



# Health Care

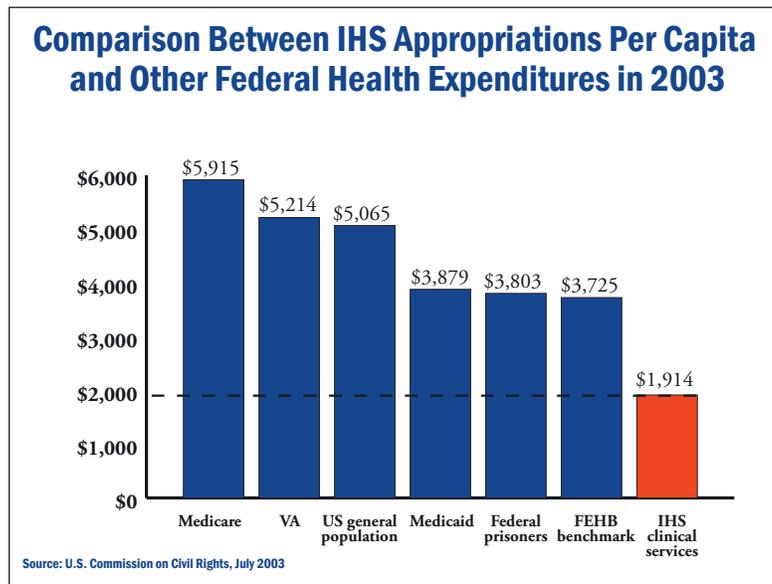
## *A Special Report Prepared by:*

*Democratic Policy Committee  
Democratic Steering and Coordination Committee  
Office of Senate Democratic Leader Tom Daschle*

There is a serious health care crisis in Indian Country, affecting over four million Native Americans. According to a study conducted by the Indian Health Service (IHS), in 2003, Native Americans had a diabetes rate which is 249 percent higher than average, a tuberculosis rate 533 percent higher than average, and an alcoholism rate 627 percent higher than average.

Native Americans born today suffer a disproportionate occurrence of disease and have a life expectancy six years below the U.S. average. For example, the life expectancy for men on the Pine Ridge and Rosebud reservations in South Dakota is lower than all but one other country in the Western Hemisphere (Haiti has the lowest life expectancy for men).

Approximately 60 percent of Native Americans rely on the IHS to provide for their health care needs, yet funding for IHS has not



kept pace with medical inflation and population growth. As a result, IHS services are underfunded, and patients are routinely denied care. For many critical services, patients are subjected to a literal “life or limb” test; their care is denied unless their life is threatened or they risk immediate loss of a limb. Care is denied or delayed until their condition worsens and treatment is costlier or, all too often, comes too late to be effective.

Federal per capita funding for Indian health is only \$1,914, about half the allotment of federal per capita funding for health care for federal prisoners. The chart below illustrates the disparity between per capita IHS spending and federal health expenditures for other groups.

Senate Democrats, led by Indian Affairs Committee Vice Chairman Inouye, will continue to fight for additional funding as Congress moves to consideration of the *Fiscal*

*Year 2005 Interior Appropriations bill.*

**Indian Health Care Improvement Act.** Senate Democrats will push for enactment this year of legislation (S. 556) to reauthorize the *Indian Health Care Improvement Act*, the key authorizing legislation for determining how the federal government provides health care services to Native Americans. Republicans have delayed the consideration of this bill for four years, in part because of cost concerns raised by the Bush Administration.

**Indian Health Service Funding Issues.** In each of the last four years, Democrats, led by Senate Democratic Leader Daschle, have offered amendments during the annual budget and appropriations processes to increase IHS funding at least enough to allow the IHS to provide basic clinical health services—both directly and through contracts with other providers—to the current IHS user population. In 2001, the Senate passed by voice vote a Daschle amendment to the Fiscal Year 2002 budget resolution to increase IHS clinical services by \$4.2 billion, but the funding increase was eliminated in the Republican-controlled conference committee.

In 2002, the Senate Budget Committee, then under Democratic control with Senator Conrad as the Chairman, added \$1 billion to the *Fiscal Year 2003 budget resolution*, but Senate Republicans effectively blocked the resolution.

In 2003, Senator Daschle introduced an amendment to increase this same account by \$2.9 billion in *Fiscal Year 2004* was defeated by a narrow two-vote margin, with all Republican Senators voting against it. The Senate subsequently adopted by voice vote a Republican alternative to increase IHS funding by one-tenth of that amount, \$292 million. Again, the Republican-controlled conference committee dropped the funding in the final bill. During consideration of the *Fiscal Year 2004* Interior Appropriations bill, Senator Daschle, joined by Senators Murray, Bingaman, and others, offered an amendment to increase IHS clinical services by \$2.9 billion. When that amendment was defeated, Senator Daschle offered an amendment to provide the \$292 million increase Senate Republicans had supported earlier in the year. Senate Republicans blocked even that minimal increase they had originally proposed. In 2004, Senate Republicans defeated an amendment to increase the *Fiscal Year 2005* IHS clinical services budget by \$3.4 billion.

**Contract Health Providers.** In addition to hurting Native American patients, the lack of IHS funding has a severe impact on the broader rural community, including the budgets of non-IHS facilities and providers throughout the nation. Indians routinely are referred to many non-IHS hospitals with the understanding that IHS will pay for the services. But provision of these services depends on the availability of funds, the severity of illness, and residence within a defined Contract Health Service Delivery Area. All these factors together mean that the non-IHS facilities are less likely to receive payment for the services they provide Indian patients. Ambulance services are particularly affected by this policy. Some IHS hospitals rely on rural ambulance services to transport patients, but they do not always have the funds to reimburse the provider for the transportation it gives to Indian patients.

**Urban Indian Health Programs.** Many Native Americans have moved to urban areas in an attempt to escape the poverty and high unemployment rates often found on reservations. Federal policy promoted this relocation during the 1950s and 1960s. Today, about 60 percent of Native Americans live in urban areas. There are 34 Urban Indian Health Centers that provide culturally appropriate health services to these Native Americans, including primary care as well as outreach and referral services. These centers receive funding from IHS as well as other government and private sources. According to the National Council of Urban Indian Health (NCUIH), insufficient funding is limiting the health services available to urban Indians. The NCUIH estimates a funding shortfall of \$1.5 billion, which is allowing IHS to serve only about 16 percent of eligible urban Indians.

**Diabetes.** The Special Diabetes Program Initiative at the Indian Health Service funds treatment and prevention programs for American Indians and Alaska Natives, whose diabetes rate is 249 percent higher than average. In 2002, Senate Democrats supported legislation that secured funding for this program at an increased rate of \$150 million per year through 2008.

**Native Veterans' Health Care.** Senate Democrats are committed to making sure that the Department of Veterans Affairs (VA) and the IHS offer the necessary services to our nation's Native veterans, including transportation and affordable prescription drugs. Native veterans with diabetes who were potentially exposed to Agent Orange in Vietnam have access to VA health benefits and disability compensation as a result of enactment of the *Agent Orange Act of 2001*, introduced by Senators Daschle and Kerry.

**GAO Investigation of IHS Clinical Services.** Senators Daschle and Dorgan have asked Congress's investigatory arm, the Government Accountability Office (GAO), to investigate the delays and denials of health care that Native Americans experience as a result of inadequate federal funding. Democrats hope the GAO report, which is expected to be completed by early next year, will help convince opposition in Congress that this "quiet crisis" must be addressed by fully funding the Indian Health Service.

**Bicameral Democratic Minority Health Bill.** Senate and House Democrats, led by Leaders Daschle and Pelosi, have introduced joint legislation (S. 1833/H.R. 3459) to identify and address health disparities experienced by racial and ethnic minorities. The bill would guarantee adequate funding for the IHS by making IHS health care an entitlement and would authorize new programs to improve health care services for Native Americans.

**Bush Administration on Health Disparities.** Senate and House Democrats have criticized changes that the Bush Administration made to a recent report on the health disparities encountered by racial and ethnic minorities including Native American communities. The changes—in language, examples used, and the report's conclusions—reflected an attempt to underestimate

the problem. Health and Human Services Secretary Tommy Thompson acknowledged that his office had been wrong to make these changes.

**Medicare and Prescription Drugs in Indian Country.** While many Senate Democrats had serious concerns about the final version of last year's Medicare legislation, and voted against final passage, they have noted that the bill included many provisions important to tribal communities. Provisions included in the final version of the legislation include:

- **Prescription Drug Discount Card.** Pharmacies operated by IHS and Indian tribes/tribal organizations would be able to participate in the Prescription Drug Discount Card program.
- **Prescription Drug Benefit.** Pharmacies operated by the Indian Health Service and Indian tribes/tribal organizations would be eligible to participate in the network of pharmacies established by an eligible entity offering a Medicare Prescription Drug Plan under the new Part D.
- **Limitation on Charges for Contract Health Services.** The bill would establish a Medicare-like rate cap on the amount hospitals are able to charge IHS and tribal health programs for inpatient care purchased under the IHS Contract Health Services program. The program is modeled on programs operated by the Departments of Defense and Veterans Affairs.
- **IHS Reimbursement for Supplemental Medical Insurance, Part B, not currently covered.** The bill would require Medicare to cover durable medical equipment, ambulance services, glaucoma screening, and other services that IHS hospitals and clinics previously could not bill Medicare for.
- **Coverage of Telehealth.** Facilities designated as "originating sites" for telehealth purposes would be expanded to include seven additional types of facilities, including those operated by the IHS, Indian tribes, and tribal organizations.
- **Loan Forgiveness.** The Secretary of Health and Human Services would be able to provide loan forgiveness packages to qualifying hospitals that have outreach programs for cancer prevention, early diagnosis, and treatment.

**Dental shortage.** Largely due to the lack of access, Indian populations have greater rates of dental caries (i.e., the decay of a tooth or bone). The GAO found that Indian children, ages 2 to 4 "have five times the rate of dental decay that all children have." Indian children ages 6 to 8 have twice the rate of caries, and the rate of untreated dental decay is often two to three times higher than for their white counterparts. Senator Daschle has introduced the *Dental Health Provider Shortage Act* (S.2740) a legislative solution to the dental benefits shortage, which includes retention bonuses for dentists and dental hygienists to remain at IHS facilities.

**Tribal Nursing Homes.** Currently, the Indian Health Service is not authorized to build or operate nursing homes and other long-term care facilities. This issue is being debated during consideration of the reauthorization of the *Indian Health Care Improvement Act*. IHS may be willing to expand its work in this area, but the agency is hesitant to add long-term care to its mission, since it currently lacks adequate funds to meet its existing responsibilities. Even if IHS funds eventually can be found to construct a facility, there is the question of providing annual operating funds.

Many tribes have expressed an interest in operating their own nursing homes to address this shortfall. Tribal nursing facilities would have to be funded through Medicare and Medicaid, which would mandate state involvement in the funding and managing of each nursing home. This raises many concerns with states that are already facing severe budget crises. Senator Daschle has proposed legislation in the past that would amend the Medicaid regulations to allow facilities that are licensed by their tribe to also receive Medicaid payments.

**Fetal Alcohol Syndrome.** With an alcoholism rate in Indian Country 627 percent higher than the national average, Native Americans are at especially high risk for Fetal Alcohol Syndrome Disorders (FASD)—a lifelong, yet completely preventable set of physical, mental, and neurobehavioral birth defects. In 2000, Senator Daschle led a bipartisan coalition to pass legislation providing \$25 million for a comprehensive Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) program at the Department of Health and Human Services and for the creation of a National FAS Task Force.

The FAS and FAE program is funding prevention and much-needed treatment assistance for individuals with FASD and their families. This funding has supported programs across the country including the Four-State Fetal Alcohol Syndrome Consortium, which serves FASD programs in South Dakota, North Dakota, Minnesota and Montana. Their successes include a direct intervention demonstration program that provided 465 women with support services to keep them from drinking alcohol during their pregnancy. Senator Daschle has introduced a FASD bill that includes assistance for FAS children on Indian reservations.

**Sudden Infant Death Syndrome.** A recent Aberdeen Area Indian Health Service Infant Mortality Study identified protective and risk factors associated with Sudden Infant Death Syndrome (SIDS). The study noted that alcohol consumption by women of childbearing age (especially during pregnancy), maternal and environmental tobacco exposure during pregnancy, and pregnancy by women under the age of 20 increase the risk for SIDS. Nationwide, SIDS rates for infants of American Indian mothers were 2.6 times those of non-Hispanic white mothers. Last year, Senator Daschle secured an additional \$2 million in the Senate-passed *Labor-HHS Appropriations bill* for the Office of Minority Health to reduce SIDS disparity rates and provide risk reduction education to African American and American Indian populations.

**Sexually Transmitted Diseases.** Senator Daschle secured \$1 million in the Senate-passed *Fiscal Year 2004 Labor-HHS Appropriations bill* for a competitive grant program administered by the Centers for Disease Control (CDC). The program will bolster American Indian reservations ability to screen for and treat sexually transmitted diseases (STDs) as well as provide education on this matter. American Indian populations have seen an alarming increase in STD prevalence in recent years. A screening, treatment and education program, administered by tribal health organizations and/or local health care providers, on reservations with high rates of STD infections will help prevent a corresponding increase in the prevalence of HIV.

**West Nile Virus.** Senate Democrats have continuously asked the Director of the CDC to address the West Nile Virus problem. In the *Fiscal Year 2004 Labor-HHS appropriations bill*, Senator Daschle offered an amendment to increase funding for the West Nile virus, which is affecting the Native American population in western states. This amendment created a set-aside for tribes who have expressed concern about their ability to access funds given to the state. Unfortunately, the amendment was defeated.