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SECOND ROUNDTABLE  
CONFERENCE

ON

HEALTH CARE REFORM, THE  
HEALTH SECURITY ACT, AND  
INDIAN HEALTH CARE



CONSENSUS STATEMENT

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Transitional and on-going funding should be provided, which includes a broad range of cost considerations including indirect costs, overhead, risk adjustment, disease surveillance

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# SECOND ROUNDTABLE CONFERENCE

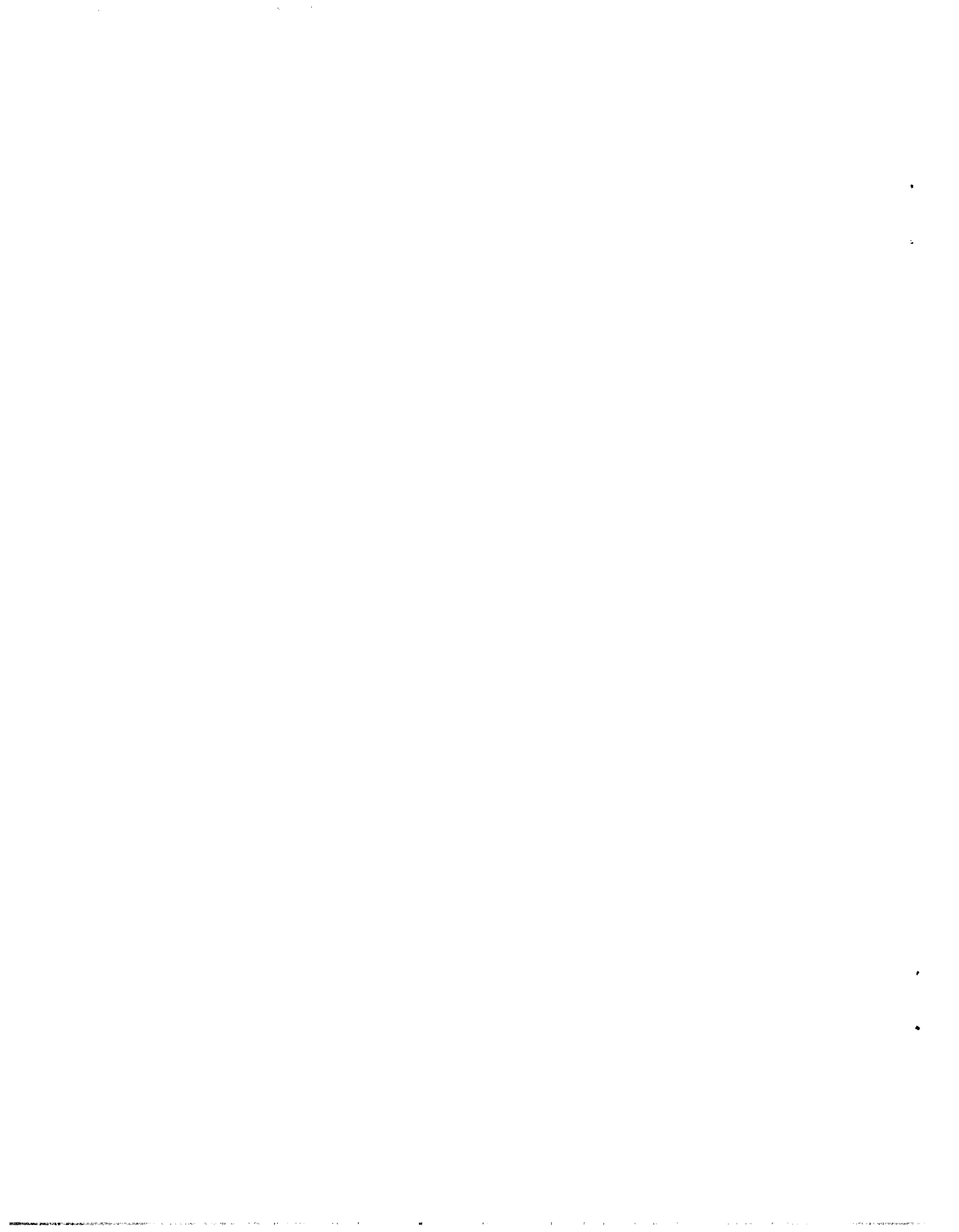
## ON

# HEALTH CARE REFORM, THE HEALTH SECURITY ACT, AND INDIAN HEALTH CARE

A CONSENSUS STATEMENT  
FINAL REPORT



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service - Indian Health Service



**SECOND  
ROUNDTABLE CONFERENCE**

**ON**

**HEALTH CARE REFORM,  
THE HEALTH SECURITY ACT,  
AND INDIAN HEALTH CARE**

**A CONSENSUS STATEMENT  
FINAL REPORT**

**February 9-10, 1994  
Indian Health Service  
Rockville, Maryland**

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**THIS REPORT IS AN  
INDEPENDENT STATEMENT  
OF THE  
ROUNDTABLE GROUP  
AND IS NOT A  
POLICY STATEMENT  
BY THE  
INDIAN HEALTH SERVICE  
OR  
THE FEDERAL GOVERNMENT**

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## **INTRODUCTION**

The U.S. Indian Health Service (IHS) has held a series of Roundtable Conferences on significant topics pertaining to policy and planning issues of the IHS. The IHS Office of Planning, Evaluation, and Legislation, has utilized Roundtable Conferences as a means to retrieve information and consensus from leaders and experts in a particular field. The Roundtable process was adapted from a National Institutes of Health model which brings together a small, but representative group of experts to discuss and arrive at consensus positions around a topic, in this case, Indian Health Care Reform.

This Roundtable on Health Care Reform was the second IHS-sponsored Roundtable on the topic of Health Care Reform and its impact on Indian health. The first Health Care Reform Roundtable was held in February 1993, shortly after President Clinton's inauguration and upon the beginning of the Administrations' health care reform task force. A Final Report was issued which set out a framework of Consensus Statements from the participants, that included tribal leaders, urban health providers, national Indian organizations, those in academia, Congressional staff, and the IHS. However; at that time, a detailed legislative proposal was not on the table. This second Roundtable was held to provide tribal leaders, urban health care providers, and national Indian organizations with the opportunity to contribute their perspectives on the detailed substance of the Health Security Act and other reform proposals, and to provide the IHS with Consensus Statements from which further policy analysis can occur.

The Health Security Act includes Title VIII, Subtitle D, dealing specifically with Indian Health Care. The President's bill was introduced in the House by Majority Leader Gephardt (D-MO) as H.R. 3600, and in the Senate by Majority Leader Mitchell (D-ME) as S. 1757. The Indian section was drafted in large part from recommendations by "Work Group 16-A," the work group within the First Lady's Health Care Reform Task Force charged specifically with Indian health. Consultation with the IHS, tribal leaders, urban health providers, and national Indian organizations occurred at numerous times as Work Group 16-A struggled to meet the toll-gate deadlines set by the Task Force throughout 1993.

The legislation poses radical changes in the manner health care will be provided to American Indians and Alaska Natives (AI/AN). The AI/AN patients will be guaranteed a prescribed comprehensive benefits package. Health Care Reform could establish set capitated rates for each enrolled patient within the IHS/Tribal/Urban (I/T/U) systems with which the patient could choose to enroll in any system. The Health Security Act includes requirements for services to non-Indians and for revolving loans for facility construction. Supplemental services, which have historically been important in the IHS public health efforts in AI/AN communities, such as outreach and transportation, may not receive priority funding under Health Care Reform.

The Consensus Statements reflected in this document were developed through a process which allowed for presentation of most current information, deliberation, and discussion by Roundtable participants, and formulation of Consensus Statements which best projected the breadth of positions. The participants were asked to develop statements which would best reflect the array of considerations and positions for a particular topic. When there was disagreement among the

participants, efforts were made to fairly reflect the many sides of the debate within the text of the consensus statement, as opposed to forcing a single position.

## **EXECUTIVE SUMMARY**

A major overriding concern expressed by the Roundtable participants that influenced the discussion of every major aspect of Health Care Reform were the cutbacks to the IHS in Fiscal Year (FY) 1994 and FY 1995. These cuts will cause devastating and potentially irreparable harm to the Indian health care delivery structure nationally. The Roundtable participants stated over-and-over again, that it will be impossible for the Indian health care system to withstand the magnitude of proposed staffing and budget cuts, and still compete under the new Health Care Reform system. The Consensus Statements developed by the Roundtable participants focused on the following major issue areas:

**TRIBAL SOVEREIGNTY:** Roundtable participants overwhelmingly supported the inclusion of tribal sovereignty within Health Care Reform. Health Care Reform should explicitly reference the moral and legal obligations of the Federal Government to provide health care to the AI/AN, and the Government-to-Government relationship with tribes. The reliance of most Health Care Reform proposals on state administration of vital components or regulation of Health Care Reform is of great concern to tribes. There is a need to protect and enhance tribal sovereignty via a separate, intact system for Indian health.

**COMPREHENSIVE AND SUPPLEMENTAL BENEFITS:** Initial IHS calculations to provide complete comprehensive benefits to the 1.3 million currently eligible IHS patients exceed \$4 billion. There are additional backlogs in facility replacement, repair, and environmental sanitation, which also number into the billions. While there was strong support for comprehensive benefits, the participants expressed serious concern about the likelihood of necessary appropriations to actually provide this level of care. Rather, the requirement upon I/T/Us to provide comprehensive benefits could result in the shifting of resources from supplemental benefits to fully fund comprehensive benefits; this would be a loss to the Indian health care delivery system. Separate legislation was recommended which would establish mandatory funding of 100 percent of actual need for Indian health.

**GOVERNANCE AND STRUCTURE:** Participants called for the establishment of a National Board on Indian Health. There was a diversity of opinion regarding composition of the board, but general agreement as to its function and oversight authority over the Indian health care delivery system. The participants recognized the need to examine new methods for collaboration between the I/T/U providers, and the need to examine innovative structures to share risk within capitated Health Care Reform. Economies of scale will require new shared structures for health care delivery.

**ELIGIBILITY AND ENROLLMENT:** While there was overall support for individual patient choice of health plans, Roundtable participants conditioned this endorsement upon a system for initial "automatic enrollment" of Indian patients or tribal members in the I/T/U plans. There is potential for mass exodus of Indian patients from the I/T/U systems, particularly if the Indian health care delivery system is not substantially upgraded for the transition and non-Indian plans come on-line a year prior to Indian plans as provided in the bill. Non-Indian enrollment in the I/T/U system must be at the consent of the affected tribe or governing body.

**FINANCING:** The Federal Government should fund 100 percent of the true need in I/T/U health programs. Financing through revolving loans should be secondary to the Federal responsibility to provide full funding for facility needs. For many smaller clinics, capitated rates may not produce the

needed capital to operate, and may expose these programs to financial disaster. A Federal reinsurance system or safety net is needed for the I/T/U systems similar to what will be provided to other plans. Collaborative efforts between tribes or among urban health providers and the IHS should be provided separate financial incentives to establish the necessary economies of scale for managed care.

Transitional and on-going funding should be provided, which includes a broad range of cost considerations, including indirect costs, overhead, risk adjustment, disease surveillance, facility/environmental backlogs, and capacity building.

**TRANSITION AND COMPETITION:** Without a major infusion of transitional dollars, most of the Indian health care delivery system will not be competitive and will likely lose patients to other plans. Other sections of the bill offer transitional funding, such as for veteran's facilities and other community health networks. Similar provisions are needed for the I/T/U systems during the transition period, accompanied by substantial Federal investments. It was stated that if the Indian Health Service was funded at 100 percent of need, it would not lose any patients. With regard to services to non-Indians, Indian plans should be able to compete to enroll non-Indian patients in the larger community, as an economic enterprise of the tribe or urban center, if that is the choice of the system.

# **Consensus Statements**

from the

**Second  
Roundtable Conference  
on  
Health Care Reform,  
The Health Security Act,  
and Indian Health Care**

**February 9 -10, 1994**



# **TRIBAL SOVEREIGNTY**

## **Consensus Statement**

*As sovereign Indian nations, we cannot support any type of Health Care Reform which threatens our sovereignty or ignores or relieves the Federal Government of its trust responsibility and the Government-to-Government relationship with the AI/AN. We are nations that have given up land, minerals, and other natural resources as prepayment for health services. We, as sovereign Nations, refuse to be identified as part of the minority population or as a special organization that receives health care.*

*We demand that the Federal Government maintain intact, a separate, publicly financed American Indian Health Care Delivery System (the IHS) which will continue to provide the best possible health care to our people and under this system, continue to fund our Public Law (P.L.) 93-638 programs and other Health Promotion and Disease Prevention Programs that have been established with annualized increases. The IHS must remain the main provider of health services to the AI/AN. Implementation of the Health Security Act must not compromise P.L. 93-638 and other legislation, but preserve the uniqueness of the present health care delivery system for the AI/AN.*

*As sovereign Nations, we reserve the right to automatically enroll our tribal members into our health system. The individual may thereafter elect to enroll with another health care provider. The decision to provide health care to non-Indians shall be the sole responsibility of the tribal government. The Federal Government must initiate meaningful and genuine consultation with tribal governments on all relevant matters that affect the implementation of the Health Security Act in accordance with the proposed Health Security Act, Section 8309, and P.L. 93-638.*

*The Federal Government cannot allow state legislation to threaten tribal sovereignty. The unique status of dual citizenship of the AI/AN will not be compromised by legislation or denial of protection of adequate health care services. The continuation of historical base funding as identified by tribal health services is critical to maintaining the status of tribal sovereignty.*

*Universal coverage and tribal sovereignty are enhanced by 100 percent funding as identified by each respective local Indian health care delivery system. Any reduction would serve to undermine the integrity of tribal sovereignty and the historical Government-to-Government relationship.*

### **Specific Recommendations:**

1. Tribes face many challenges to their sovereignty, particularly in relation to State governments. The sovereignty of tribes should be recognized in the language of Health Care Reform legislation. If it is not exercised, it will be compromised under health reforms which are substantially based on state systems and state administration.
2. Consultation with tribes must continue throughout the development of Health Care Reform legislation and upon Health Care Reform implementation.
3. Tribes must maintain the sole authority and discretion with regard to the provision of services to

non-Indian beneficiaries of their own health care delivery system. No compromises should be implemented with regard to tribal authorities under P.L. 93-638 and subsequent amendments.

4. Tribes should be treated similar to states within the Health Care Reform legislation, particularly in regards to benefits provided to states for the transition and implementation of Health Care Reform. Specifically, there should not be a difference in dates when tribal and state systems must be able to provide the full range of comprehensive benefits. Both should be implemented simultaneously to avoid unfair advantages by states in marketing to Indian beneficiaries:

- a) Tribes should be provided ample flexibility under reforms to elect to develop cooperative agreements with states;
- b) Medicare and Medicaid reimbursements for tribal health programs must include a means to allow for a direct billing arrangement with Federal programs for tribes independent of state administration; and,
- c) Amendments should accompany health care reforms which will provide for tribal set-asides of categorical block grants currently going only to states which are health-related and which will be included in Health Care Reform.

5. Within the preamble of the Act, there should be a statement of Federal policy with regard to Indian health care which reflects the historical, legal, and moral obligation of the Federal Government to elevate Indian health status based upon treaties and statute. This statement will formulate the basis upon which all other Indian specific provisions within the Act are based, and shall demonstrate that Indian populations are dealt with separately due to this special status, and not due to any status as minorities or special interests.

6. Reforms must keep the IHS as the main health care delivery system, and the direct relationship between tribes and the Federal Government will be enhanced, via reforms.

7. Amendments to statutes governing the U.S. Public Health Service (PHS) Commission Corps are necessary to ensure tribal controls at the local level over Commission Corps Personnel.

8. While there was general agreement supporting the individual patient's right to choose health providers, this was on the condition that there would be automatic enrollment of Indian beneficiaries initially. Tribes must be guaranteed adequate transitional and base funding to ensure immediate and long term competitiveness. Without these assurances for a competitive and comparably equipped health care delivery system, the health care reforms could result in *de facto* termination of a unique health care delivery program for Indians. One-hundred percent of the I/T/U health care delivery needs must be funded to avoid *de facto* termination and to continue a unique delivery system, which is geared to

meet Indian health care needs and which respects the legal and political relationship with the Federal Government.

9. The "dual eligibility" of AI/AN patients for the I/T/U system and other state or Federal programs should continue under Health Care Reform. Provisions should be included that will clearly provide for dual eligibility.

# COMPREHENSIVE AND SUPPLEMENTAL BENEFITS Consensus Statement

*The Tribal Leaders Roundtable on Health Care Reform applauds President Clinton and the Health Security Act for recognizing the unique Government-to-Government relationship of tribes and the Federal Government and the trust responsibility owed to tribes by the Federal Government by incorporating a separate subtitle for the Indian health care delivery system within the Act.*

*However, after our review of the issues that necessarily involve Health Care Reform in Indian Country, we conclude that the comprehensive benefits package and wrap-around services as provided for in the Health Security Act cannot feasibly be delivered in Indian Country, in light of the planned reductions of Full Time Equivalents in the IHS, the FY 1995 planned budget reductions (\$247 million) for the IHS, and the unrealistic third-party collections estimation of \$276 million. The FY 1995 IHS budget proposal could result in a total shortfall for the Indian health care delivery system of \$385 million in FY 1995 alone. This is inconsistent with the goal of the Health Security Act and the Federal Government's trust responsibility.*

*For this reason, we recommend the introduction of a separate Act - - The American Indians and Alaska Natives Health Security Act - - to be developed in consultation with tribes. This Act would incorporate explicitly the 1992 Re-authorization of the Indian Health Care Improvement Act. This Act would mandate 100 percent funding of the established Indian health care needs and projected needs of new initiatives, to be phased in from FY 1995 to FY 1999. Moreover, this Act would mandate a separate and improved funding mechanism for the I/T/U system that reflects the Government's intention to uphold its Federal trust responsibility.*

## **Specific Recommendations:**

1. The Roundtable participants reached consensus that the fundamental starting point for Indian Health Care Reform should be to fully fund the actual health needs of Indian communities at 100 percent. If I/T/Us are funded at a level of 100 percent, we will not lose any patients to other providers. The Health Care Reform proposal is significantly compromised by insufficient authorizations for Indian health transition and base funding needs. The reduction of the IHS budget in FY 1995 of \$247 million and the push by the Administration for significant staffing reductions will cripple the Indian health care delivery system and eliminate any hope for Health Care Reform. The Roundtable participants were unanimous in the concern about these reductions and the affect these reductions will have on reform.
2. It is proposed that Indian Health Care Reform be dealt with under unique and separate legislation which focuses upon the unique relationship existing between tribes and the Federal Government. This legislation should secure 100 percent funding for Indian health care to meet the comprehensive benefits package, supplemental services, and fully fund all provisions of the Indian Health Care Improvement Act.
3. Geriatric care should be defined in the Act to include the necessary training of I/T/U staff for

geriatric care, and include necessary increases in funding for geriatric services. A special Elder Health Task Force was recommended to assist in the development of these new services within the I/T/U delivery system. Access to nursing home care should be provided at all levels of the I/T/U system. There was general agreement that the current funding allocation methodology, which relies upon the "years of productive life lost" formula, is unacceptable to Indian elder groups and elder organizations and should be replaced.

4. Provisions are needed to protect individual Indian patients from collections and judgement procedures for services provided to them under the I/T/U system, including those services which may be purchased through the Contract Health Services or similar system.

5. "Level of need" definitions utilized in Health Care Reform needs to be more accurately defined, in consultation with I/T/Us, and to include, at a minimum, all services described as comprehensive benefits, supplemental benefits, currently unfunded authorizations of the Indian Health Care Improvement Act, and the funds necessary to address all facility and sanitation backlogs among I/T/Us.

6. The Health Security Act must maximize the uses and capacity of reservation-based hospitals and clinics by providing added staff, technology, equipment, and innovative uses of inpatient and outpatient facilities and available bed space. Health Care Reform should provide incentives to maximize existing facilities and existing beds.

7. Amendments are needed to include native traditional healers in the plan with specific references in the Indian subtitle.

8. The I/T/Us need a national index of current services at every I/T/U in the U. S. to calculate current level of services in comparison to what will be required under Health Care Reform, and how much it will cost to reach the 100 percent need nationally and at each site.

9. The U.S. Department of Housing and Urban Development's problems with water and sewer systems need to be covered financially under supplemental benefits of Health Care Reform. The IHS has not been provided any funding in FY 1995 for sanitation. The Roundtable participants expressed concern that, in the past, the IHS has refused responsibility for sanitation problems that, the IHS maintains, falls within the parameters of HUD responsibility. Funding should be specified in the Act for operation/maintenance of local water and sewer systems. Environmental health monitoring and enforcement will require coordination with tribal governments, the IHS, and the Environmental Protection Agency to protect the environmental health of the AI/AN communities.

10. In protection of the "dual citizenship" status of the AI/AN, the Act should provide sanctions against removing Indians from state-funded programs, as states attempt to reduce their spending on health-related programs.

11. When the IHS system proceeds with activities of downsizing, right-sizing, and restructuring, or is in the process of conducting reductions-in-force, direct services should not be cut. Instead, the IHS Administration should be cut before cuts are applied to direct services.

# GOVERNANCE AND STRUCTURE

## Consensus Statement

*New opportunities should be provided for inter-tribal collaborative arrangements and AI/AN practitioners to work independently of the IHS to meet the needs of tribal governments under National Health Care Reform. A policy statement is needed to reinforce cultural appropriate health delivery in I/T/U systems of care.*

**Governance:** *Based on treaty obligations, the intent of the Federal Government was to provide adequate and equal health care to the AI/AN and the right to exercise governance over the IHS and state-run programs responsible for health care programs to their AI/AN citizens.*

*A National Board on Indian Health is recommended to establish authority over the IHS. This Board should be composed of elected tribal officials that will oversee finances, implementation of existing authorities, recruitment, retention, research, and other Federal and state Health Care Reform efforts. This Board will seek representation on the National Health Board under the Health Security Act. The states shall not exercise jurisdiction over the delivery of Indian Health Care unless mutually agreed upon under a Government-to-Government relationship.*

**Structure:** *Budget reductions are contradicting the intent of Health Care Reform and violates the treaty obligations of the Federal Government, for which there is overwhelming opposition by tribal governments. Health Care Reform should not be considered in a climate of budget reductions. Rather, Health Care Reform should be developed with the resources necessary to provide for the highest quality of health care for the AI/AN.*

### **Specific Recommendations:**

1. Current staffing and budget cuts slated for the IHS in FY 1994 and FY 1995 severely undermines the I/T/U stability, structure, and ability to move into Health Care Reform. The Roundtable participants felt strongly that the staffing and budget cuts to the IHS are a violation of stated Federal policy, a violation of Indian treaties, and is inconsistent with the stated goals of Health Care Reform. Staffing cuts in the IHS are having a direct impact on patient care positions and patient care capacity at the local Service Unit and tribal levels. Further, the Roundtable participants believe these current cuts to the IHS will cause irreparable harm to the basic infrastructure of the I/T/U delivery system and its ability to be competitive under Health Care Reform. If the I/T/Us cannot be competitive, Health Care Reform will in fact result in health reductions to Indian communities and *de facto* termination of the unique Indian health care delivery program. The Roundtable participants observed that Indian staff are the ones most likely to be cut in the IHS staffing reductions. The Roundtable participants support all the letters, resolutions, and other positions taken by tribes, national Indian organizations, and urban health care providers in opposition to the large staffing and budget cuts to the IHS, and request that the letters and resolutions be attached to the final report of this Roundtable.

2. The preamble to the Act must include language which reinforces the unique delivery system for the AI/AN, and the special legal and political relationship between tribes and the Federal Government. This statement must underscore that the Act will not infringe upon tribal sovereignty

with regard to the responsibilities of states under Health Care Reform. Further, the statement must reinforce the cultural appropriateness of health care for the AI/AN served through the I/T/U system.

3. Inter-tribal, tribal-urban, or other collaborative forms of health care restructuring should be considered by I/T/U providers for the purposes of creating the economies of scale needed to generate capitated revenues to support the broad range of direct services required under the comprehensive benefits package and supplemental services. Preferential language should be provided for I/T/U collaborations under current provisions, such as the Community Health Network under Title III of the Health Security Act, which would allow for preferential funding to Indian alliances seeking to serve under-served AI/AN populations. Such provisions should reference that Indian health programs will not acquire authority over any other Indian health program, unless mutually agreed by both parties.

4. Amendments to Title VIII, Subtitle D, are needed to specifically provide for the continuation of 100 percent cost-based reimbursement for Indian programs designated as Federally Qualified Health Centers under the provisions of Medicare and Medicaid.

5. Title VIII should be amended to allow the AI/AN solo practitioners who work independently under Health Care Reform within the I/T/U service areas to be incorporated into the system, including providing incentives for alliances with existing I/T/U systems.

6. Staffing and work force changes, which will be required under managed care systems for the AI/AN I/T/Us, need immediate analysis to plan and implement managed care within financing limits. The Health Security Act, Title III, should be amended to provide for transitional funding to build the work force capacity and for necessary staff training.

7. There was consensus that a National Board on Indian Health should be established, but a diversity of opinion remains with regard to representation and structure. Suggestions from the Roundtable participants include the following:

- (a) Area elected tribal leaders;
- (b) Urban health representatives; and
- (c) National Indian organizations.

There was consensus regarding the general purposes of a National Board on Indian Health, including the following:

- Oversee the activities of the IHS;
- Oversee finances dedicated to Indian health care;
- Oversee implementation of Title VIII, Subtitle-D;
- Oversee Indian health care status (health objectives);
- Provide for representation on the National Health Board;
- Recruitment/retention of Indian health care work force;
- Oversight on Indian health care research; and
- Must have autonomy from the IHS.

## **ELIGIBILITY AND ENROLLMENT**

### **Consensus Statement**

*The I/T/Us will automatically enroll “members” into their health plans and individual choice will be provided to members if they choose to change plans. The AI/AN will be enrolled into a health care system and be ensured universal coverage regardless of residence; non-Indian beneficiaries may receive services at the discretion of the tribe or the I/T/U provider.*

#### **Specific Recommendations:**

1. An amendment to Health Care Reform legislation is needed to allow for the “automatic enrollment” of AI/AN patients within the I/T/U system initially, and allow for patients to change health plans, if desired.
2. The current Federal policy enacted annually under Interior Appropriations, which protects the rights of tribes from Federally-mandated eligibility criteria, should be incorporated into Health Care Reform. Tribes should maintain sole authority over tribally-based eligibility criteria. For example, the Federal Government should not dictate who is eligible for contract health services under Health Care Reform. However, it was also agreed that there continues to be a problem for Indian patients with inter-tribal blood quantum, not representing enough blood from any one tribe to be enrolled; yet, in some cases, representing full blood or at least total Indian blood, to be eligible for care under the I/T/U system.
3. The AI/AN residing outside currently established IHS service delivery areas have been left out of the Indian-specific Health Care Reform agenda. This oversight should be corrected and as a means to bring on new Indian health care delivery systems, and incorporated into the legislation. While the U.S. Census cites a 2.2 million AI/AN population, only 1.3 million are identified as IHS beneficiaries. Provisions are needed for currently unserved urban Indian populations, non-recognized tribes, and tribes Federally- recognized after the enactment of reform to receive care.
4. Reciprocity between the various I/T/U systems should be addressed in the legislation, to clarify how patients may be seen, and how payment is received for services to patients from other Indian health plans. Adequate funding should accompany patient care within the I/T/U system to serve as an incentive for reciprocity or portability among Indian programs.
5. While a capitated financing system may create an incentive to enroll patients not previously enrolled, such as Indians from other tribes or non-Indians, the decision to do so must rest with the governing body of the I/T/U.

## **FINANCING Consensus Statement**

*The FY 1994/FY 1995 Administration budget actions are inconsistent and contrary to the intent of the American Health Security Act of augmenting the agency. The IHS budget for comprehensive benefits package, supplemental benefits, and construction needs a fast-track upgrade (to 100 percent of tribally-identified needs) to be competitive with state and regional alliance alternatives, and to fulfill Federal trust obligations. Health Care Reform financing should not threaten current revenues to I/T/U programs for any source: indirect costs, Federally Qualified Health Centers, Medicaid, Medicare, and private insurance. The IHS appropriations should not be offset by these revenues. Supplemental benefits funding should not be reduced to fund the comprehensive benefits package.*

*Indian set-asides through block grants should be established for each public program outside of Subtitle D (e.g., school programs, etc.). The I/T/U staff will need retraining to manage the new Health Care Reform financing systems. Tribes and small IHS and urban programs need to consider "regional alliances" to meet essential economies of scale to provide comprehensive benefits. Funding allocations need to consider that the IHS beneficiaries are served at multiple sites. Transition money must be provided for the I/T/U system.*

*Direct IHS financing of total facility needs is preferred over tribal financing. Tribal facility planning must not risk tribal assets or sovereignty, and should include adequate planning to assure long-term viability of facilities. At least \$3.5 billion to \$5 billion should be authorized for appropriations for transitional facility upgrades.*

### **Specific Recommendations:**

1. There was strong support among the Roundtable participants that the Federal Government should provide the full amount of funds to meet immediate and transitional facility construction needs. Pursuant to this, it is recommended that the Act be amended to include an authorization level of \$5 billion for the I/T/U Facility Replacement and Construction.
2. The I/T/U delivery systems must calculate a minimum patient enrollment needed to repay facility loans prior to considering programs under the revolving loan fund for facility construction. It is incumbent upon the IHS in carrying out its trust responsibility to advise the I/T/Us and provide technical assistance, data, and other assistance to determine patient load projections and needed revenue streams for successful implementation of the loan program.
3. While the participants support the right of tribes to elect alternate financing to meet facility needs, the Federal Government has a trust responsibility to protect I/T/Us from being forced to enter into loan programs which cannot be supported by diminished capitation revenues under Health Care Reform. This Federal trust responsibility should  
  
not be absolved by the loan program; tribes must be protected from being forced to pledge land or any other natural resource for health facility financing.
4. Any savings realized from the down-sizing of the IHS programs should be passed directly to the



I/T/Us for patient care.

5. A formula for base funding of I/T/Us should be established that will lead to 100 percent of true need, not necessarily the “Level of Need Funded” formula currently utilized by the IHS, which does not include many important services of the comprehensive benefits package, such as long-term care. Funding calculations should consider the following:

**Immediate Transitional Funding Needs:**

- a) Facilities: repair, replacement, construction;
- b) Capacity Building: staffing, equipment, recruitment;
- c) Enabling: technology, software, marketing; and,
- d) Backlogs: sanitation, water, sewer, environment.

**Ongoing Operating Funding Needs:**

- e) Average-weighted patient premium for the comprehensive benefits package;
- f) Risk adjustments for Indian patient populations for the comprehensive benefits package;
- g) Public Health & supplemental services funding;
- h) Support for tribal government operations;
- i) Full funding for all provisions of the Indian Health Care Improvement Act (including unfunded sections);
- j) Ability to focus on high need areas as need arises (water/sewer in Alaska, tuberculosis outbreaks and other epidemics, high alcoholism or suicide locations);
- k) Disease surveillance, intervention, and prevention;
- l) Base funding for I/T/U operations;
- m) Indirect funds for administration of I/T/Us;
- n) Federal re-insurance fund for costs exceeding capitation; and,
- o) Full funding from third-party coverage of patients.

6. Transitional funding must be provided to bring the I/T/Us up to capacity to provide the full-range of services identified under the comprehensive benefits package.

7. Adequate language should be provided in the Act to allow I/T/U competition and recognition for those tribes that elect to function as Alliance approved health plans and who market their services to non-Indian patients. Subject to the election of the I/T/U governing body, an Indian plan that markets its services to non-Indian patients should be provided preferential treatment in the areas traditionally served by that provider, for example, in rural remote areas or urban under-served areas historically served by the I/T/U.

8. Direct block grant funding to the I/T/Us for any and all categorical programs which are reconfigured under Health Care Reform must be included in the legislative language.

9. The Federally Qualified Health Centers provision, which allows for 100 percent of actual costs to be paid to the I/T/Us, should be protected from Federal waivers under state Health Care Reform, and should be protected for all subsidized payments to the I/T/Us under national Health Care Reform. The I/T/Us should be provided 100 percent reimbursement for actual costs of serving Medicare and Medicaid eligible patients. The I/T/U resources should not be diverted to cover any percentage of

Medicare or Medicaid services not otherwise covered by Medicare or Medicaid payment.

10. Title III of the Health Security Act should be amended to provide for set-asides with specific preferential language for I/T/Us under each of the Public Health Initiative categories under this Title including:

- a. Work Force Priorities;
- b. Academic Health Centers;
- c. Health Research Initiatives;
- d. Core Functions of Public Health and Prevention;
- e. Medically Under-served Populations;
- f. Mental Health and Substance Abuse;
- g. School Health Education and School Health Services; and,
- h. Public Health Initiatives.

11. The Indian subtitle should be amended to provide for protection of supplemental services, so that any shortfalls in the area of the comprehensive benefits package must not dilute supplemental funds.

12. Risk adjustments for Indian populations must ensure adequate capitated rates for I/T/Us. The Health Security Act should be amended to provide for appropriate risk adjustments and a national or regional risk pool or Federal re-insurance system for I/T/Us to protect against insolvency of local Indian health programs when the capitated rates are insufficient to meet patient demand for required level of services. Similar provisions are included for state and regional plans under Section 1541 of the bill. Indian programs will require the same protection, but the program should be a Federal, and not a state administered reinsurance system.

13. Indirect costs are a vital part of the I/T/U stability and operations. Adequate language is needed to ensure that indirect rates are paid to local health operators, in addition to capitated rates and base funding.

14. Amendments to the bill should provide that any and all third party collections of I/T/Us will go directly to the program to be available until expended, and will not be used by the Federal Government as off-sets to further appropriations or to reduce overall capitated rates. The Federal budgeting process should not utilize anticipated third party collections in developing the IHS budget. Unrealistic levels of anticipated third party collections serves to reduce the overall IHS budget and undermines Indian health care. Any and all fund balances, which accrue to a local I/T/U provider, must not be used to off-set appropriations.

15. Sharing of risk and sharing of capitated rates for Indian patients seen in multiple systems needs to be better described, evaluated, and monitored throughout the planning and implementation of Health Care Reform. Specifically, the Federal Government must provide to the I/T/Us:

- (a) Technical assistance on patient utilization, financial management, and other managed care principles;
- (b) Training of the I/T/U staff, councils, and boards;
- (c) Personnel development;
- (d) Advanced technology and equipment; and,
- (e) Cost accounting.

Economies of scale must be examined by the IHS, in consultation with the I/T/Us, to assess the impact on the current system for the I/T/U delivery. Immediate assessment of health patient needs, utilization data, cost accounting, and provider training must be made available to the I/T/Us to ensure successful transition. Incentives for collaboration and inter-tribal or inter-system ventures must be clearly spelled out at Indian health forums, conferences, and other consultations. The IHS has the primary responsibility to provide the necessary data and technical assistance in these discussions.

16. A non-Federal, national oversight of the I/T/U financing is needed to monitor and advocate for local Indian programs. Although this may create another layer of bureaucracy, such an entity could prove vital in protecting the solvency and ultimate success of Indian Health Care Reform.

## **TRANSITION AND COMPETITION**

### **Consensus Statement**

*Competition necessitates a change in mind-set from an institutional orientation to a customer orientation. The I/T/Us must become pro-active in creating collaborations to provide comprehensive benefits package services. Competition will require stronger business practices emphasizing financial management, data management, staff recruitment, etc. The President's FY 1995 budget undermines the ability of I/T/Us to prepare for participation in Health Care Reform.*

#### **Specific Recommendations:**

1. The Roundtable participants agreed that as the I/T/Us move toward a system of competing for patients, there needs to be protection against losses to quality or quantity of services to the AI/AN patients, and a means to ensure continued cultural sensitivity.
2. Competition can undermine tribal politics, governance, and structure. The Act should allow the I/T/U governing bodies to have control over the selection of specialists or alternate providers and not allow bidding wars to fractionate the internal structures of the AI/AN health care delivery system.
3. Inter-tribal, tribal-urban, or other collaborative agreements should receive financial and other incentives to work together in securing high cost technology or specialty care for the AI/AN patients. Mergers will increase survival of Indian delivery systems, quality of care, and improve economies of scale and financial solvency.
4. Manpower issues of the AI/AN health care delivery system should be addressed by Health Care Reform. Overall, it was noted that the IHS has not done an adequate job of recruitment and retention of AI/AN practitioners into the IHS or other Indian health programs. It was the opinion of the participants that the PHS Commission Corps serve as gatekeepers to the IHS manpower system, and that this obstacle should be eliminated. The IHS physician salaries are less than the physician salaries of other Federal health programs, such as the Veteran's Administration and the Department of Defense. Health Care Reform legislation should, at a minimum, provide for increased recruitment and retention of AI/AN physicians and mid-level providers, particularly in the area of primary care. An amendment to the Health Security Act expanding the National Health Service Corps should provide for a set-aside for the AI/AN practitioners and placements in the I/T/Us of National Health Service Corps providers.
5. Health Care Reform should provide for the expansion in recruitment of the AI/AN into the health professions at earlier ages, such as elementary, high school, and college; tribal community colleges also need to be utilized. There was strong support for Indian specific residency programs for Indian medical students through partnerships between the IHS, I/T/Us, and medical schools.
6. Much of the competitive edge for the I/T/Us will be eliminated if adequate funds are not provided for transitional and base funding needs. Full funding must accompany Health Care Reform. The I/T/Us need to be able to keep any and all third party reimbursements without penalty or off-set; add funds for the I/T/Us for marketing, transition, and upgrades; and, show the I/T/U as a health plan

option in information produced by state or national information materials regarding qualified plans.

7. Finally, the Roundtable participants were unanimous in their concern that the cuts to the IHS positions, excessive overestimates of third-party revenues, and a \$247 million budget cut in FY 1995 could have the cumulative effect of \$0.5 billion reduction to the IHS in this year alone. This is an ill-timed cut occurring during proposed transition and competition under Health Care Reform.

## **Background on Indian Health Care:**

The U. S. maintains a legal and moral obligation to provide health care to the AI/AN based on treaties signed between the U. S. and various Indian tribes, and a history of statutes related to Indian health and protection. What has evolved for Indian health care is a complex system of health care delivery and contract systems serving a large percentage of AI/AN.

## **Legal History of Federal Responsibility to Provide Care:**

As early as 1802, the Federal Government became involved in delivering health care services to American Indians when the U.S. Army first attempted to address smallpox outbreaks among American Indians living near Army posts. In some cases, treaties specifically required the provision of health care.

*“Three hundred dollars per anum for vaccine, matter, medicines, and the services of physicians,...” (1836 Treaty with the Ottawas and Chippewas)*

*“And the United States shall further agree to employ a physician to reside at the said central agency, who shall furnish medicine and advice to the sick, and shall vaccinate them; the expenses of the said school, shops, persons employed, and medical attendance to be defrayed by the United States and not deducted from the annuities.” (1855, 1856, Treaty with the Quinault and Quileute)*

The Federal obligation to provide health care to American Indians was further articulated over the 20th century through the following statutes:

**The Snyder Act of November 2, 1921 (25 United States Code (U.S.C.) 13)** - The Snyder Act authorizes the Congress to appropriate funds for the “relief of distress and conservation of health and for the employment of physicians” for American Indians throughout the U.S. It represented the first time the Congress enacted permanent authorization for funding of health care for American Indian people, and has been the foundation for the IHS and other Indian programs.

**The Johnson O’Malley Act of April 16, 1934, amended June 4, 1936 (25 U.S.C. 452)** - The Johnson O’Malley Act authorized the Secretary of Interior to enter into contract with states and other local governments to provide for the education, medical attention, agricultural assistance, and social welfare for American Indian people in situations where the allotment process and other hardships resulted in American Indians living off the reservations.

**The Transfer Act of August 5, 1954, amended by Health Maintenance Organization Act of 1973, Section 69(a) (42 U.S.C. 2001 et seq.)** - This Act transferred the responsibility for health care for American Indians from the Department of Interior to the Department of Health, Education, and Welfare as a means to improve the quality of care provided by the IHS under PHS.

**The Indian Health Facilities Act of 1957 (42 U.S.C. 2005)** - This Act provided the IHS with authority to contribute toward the construction of community hospitals when tribal patients would substantially benefit from the facility.

**The Indian Sanitation Facilities and the Services Act of 1959 (42 U.S.C. 2004)** - This Act substantially expanded the role of the IHS to ensure safe public health environments for American Indian communities, including safe water supplies and systems, drainage facilities, sanitary waste and sewer systems, and access of these services to Indian homes.

**The Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450) (PL 93-638)** - This landmark Act provided Indian tribal governments with the authority to take over the operation of Federally-run programs of the IHS and the Bureau of Indian Affairs through tribal contracts. This authority, which was further expanded by amendments in 1988, opened the door to tribally-operated health care systems.

**Indian Health Care Improvement Act of September 30, 1976, as amended in 1980, 1988, 1990, and 1992 (25 U.S.C. 1601 et seq.)** - This Act provided a clear Federal policy “to elevate the health status of the AI/AN to the highest possible level” and began to articulate specific components of the national strategy to accomplish its stated goal. This Act also established the role of the IHS in the assistance and provision of services to the AI/AN living off-reservation in urban areas.

## **The American Indians and Alaska Natives Delivery System Today:**

The IHS is administered through 12 Area Offices, which includes 140 Service Units nationally. There are three basic components to the Indian delivery system:

**IHS Direct System:** The IHS directly administers 42 hospitals, 66 health centers, 4 school health centers, and 53 health stations. The IHS also operates a Contract Health Services Program to reimburse non-IHS hospitals and other providers for pre-approved care to IHS beneficiaries.

**Tribal System:** The IHS contracts with tribal governments under authority of the Indian Self-Determination Act (P.L. 93-638), through which tribes operate 8 hospitals, 98 outpatient health centers, 3 school health centers, 59 health stations, and 172 Alaska Village Clinics.

**Urban System:** The IHS has established an Urban Health Branch under authority of the Indian Health Care Improvement Act (P.L. 94-437, as amended), which contracts with 34 urban Indian communities to provide health delivery systems which range from outreach and referral stations to comprehensive outpatient health clinics.

The IHS estimates its patient population to be 1.34 million AI/AN in 1994. This represents approximately 61 percent of the total number of the AI/AN identified in all areas in the U.S. Census of 1990. Health status data is limited to the AI/AN residing within established IHS service areas. The system developed by the IHS is targeted at those AI/AN within identified service areas or those which fall under the existing delivery system of I/T/U providers. Substantial infrastructure is in place within the IHS delivery system. The IHS owns and operates 2,600 buildings and other structures with a replacement value of \$1.4 billion. This does not include the many facilities dedicated for health care delivery owned and operated by tribes and urban providers.

Over 98 percent of all the IHS/tribal health care systems have earned accreditation from the Joint Commission for the Accreditation of Healthcare Organizations. The focus of the IHS delivery system is on preventive, curative, rehabilitative, and environmental health services, including sanitation oversight for water and sewer systems.

The care provided through the I/T/U system strives to be culturally sensitive to the service population and accessible despite numerous geographic, economic, and facility barriers. As a culturally-based, comprehensive model for health care, more than just clinical services are provided. Community Health Representatives and Community Health Aids have extended health services into the community setting and provide a vital link between clinical and home-based care. In addition to inpatient and outpatient medical care, the IHS has established services in dental care, mental health, alcohol/substance abuse treatment and prevention, public health nursing, community health, nutrition and dietetics, injury prevention and control, and environmental health.

Unfortunately, while the model is comprehensive, not all services are available to all IHS beneficiaries all the time. The word "rationing" has been used to define the manner in which services are apportioned and/or withdrawn throughout Indian country, depending upon the limitation on funding. At the March 1993 meeting on National Tribal Summit on Indian Health Care Reform; Mr. Michel E. Lincoln, IHS Acting Director, described the situation to First Lady Hillary Clinton:



*“The Indian Health Service program is comprehensive in nature, but it is, in my opinion, a mile wide and an inch deep. If you live near the Phoenix Medical Center, you have greater access and greater benefits than if you do not. . . . We need to increase access to a benefits package and that it be complete and deep.” (Michel E. Lincoln, 1993)*

The health status of the AI/AN remains poor in comparison to the rest of the U.S. population. Inadequate access to basic health care, poor living conditions, poverty, remote rural roads, and alcohol and substance abuse, contribute to an annoying health care picture which continues to undercut progress made in health care delivery systems. *The IHS Trends In Indian Health* for 1993 shows that the AI/AN people continue to die from the following causes at rates far exceeding the U.S. All Races population:

Tuberculosis	520 percent greater
Alcoholism	433 percent greater
Diabetes mellitus	188 percent greater
Accidents	166 percent greater
Homicide	71 percent greater
Suicide	54 percent greater
Pneumonia and Influenza	44 percent greater

The median age for the AI/AN population is 24.2 years as compared to 32.9 years for the U.S. All Races. The AI/AN people are three times more likely to live in poverty than all other races. Of all deaths among AI/AN people, the IHS reports that 33 percent are younger than 45 years, as compared to only 11 percent for U.S. All Races, including 22 percent for Black decedents and only 9 percent for White decedents.

Alcoholism continues to be a major health and social problem for many AI/AN communities. Although alcohol death rates among AI/AN declined steadily, the rates have increased sharply beginning in 1986 and continue to increase. Increasing trends in deaths rates for AI/AN can also be seen in tuberculosis and diabetes. From region to region, stark differences are apparent in the overall health status of the AI/AN. While the IHS has achieved national infant mortality rates which approach the national average, some regions, such as the Aberdeen and Billings Area, and many urban Indian communities, face infant mortality rates two to three times the national rate. Environmental health remains a serious problem in remote reservations and Alaska, with 50 percent of the Alaska Native villages lacking sanitary water and sewer systems.

To make a healthier and safer environment for AI/AN families and to truly achieve improved health status will require resources beyond basic primary care services. Comprehensive community-based, preventive, and culturally-sensitive systems, which empower individuals and communities to overcome health problems, is necessary. The I/T/U delivery system provides only a framework. The system will require substantial reinvestment, and expanded continual services to achieve the goals of Health Care Reform, and to ensure the policy of the Federal Government with regard to Indian health.

## **Health Care Reform and Indian Health:**

*"In 1970, U.S. public and private spending on health care roughly equaled our public and private spending on education. In 1992, we will spend more on health care than on all of education -- plus all our nation's spending on defense, prisons, farm subsidies, food stamps, and foreign aid. . . . More than 60 million Americans periodically lack health coverage and 35 million lack any insurance whatsoever."*

(Mandate for Change, 1992)

Health Care Reform in one form or another is expected to be enacted during the 103rd Congress. While the Administration's reform package will undergo pressure from all sides and be amended, there is growing concern that something must be done to address both the problems of rising health care costs and the growing number of people in the U.S. who are without health coverage. In addition to the President's proposal, there are other health care reform bills which are under consideration in Congress.

Congressman Cooper (D-TN) and Senator Breaux (D-LA) introduced a bill which also endorses "managed competition", but does not include employer mandates or premium caps for insurers. A more conservative measure was introduced by Congressman Michel (R-IL) which provides for incremental insurance reform, malpractice reform, and expansion of community health centers. A Senate proposal, which is being taken seriously, was introduced by Senator Chaffee (R-RI) and Congressman Thomas (R-CA) which also embraces "managed competition", individual requirements for premium payments, or penalty payments, purchasing cooperatives for small businesses, and community ratings. Finally, a strong showing of support also exists for the "single payor" model of Health Care Reform.

Congressman McDermott (D-WA) and Senator Wellstone (D-MN) have sponsored bills to establish a national health insurance system which would eliminate insurance companies and require the government to act as the financier of health care through corporate and individual taxes. In this plan, states would have the lead role in administering a set budget and negotiate with providers. None of these other bills have incorporated an Indian health subtitle, while the single-payor bill proposes to maintain the IHS.

The Senate Committee on Indian Affairs and the House Subcommittee on Native American Affairs will have primary jurisdiction over aspects of the legislation affecting Indian health. Provisions of importance to the Indian health system will also be considered by the House Subcommittee on Health and Environment, the Senate Committee on Labor and Human Resources and the Senate Finance Committee.

Dr. Philip Lee, Assistant Secretary for Health, Department of Health and Human Services, is holding a series of field hearings throughout the U.S. to gather additional testimony from American Indian tribes and urban Indian health providers regarding the President's proposed legislation. Legislation could be voted on the House floor as early as May or June, with Senate action expected in July 1994.

A significant number of meaningful meetings and tribal consultations have already taken place. These are summarized below:

**Meeting with Transition Team on Health Care, January 1993** - Tribal leaders, urban Indian health care providers, and representatives from the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB), and the American Indian Health Care Association (AIHCA), met early with the individuals who would eventually constitute the Health Reform Task Force, to discuss the unique status of the AI/AN health care.

**IHS Roundtable on Indian Health, February 17, 1993** - The IHS sponsored a Roundtable Conference on National Health Care Reform and Indian Health, which developed consensus statements outlining fundamental points centered around: (1) Protecting the Moral and Legal Obligation of the Federal Government; (2) Ensuring Quality of Care; (3) Acceptance and Cultural Appropriateness; (4) Access and Equity; (5) Financing Mechanisms; and, (6) Organization and Structure.

**House and Senate Sponsored Summit on Indian Health Reform, March 1993** - Several hundred tribal leaders, urban health providers, and representatives from health care or Indian organizations met in Washington, D.C., to discuss the status of Indian health, and to develop recommendations for reform. Basic principles for discussing Health Care Reform included: (1) Special legal obligations involving American Indians; (2) Cultural considerations in Indian health care; (3) The distinctive health needs of Indian people; (4) The right to comprehensive health care; (5) Existing Indian health care systems; and, (6) American Indian tribes as sovereign governments.

**Tribal/IHS Consultation Conference, May 1993** - The IHS held its annual consultation with Indian tribes in cooperation with the NIHB in Denver, Colorado. A Tribal Leader Consensus Statement was issued which provided that "There was total opposition to full integration of Indian health programs with other elements of national Health Care Reform. The majority of tribal leaders spoke against the creation of any new health care financing mechanism for Indian people..." Recommendations were made by various tribal leaders and others attending the meeting in the following areas: (1) Government-to-Government relationships should be protected; (2) Health Care Reform should not deplete, but build-up the current systems; (3) Funding needs should address severe and chronic underfunding of services; (4) Technical assistance should be provided to expand third-party systems and improve care; (5) IHS Operations require improved responsiveness to tribes; and, (6) Other comments centered on traditional healers, sacred sites, cultural sensitivity, and continued consultation.

**Technical Steering Committee Recommendations, October 1993** - The NIHB, the AIHCA, and the Association of American Indian Physicians, provided significant coordination of information throughout the year as Health Care Reform information became available. These organizations met with tribal representatives in October to hear draft recommendations from the White House Health Care Reform Task Force Work Group 16-A, and to provide feedback. A letter to President Clinton was submitted which asked for more tribal consultation, reaffirmation of Indian health policy, support for both comprehensive and supplemental services, facility issues, manpower issues, premium exemption for tribal employers, and the establishment of a National Board on Indian Health to oversee the new program.

**National Congress of American Indians, November 1993** - At the annual convention of the NCAI, the health committee conducted extensive deliberations on Health Care Reform and produced the following resolutions which were adopted by the full membership. These included statements supporting health care as an "entitlement," the IHS as primary

provider, automatic enrollment of tribal members, premium exemptions for all reservation businesses, funding for 100 percent of need including long-term care, infusion of funds for transitional capacity building, protection of supplemental services, and also called for a Health Summit with President Clinton by September 1994.

**IHS Roundtable on Capital Financing Under the National Health Act** - The IHS held a Roundtable which examined the impact on financing strategies for tribes and Indian organizations under the President's proposal for Health Care Reform. Recommendations included immediate consultation with tribes and urban systems regarding financing; develop strategies that are based more on generating revenues than on appropriations; the IHS should assist tribes in exploring alternatives to Federal appropriations; the IHS needs to generate data supporting risk adjustments for Indian populations; the streamlining of I/T/Us to successfully compete; ensure a fair share of loan guarantees under the Act for I/T/Us; develop "alliance" models for tribal, inter-tribal, or national Indian alliances; the I/T/Us strive to improve credit ratings; pursue legislative amendments for tax exemptions, security mortgages, FAR exceptions, lease scoring, asset transfers, and insurance guarantees.

**IHS Roundtable on Pharmaceutical and Medical Supplies Purchasing Under Health Care Reform** - Another IHS Roundtable which focused on aspects of Health Care Reform produced the following recommendations: The IHS should evaluate managed care as a model and how it will impact Indian health; treaty-based obligations and commitment to tribes should continue under Health Care Reform; the IHS should study the advantages and disadvantages of Health Care Reform; the IHS should balance the benefits of volume purchasing against the needs of tribes to ensure quality care is maintained while reducing costs; and finally, the IHS should utilize advanced technology to overhaul existing supply management systems.

**Indian Health Service  
Second Roundtable Conference on Health Care Reform**

**A G E N D A**

**Wednesday, February 9, 1994**

- 8:30 a.m. Welcome and Introductions  
Bill Pearson, IHS Associate Director  
Office of Environmental Health and Engineering
- Luana L. Reyes, IHS Associate Director  
Office of Planning, Evaluation, and Legislation
- 8:45 a.m. Overview of the Roundtable Process  
Leo J. Nolan, IHS Director  
Office of Planning, Evaluation, and Legislation
- 9:00 a.m. Overview of the Health Security Act:  
Cliff Wiggins, IHS Operations Research Analyst  
Office of the Director
- 9:45 a.m. How Health Care Reform Will Impact Indian Health:  
Yvette Joseph, Senate Indian Affairs Committee  
June Tracy, Senate Indian Affairs Committee  
Michael Mahsetky, IHS Office of Planning, Evaluation, and Legislation
- 10:30 a.m. -Break-
- 10:45 a.m. Discussion of Major Issues:
- Tribal Sovereignty*  
Discussion Leader: Mike Knight, Chairman  
Sherwood Valley of Pomo Indians
- Eligibility and Enrollment*  
Discussion Leader: Genevieve Jackson  
Navajo Nation
- Governance and Structure*  
Discussion Leader: Gordon Belcourt, Executive Director  
National Indian Health Board
- 12:00 Noon -Lunch-

## **A G E N D A**

Continued ...

1:30 p.m. Continue Discussion of Major Issues:

*Comprehensive and Supplemental Benefits*

Discussion Leader: Caleb Shields, Chairman  
Fort Peck Tribal Executive Board

*Transition and Competition*

Discussion Leader: Ralph Forquera, President  
American Indian Health Care Association

*Financing*

Discussion Leader: Paul Sherry, Deputy Director  
Alaska Native Health Board

4:30 p.m. Review Process to Develop Consensus Statements  
JoAnn Kauffman, KAI

5:00 p.m. -Recess-

### **Thursday, February 10, 1994**

8:30 a.m. Reconvene and Review Objectives for the Day  
JoAnn Kauffman, KAI

8:45 a.m. Begin Drafting Consensus Statements in Small Groups

10:00 a.m. -Break-

10:45 a.m. Review of Consensus Statements in Large Group

12:00 Noon -Lunch-

1:30 p.m. Adoption of Consensus Statements

3:00 p.m. -Break-

3:30 p.m. Develop Overall Statement from the Roundtable

4:30 p.m. Adjourn

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**IHS ROUNDTABLE ON HEALTH CARE REFORM**  
**February 9 - 10, 1994**

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