1994

The Impact of IHS Tribal Evaluation Contracts

Indian Health Service, Rockville, MD.

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INDIAN HEALTH SERVICE

CAPITAL FINANCING

AND

HEALTH CARE REFORM

FINAL REPORT

OF

ROUNDTABLE PROCEEDINGS

ROCKVILLE, MARYLAND
JANUARY 12, 1994

OFFICE OF PLANNING, EVALUATION, AND LEGISLATION

This report is a summary of roundtable discussions held January 12, 1994 to explore how capital financing might be utilized by Indian health care programs. It is not a policy statement by the Indian Health Service or the Federal government.

INDIAN HEALTH SERVICE

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Executive Summary

Since 1987, the IHS Office of Planning, Evaluation and Legislation (OPEL) has conducted a series of Roundtable Conferences to convene experts in Indian health, Indian law, federal services and the health care industry. Each roundtable has focused on a specific issue and has resulted in "Consensus Recommendations." These recommendations are intended as a springboard from which to initiate a process for reviewing and developing IHS policy.

On January 12, 1994, OPEL held a roundtable in Rockville, Maryland, to focus on financial provisions contained in the Clinton Administration's national health care reform package. Discussions centered on how these provisions would impact approximately 1.3 million American Indians/Alaska Natives who currently receive health care from the Indian Health Service.

At the roundtable, health care financial specialists from two prominent private sector investment firms exchanged ideas with IHS policy makers and with representatives from the Warm Springs and Choctaw tribes.[1] Topics explored included: the Indian-specific provisions of proposed federal health care legislation; the IHS, tribal and urban Indian health care programs (ITUs) outlined in the legislation; primary revenue sources for these programs; ITU infrastructure needs; and the private investment market as a source of capital for facility development.

Discussions focused on selling debt in the private market. Types of bonds and requirements for obtaining financing were reviewed with special emphasis on the credit rating system. Attention was also given to the federal loan guarantee program proposed in the President's health care reform legislation.

In concluding the roundtable, participants prepared a list of recommendations. The recommendations are summarized below.

1. Consultation and collaboration between HHS and representatives of Indian tribes, tribal organizations and urban Indian organizations should begin immediately to design new financial strategies for Indian health care programs.

2. Future strategies for financing Indian health care should depend more on reimbursement for services and less on appropriations.

3. IHS should assist tribes in exploring alternatives to federal appropriations by providing information and technical assistance.

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[1] These tribes are independently implementing creative health care financing.

a) Recent data obtained through IHS surveys of health facilities in Indian Country should be made available.

b) Specialists involved with state-of-the-art health care financing should be consulted to help identify how various market strategies can be adapted to IHS/tribal regulations and needs.

4. In seeking higher per capita appropriations from the federal government, IHS should provide data to demonstrate that Indians are at high risk for health problems.

5. Federal regulations require streamlining if individual ITUs or an IHS alliance are to successfully compete in the capital investment market.

6. IHS, in collaboration with tribes/tribal organizations, should review the federal loan guarantee provisions of the President's proposed health care legislation.

a) ITUs must develop strategies for obtaining their fair share of the loan guarantee pot. ITUs should advocate for a tribal funding set-aside.

b) The President's proposed health care reform legislation allows prioritization when appropriations are insufficient to meet all needs and ITUs must be prepared to draw attention to the federal government's obligation to assure health care for all Indians. Mechanisms should be defined for guaranteeing loans in geographical areas with low population density.

7. ITUs should work to expand their patient base. Networking with local non-Indian health plans, as well as with Indian programs, should be explored. ITUs should evaluate the advantages and disadvantages of forming regional alliances or one national "super alliance."

An alliance model should be created. It should draw on the positive aspects of collective association while avoiding sacrifice of autonomy and other problems that accompany bureaucratic management.

Questions to be considered include:

a) How much local autonomy should be allowed to each participating ITU?

b) How much centralization will be necessary in order to obtain capital financing?

c) Might corporate financial structures, in which cash is taken to the center to raise capital for distribution to satellite operations, offer an appropriate alliance model for ITUs?

8. Tribes should work to increase their credit ratings. Audits are essential. Any ITU with a budget more than $1 million should adopt the GAPP (Generally Accepted Accounting Procedures) system.

Credit enhancement questions include:

a) Is there any means by which tribal land can be given as security?

b) Is there a way to pledge tribal assets to escrow?

c) How can ITUs protect lenders from the failure of a health care facility due to lack of market, a situation which makes a repossessed facility worthless?

d) In any effort to enhance credit, what must be done to protect tribal sovereignty?

9. ITUs should advocate for legislative amendments to provide:

a) tax-exemptions for IHS/ITUs;

b) power to grant security, mortgages and Federal Acquisition Regulations (FAR) exceptions;

c) authority to allow lease scoring and asset transfers between IHS and tribes; and

d) Indian-specific appropriations to set up a tribal insurance guarantee program to sell stock to tribes as a method of helping ITUs qualify for credit through federal programs such as FHA or Connie Lee programs.

IHS and Indian Health Care

By law, the United States must provide health care to American Indians and Alaska Natives. Approximately 60 percent (1.3 million) of the nation's 2.2 million Native Americans reside in the IHS service area and are eligible for health care from the federally-funded Indian Health Service. The remainder must travel to an IHS facility or

seek services from private providers or through private or employer-based insurance coverage, indigent care systems, or emergency rooms.

IHS is administered through 11 regional Area Offices. It provides care through three primary service delivery programs: (1) its own IHS-operated and staffed direct service program; (2) its Tribal Contract program through which IHS funds tribally-operated health care systems; and (3) its urban health program through which IHS provides grants/contracts to urban Indian organizations. In all three programs, services which cannot be provided "in-house" are purchased with IHS funds from private providers.

Currently, there are 41 hospitals, 66 health centers, four school health centers and 44 health stations in the IHS-operated program. Tribes operate eight hospitals, 110 health centers, four school health centers, 62 health stations and 171 Alaska village clinics. There are 34 urban Indian organizations providing services in 41 cities.

Underfunding, both of services and facilities, is a major problem. Congressional appropriations are discretionary and meet less than half of the documented Indian health care needs each year. Per capita funding for IHS services is $1,047, substantially lower than the $2,828 expended for the larger US population.

Tribally-operated programs and many urban Indian programs attempt to supplement their service budgets with other federal and state or private funds. They also seek reimbursements from third party billing. Medicare/Medicaid provides benefits for some IHS clients; private comprehensive or supplemental insurance covers about 28 percent of the IHS service population. Only 47 percent of Indians who reside in the IHS service area and who are fully employed have employment-related insurance.

Indian health care facilities are grossly inadequate. Many are small and in poor condition. Half are more than 30 years old. Ambulatory care facilities, in particular, are needed.

A recent IHS survey estimated that approximately $3.5 billion is currently needed to bring Indian health care facilities to required capacity. Another $400 million per year is necessary to maintain and systematically replace the facilities once they are on-line. These figures are based on plans which accommodate increased ambulatory care and less in-patient care; they do not include funds for any new hospital facilities nor do they provide for any newly recognized tribes.

National Health Care Reform
as it affects
Indian Health Care

National health care reform proposes universal and affordable access to quality health care for all Americans. The new health care legislation proposed by the Clinton Administration addresses Indians as a specific population.

Its provisions for Native Americans include the following.

- IHS will continue to provide health care to American Indians through three primary outlets: IHS operated programs; tribally contracted programs; and programs contracted to urban health centers. Each program will operate independently but will be subject to IHS certification and monitoring. When collectively referred to, these various independent programs will be called IHS/ Tribal/Urban programs or ITUs.

- IHS basic comprehensive health benefits, currently supported by 70 percent of the IHS budget, will be provided to eligible Indians who elect enrollment in an ITU health plan. Supplemental services, such as those presently offered through environmental health workers or Community Health Representatives, will continue to be available to all eligible Indians regardless of what basic benefit health plan they choose.

- To be federally eligible for IHS programs, a person must be an Indian as described in section 809(b) of the Indian Health Care Improvement Act or a descendent of a member of an Indian tribe who is regarded as Indian by the Indian community. In addition, the Indian must reside on or near an Indian reservation, in a geographic area designated by statute, in an urban area served by an urban Indian program, or in specified California counties.

- An Indian eligible for IHS health services shall have a choice concerning the plan he elects for basic health services. He may choose between IHS enrollment or enrollment in a non-IHS health plan. Choices may be changed annually.

- Indians electing IHS basic benefits shall enroll through a service unit, tribal organization or urban Indian program in a specific ITU health plan.

- Indians in an ITU health plan will not pay premiums, co-payments or any other costs; those who enroll in a non-IHS plan will be required to pay these costs.

- An eligible Indian may enroll non-eligible family members in an ITU plan as part of his family unit. Any enrolled family members who are not eligible as Indians will be subject to the same kind of premium and co-payment costs that they would have to pay under a non-IHS plan. However, these expenses may be reduced by the Secretary of HHS, in which case HHS will pay the reductions.

  The Secretary of HHS shall ensure that the ITU basic benefit health plans are operating by January 1, 1999. These plans will be governed by certification requirements established by HHS.

- Benefits provided in ITU health plans will include: hospital, emergency, and physician/provider services; disease prevention services; preventive dental care for children; health education; family planning and pregnancy services; mental health and substance abuse treatment; home health and hospice care; outpatient rehabilitation; outpatient lab and diagnostic services; vision and hearing care; outpatient prescription drugs; prosthetic and orthotic devices; and ambulance service.

- ITUs that meet certain specified requirements will be eligible to accept and service non-Indians who elect prepaid membership in the ITU plan and pay required premiums and co-payments.

- ITUs may enter into contracts with non-Indian health plans to serve Indian and non-Indian enrollees of the other plans on a reimbursable basis if ITU services to its own enrollees are not affected.

- The Secretary of HHS shall consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations on an annual basis concerning health care reform initiatives that affect Indian communities.

- The Secretary of HHS may expend funds from the IHS Services budget to construct and renovate facilities to allow the delivery of comprehensive benefit packages.

- A revolving loan program is authorized for capital financing and the Secretary of HHS, acting through the IHS, shall provide guaranteed loans under such terms and conditions as the Secretary may prescribe.

It is anticipated that the basic benefits package provided to Indians electing enrollment in an ITU health plan will be equivalent to the packages offered by Fortune 500 Corporations and will be as good or better than two thirds of the health care plans on the market today.

Revenue Sources for ITU Basic Benefits

The health care reform legislation proposed by the President recognizes the authority of each ITU to maintain and manage a separate budget. Funds to finance basic comprehensive health services will come to each ITU from four primary revenue sources. They include:

- Health insurance premiums paid to provide care for non-Indian family members of tribal enrollees.
- Health insurance premiums paid by non-Indian employers for Indian employees who elect an ITU plan.
- Low income medical assistance subsidies provided through federal entitlement programs
- Federal reimbursements for services provided to individuals eligible for Medicare and other similar benefits.

The proposed Clinton legislation contains several provisions which offer special support for ITUs.

For example, the legislation provides the Secretary of HHS discretionary power to reduce the 20 percent premium copayment that non-Indian family members would normally be assessed when their family elects an ITU plan. On the other hand, the legislation mandates that Indians who elect enrollment in a non-IHS plan must pay the usual 20 percent premium copayment required for membership. These provisions offer incentives for electing ITU coverage.

Because many Indian people who elect ITU membership will qualify for low-income medical assistance subsidies and Medicare reimbursements, a substantial amount of fee-for-service reimbursement will be channeled into ITU budgets. These subsidies and reimbursements will provide a cash flow which directly offsets expenditures, lessening some of the financial risk assumed by plans which must rely more heavily on prepaid insurance premiums.

Financing Facility Construction/Renovation

Presently, the IHS Division of Facilities Planning and Construction is responsible for administering the planning, design and construction of hospitals, health centers, substance abuse treatment centers and staff quarters.

Eight construction/modernization/renovation programs are operated by DFPC. They include: an Inpatient Facilities program; an Outpatient Facilities program; a Staff Quarters program; a Non-IHS Funds Renovation program in which a tribe assumes financial responsibility for renovating an existing IHS or IHS contract facility; a Small Ambulatory Health Center Grants program; an Indian Health Care Delivery Demonstration program in which grants are made to tribes for constructing alternative, innovative facilities; a Youth Regional Treatment Center program; and a Joint Venture Demonstration program through which a tribe finances the construction of a facility and then leases the completed structure at no cost for 20 years.[2]

IHS determines where it will spent its in- and outpatient construction/renovation funds through its Health Facilities Construction Priority System. Under this three phase system, IHS solicits proposals for construction/renovation and ranks them according to relative need.

Building is financed by annual federal appropriations to the IHS facilities construction/renovation budget. The amount of this budget fluctuates wildly.

In FY 1993, it peaked at $125 million, falling to $59 million in FY 1994. This FY 94 appropriation is still generous by Congressional standards in that it is the third highest appropriation in 12 years.

In 1992, IHS had a backlog of 149 applications for facility construction or renovation. Twenty two of these applications were accepted for funding. With the current federal appropriation pattern, it will take the next 10 to 12 years to complete the 22 selected projects.

An effort to increase IHS construction/renovation funds was recently made when Congress granted IHS authority to spend up to $1 million in Medicare/Medicaid collections for facility improvement aimed at correcting deficiencies cited by the Joint Commission on Accreditation of Health Care Organizations. In other recent actions, Congress also approved (1) transfer of $6 million from the FY 94 IHS Services budget to the IHS Facilities budget for facilities where health services are being increased and (2) use of annual PL 93-638 tribal contract carryover funds for purchasing and erecting modular buildings. Using any of these monies for construction/renovation, however, lessens funds available for other IHS programs and for basic health care services.

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[2] The facilities constructed by the Confederated Tribes of Warm Springs and by the Choctaw Tribe of Oklahoma were constructed under the Joint Venture Demonstration program. Representatives from the financial staffs of both these projects participated in the roundtable.

Accessing Private Capital through Federal Loan Guarantees

Section 8310 of the President's proposed health care reform legislation offers the potential for at least some relief to the Indian health facilities problem by establishing an IHS revolving loan program. Under the program, the Secretary of HHS, acting through IHS, shall provide guaranteed loans "under such terms and conditions as the Secretary may prescribe." The guarantees will be used to "improve and expand health care facilities to enable the delivery of the full array of items and services guaranteed in the comprehensive benefit package" of the proposed legislation.

The IHS revolving loan guarantee program is part of a larger loan program to be available for financing all kinds of public health programs. The amount to be earmarked for loan guarantees has not been established nor has an amount been specified for the IHS program. A dollar available to an ITU through the federal loan guarantee program can be expected to qualify the ITU for a loan of ten dollars through the private investment market.

The guaranteed loan program of the proposed health care legislation opens the potential for new types of financing for Indian health care facilities. The federally-backed guarantees will allow ITUs to approach the private investment market and access needed funds by "selling debt."

The debt to be sold will be the amount which an ITU borrows to build or renovate a facility. The ITU will seek its loan from a private investor or a group of investors, offering the federal loan guarantee as partial security. An agreement, or bond, will result specifying terms for payback. The terms will include a specified loan period (usually 30 years) and a schedule for repayment. Besides paying back the amount borrowed, the ITU will also pay a negotiated interest rate.

Types of Bonds

There are several kinds of bonds: fixed rate; variable rate; taxable; and tax-exempt.

Fixed rate bonds are the most common. Their interest rates are established up front and remain constant over the life of the loan. As the bonds mature and the amount owed decreases, the ratio of principal to interest changes and each successive payment includes more principal and less interest. Fixed rate bonds are attractive

in that their interest cannot go above what is originally established regardless of inflation or any other market condition which may make the borrowed funds more valuable. Fixed rate bonds generally carry a higher interest than other kinds of bonds.

The overall cost of a fixed rate bond can be lowered through a process in which the borrower takes new mini-loans against the paid-back principal. The new mini-loans, which are called serial bonds, carry lower interest rates than the original bond, increase available funds and lower the overall cost of securing capital. They are sold to retail investors through brokerage firms.

Variable rate bonds have interest rates that change over the life of the loan. The interest rate may be adjusted automatically by floating or changing as national interest rates fluctuate. Or, the interest may change at specified time intervals. Sometimes the changing rate is determined through periodic reevaluation of the borrower's credit worthiness.

Bonds are either taxable or tax-exempt. The lender, on taxable bonds, pays tax on the interest he receives. The lender does not pay tax on the interest of a tax-exempt bond.

A bond's tax status is determined by the use to which the loan will be applied and by whether the borrower has tax-exempt status, a classification obtained through a rigorous qualification process. Most ITUs and ITU projects are theoretically eligible for tax-exemption although qualifying requirements may be so stringent and costly[3] as to make eligibility infeasible in some cases. Tax-exempt transactions also carry some special costs such as basis points.

Lenders are usually willing to accept a lower interest rate if a bond is tax-exempt. Traditionally, the amount a borrower saved through lower interest rates more than offset the special costs involved in obtaining tax-exemption. In today's market, however, interest rates are low enough that the costs involved for tax-exemption may not be worth the savings.

In the health care market, most bonds require that the borrower establish a debt service fund. This means that the original loan includes an added amount equal to one year's payments. These funds are put aside as a reserve from which the lender may draw in the event the borrower misses a payment.

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[3] The Warm Springs Tribes, in order to qualify for tax-exempt loans to build their clinic, had to agree to provide the facility rent-free to IHS which, in turn, would operate it. The tribes also had to agree not to charge IHS for certain tribally-incurred maintenance once IHS occupies the building.

Payback Guarantee

The marketability of a bond is largely dependent on how payback is guaranteed.

Many government bonds are backed by taxes which the public agrees to pay. These bonds, called general obligation bonds, get the highest credit ratings and, therefore, provide the lowest interest rates for the borrower. Other bonds, called revenue bonds, are guaranteed by the revenue that the financed project will generate. Revenue bonds are becoming increasingly common in the health care market.

Attributes used to rate the soundness of a revenue bond include "essentiality" and "monopoly of service." Sellers of all health care facility bonds say that, as long as people continue getting sick, a health care facility is essential and some facility will earn money. When a facility is the only one in a remote area, the bond seller can additionally claim a service monopoly which will force captive-market clients to the financed facility thus keeping its revenue flowing.

Between 1981 and 1992, the number of hospitals in the US that were financed by revenue bonds increased four-fold. If this trend continues, more and more public health care facilities will have to be self-sustaining in order to qualify for financing. Interestingly, only half of the approximately 3,000 not-for-profit hospitals in the United States are presently considered credit worthy.

The Credit Rating System

Organizations seeking capital financing through the private investment market are required to demonstrate that they are credit worthy. A common way of doing this is through a credit analysis by one of the national credit rating systems. These systems give ratings A through D with options of single, double and triple letters within each category. The best ratings are AAA, AA, A and BBB. If an organization can attain one of these top four ratings, it will have access to capital through the market. Someone will lend it money.

Besides essentiality and monopoly of services, other factors are considered in rating the financial soundness of a health care program. These factors include: patient population, demographics and demand; managerial expertise; staff characteristics;

facilities' profile; and profitability, liquidity and capital structure. To evaluate these factors, the following questions are asked.

What are the characteristics, needs, size and stability of the client?

What is the quality of management? What are the facility's average collection periods or how long do clients and other obligors take to pay their bills?

What are the characteristics of the care-giving staff? What are the specialties, average age and board certifications of the providers? Are there sufficient resources to provide good quality comprehensive care?

What is the actual age, condition and use rate of current facilities? What percentage of the facilities is represented by long-term debt?

What sort of operating revenue is being achieved or projected and how does this compare to program debts? How much cash does the organization have on hand? What kinds of non-operating functions (IHS appropriations, government grants etc.) produce revenue?

Qualifying as a Borrower

If the bond market is to become a feasible source of financing for Indian health care facilities, ITUs must prepare themselves for rigorous credit analysis. Indeed, it may take three to five years before an ITU can assemble the financial credentials necessary to convince investors to lend it money.

Strategies to improve credit ratings must be designed. Audited financial statements, management letters, utilization statistics and feasibility studies are necessary as are legal documents including a master trust indenture, a bond resolution or series trust indenture, a lease or loan agreement and an escrow agreement.

Strategy #1: Pooling ITUs into an Alliance

One possible strategy for improving the credit ratings of ITUs is to unite them into a number of regional alliances or into one IHS-wide super alliance. Health service alliances are popular with investors who see the arrangement as quality and cost effective. An alliance system, many investors believe, allows affiliates to share resources, avoid costly duplication, lower operating costs and achieve better management.

Another reason for the popularity of alliances is that investors are familiar with the alliance prototype employed by many for-profit organizations. In this model, an organization draws cash into a central control center from which funds are disbursed to satellite programs. Cash reserves generated in the center are used to leverage the acquisition of more funds.

Alliances have the advantage of an increased client base. An IHS super alliance would include almost two million people allowing lenders to accept higher risks for other investment criteria. The super alliance would also spread the risk of default. Large, stable ITUs with low default risks could carry smaller tribal programs which cannot obtain capital financing on their own.

The concept of a national ITU health care alliance is not new. The current IHS structure is basically that of an alliance. One model for continuing the existing IHS alliance structure is to pool premium payments from member ITUs into a central headquarters from which contracts are made with the various ITU affiliates for the provision of local services.

Any proposal to continue the current IHS centralized structure under health care reform raises the difficult issue of sovereignty. Health care reform provides each tribe the opportunity to operate its own health program. The tribal battle for recognition of this right has been hard fought and the concept of a national Indian health alliance will likely be viewed by many tribal people as a rejection of self-determination.

The challenge, therefore, is to design an alliance-type health care structure which allows ITUs to maintain their autonomy while equipping them to compete in the capital market for necessary funds.

Two existing health care structures are offered as models.

- Approximately 15 independent and geographically dispersed social service units of the Catholic Church have come together to approach the capital market as a unit. The unit presents a joint management/financial plan which stresses economy of scale and efficiency. Through this approach, the unit has been successful in leveraging funds to be used for projects determined and controlled on the local level.

- In New York state, a network of 100 independently-operated mental health programs direct all of their Medicaid collections into a central treasury. Offering this single revenue stream as security, the network has been successful in accessing private funds.

Strategy #2: Insuring a Bond

Purchasing bond insurance is a means by which an organization may enhance its credit rating. Some organizations may require enhancement merely to be considered for any loan. Others may use their improved credit ratings to qualify for reduced interest rates. Currently, forty percent of all health care bonds are credit-enhanced.

Bond insurance is available from private insurers or, in some cases, an organization may qualify for federal insurance such as that issued by the FHA.

The federal loan guarantee program proposed in the President's health care reform package is a kind of bond insurance.

Strategy #3: Marketing IHS Quality Assurance

Under health care reform, emphasis is given to buying the lowest cost services and the best outcomes. Lenders will increasingly focus on quality of service as a credit criteria.

IHS health programs have good quality analysis data. Where other health care programs have concentrated on amassing profit and pricing data, IHS programs have been evaluating quality. ITUs will be able to present this data, gaining an advantage over many programs competing for the same market funds.

Strategy #4: Addressing Staff Turnover

High turnover of health care staff, a phenomenon experienced by many Indian health care programs, should not necessarily damage Indian programs in the capital bond market. Efforts must be made to educate lenders to the idea that the credit value of physicians in Indian programs is not the same as it is in the private sector.

In the private sector, because of the large number of available health care facilities, each single facility depends upon its physicians to "recruit" or "draw" patients. Patients in most ITU areas, on the other hand, are a captured population who must use the single available facility. High levels of facility use for most ITUs, therefore, depend on location not on staffing.

In addition, the credit value of physicians throughout the country will decline as health care reform proceeds and more locally trained paraprofessionals are employed. This shift may, in fact, cause doctors to look at employment in remote areas more kindly, making more physicians available to Indian programs.

Recommendations

The following recommendations summarize ideas and opinions expressed during the January 12, 1994, IHS roundtable. They do not constitute a policy statement by IHS.

1. Consultation and collaboration between HHS and representatives of Indian tribes, tribal organizations and urban Indian organizations should begin immediately to design new financial strategies for Indian health care programs.

2. Future strategies for financing Indian health care should depend more on reimbursement for services and less on appropriations.

3. IHS should assist tribes in exploring alternatives to federal appropriations by providing information and technical assistance.

    a) Recent data obtained through IHS surveys of health facilities in Indian Country should be made available.

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   a) tax-exemptions for IHS/ITUs;

b) power to grant security, mortgages and Federal Acquisition Regulations (FAR) exceptions;

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d) Indian-specific appropriations to set up a tribal insurance guarantee program to sell stock to tribes as a method of helping ITUs qualify for credit through federal programs such as FHA or Connie Lee programs.

Appendix A: Case Study
WARM SPRINGS HEALTH CENTER

In the early 1980s, the Confederated Tribes of Warm Springs, Oregon, through a community planning process, identified a new health clinic as a priority need.

Because federal money did not appear to be realistically available then or in the near future, the tribes began to explore building the facility themselves. Working in partnership with IHS, the tribes developed a proposal by which they would construct the facility and provide it rent-free to IHS. In turn, IHS agreed to equip and operate the clinic, activities which IHS is presently able to assume under its regular annual budget.

In 1991, Congress approved the Warm Springs proposal. Ground was broken in July 1992 and the building was ready for occupancy in August 1993.

To obtain financing for construction costs, the tribe offered tax-exempt bonds on the capital investment market. The bonds, backed by a letter of credit from Kemper Securities, sold quickly at an average interest rate of 4.75 percent to be paid back over 10 years.

"We experienced a lot of interest and competition from institutions interested in providing the letter of credit which would guarantee our bonds," says Jim Sizemore, former Comptroller for the Confederated Tribes. "We appeared a good risk," says Sizemore, "because we were able to demonstrate the value of the tribes' natural resources, diversified business investments, efficient tribal management, and a consistent incoming cash flow."

The letter of credit obligates Kemper Securities to guarantee payments to bond purchasers should the tribes forfeit on their payment obligations of the loans made through sale of the bonds. To qualify for the letter of credit, the Confederated Tribes had to agree to waive sovereign immunity. The waiver, which allows Kemper to take possession of tribal assets in case of default, is limited to general business assets. It does not apply to trust assets.

The Confederated Tribes of Warm Springs has also been innovative in the area of health care insurance. Under a tribal insurance program, the tribes' will pay the first $15,000 per year of medical expenses for its enrolled employees. After an individual's annual expenses reach $15,000, his care is transferred to IHS.

Appendix B: PARTICIPANT LIST
IHS Roundtable on Capital Financing
January 12, 1994

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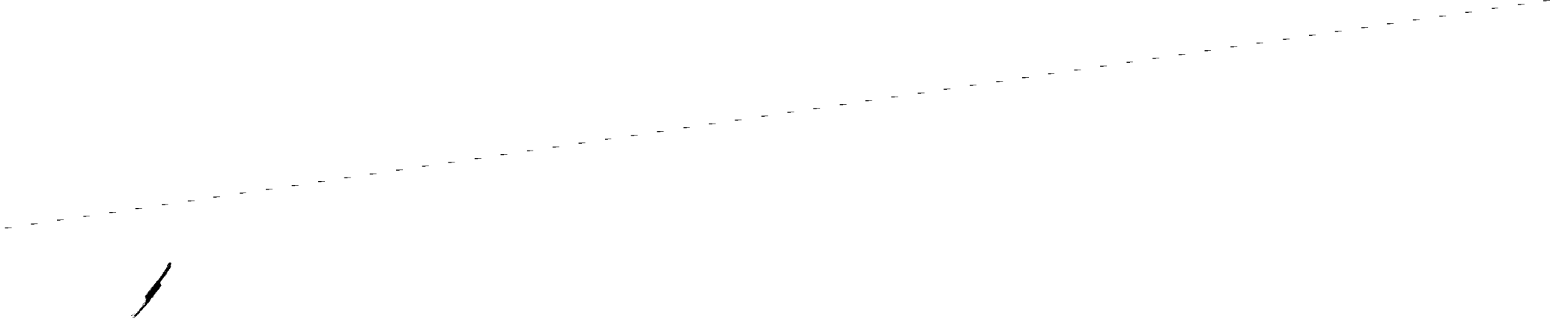
EXECUTIVE SUMMARY
IHS Roundtable on Capital Financing
January 12, 1994

Since 1987, the IHS Office of Planning, Evaluation and Legislation (OPEL) has conducted a series of Roundtable Conferences to convene experts in Indian health, Indian law, federal services and the health care industry. Each roundtable has focused on a specific issue and has resulted in "Consensus Recommendations." These recommendations are intended as a springboard from which to initiate a process for reviewing and developing IHS policy.

On January 12, 1994, OPEL held a roundtable in Rockville, Maryland, to focus on financial provisions contained in the Clinton Administration's national health care reform package. Discussions centered on how these provisions would impact the 1.3 million American Indians/Alaska Natives who currently receive health care from the Indian Health Service.

At the roundtable, health care financial specialists from two prominent private sector investment firms exchanged ideas with IHS policy makers and with representatives from the Warm Springs and Choctaw tribes.[1] Topics explored included: the Indian-specific provisions of proposed federal health care legislation; the IHS, tribal and urban Indian health care programs (ITUs) outlined in the legislation; primary revenue sources for these programs; ITU infrastructure needs; and the private investment



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Discussions focused on selling debt in the private market. Types of bonds and requirements for obtaining financing were reviewed with special emphasis on the credit rating system. Attention was also given to the federal loan guarantee program proposed in the Clinton legislation.

In concluding the roundtable, participants prepared a list of recommendations. The recommendations are summarized below.

1. Consultation and collaboration between HHS and representatives of Indian tribes, tribal organizations and urban Indian organizations should begin immediately in regards to designing new financial strategies for Indian health care programs.

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[1] These tribes are independently implementing creative health care financing.

2 New strategies should depend more on revenues and less on appropriations.

3. IHS should assist tribes in exploring alternatives to federal appropriations by providing information and technical assistance.

   a) Recent data obtained through IHS surveys of health facilities in Indian Country should be made available.

   b) The expertise of financial experts involved with state-of-the-art health care financing should be sought to help identify how various market strategies can be adapted to IHS/tribal regulations and needs.

4. Where it is necessary to rely on federal appropriations, in an effort to achieve a higher federal per capita appropriation, IHS should assemble data to support the contention that the Indian population is at high risk for health problems.

5. Federal regulations require streamlining if individual ITUs or an IHS alliance are to successfully compete in the capital investment market.

6. IHS, in collaboration with tribes/tribal organizations, should review the federal loan guarantee provisions of the Clinton Administration's proposed health care legislation.

   a) ITUs must develop strategies for obtaining their fair share of the loan guarantee pot. ITUs should advocate for a tribal funding set-aside.

   b) The proposed Clinton legislation allows prioritization when appropriations are insufficient to meet all needs and ITUs must be prepared to draw attention to the federal government's obligation to assure health care for all Indians. Mechanisms should be defined for guaranteeing loans in geographical areas with low population density.

7. ITUs should work to expand their patient base. Networking with local non-Indian health plans, as well as with Indian programs, should be explored. ITUs should evaluate the advantages and disadvantages of forming regional alliances or one national "super alliance."

   An alliance model should be created. It should draw on the positive aspects of collective association while avoiding sacrifice of autonomy and other problems that accompany bureaucratic management.

Questions to be considered include:

a) How much local autonomy should be allowed to each participating ITU?

b) How much centralization will be necessary in order to obtain capital financing?

c) Might corporate financial structures, in which cash is taken to the center to raise capital for distribution to satellite operations, offer an appropriate alliance model for ITUs?

8. Tribes should work to increase their credit ratings. Audits are essential. Any ITU with a budget more than $1 million should adopt the GAPP system.

Credit enhancement questions include:

a) Is there any means by which tribal land can be given as security?

b) Is there a way to pledge tribal assets to escrow?

c) How can ITUs protect lenders from the failure of a health care facility due to lack of market, a situation which makes a repossessed facility worthless?

d) In an credit enhancement technique, what must be done to protect tribal sovereignty?

9. ITUs should advocate for legislative amendments to provide:

a) tax-exemptions for IHS/ITUs;

b) power to grant security, mortgages and FAR exceptions;

c) authority to allow lease scoring and asset transfers between IHS and tribes;

d) Indian-specific appropriations to set up a tribal insurance guarantee program to sell stock to tribes as a methods of helping ITUs qualify for credit through federal programs like, for example FHA or Connie Lee programs.