriations fail even to keep up with the inflation, let alone begin to close the gap between need and the resources to respond even in part to that need. Third-party revenue simply had to become part of the mix of funding.

To begin to achieve the targets set by the Congress in its budget for the Indian Health Service, the IHS and tribal health programs were compelled to divert resources from other activities to develop billing and coding expertise and systems. As other testimony being provided to you today describes, developing the capacity to carry out this Congressional mandate has been difficult. The information system principally relied upon by IHS, and inherited by tribal health programs as they assumed responsibility under the Indian Self-Determination and Education Assistance Act, is ill-suited for billing. Efforts to develop new software for billing as an add-on or to find software that was compatible has consumed thousands of hours and millions of dollars.

Nor, has the task been made easier by the entities from whom reimbursements are due. Private insurance companies who have been obliged to reimburse IHS and tribal health programs have resisted. Although they collected premiums for the provision of insurance, the fundamental principle underlying most insurance is that it pays only when the covered individual has a personal duty to pay, but for the insurance. Since American Indians and Alaska Natives do not have such a duty when they receive care from an Indian health program, many insurers simply would not believe that the law meant what it said. Both the IHS and tribes have had to resort to litigation to overcome the resistence from private insurers. Although that litigation has been successful, skirmishes occur regularly.

Medicare and Medicaid have posed different, but equal challenges.[1/]

Medicare. Medicare is a national health insurance program for the elderly and disabled. Individuals over 65 years of age are automatically entitled to Medicare Part A if they (or their spouse) are eligible

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1/ I am indebted in the following descriptions of Medicare and Medicaid to the work of the Kaiser Family Foundation for its remarkable work in translating complex Social Security Act programs into English and thereby making them more accessible. *See* MEDICARE FACT SHEET, MEDICARE AT A GLANCE, April 2003, and THE MEDICAID PROGRAM AT A GLANCE, February 2003, published by the Kaiser Family Foundation, and available, along with many other documents, at its website: www.kff.org.

for Social Security payments. A relatively small percentage of Indians enjoy eligibility for Medicare since many elders lacked opportunities to work at jobs that contributed to Social Security. As the life span grows for Indians and more participate in the workforce, the numbers of Indians who are eligible for Medicare will increase.

Medicare Part A pays for inpatient hospital and skilled nursing facility services, home health visits following a hospital or skilled nursing facility stay, and hospice. Medicare Part B is available only to those Medicare eligibles who enroll and pay a monthly premium of $58.70 or $740 annually in 2003. Few elders who have access to an Indian Health program enroll for this benefit since they correctly believe they should be entitled to free health care. For the poorest elders, Medicaid may pay the premiums. Medicare Part B reimburses providers for outpatient hospital services, physician services, laboratory costs, durable medical equipment, and other services. All Medicare payments are subject to deductibles, copayments, and various limitations on the amount of service for which it will pay.

Currently, IHS and tribal facilities may recover only for services provided by hospitals and skilled nursing facilities and, in the past two years, for a limited number of outpatient services reimbursed under Part B. Medicare payments for inpatient hospital services are based on diagnosis; for outpatient hospital services most providers will be required to bill according to a new and complex classification system that is part of the implementation of the outpatient prospective payment system adopted by Medicare. Other services are generally reimbursed on the basis of fee schedules or cost reporting data. The exceptions to the general rules are many, however. There are special reimbursement standards for federally qualified health centers, critical access hospitals. disproportionate share hospitals, certain cancer treatment hospitals, certain children's hospitals, and, at least for now, IHS hospitals (whether operated by IHS or a tribe.)

Reimbursements to IHS and tribal hospitals for outpatient services have been based on a per day rate sometimes referred to as the "encounter rate," "the OMB rate," or the "all-inclusive rate." It is a per day amount for all outpatient services provided on that day. It is negotiated annually between IHS and the Centers for Medicare and Medicaid Services (CMS) based on cost reports submitted by a number of IHS and tribal hospitals. (All payments are less the 20 percent copayment even though the Indian beneficiary is not obliged to pay the copayment.)

This simplified billing method has made recovery possible for facilities that have lacked the capacity to do full individual cost reports and for whom satisfying the requirements of the new outpatient prospective payment system regulations would have been virtually impossible and would have diverted millions of dollars away from other services into new information systems necessary to comply with the complexities of that system.

IHS and tribal clinics not closely connected to an IHS hospital have largely been without any Medicare reimbursement. The newly authorized recovery for Part B services helps a little, but as noted above there are a relatively small number of Indian enrollees. In addition, the recovery for professional services is very low relative to the cost of providing the services and no reimbursement for the cost associated with the facility are included. A few overcome this problem by enrolling as federally

qualified health centers, but for many the cost of compliance with the cost reporting requirements, combined with the reality that actual cost is never paid,

Medicaid. Medicaid is the principal public health insurance program for poor Americans. It is a state/federal partnership in which both contribute financially in varying amounts. Federal participation imposes certain limitations on states about who must be served, principally children and their parents living below a certain poverty level; the services that must be covered; and the practitioners who must be allowed to provide certain services. Beyond these minimums, states have great, although not unlimited, flexibility in adding additional populations to be served, services that are covered, and practitioners whose work may be compensated. States are largely responsible for setting their own reimbursement methodologies, again subject to certain constraints. Thus, there are effectively 50 nearly unique Medicaid programs.

When the IHS, tribal health programs and urban Indian organizations participate in Medicaid, they do so largely under the unique conditions imposed by each state as it develops its own program, Thus, the scope of the activity that each program may be reimbursed for and how it will be reimbursed varies dramatically from one state to another. This creates significant challenges for IHS and those tribes that operate health programs in more than one state.

In fiscal year 1997, IHS and tribally operated facilities were projected to receive $184.3 million in Medicaid reimbursements.[2/] This was about 10 percent of the $1.8 billion appropriated for IHS health care services. *Id.* It was only .07 percent of the $258 billion in combined federal and state expenditures in fiscal year 2002.

Medicaid is an especially important program for Indians because of their disproportionate poverty and for Americans generally. Due to the limitations in Medicare, it is the only source of payment for prescription drugs and for long term care for most elders in America. Since the advent of welfare reform, it is increasingly disconnected from other public assistance programs with some children being eligible up to 200 percent of the poverty level.

Although the way states reimburse IHS and tribal health programs varies widely, for most hospital and clinic based services reimbursement is made on the basis of the simplified encounter rates described above. Again these rates assure that some of the cost of the facility are covered and they minimize the complexities of billing and preparing cost reports. For these facility-based services states are reimbursed 100 percent by CMS. The fact that states can count on this level of reimbursement has generated much more positive working relationships between IHS and tribal health programs and the states than generally exist over other issues. While the financial incentive is not a uniform guarantee of cooperation, it is generally effective and has led to significantly more cooperation, especially in states with many tribes and relatively large numbers of Indians.

2/ "Native Americans and Medicaid: Coverage and Financing Issues," Andy Schneider and JoAnn Martinez, the Center on Budget and Policy Priorities for the Kaiser Commission of the Future of Medicaid, December 1997, p. 2.

The Need for Further Change.

The Indian Health Service and tribal health programs reliance on third-party revenues has grown substantially, as direct appropriations have failed to keep up. For some tribal health programs, more than half of the budget for delivery of health care now must be generated through third-party revenues. This poses huge challenges and new risks. The proposed amendments to the IHCIA address these, as well as eliminating barriers that are currently found in the program.

As the National Steering Committee undertook to consider changes needed to the provisions of the Act relating to access, it had to consider many factors. It helps to understand how relatively constrained its requests are, if one considers the following:

- The United States owes a duty to American Indians and Alaska Natives to provide them with health care. As Senator Inouye has often commented, Indians have the first pre-paid health plan in the United States – paid for with their lands and resources.

- Congress determined that its obligations to provide this health care could best be met by a combination of direct appropriations and authorizations for IHS and tribal health programs to be reimbursed for the health services they provide. Resources that are not needed to manage direct appropriations have been and continue to be devoted to pursuing these reimbursements.

- The total funds available for direct delivery of health services from direct appropriations and third-party recovery still provides on a per capita basis not much more than half of the per capita amount spent by the Federal Employee Health Benefit Plan for a much healthier population. There is no point in the foreseeable future when the combination of funds will come close to meeting the need for health care of American Indians and Alaska Natives.

- Since the 1970s when recovery from Medicare and Medicaid were first authorized, there has been a revolution in health care delivery; one that moved patients out of inpatient facilities and instead relies on outpatient services, ambulatory surgeries, and home- and community-based services. The "facility" based model of recovery initially authorized fails to provide adequately for changes in delivery that have occurred.

- American Indians and Alaska Natives "continue to suffer the highest rates of unemployment and poverty;" 31.2 % live in poverty. The unemployment rate is nearly 50% while the national average is 5.8%. Health status continues to be poor and is most striking with regard to diabetes, tuberculosis, alcoholism and fetal alcohol syndrome.[3/]

3/ Letter from the Chairman and Vice-Chairman of the Senate Committee on Indian Affairs to the Chairman and Ranking Member of the Committee on the Budget, United States Senate, March 11, 2003.

- Improving life expectancy will increase health care costs as the population ages.

Another consideration also guided the thinking of the NSC. Both Medicare and Medicaid are riddled with special provider types (federally qualified health centers, rural health centers, critical access hospitals, disproportionate share hospitals, teaching hospitals, to name just a few) and for each there are special reimbursement rules. These special rules are designed to assure that a certain population will have access to care or that a certain objective of the program will be achieved. The NSC seeks only to assure that similar consideration is given to ensuring that these federally funded health insurance programs treat Indian programs similarly – by ensuring that the special conditions under which they operate are taken into account.

Having been compelled to invest in the means to participate in Medicare and Medicaid, tribes simply want to assure that the investment gives them full access to the benefits of the programs, not merely cut-outs designed nearly three decades ago.

Achieving the objectives of full participation in Medicare and Medicaid is no easy task. As the background discussion demonstrates, the programs are complex. They are outside the ordinary experience of tribal leaders and the jurisdiction of those committees of Congress with whom tribal leaders most often work. The National Steering Committee did not allow those factors to be a barrier to putting together a restrained package of proposed improvements. Neither should the Congress allow the relative insignificance of the program changes (when compared to massive changes like the addition of a Medicare Prescription Drug benefit currently being considered in conference, to be an excuse to not consider the proposals. While truly not even a "rounding error" in either the Medicaid or Medicare budget, the fiscal and programmatic impact for Indian health programs can be profound.

Conclusion

A section-by-section analysis of the changes found in H.R. 2440 and the differences between it and S. 556 is attached as an addendum. The analysis is accompanied by brief commentary. I hope it will help explain the purpose of each proposed amendment to the current law. I also hope it will dispel the impression that huge changes are being sought. In fact, the true change could occur only if the funds necessary to keep the commitments of the United States to provide health care to American Indians and Alaska Natives were made available.

In the meantime, swift action to improve access to care by American Indians and Alaska Natives to health programs operated by the Indian Health Service, tribes, and urban Indian organizations by making increased access to federally funded health insurance plans is the next best thing.

Thank you for your consideration. I will be glad to try to respond to your questions, and, if I can't to find someone who can.