From Families USA Minority Health Initiatives

IssueBrief

May 2010

Health Reform: Help for American Indians and Alaska Natives

Photo Courtesy of the Indian Health Service/U.S. Department of Health and Human Services.

Despite their legal right to health care, American Indians and Alaska Natives face dire health conditions. According to recent data, nearly 30 percent of American Indians and Alaska Natives are without health coverage. American Indians and Alaska Natives are also disproportionately affected by a host of chronic conditions, such as diabetes, stroke, and heart disease. These disparities are evidence of the importance of the new health reform law, which addresses many of the unique needs of this population.

The ongoing debate about whether health care is a right or a privilege does not apply to Indian Country. American Indians and Alaska Natives are the only citizens of the United States who are born with a legal right to health care. The federal obligation to provide health services to members of federally recognized tribes was developed from a special relationship between the federal government and Indian tribes that was established in 1787.[1] In exchange for land and resources, the federal government made an agreement with American Indians to provide quality education and health care to Indian people and tribes.[2] This relationship, often referred to as the federal trust responsibility, has been defined in the U.S. Constitution, treaties, statutes, and in Supreme Court decisions.

To fulfill the federal obligation, the Indian Health Service (IHS) was established within the Department of Health and Human Services (HHS) in 1955. IHS is responsible for providing culturally appropriate and personal and public health services to American Indian and Alaska Native people. Also as part of tribes' special relationship with the U.S.

government, the Indian Health Care Improvement Act (IHCIA) was enacted in 1976 to ensure that American Indians and Alaska Natives received the health care services they needed and to elevate their health status to parity with other ethnic groups in the United States. (For more information about the legislation leading up to the Indian Health Care Improvement Act, read "Legislative History" below.)

Despite these efforts, IHS has historically been underfunded and has not been able to keep up with the health needs of Indian Country. In addition, the Indian Health Care Improvement Act expired in 2002. The passage of national health reform gives Indian Country the opportunity to address disparities by expanding coverage and improving access through broader health reforms and through the reauthorization of the Indian Health Care Improvement Act (IHCIA).

Legislative History

In 1921, Congress enacted the Snyder Act, the principal piece of legislation authorizing federal funds for health services to recognized Indian tribes.[3] In 1975, President Ford signed into law the Indian Self-Determination and Education Assistance Act (ISDEAA), which recognized the significance of the government-to-government relationship between the United States and Indian tribes. This legislation gave Indian tribes the option of assuming the administration and operation of health care services and programs from the Indian Health Service (IHS) and allowed the tribes to design programs to fit the needs of their communities.[4] Then, in 1976, Congress passed the Indian Health Care Improvement Act (IHCIA) to encourage tribes to participate in the planning and management of health services for their members and to ensure that American Indians and Alaska Natives received the quality and quantity of health care services necessary to improve their health status.[5]

In order to receive services from IHS or to benefit from the provisions in the Indian Health Care Improvement Act, a tribe must be federally recognized. A tribe is deemed federally recognized if the United States government acknowledges its status as a government.[6] Members of tribes are recognized as citizens of their tribes, the state in which they reside, and the United States.

Health Reform

The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, has made some significant steps toward maintaining and improving programs that support the health of the American Indian and Alaska Native population. The reauthorization of the Indian Health Care Improvement Act, the expansion of Medicaid, and several other provisions show the federal government's renewed commitment to Indian health.

Reauthorization of the Indian Health Care Improvement Act

The Indian Health Care Improvement Act was enacted in 1976 to ensure that American Indians and Alaska Natives received the health care services they needed. However, until health reform passed, it had not been comprehensively updated since 1992.[7] In fact, according to a concept paper that the chairman of the Senate Indian Affairs Committee, Senator Byron Dorgan, sent to tribal leaders regarding health care, "Were it not for the Snyder Act of 1921, the IHS would not have been authorized to receive appropriated resources to provide health care services to American Indians and Alaska Natives after the expiration of the IHCIA in 2002."[8]

IHS provides more than half of the American Indian and Alaska Native population with health care services.[9] Despite this population's dependence on this Indian health care delivery system, IHS is chronically underfunded and lacks the authority to have funding appropriated for health care upgrades and improvements. For well over a decade, advocates have asked Congress to address these issues by

The Indian Health Service (IHS)

IHS, which provides the majority of health services to the American Indian and Alaska Native community, is not a form of health insurance. IHS manages a unique health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 564 federally recognized tribes in 35 states.[10] Health care services are provided through IHS programs, tribal programs, and urban Indian programs. A small number of American Indians and Alaska Natives living in urban areas receive health care services from urban Indian health programs. Currently, there are 34 urban Indian health programs that provide services to approximately 600,000 American Indians and Alaska Natives living in cities.[11]

Through the Indian Health Service (IHS), Indian tribes can choose to receive health care in one of three ways:

1. by receiving direct care from IHS,
2. by contracting with IHS to control the administration and funding of individual programs and services that the Indian Health Service would normally run (known as self-determination contracts), or
3. by signing a compact with IHS to design and oversee health care programs that IHS would normally manage (known as self-governance compacts).[12]

reauthorizing and amending the Indian Health Care Improvement Act.

Fortunately, the health reform law included a reauthorization of the Indian Health Care Improvement Act. This was quite significant for Indian Country because the Act is now permanently reauthorized, demonstrating the federal government's commitment to honoring its trust responsibility to Indian tribes.

In addition to expanding the authorities of the IHS Director to include advocacy and consultation on matters relating to Indian health within the Department of Health and Human Services (HHS), below are a few key areas that the Indian Health Care Improvement Act ("the Act") addresses:[13]

- ## Medicare, Medicaid, and CHIP

  Current Issue: Despite disproportionately high rates of poverty, American Indians and Alaska Natives are under-enrolled in public programs like Medicaid, particularly on reservations. For many, it is difficult to obtain these services because most tribal communities are in rural or remote areas. Further, due to how the current payment structure is set up, providers in Indian Country may not be adequately reimbursed for the services they provide.

  How the Act Addresses This: The reauthorization updates the current authority for IHS to issue grants or contracts to tribes, tribal organizations, and urban Indian organizations so that they can conduct outreach to enroll eligible Indians in Medicare, Medicaid, and CHIP. In addition, there is a requirement for the Centers for Medicare and Medicaid Services (CMS) to submit an annual report to Congress regarding the enrollment and health status of Indians receiving services. The Act also updates the current law regarding collection of reimbursements from Medicare, Medicaid, and CHIP by Indian health facilities and revises the procedures that allow tribally-operated programs to directly collect such reimbursements for the services that they provide.

- ## Health Care Provider Shortage

  Current Issue: Most Indian health care facilities are located in isolated rural areas on or near reservations. As a result, many Indian health programs have historically experienced difficulty recruiting and retaining staff. According to the latest data, vacancy rates are 26 percent for nurses, 24 percent for dental professionals, 21 percent for physicians, and 11 percent for pharmacists.[14]

  How the Act Addresses This: The Act strengthens scholarship and loan programs to attract health professionals to, and to retain them at, IHS facilities and tribal sites. It also strengthens scholarship programs to recruit American Indian students into psychology and behavioral health professions, and it establishes a Community Health Representative program for urban Indian organizations to train and employ individuals to provide health care services.

- ### Facilities and Sanitation

  Current Issue: IHS health care facilities are, on average, more than 30 years old. Medical equipment, which has an average life span of six years, is generally used for twice as long in Indian Country. In addition, many of these health care facilities are overcrowded—there isn't enough space to accommodate the additional staff or services that are desperately needed.[15]

  When IHS does not have the resources to address operation and maintenance needs, they are added to the maintenance backlog each year. The IHS and tribal backlog is currently estimated to be $476 million.[16]

  How the Act Addresses This: The Act allows IHS and tribal health facilities to come up with innovative ways to address deficiencies in heath care facilities, sanitation systems, and construction backlogs. It also authorizes the development of new health programs that provide care in alternative settings or outside of regular clinic operating hours.

- ### Elder and Long-Term Care

  Current Issue: Across Indian Country, there are fewer than 25 assisted living facilities for the elderly or people with disabilities. The lack of facility space and authority to provide this type of care means that most elderly Indians or Indians with disabilities must travel off their reservation to get needed care.

  How the Act Addresses This: The Act permits IHS and tribal facilities to create elder care programs that focus on behavioral health. It also allows hospice, assisted living, long-term care, and home- and community-based services to be established.

- ### Cancer Screening

  Current Issue: Currently, IHS and tribal facilities lack the authority to provide cancer screenings, except mammograms. Late detection and treatment of cancer contribute to lower survival rates for this population.

  How the Act Addresses This: The Act expands IHS and tribal facilities' capacity to provide preventive services, such as other cancer screenings in addition to mammograms.

- ### Diabetes

  Current Issue: According to the latest data, American Indian and Alaska Native adults are nearly three times more likely than non-Hispanic whites to be diagnosed with diabetes and almost twice as likely to die from it.[17]

  How the Act Addresses This: The Act reauthorizes existing diabetes screening and prevention programs and permits funding of dialysis programs.

Coverage Expansion

Having health insurance has been shown to increase an individual's access to health care and to improve health outcomes. Despite the U.S. government's responsibility to provide health care to American Indians and Alaska Natives, this population remains disproportionately uninsured or relies solely

on the direct services provided by IHS. In 2008, nearly one in three nonelderly American Indians or Alaska Natives was uninsured.[18] As a result, American Indians and Alaska Natives are less likely to have a regular provider and more likely suffer from worse health and to die prematurely.

The health reform law is critical to closing this coverage gap and is especially important for low-income individuals. For millions of Americans, particularly for those living in poverty, health insurance is just too costly. In 2008, more than a quarter of the American Indian and Alaska Native population lived at or below the federal poverty level ($17,600 for family of three in 2008)—more than any other racial or ethnic group. The most recent estimates show that almost half (44 percent) of American Indians and Alaska Natives who were uninsured or had only IHS coverage lived in families with incomes below the federal poverty level.[19] For many of these individuals, public health coverage programs are an important safety net.

Although IHS provides American Indians and Alaska Natives with health care services, that care has its limitations. First, the majority of IHS facilities are located on reservations, which can be a challenge for those living off reservations. Secondly, individuals who receive care from IHS facilities are limited to the services provided there or providers who contract with IHS. Lastly, IHS underfunding has made it difficult to upgrade facilities with new technologies and to expand services. As a result, oftentimes, only basic health care services are available, and when available, access may be limited due to demand or to the remote location of the facility.[20]

Public health coverage programs, such as Medicaid, have been a key source of coverage for the American Indian and Alaska Native population. For example, in 2008, Medicaid and/or CHIP covered almost a quarter of American Indian and Alaska Native adults and nearly 45 percent of children.[21] The program offers comprehensive health care benefits and some services not typically covered by private insurers, such as transportation and language assistance services.

However, contrary to popular perception, the Medicaid program has not been available to all low-income people. In fact, in 43 states, adults without dependent children cannot enroll in Medicaid, even if they are penniless. This leaves millions of low-income adults with no options for affordable health coverage, including many American Indians and Alaska Natives. Health reform strengthens these public coverage programs and makes coverage available to those who need it.

The health reform law expands Medicaid eligibility levels to 133 percent of the federal poverty level ($14,404 for a single adult and $24,352 for a family of three in 2009) and includes childless adults. These coverage expansions will offer American Indians and Alaska Natives access to the health services that are available to those with health insurance. They will also help to reduce disparities in coverage and improve the overall health of American Indians and Alaska Natives, moving us closer to the ultimate goal of health equity.

Funding for Prevention and Wellness

The health reform law contains a significant amount of grant funding for prevention and wellness programs. The new law considers tribal organizations, urban Indian organizations, and American Indians and Alaska Natives to be eligible for these grants.

The health reform law includes funding for maternal and child health services, such as early childhood home visitation programs, as well as grants for trauma centers, school-based health clinics, and an infant mortality pilot program. In addition, there is grant funding for the improvement of regionalized systems of emergency care response, the establishment of community health teams to support the patient-centered medical home, and oral health care prevention activities.

Other Provisions

Many American Indians and Alaska Natives receive health care services that are associated with health coverage through IHS, which is not a form of health insurance. However, health reform recognizes the existing obligation of the federal government to provide health care to American Indians and Alaska Natives. Due to the unique relationship that American Indians and Alaska Natives have with the government, health reform will not require American Indians and Alaska Natives to purchase health insurance.

Health reform eliminates the cost-sharing for insurance plans offered through new health insurance marketplaces, or exchanges, for any American Indian or Alaska Native individual who makes less than $32,490 a year, and establishes special monthly enrollment periods for American Indians and Alaska Natives. It also recognizes Indian tribes, tribal organizations, and urban Indian organizations as entities that can enroll Indians in Medicaid, Medicare, and CHIP using presumptive eligibility, which will empower Indian health providers and organizations to give temporary insurance cards and coverage to American Indians and Alaskan Natives.

Under the new law, IHS, tribes, and tribal and urban Indian organizations are considered the payer of last resort for services provided to Indians. Reform also eliminates the sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics.

Conclusion

American Indians and Alaska Natives face many barriers to obtaining quality health care. The passage of health reform and the reauthorization of the Indian Health Care Improvement Act help to address the health disparities that are prevalent in Indian Country. The coverage expansions in the health reform law will ensure that more American Indians and Alaska Natives can get the care they need. The Indian Health Care Improvement Act will help to improve the shortage of health care providers, maintain IHS facilities, and create programs to enhance the health of the Indian people. Health reform enables the United States to begin to better fulfill its responsibility to provide quality health care services and resources to American Indians and Alaska Natives.

Endnotes

[1] Indian Health Service, *Indian Health Service Introduction* (Rockville: IHS, January 2010), available online at http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp.

[2] National Congress of American Indians, *An Introduction to Indian Nations in the United States* (Washington: National Congress of American Indians, 2004), available online at http://www.ncai.org/fileadmin/initiatives/NCAI_Indian_Nations_In_The_US.pdf.

[3] Indian Health Service, *IHS Fact Sheets: The Indian Health Care Improvement Act* (Rockville: IHS, January 2010), available online at http://info.ihs.gov/HlthImprvAct.asp.

[4] Indian Health Service, *IHS Fact Sheets: Tribal Self- Governance* (Rockville: IHS, January 2010), available online at http://info.ihs.gov/TrblSlfGov.asp.

[5] The Indian Health Service, *IHS Fact Sheets: The Indian Health Care Improvement Act*, op. cit.

[6] National Congress of American Indians, op. cit.

[7] Senator Byron L. Dorgan, *Reforming the Indian Health Care System* (Washington: United States Senate Committee on Indian Affairs, July 6, 2009), available online at http://www.indian.senate.gov/public/_files/IndianHealthConceptPaper2009.pdf.

[8] Ibid.

[9] The Indian Health Service, *IHS Fact Sheets: Indian Health Disparities* (Rockville: IHS, January 2010), available online at http://info.ihs.gov/Disparities.asp.

[10] The Indian Health Service, *IHS Fact Sheets: Indian Health Service: A Quick Look* (Rockville: Indian Health Service, June 2008), available online at http://info.ihs.gov/QuickLook.asp.

[11] U.S. Department of Human and Health Services, Office of Minority Health, *American Indian/Alaskan Native Profile* (Rockville: Office of Minority Health, October 2010), available online at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=52; The Indian Health Service, *IHS Fact Sheets: Urban Indian Health Program* (Rockville: IHS, January 2010), available online at http://info.ihs.gov/UrbnInds.asp.

[12] The Indian Health Service, *IHS Fact Sheets: Tribal Self- Governance*, op. cit.

[13] Jennifer Cooper, *Preliminary Summary of the Patient Protection and Affordable Care Act and the Indian Health Care Improvement Act* (Washington: The National Indian Health Board, March 26, 2010), available online at http://www.nihb.org/docs/03292010/Summary%20of%20IHCIA%20and%20PPACA_March%2026%202010.pdf; Jennifer Cooper, *How the Indian Health Care Improvement Act Addresses Health Issues in Indian Country* (Washington: The National Indian Health Board, July 2009), available online at http://www.nihb.org/docs/10012009/IHCIA%20Health%20Disparities%20One%20Pager_July%202009.pdf; The United States Senate Committee on Indian Affairs, *The Indian Health Care Improvement Reauthorization and Extension Act of 2009, Draft Section-by-Section Summary* (October 13, 2009), available online at http://www.indian.senate.gov/public/_files/IndianHealthCareSectionbySection101309.pdf.

[14] The Indian Health Service, *IHS Fact Sheets: Workforce* (Rockville: IHS, January 2010), available online at http://info.ihs.gov/Workforce.asp.

[15] The Indian Health Service, *IHS Fact Sheets: Facilities Construction* (Rockville: IHS, January 2010), available online at http://info.ihs.gov/FcltCnstr.asp.

[16] Ibid.

[17] U.S. Department of Health and Human Services, Office of Minority Health, *Diabetes and American Indians/Alaska Natives* (Rockville: HHS, March 5, 2010), available online at http://minorityhealth.hhs.gov/templates/content.aspx?ID=3024.

[18] Families USA, *Health Coverage in Communities of Color: Talking about the New Census Numbers* (Washington: Families USA, September 2009), available online at http://www.familiesusa.org/assets/pdfs/minority-health-census-sept-2009.pdf.

[19] Cara James, Karyn Schwartz, and Julia Berndt, *A Profile of American Indians and Alaska Natives and Their Health Coverage* (Washington: Kaiser Family Foundation, September 2009), available online at http://www.kff.org/minorityhealth/upload/7977.pdf. Please note that the latest data available are from 2006-2007.

[20] Ibid.

[21] Families USA, op. cit.

Acknowledgments

This report was written by:

Sherice Perry
Program Manager, Minority Health Initiatives
Families USA

and

Jonay Foster
Wellstone Fellow
Families USA

The following Families USA staff contributed to the preparation of this report:

Rea Pañares, Director of Minority Health Initiatives

Peggy Denker, Director of Publications

Ingrid VanTuinen, Senior Editor

Tara Bostock, Editor

Colleen Haller, Editorial Assistant

Nancy Magill, Senior Graphic Designer

Special thanks to:

Jennifer Cooper
National Indian Health Board

1201 New York Avenue NW, Suite 1100 ■ Washington, DC 20005
Phone: 202-628-3030 ■ E-mail: info@familiesusa.org
www.familiesusa.org