

## **Summary: Coburn amendment 4034 empowers tribal members to choose for themselves how they get their health care.**

**Tribal members receiving care in the Indian Health Service system are condemned to a system that rations health care services on a “life or limb” basis. Long wait times for services exacerbate patients’ conditions. The IHS is an inefficient bureaucracy that has underperformed for decades, insulated from any competition because tribal members have no other choice. The underlying bill being debated only compounds the current problem by adding more of the same.**

**Coburn amendment 4034 creates a new option in the IHS that allows tribal members to choose from various health care coverage options. If a tribal member has to wait months before they see a doctor, the tribal member can demand that IHS give them a risk-adjusted amount to purchase private health insurance like every other American can do. Not only will this compel the IHS bureaucracy to start delivering results, this will allow tribal members to decide if health care choice can improve quality, outcome, satisfaction, and affordability. The Congressional Budget Office has said this amendment’s score is zero.**

### **Congress has a moral obligation to fix the broken IHS system.**

This amendment gives tribal members some of the same choices in health care coverage that members of Congress and their staff enjoy. It is wrong for Washington politicians to force tribal members into a failed government run health care bureaucracy when other options are available that can provide access to affordable quality health care.

The only way to improve a failed system is to provide an alternative. No one would be forced into a health care plan that they do not want, as they are now under the current system. Rather, this amendment puts patients in control of their own health care by providing tribal members with a choice of health care coverage options. After all,

patients and doctors, not Washington politicians and bureaucrats, should make health care decisions.

If Congress is to keep its commitments to Native Americans, it is not satisfactory to force tribal members into a shamefully failing, one sized, fits all health care bureaucracy.

Senator Dorgan has often told the story from North Dakota about a woman from the Fort Berthold Indian Reservation that had severe chest pains and extremely high blood pressure. At a local IHS clinic, she was diagnosed as having a heart attack. The staff of the clinic insisted she go by ambulance to the nearest major hospital, 80 miles away. She resisted because she knew she would be billed for the trip and could not afford it, but the clinic insisted.

When she arrived at the hospital and was being transferred from the ambulance to a gurney, an envelope was found taped to her leg. In the envelope was a letter stating that the IHS lacked funds to pay for the health care she needed because a "life or limb" medical condition was not involved.

Senator Dorgan has also shared the story about Avis Littlewind, a 14-year-old who was lying curled in the fetal position for 90 days before killing herself because no treatment center existed to help her.

Senator Dorgan is correct about what's going on. The problem with the Indian Health Care Improvement Act is that its diagnosis for a sick system is to reauthorize the same system.

Life and limb are at risk, and so are our trust obligations. Anything short of revolution is a slap in the face of every mom and dad out there who depends on IHS for their health care.

### **Rationing Plagues the Indian Health Service**

Native Americans, the general population, Democrats, and Republicans have all decried the rationing in the Indian Health Service.

Indian Health Service facilities typically ration services on the basis of whether or not it will save a “life or limb.”<sup>1</sup>

For 2005, the per capita federal health expenditure by the IHS was \$2,130—about one-half the per capita spending for federal prisoners' health care. IHS per capita spending was far below the estimated per capita benchmarks of Medicare at \$6,784 and the Veterans Administration at \$4,653.<sup>2</sup>

IHS has job vacancy rates of 32% for dentists, 17% for nurses, 13% for optometrists, and 12% for physicians and pharmacists.<sup>3</sup>

It's common to hear “Don't get sick after June” in Indian country because there isn't sufficient funding to treat patients that late in the fiscal year.<sup>4</sup>

Dr. Charles Grim, Director, IHS: "We're only able to provide a certain level of dental services in certain populations. We're only able to refer a certain level or number or types of referrals with our contract health service budget into the private sector.... But I guess one generalized statement would be that we have a defined population and a defined budget ....But it has led to rationing in some parts of our health care system."<sup>5</sup>

**Gaps in services result in diagnosis or treatment delays that exacerbate the severity of a patient's condition** and create a need for more intensive treatment, and mean that many Native Americans live with debilitating conditions.

- IHS reports that their facilities are required to pay for all "Priority I" services but admits that, at many of their facilities, available funds are expended before the end of the fiscal year and payment is not made.
- 21 percent of their maternity patients had three or fewer prenatal care visits, well below the recommended number.

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<sup>1</sup> Senator Byron Dorgan <<http://www.indiancountry.com/author.cfm?id=778>>

<sup>2</sup> Senator Byron Dorgan <<http://www.indiancountry.com/author.cfm?id=778>>

<sup>3</sup> Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues *CRS Report for Congress*

<sup>4</sup> [http://www.fcni.org/issues/item.php?item\\_id=1949&issue\\_id=109](http://www.fcni.org/issues/item.php?item_id=1949&issue_id=109)

<sup>5</sup> Political Transcripts by CQ Transcriptions, "HOUSE COMMITTEE ON APPROPRIATIONS, SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES HOLDS A HEARING ON INDIAN HEALTH SERVICE," April 17, 2007

The American College of Obstetricians and Gynecologists recommends a minimum of 14 visits for a full-term (40-week) pregnancy with no complications.

According to a 2005 GAO report entitled Indian Health Service: Health Care Services Are Not Always Available to Native Americans, **there are wait times and insufficient care.**

- GAO visited 13 IHS-funded facilities (in 2005) and found that waiting times at 4 IHS-funded facilities ranged from 2 to 6 months for women's health care, general physicals, and dental care.
- 3 facilities said that all same-day appointments were filled within 45 minutes of the phone lines being opened; they were turning away at least 25 to 30 patients a day.
- 3 IHS-funded facilities reported that many Native Americans were required to travel over 90 miles one-way to obtain care. Hence, rather than go and wait all day at the facility to see a provider, patients would wait to seek care until their condition became an emergency that required a higher level of treatment.
- Most facilities did not have the staff or equipment to offer certain services on site, so resorted to contract care. However, contract care was not readily available because care was rationed on the basis of relative medical need at 12 of the 13 facilities.

**The Indian Health Improvement Act reauthorizes the same IHS dinosaur that has been underperforming for decades.**

Statistics for the Indian Health Service:

- The Indian Health Service has 14,392 employees, including 2,162 Commissioned Officers (CO). The latter CO's include 8 Assistant Surgeon Generals, 439 "Director Grade," 601 "Senior Grade." Salaries for the CO's total \$135 million. Salaries for all other IHS employees is estimated at: \$655 million.

- The IHS spent \$2.8 million on conferences in FY 2006 and \$33.7 million on travel for the same period—and the travel numbers don't even include reimbursements!<sup>6</sup>
- The Office of Management and Budget (OMB) estimates that IHS carries an unobligated balance of \$162 million. The actual number for FY 2005 was \$183 million.<sup>7</sup>

**The Indian Health Care Improvements Act that we are considering doesn't "improve" IHS, it just adds new programs to an overburdened system.**

For example, why would does the bill expand the definition of "health promotion" to include "personal capacity building" or "healthy work environments" or "improving the physical, economic, cultural, psychological, and social environments" at a time when the Indian Health Services is rationing basic services on a "life or limb" basis?

This bill dramatically expand the type of health services—long term care, assisted living, home- and community-based services, and hospice—when the Indian Health Service can't even provide basic medical services. Remember the "Don't get sick after June" mode of operation in the Indian Health Service.

Before we start talking about adding new programs, we need solutions to the problems that are causing an inefficient and overburdened system. This bill doesn't change the basic delivery systems that are part of the problem to begin with.

Some will argue that the solution involves just passing this bill that's loaded with new programs. However, that's just "more of the same." Every time we pass an "Indian Health Care Improvements Act" bill we cite the same terrible statistics. We pass the bill because we "need to do SOMETHING."

Those who say that a failure to reauthorize the Indian Health Care Improvement Act is a violation of our trust obligations—are correct.

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<sup>6</sup> Department of Health & Human Services, Letter to Tom A. Coburn, MD; February 16, 2007

<sup>7</sup> <http://www.whitehouse.gov/omb/budget/fy2008/pdf/balances.pdf>

However, simply reauthorizing the same old system with minor modifications is an ever greater violation of that commitment.

Each time we've passed an "Improvement Act," Indian health care never improves.

Reauthorizing a system that is failing its target population should not be our goal. We have a duty to ensure that scarce resources go to patient care.

**The only choice** that tribal members have is to **wait** 2-6 months for a basic medical visit or **not go at all**.

**Let's contrast those options with the choices that Members of Congress get.**

Under the Federal Employee Health Benefits program, Members of Congress can choose an HMO, a PPO, a FFS plan, an HSA, or any number of consumer-driven health plans.

Furthermore, Members of Congress have options about **which** plan from those **types** of plans to choose from. Do they want BlueCross BlueShield, Aetna, Cigna, United Health, etc...

Members of Congress have 284 health plan options to choose from.<sup>8</sup>

**Instead of condemning tribal members to an outdated and rationed system, we need to give tribal members choice and freedom that Members of Congress enjoy.**

How could fulfilling our trust obligations mean anything less than the choices that we give ourselves?

There is little enthusiasm among tribal leaders for current structure. There is constant and consistent theme of frustration, anger, and resolve that we must do better, that we must unlock the potential of tribes to design their own health care systems that recognize the unique needs of the community. This country needs a system that

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<sup>8</sup> Office of Personnel Management

maintains the flexibility of tribes to seek outside investment, and that rewards innovative health practices, instead of punishing those whose try to make the lives of their citizens better.

The myriad of problems facing health care in Indian Country, are many of the same issues confronting health care delivery throughout rural America. They are compounded, however, by a system that refuses to recognize its own role in holding back health care delivery for tribal citizens.

In designing health care reform, markets work when they are allowed to: they lower the price of all goods and services and they attract much needed outside investment. Many tribes in Oklahoma are at the forefront of new and innovative health care delivery systems, and they are poised to become a model for delivery throughout the system. Congress must ensure, however, that their efforts aren't discouraged or stopped altogether by the current system.

Furthermore, there is no good reason that forward thinking tribal governments should be prevented from developing market driven health care centers of excellence that will attract researchers, physicians and patients for cutting edge, life-saving treatments.

**Towards that end, my amendment would establish a demonstration program to give tribal members a choice and freedom about their health care.**

Under this amendment the Secretary of HHS would set up at least 3 demonstrations in the 12 IHS regions to give tribal members the money that we're spending—or mis-spending—on their health care and let them go out and purchase their own health care.

This demonstration program would empower the tribal members themselves—instead of leaving those tribal members condemned to the same broken system.

Tribal members would be eligible for the monetary value of the services that they are receiving through the IHS. Tribal members could then go out and buy whatever type of health plan is right for them as individuals.

The problem with the Indian Health Care Improvement Act is that it fails to focus on empowering **individual** tribal members. Individual patients tend to receive better, more effective care when they are empowered to make their own health care decisions. This amendment explores a way to accomplish this objective, and gives tribal citizens a reason to invest in their own health.

Long lines, bureaucratic headaches and rationed, substandard care completely disallow this sort of investment.

This amendment gives tribal members the chance at something better. This demonstration program offers—what we've been hearing a lot about lately—**the hope of change.**

**The per capita spending on tribal members through IHS is \$2,130—enough money to purchase a market-based policy.**

A 2004 survey of the Individual health insurance market in this country revealed that an individual could buy a health plan for an average of \$2,268 in this country. Naturally, that price can vary by where you live and what kind of plan you choose.<sup>9</sup>

A recent eHealthInsurance survey showed an even lower national average price: the average individual policy holder paid \$1,776 for their health insurance. Half of eHealthInsurance policy holders paid less than \$1,464 a year.<sup>10</sup>

Under this amendment tribal members participating in the demonstration project would be able to use their risk-adjusted amount of money and go out and buy the health care that's right for them.

**If anyone believes that this will drain resources away from improving the provision of basic medical services, then they should also be against adding the new programs in this bill.**

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<sup>9</sup> [http://www.ahipresearch.com/pdfs/Individual\\_Insurance\\_Survey\\_Report8-26-2005.pdf](http://www.ahipresearch.com/pdfs/Individual_Insurance_Survey_Report8-26-2005.pdf)

<sup>10</sup> *The Cost and Benefits of Individual Health Insurance Plans: 2007*, ehealthinsurance

Anyone that supports the funds in this bill going towards yoga or Reiki and energy healing—shouldn't have a problem with this amendment.

Anyone who supports expanding the scope of the Indian Health Service to providing long term care, hospice, assisted living, and home- and community-based services—shouldn't have a problem with this amendment.

Anyone who supports the funding in this bill going towards “personal capacity building”— shouldn't have a problem with this amendment.

**This is only a demonstration program in 3 Indian Health Service regions to get the facts about new approaches.**

Before we reform the whole system, or even dismiss this idea, we need to see if it will work. This amendment doesn't change the whole system, it simply gets the facts.

This amendment is about changing the **broken system** of the Indian Health Service. Until we try new approaches, we're not going to get real solutions. I believe we need real change. Only real change can improve quality of care for tribal members.

This amendment doesn't take anything away from people. No one will be forced into this demonstration program—it simply creates a new option for tribal members.

This may not work for tribal members in extremely rural regions, and that's why it's voluntary and it's a choice.

It doesn't affect an Indian's right to services through Indian Health Service facilities, it's about giving more options and choice to those Indians.

**There will be differences on the specific steps, but there can be no doubt that we all agree on the urgent need to deliver higher quality health care in Indian Country.**

To that end, Congress should work to bring about a system that upholds its commitments and best serves all tribal citizens.

Congress should consider innovative approaches to care—like this demonstration project that will allow tribal citizens to receive health care wherever is best for them with dollars the IHS might have otherwise misused. While this might not be a perfect panacea, in more developed regions, it will inject competition into a sector that desperately needs it.

What we've been doing hasn't worked, and it's time to figure out what will. Fulfilling our commitment to tribal members doesn't mean "more of the same," it means having the courage to be about **change** and offer something better.