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ROUNDTABLE CONFERENCE ON HEALTH CARE REFORM, THE HEALTH SECURITY ACT, AND INDIAN HEALTH CARE

A BRIEFING BOOK

held on
February 9, 10, 1994

U.S. Indian Health Service
Rockville, Maryland
This briefing book was prepared in partial completion of Indian Health Service purchase order # 931F01086101D, and does not represent the policies of the Indian Health Service or the Federal Government.

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Second Roundtable Conference on Health Care Reform

AGENDA

Wednesday, February 9, 1994

8:30 a.m. Welcome and Introduction
Dr. Trujillo, Director IHS or Designee

8:45 a.m. Overview of the Roundtable Process
Leo Nolan, IHS/OPEL

9:00 a.m. Overview of the Health Security Act
Laurel Hixon Illston
Brookings Institute

9:45 a.m. How Health Care Reform Will Impact Indian Health
Yvette Joseph - Senate Indian Affairs Committee
Steve Heeley - House Native American Subcommittee
Mike Mahsetky - IHS/OPEL Legislation

10:30 a.m. Break

10:45 a.m. Discussion of Major Issues
Tribal Sovereignty
Discussion Leader: gaiashkibos, NCAI
Eligibility and Enrollment
Discussion Leader: Greg Borland, Aberdeen Area
Governance and Structure
Discussion Leader: Julia Davis, NIHB

12:00 Noon Lunch Break (provided)

1:30 p.m. Continue Discussion of Major Issues
Comprehensive and Supplemental Benefits
Discussion Leader: Caleb Shields, Billings Area
Transition and Competition
Discussion Leader: Ralph Forquera, AIHCA
Financing
Discussion Leader: Phillip Martin, Nashville Area

3:00 p.m. Break

3:45 p.m. Continue Discussion of Major Issues
Facilities and Capital Financing
Discussion Leader: Thomas Clary, TCI
Identify Other Issues
Facilitator
AGENDA

Continued...

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

5:00 p.m. Recess (Dinner on your own)

Thursday, February 10, 1994

8:30 a.m. Reconvene and Review Objectives for the day  
           Jo Ann 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 (provided)

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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Introduction

The U.S. Indian Health Service (IHS) has held a series of Roundtable Conferences on topics of significance to the policy and planning of the IHS. The IHS Office of Planning, Evaluation and Legislation (OPEL) has utilized Roundtable Conferences as a means to retrieve information and consensus from leaders and experts in a particular field. This Roundtable on Health Care Reform is the second IHS sponsored Roundtable on this topic. The first health care reform Roundtable was held in February of 1993, shortly after President Clinton’s inauguration and upon the beginning of the Administration’s Health Care Reform Task Force. At that time a Final Report was issued which set out a framework of consensus statements from the Roundtable participants, which included tribal leaders, urban health providers, national Indian organizations, those in academia, congressional staff and the IHS. However, at that time there was not a detailed legislative proposal on the table.

Today, the President has submitted his detailed plan to the U.S. Congress, which includes a 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 workgroup 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 workgroup 16-A struggled to meet the toll-gate deadlines set by the Task Force.

Additional analysis and consultation is required. Many issues still remain. This second Roundtable will offer the time and opportunity to make specific and detailed statements about the President’s and other health care reform proposals currently before Congress. It is clear that although IHS, tribal and urban Indian health care delivery systems have been dealt with separately under the President’s proposal, these systems will also be significantly impacted by changes in the overall health care industry and the manner in which financing for care is redistributed. This is a critical period for tribes, urban Indian health providers and others focused on the health and wellbeing of American Indian and Alaska Native populations. Not since the Federal Government enacted Social Security, has Congress undertaken such a major social agenda as “Health Care Reform”.

This Briefing Book is provided to Roundtable participants to aid in your preparation for and reference during the conference. A Final Report will be issued by the Indian Health Service which will include the consensus statements developed by participants at this second Roundtable Conference on Health Care Reform.
Background on Indian Health Care

The United States maintains a legal and moral obligation to provide health care to American Indians and Alaska Natives 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 is a complex system of health care delivery and contract systems serving a larger percentage of Indians and Alaska Natives in the United States.

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 Indians living near Army posts (Fox). In some cases, treaties specifically required the provision of health care.

"Three hundred dollars per annum 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 Indians was further articulated over the 20th century through statute.

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


The JOM 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 Indian people in situations where the allotment process and other hardships resulted in Indians living off the reservations.

The Transfer Act, 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 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 the Public Health Service.

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 Services Act of 1959, (42 U.S.C. 2004). This Act substantially expanded the role of IHS to ensure safe public health environments for Indians and 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) This landmark Act provided Indian tribal governments with the authority to take over the operation of Federally run programs of the IHS and BIA 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 Indians and Alaska Natives 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 IHS in the assistance and provision of services to Indians living off-reservation in urban areas.

The Indian and Alaska Native Delivery System Today

The Indian Health Service is administered through 11 regional Area Offices, which includes 140 local Service Units nationally. There are three basic components to the Indian delivery system:

**IHS Direct System:** IHS directly administers 42 hospitals, 65 health centers, 4 school health centers, and 52 smaller health stations. 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, 93 outpatient health centers, 3 school health centers, 63 smaller health stations and 173 Alaska village clinics.

Urban System: 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 Indian Health Service estimates its patient population to be 1.33 million Indians and Alaska Natives in 1993. This represents approximately 57% of the total number of Indians and Alaska Natives identified in all areas in the United States Census of 1990. Health status data on Indians not residing within established IHS service areas is limited. The system developed by IHS is targeted at those Indians within identified services areas or which fall under the existing delivery system of IHS/tribal/urban providers. Substantial infrastructure is in place within the IHS delivery system. 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% of all the IHS/tribal health care systems have earned accreditation from the Joint Commission for the Accreditation of Health Care 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 IHS/tribal/urban systems strive 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 (CHR) and Community Health Aids (CHA) have extended health services out into the community setting and provided 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 a March 1993, summit on Indian Health, Michel 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." (Michael Lincoln, 1995)

The health status of Indians and Alaska Natives remains poor relative to the rest of the United States 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 delivery systems. The IHS Health Trends Report for 1993 shows that Indian 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 Indian population is 24.2 years as compared to 32.9 years for the U.S. All Races. Indian people are three times more likely to live in poverty than all other races. Of all deaths among Indian people, the IHS reports that 33% are to those younger than 45 years, as compared to only 11% for U.S. All Races, including 22% for Black decedents and only 9% for White decedents. Alcoholism continues to be a major health and social problem for many Indian communities. Although alcohol death rates among Indians declined steadily, the rates have increased sharply beginning in 1986 and continue to increase. Increasing trends in deaths rates for Indians can also be seen in tuberculosis and diabetes. From region to region, stark differences are apparent in the overall health status of Indians. While 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% of the Alaska Native villages lacking sanitary water and sewer systems.

To make a healthier and safer environment for Indian families 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. IHS, tribal and urban delivery systems provide only a framework. These systems will require substantial reinvestment and expanded, continual services to make achieve the goals of health care reform and to ensure the policy of the Federal government with regard to Indian health is achieved.
Health Care Reform and Indian Health

The President's blueprint for health reform was first introduced in a book by The Progressive Policy Institute entitled, "Mandate for Change". The chapter on health care reform began as follows:

"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."

Clearly, something must be done to address the problem of rising health care costs and a growing number of people in the U.S. who are without health coverage. Upon his inauguration, the President established a Health Reform Task Force chaired by First Lady, Hillary Rodham Clinton. The Task Force, working on a self imposed deadline of 100 days, included a work group on Indian health, "work group 16-A". The Indian work group included staff from the Senate Indian Affairs Committee, Indian Health Service officials and individuals from tribal programs.

In addition to the President's proposal, there are other health 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 more seriously, is the bill 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 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 title.

Hearings before Congress have already begun regarding health care reform.
The Senate Committee on Indian Affairs and the House Subcommittee on Native American Affairs will have jurisdiction over aspects of the legislation affecting Indian health. In addition, the Department of Health and Human Services (DHHS) Assistant Secretary for Health, Dr. Phil Lee, will be holding a series of field hearings throughout the United States to gather testimony from Indian tribes and urban Indian health providers regarding the President's legislation. Health care reform is expected to move quickly through the legislative process. Legislation could be voted on the House floor as early as May or June, with Senate action expected in July, 1994. Involvement of tribes, urban health providers, IHS, national Indian organizations and others concerned about the improvement of Indian health is critical and time is of the essence. A significant number of meaningful meetings and consultations have already occurred. 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, the National Indian Health Board and the American Indian Health Care Association met early with the individuals who would eventually constitute the Health Reform Task Force, to discuss the unique status of Indian health care.

**IHS Roundtable on Indian Health - February 17, 1993.** The IHS sponsored a Roundtable Conference in Health Care Reform and Indian Health, which developed consensus statements outlining fundamental points centered around, (1) Moral and Legal Obligation of the Federal Government; (2) Quality of Care; (3) Acceptance of Care; (4) Access to Care; (5) Financing; (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 develop recommendations for reform. Basic principles for discussing health care reform included (1) Special legal obligations involving American Indians; (2) Cultural consideration 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 National Indian Health Board 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 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; (6) Other Comments centered on traditional healers, sacred places, cultural sensitivity and continued consultation.

Technical Steering Committee Recommendations - October, 1993. Three national Indian organizations provided significant coordination of information through-out the year as health reform information became available. Theses organizations met along with tribal representatives in October to hear draft recommendations from the White House Health Reform Task Force work group 16-A, and to provide feed-back. A letter to the President, along with specific recommendations was signed by the directors of the National Indian Health Board, the American Indian Health Care Association and the Association of American Indian Physicians. These recommendations centered upon (paraphrased):

1. Policy - must reaffirm the policy of the Nation regarding Indian health, federal responsibilities, and explicitly not alter or affect existing law;

2. Definitions - Specific recommendations were made to conform health reform legislation to Indian law, and to expand Indian participation in other programs;

3. Governance - A national board was proposed to manage funds for Indian health;

4. Services - Specific recommendations were made to ensure "Comprehensive Benefits Package" limitations do not exclude supplemental services for Indians, and to exempt Indian delivery systems from the Anti-Deficiency Act;

5. Infrastructure - Recommendations were provided to bring existing facility deficiencies up to standard;

6. Manpower - Calls for Indian participation in the National Health Service Corps program including placement of 25% of those trained at Indian sites;

7. Financing - Recommends IHS beneficiaries not required to make copayments, exemption of employer payments, capitated adjustments for Indian populations, and prompt payment systems;

8. Health Research Initiatives - Calls for a separate research system for Indian research;

9. Medicaid/Medicare - Calls for expanded reimbursement for tribal and urban programs.

National Congress of American Indians - November 1993. At the annual convention of NCAI, the health committee conducted extensive deliberations on health care reform and produced the following resolutions which were adopted by the full membership (in paraphrase):

☑ That the Health Security Act define services to Indians as an "entitlement"
by virtue of the special legal/political relationship which exists.

☑ The current Alternative Resource Rule/Payor of Last Resort be eliminated, and clarify that IHS is the “primary provider” of care.

☑ Ensure the right of tribal governments to authorize “automatic enrollment” of their tribal members, unless or until the member enrolls elsewhere.

☑ Exempt employer premium payment of all businesses located within the reservation boundary, former boundary or Indian community.

☑ Automatic enrollment of tribal member, without regard to residency.

☑ Fund Indian programs to be able to compete with other health plans.

☑ Ensure no adverse impact from state health reform efforts.

☑ Clarify relationship between Indian and Regional/Corporate Alliances

☑ Provide funding for Indian Long term Care comparable to states.

☑ Fund comparably Indian involvement in Public Health Initiatives

☑ Do not divert funding for “Supplemental Services” to cover shortfalls in funding for “Comprehensive Benefits Package”.

☑ All Congressional Committees with jurisdiction over the Health Security Act should hold field hearing in Indian country to determine impact there.

☑ Funding for an infrastructure from which to provide the Comprehensive Benefits Package must be guaranteed.

☑ Transitional funding must be provided for planning and implementation.

☑ Funding to achieve and exemption from penalty until accreditation and other required standards are achieved, must be ensured for tribes.

☑ Consultation with tribes must continue.

☑ Call for a tribal nations Health Summit with President by September, 1994.

☑ Support for Indian reservations, communities, and off-reservation members to join state health care reform up to 1999, and Congress set-aside funds to build capacity of tribes to offer equal or better health care systems.
ANALYSIS OF INDIAN HEALTH REFORM
UNDER THE
HEALTH SECURITY ACT

The President's national health care reform proposal was delivered to Congress on October 27, 1993 and provides for major changes within the delivery system serving American Indians and Alaska Natives. The Health Security Act sets out to accomplish the following objectives:

SECURITY: The Act guarantees universal coverage for U.S. citizens and other identified persons to receive a comprehensive benefits package, which cannot be interrupted due to a change in jobs or the advance of disease. It will be illegal for insurers to disallow enrollment due to "pre-existing conditions".

CONTROL COSTS: Through a system of "managed competition" premium rates will be controlled and monitored. Large purchasing groups called Regional Alliances, State Alliances and Corporate Alliances will provide consumers with choices of plans which meet cost restrictions. A strong paper-work reduction emphasis also promises to reduce bureaucracies associated with Medicare, Medicaid and insurance reimbursement.

QUALITY OF CARE: Malpractice reform proposes alternative dispute resolution for physicians and reduce malpractice suits. The proposal is aimed at reducing "defensive medicine".

CHOICE: A fundamental component is maintaining the patients’ right to choose his or her own health care provider. Individual patients will be able to follow their own doctor into whichever plan he or she joins. Individuals will be able to choose from a variety of health plans through the alliance.

SIMPLICITY: A "Health Security Card" will be issued to allow electronic billing within the system and reduce paperwork. Insurers will be required to go to a "one-form" system. Everyone will know and understand their eligibility for the comprehensive benefits, without fear of loop holes or other denials.

RESPONSIBILITY: There is a strong emphasis on preventive health care by offering coverage for certain prevention services. The proposal is based on everybody making a contribution into the system in one form or another, even if it is a small amount (except Indian beneficiaries enrolled in an IHS/tribal/urban plan). Small businesses and low-wage workers will get substantial discounts on the cost of insurance premiums.
FINANCING: The system is financed by (1) Medicare Savings: from reduced growth in Medicare, which is channeled back for expanded Medicare services such as longterm care and prescription drugs; (2) Medicaid Savings: which are expected by folding the acute care component into the overall system, and reducing the need for "uncompensated care"; (3) Federal Employees: All federal workers will be integrated into the overall system resulting in a reduction in Federal coverage; (4) Taxing Expanded Care: the proposal reduces the amount of compensation paid as tax-free health benefits and provides for increased revenues. Employer mandates for at least 80% of health premiums is required for all but very small businesses; (5) Sin Taxes: Increased taxes on tobacco products is proposed.

Under Title VIII - Subtitle D, the draft bill includes "Indian Health Service" provisions. These provisions set out a major change in the manner in which services are provided to IHS, tribal and urban Indian health system patients. The top-to-bottom system of health care which has characterized IHS delivery systems is being turned over. Individual patients will be covered regardless of which system they elect to enroll in, and understanding patient needs, patterns and preferences will become the foundation for the survival of IHS, tribal and urban clinics in the future. If fully funded, the Health Security Act could bring Indian health up to 100% of the level of need funded through-out Indian country, including in historically underserved and neglected rural and urban areas.

While individual patients will have a right to choose any health plan, there are significant incentives for Indian patients to remain with the IHS system. These include full payment of premiums, deductible and supplemental benefits beyond what is provided under the comprehensive benefit package. If fully funded, there are significant benefits for all Indian health delivery systems. IHS, tribal and urban systems are provided with a revolving loan program to finally address longstanding facility renovation and construction needs. By the year 1999, all of the Indian programs (IHS, tribal and urban) must ensure that all services of the comprehensive benefit package are provided to their patients. This is a tremendous potential improvement for Indian patients who have been rationed care through waiting lists, deferrals and inadequate facilities.

Many questions remain unanswered, however. While the proposed bill clearly provides that it does not amend the contracting authority of tribes under P.L. 93-638 and related amendments, the financing system for health care delivery is based on the allocation of premium payments and congressional appropriations which may not be sufficient to cover the full range of services. There could be a defacto negative impact on smaller health delivery systems which lack the critical mass to operate capitlated based budgets. For all urban programs and many of the tribal delivery systems which lack the full spectrum of services required, contracting with local Regional Alliances is inevitable.
SUMMARY AND ANALYSIS OF INDIAN PROVISIONS

DEFINITIONS

Section 1004 of the Act establishes "Applicable Health Plan Providing Coverage" describes the health plans as Regional Alliance Health Plans, Corporate Alliance Health Plans, and a choice of plans for certain other groups including:

"Sec 1004 (b)(3) INDIANS -- For those individuals who are eligible to enroll, and who elect to enroll, in a health program of the Indian Health Service under section 8302(b) or 8306(b), that program shall be the applicable health plan."

Section 8301 of the bill provides definitions for key aspects of the Indian health proposal. Health programs are defined to include the Indian Health Service (IHS), a tribal organization under authority of P.L. 93-638, the Indian Self-determination Act; and urban Indian health programs funded under Title V of P.L. 94-437, the Indian Health Care Improvement Act.

A reservation means the "reservation of any federally recognized tribe or former reservations in Oklahoma, or lands held by Native groups, regional corporations and villages under the Alaska Native Claims Settlement Act."

The bill relies upon the definitions already established in the Indian Health Care Improvement Act for defining "Indian", "Indian tribe", "tribal organization", "urban Indian" "urban Indian organization" and "service unit".

Recommendations from tribal groups and urban health programs has cited the need to reaffirm the commitment of the Federal Government to its stated policy under the Indian Health Care Improvement Act, to "elevate Indian health status to it highest possible level". NCAI has also recommended clarifying the role of IHS as the "primary" provider of health care and not the residual provider, defining the right of Indian people to receive health care through the Federal Government as an entitlement. Protection of "dual citizenship" rights of individual Indian patients will also need to be examined, as there may be other state administered programs of importance to Indian communities.
ELIGIBILITY AND COVERAGE

Sec. 8302 - “Eligibility and Health Service Coverage of Indians” of the bill provides relatively open language. One goal of the Health Security Act is to provide “universal coverage”. The bill states that an eligible individual as defined in the Health Security Act (U.S. Citizen, or approved non-citizen), is also eligible to enroll in the Indian system if that person meets any of the following criteria:

“(1) an Indian, or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the Indian community which the individual lives, who resides on or near an Indian reservation or in a geographical area designated by statute as meeting the requirements of being on or near an Indian reservation notwithstanding the lack of an Indian reservation;
(2) an urban Indian; or
3) an Indian described in section 809 (b) of the Indian Health Care Improvement Act (25 U.S.C. 1679 (b)).”

ELECTION AND ENROLLMENT

Under the same section, it is provided that any individual described above may “elect” to enroll in a health program of the Indian Health Service instead of another health plan offered by a Regional Health Alliance or State. This person may also elect to enroll in another plan, which is covered in more detail later. The individual can enroll in the Indian Health System through any of the three identified IHS delivery systems,

(1) IHS;
(2) Tribal Self-Determination Act Programs;
(3) Urban Indian Health Programs.

Any individual who is eligible for and enrolls into the Indian health system will not be subject to any charge for health insurance premiums, deductibles, copayments, etc. If an Indian person who would otherwise be eligible for the Indian Health Plan decides instead to enroll in a Regional Alliance or some other plan, the Indian Health Service is not responsible to make payment to that individual directly, nor on behalf of that individual for the premiums charged for the alternate plan, nor is the IHS responsible to pay for any other cost which the individual would be required to pay under the alternate plan, such as the copayment. It is not clear if this person would be sponsored under the alternate plan, if for example the person were unemployed, lacking any means for employer or personal payment of premiums. It is assumed that such an individual could qualify for reduced
premium enrollment in Regional Alliances or State programs as provided in other sections of the bill. This provision could be helpful to avoid shifting of health care revenue during the transition period if there is a major shift in patient choice to some other provider.

However, should the total enrollment of a tribal, urban or IHS health program continue to decline, the capitated allocation of funding to provide comprehensive benefits would likely decline proportionately from one year to the next. While the language in Section 8302 does not provide for IHS to directly support payment for health care in alternate alliances, it is likely this shift will occur at an appropriations or allocations level and have the same negative result.

The National Congress of American Indians has proposed that this section be changed to provide that all current tribal members be enrolled automatically within the tribal or IHS delivery center, and that the option to withdraw and enroll in a different system still rests with the individual patient. NCAI has proposed this amendment to eliminate the “active” enrollment process, which could simply miss or overlook thousands of Indian patients. A “passive”, automatic enrollment system is more likely to truly represent the Indian patient population and avert disastrously low false budget projections.

SERVICES TO NON-INDIANS

Section 8306 provides an extensive description of cases under which it will be allowable for the Indian delivery systems to care for non-Indians. The first provision is in the case of “Non-Enrollees”, who are members of another health plan or Regional Alliance, which has negotiated shared services with the Indian health provider. Care may be provided in this case, if it is determined that this will not diminish care to Indian enrollees. The second provision for non-Indians or non-eligible Indians is for “Family Treatment”. Indian health programs may elect to enroll family members of eligible individuals who would not otherwise be eligible. Charges for premiums or copayments will be made to the individual members of the family not otherwise eligible for the Indian health plan. If the non-eligible person enrolled through Family Enrollment is employed, then the employer must pay the employer portion of the premium (unless that employer is a tribal government, which is exempt). The Secretary will establish a means to compute premiums charged to individuals in Family Enrollment, including reductions to the premium for allowable cases. These payments will be forwarded to the Indian health plan, as if it were a Regional Alliance. It will be important to ensure accounting of non-Indian enrollees to avoid the situation where health care resources to Indians is depleted.
Section 1431 of the bill designates the IHS, tribal and urban delivery systems of the Indian Health Plan to be automatically eligible to become "Essential Community Providers". This designation will entitle these providers with preferential treatment in negotiating shared services agreements with larger Regional Alliances or State programs to serve enrollees of that alliance. Section 1431 requires that,

"... each health plan shall, with respect to each electing essential community provider... located within the plan's service area, either,
(1) enter into a written provider participation agreement...
with the provider, or
(2) enter into a written agreement under which the plan shall make payment to the provider ..."

This could also be an important provision for IHS, tribal and urban health care providers which do not currently have the capacity to provide the range of Comprehensive Benefits Package as described in the Act, and plan to contract with an Alliance for additional services for their patients. Provisions in this section of the bill require that Essential Community Providers will be entitled to receive treatment under the plan in accordance with the terms and conditions at least as favorable as those that are applicable to other providers participating in the same health plan with respect to scope of services for payment, rate of payment, financial incentives, limitations on financial risk, assignment of enrollees, and access to medical specialties and subspecialties in the plan.

This section speaks primarily about Regional Alliances which contract with "essential community providers" to provide certain services for the Alliance patients. What will be more beneficial for IHS, tribal and urban providers, is clarifying language which ensures that I/T/U systems can easily contract with Alliances to cover care for the I/T/U enrolled patients, such as inpatient care, and to do so at reasonable rates.

SUPPLEMENTAL BENEFITS

Section 8303 provides for Supplemental Indian Health Care Benefits for all individuals who are eligible for benefits under laws administered by the Indian Health Service, which are considered to be "supplemental" to the Comprehensive Benefits Package (CBP). No charges will be made to the individual for these supplemental services. These may include the water, sewer, public health, community health representative, and other services currently existing within the IHS system, which are not included specifically under the definition of the CBP.
Funds are authorized to be appropriated for supplemental benefits at $180 million in FY95 and $200 million per year from FY 96 until FY99. This amount represents approximately 10% of the current appropriated budget for IHS in FY 94. Will this amount be sufficient for supplemental services? Clearly it will not. If the Indian Health Service were to be able to fund supplemental services at 100% of need, IHS will require an additional $700 million, just for supplemental services. This does not include added costs to cover services which IHS, tribal and urban programs see as essential, but which are not included in the CBP, such as adult dental care.

The Act will require the IHS, tribal and urban health plans to provide the full range of CPB to their patients by the year 1999 (Section 8304). A serious problem could arise if funding for the CPB is insufficient and supplemental services funds are redirected. The supplemental services provision represents the integrity of the Federal Government's commitment to elevate Indian health status. It focuses on the non-clinical aspects of public health and disease prevention activities. It will be important to quantify the supplemental services, just as the comprehensive benefits have been quantified to avoid erosion of support over time.

**COMPREHENSIVE BENEFIT PACKAGE**

Section 8304 requires that the Indian Health Service delivery system (IHS/Tribal/Urban) ensure that ALL services identified under the Comprehensive Benefit Package is provided at ALL health programs by January 1, 1999. These include:

- Hospital Services;
- Services of health professionals;
- Emergency and Ambulatory Medical and Surgical Services;
- Clinical Preventive Services;
- Mental Health and Substance Abuse Services;
- Family Planning Services and Service for Pregnant Women;
- Hospice Care;
- Home Health Care;
- Extended Care Services;
- Ambulance Services;
- Outpatient Laboratory, Radiology, and Diagnostic Services;
- Outpatient Prescription Drugs, and Biologicals;
- Outpatient Rehabilitation Services;
- Durable Medical Equipment, Prosthetic and Orthotic Devices;
- Vision Care;
- Dental Care;
- Health Education Classes;
- Investigational Treatments.
While it could be said the IHS provides all these services “someplace” in the U.S., it is not true that IHS provides ALL these services EVERYWHERE a tribal or urban facility is located. On the contrary, a significant, sizeable gap exists between what IHS/tribal/urban programs provide and what is required under the CBP on a year around, continual basis. The Secretary of HHS must ensure that the full CBP and other requirements including certification requirements of approved health plans, must be met by the Indian Health Service and its three delivery systems, by January 1, 1999. How will Indian delivery programs, which have operated at 25% - 60% Level of Need Funded through-out the United States, be able to meet the 1999 deadline to provide the full CBP, without substantial Federal dollar investment? It will be incumbent upon tribal, urban and IHS planners to maintain quality care, expand services and provide the full range of CBP services as early as possible, to avoid a drain of Indian patients (and their proportionate revenues) from leaving the IHS/tribal/urban systems and enrolling elsewhere. The timing of the transition for Indian health plans, should parallel that of the rest of the United States to avoid a shifting of patients and revenues.

The IHS Office of Health Programs estimates it will require an additional $700 million for increased staffing just to provided the full CBP in all IHS, tribal and urban delivery systems. This number is based on unmet need from Contract Health Services and RIM methodologies. It is a difficult climate for increased funding, as the IHS is facing a Reduction in Force of 1,000 positions in 1994 alone. Finding an additional $700 million may prove difficult, but is essential if IHS, tribal and urban health delivery programs are expected to compete with Regional and State Alliances for patients.

In the state of California, the health care reform has been extremely difficult for many Indian clinics. Many have had a difficult time holding on to patients, when they do not have an inhouse medical laboratory, pharmacy and other features of a clinic which will keep them competitive with larger managed care corporations now trying to enroll previously uninsured or Medi-Cal patients.

TRIBAL EMPLOYERS EXEMPT FROM PREMIUMS

Under Section 8305, the bill provides that,

"a tribal government and a tribal organization under the Indian Self-Determination and Educational Assistance Act or a self-governance compact shall be exempt from making employer premium payments as an employer under section 6121". 
This means that the tribe will not be required to pay the employer premium for all employees. Some tribes had requested this exemption to apply to only Indian employees, while the NCAI resolution calls for all businesses, Indian and non-Indian, located on Indian lands be exempt from premium payments, as an inducement for economic stimulation. It is not clear how the premium will be paid for non-Indian employees working for tribal governments and enrolled in a Regional Alliance. The Federal Government will likely serve as a subsidy for non-Indian tribally employed patients of the system.

PAYMENT BY OTHER PAYORS

Several provisions clarify the added contracting authority of the Indian Health Service to acquire professional services for direct care. It is specified that nothing in the Act proposes to amend existing authority of the IHS related to the Contract Health Services and the IHS policy of “payor of last resort” regarding CHS services.

(b) PAYMENT FOR SERVICES PROVIDED BY CONTRACTORS -- Nothing in this subtitle shall be construed as affecting any other provision of law or policy concerning the status of the Indian Health Service as the payor of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

It is presumed that the IHS will continue to contract for services from providers of care outside the IHS system. However, the notion that IHS would remain the payor of last resort, seems to be inconsistent with the objectives of health care reform, that is to ensure universal and uninterrupted health care coverage for the patient. Recommendations from tribes, as evidenced in the NCAI resolution call for an elimination of this policy, and clarification of IHS as the primary provider. If IHS/tribal/urban health plans are to function just as a Regional Alliance or State Alliance, then ample funds must be calculated in the capitated rate for Indian beneficiaries to cover uninterrupted care and ensure all services under the Comprehensive Benefits Package.

Section 1541(b)(7) of the Health Security Act specifically identifies a process by which “Risk Adjustment and Reinsurance” will be implemented to “protect health plans that enroll a disproportionate share of ... eligible individuals ... to whom expected utilization ... and expected health care expenditures for such services are greater than the average...”. In these cases adjustments are to be made, or the plan will be mandated to acquire reinsurance. Included in the lists of those to be consider is included “special consideration for veterans, military and Indian health plans”.

FACILITIES RENOVATION AND CONSTRUCTION

Section 8310 provides authority for the IHS to expend funds appropriated under the "Public Health Initiatives Fund" established in section 3701 of the Act for the purposes of

".. construction and renovation of hospitals, health centers, health stations, and other facilities for the purpose of improving and expanding such facilities to enable the delivery of the full array of items and services guaranteed in the comprehensive benefit package."

A means for capital financing is proposed through the establishment of a revolving loan program. The Indian Health Service will provide guaranteed loans to IHS, tribal and urban providers within the system to improve and expand facilities in order to guarantee delivery of services under the CBP. Authorization of appropriations however, are limited to accomplish the task. Funds identified to cover this section and other sections, including the Comprehensive Benefits Fund, provide for $40 million in FY 95, $180 million in FY 96 and $200 million for FY97 to FY 2000. These amounts are in addition to what may otherwise be appropriated.

The IHS estimates to bring facilities up to a level appropriate to compete under health care reform, it will require the following amounts for new or replacement construction of facilities and related maintenance.

<table>
<thead>
<tr>
<th>One-Time Cost</th>
<th>Maintenance/Replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals</td>
<td>1.186 Billion</td>
</tr>
<tr>
<td>Clinics (outpt)</td>
<td>1.137 Billion</td>
</tr>
<tr>
<td>Urban Clinics</td>
<td>374 Million</td>
</tr>
<tr>
<td>Extended Care</td>
<td>199 Million</td>
</tr>
<tr>
<td>Alcohol (inpt.)</td>
<td>428 Million</td>
</tr>
<tr>
<td>Alcohol (outpt.)</td>
<td>70 Million</td>
</tr>
</tbody>
</table>

Another option which is available for tribes and urban providers is Section 3441 which provides for loans and loan guarantees for community plans and networks which join together to serve medically underserved areas and populations.

ESTABLISHMENT OF LOCAL "CHB FUND" FINANCING

Section 8311 on "Financing", authorizes the establishment for each program of the
Indian Health Service (IHS, tribal and urban) a fund, known as the comprehensive benefit package fund.

“(a) Each health program of the Indian Health Service shall establish a comprehensive benefit package fund...”
“(b) There shall be deposited into the fund...(1) all amounts received as employer premium payments... (2) All amounts received as family premium payments and premium discount payments... (3) All amounts appropriated for the fund for the purpose of providing the comprehensive benefit package to individuals enrolled in a health program of the Indian Health Service. (4) Any other amount received with respect to health services for the comprehensive benefit package.”
(c) (1) The fund shall be managed by the health program of the Indian Health Service ... (2) ...to provide for the delivery of the items and services of the comprehensive benefit package... (3) shall be available without further appropriation and shall remain available until expended.”

Herein lies the crux of the success or failure of the proposed Indian health reform. Will the IHS/tribal/urban programs be funded at a rate adequate to fully provide for comprehensive benefits? While this section specifies minimal funding authorization ($200 million) to be applied to this and other sections, including the facilities revolving loan fund, there is language which states:

"Sec. 8313 (b) The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purposes of carrying out this subtitle.”

This provision allows for funding authorizations under the Indian Health Care Improvement Act, the Indian Self-Determination Act, the Snyder Act and any other authorizations to be included within the amount appropriated for the full funding of the comprehensive benefits package. The most serious consideration for the IHS/tribal/urban health delivery system will be the methodology for calculating the rates by which Indian patients will be paid into the system. Section 1541 of the Act provides a mechanism for “risk adjustment” health plans which for some reason enroll a disproportionate number of costlier patients. Indian health programs are specifically identified to receive consideration under Section 1541(b)(7). Further, section 1541 of the Act provides that a health plan which requires risk adjustment, but cannot produce the data to justify the adjustment may be mandated to purchase “reinsurance” through a state reinsurance program to cover cost overruns for these patients. Section 3441 also provides for grants to community health networks.
which involve the joint effort of eligible providers, including tribes and urban clinics, to serve medically underserved areas and populations.

Another key element to IHS/tribal/urban health plans accruing the needed funding base, in addition to receiving appropriately adjusted rates, will be enrolling the maximum number of Indian beneficiaries into each system as early as possible. Data and technical assistance will be needed for each of the Indian delivery systems to establish a cost/patient volume ratio which can be used in planning and developing each of the systems. If a community will serve only 300 patients, the capitated rate for these patients will add-up to an amount to provide only a small fraction of the CBP services required. Each local Indian delivery system will need to understand this formula and be prepared to negotiate with another Indian plan or perhaps a non-Indian alliance to guarantee full coverage for their patients. In so doing, there will be a sharing of the services, a sharing of the capitated payment and a sharing of the risk if the total costs for the plan exceeds the total income.

P.L. 93-638 AND P.L. 94-437

Section 8312 of the bill provides that unless otherwise stated in the Act,

"no part of this Act shall be construed to rescind or otherwise modify any obligations, findings, or purposes contained in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) and in the Indian Self-Determination and Education Assistance Act."

CONSULTATION

Finally, the bill sets out in section 8309 the requirement that consultation occurs between the Secretary and representatives of the Indian delivery system,

"The Secretary shall consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities."

The National Indian Health Board, the American Indian Health Care Association and the Association for American Indian Physicians worked together as a Steering Committee on health care reform, and recommended to the Administration to create a national governing board to oversee the Indian fund. The recommendation
of October, 1993, provided that the governing board would review the collection, appropriation and distribution of the funds. The board would be composed of representatives from each of these organizations, along with tribal leaders appointed by the President and representatives from the IHS and Public Health Service. Finally, the Chairperson of the Indian board would serve on the National Health Board created by this Act. The consultation section is extremely important to tribes and urban health providers, but falls short of the recommendation made by the Steering Committee.
OVERALL HEALTH SECURITY ACT SUMMARY

Title I - HEALTH CARE SECURITY: This title provides for the changes in the overall delivery system nationally and sets out the fundamental changes in policy with regard to universal coverage and comprehensive benefits for all Americans. The title includes the following subtitles:

Subtitle A -- Universal Coverage and Individual Responsibility. Every U.S. Citizen is entitled to the comprehensive benefit package. Language is also provided for the treatment of non-citizens, family coverage and multiple employer situations.

Subtitle B -- Benefits. The subtitle lists services included under the term "comprehensive benefits package" to be, hospital services; services of health professionals; emergency and ambulatory medical and surgical services; clinical preventive services; mental health and substance abuse services; family planning services and services for pregnant women; home health care; extended care services; ambulance services; outpatient laboratory, radiology and diagnostic services; outpatient prescription drugs and biologicals; outpatient rehabilitation services; durable medical equipment and prosthetic and orthotic devices; vision care; dental care; health education classes; investigational treatments. Detailed descriptions of each category and restrictions related to these services is provided in this subtitle.

Subtitle C -- State Responsibilities. Sets outs the requirements for state participation and the responsibilities of the state in relationship to Regional Alliances, certification of health plans and assurance of financial solvency of plans.

Subtitle D -- Health Alliances. This section address the establishment of Regional and Corporate Health Alliances. A Regional Alliance means a non-profit, organization, an independent state agency or an agency of the states which meets the Regional Alliance requirements. Extensive detail is provided regarding Alliance governance, financing, and payments.

Subtitle E -- Health Plans. The requirements related to the Comprehensive Benefit Package are listed, including applications, enrollment, community rating, marketing, grievance procedures, data management etc.

Subtitle F -- Federal Responsibilities. These include the establishment of a National Health Board, Review and Approval of State Systems, responsibilities in the absence of state systems, premium class factors, and the establishment of "Essential Community Providers". NOTE: IHS, tribal programs and urban Indian health providers are defined in this subtitle as "automatically certified" as Essential Community Providers.

TITLE II -- NEW BENEFITS: This title provides for new services added to the existing Medicare and Medicaid systems through the individual states. Including:
Subtitle A -- Medicare Outpatient Prescription Drug Benefit. Expands Medicare to include outpatient drugs, rebates, pharmacy counseling, home infusion drug therapy, and related requirements.

Subtitle B -- Long Term Care. Provides for State programs for home and community based services for individuals with disabilities, amends Title XIX of the Social Security Act to cover long term care, establishes standards covering private long term care and enforcement mechanisms.

TITLE III -- PUBLIC HEALTH INITIATIVES: A wide range of initiatives is proposed to enhance health care access, research, and promotion. These include:

Subtitle A -- Workforce Priorities Under Federal Payments. Sets out approved physician training, graduate medical education and training programs, and related funding provisions. Includes provision for minority and disadvantaged populations to receive physician and graduate medical training.

Subtitle B -- Academic Health Centers. Establishes payment formula to teaching hospitals and ensures access of patients to receive care at teaching hospitals.

Subtitle C -- Health Research Initiatives. Amends the Public Health Service Act directing the National Institutes of Health to target research in the area of health care reform and health promotion.

Subtitle D -- Core Functions of the Public Health Programs; National Initiatives Regarding Preventive Health. This subtitle establishes a “Public Health Service Initiatives Fund” to be used for “Core Public Health Functions” beginning with $12 million in FY95 growing to $750 million by FY 2000, and for Health Promotion and Disease Prevention Initiatives beginning at $175 million in FY 96 growing to $200 million in FY 2000. Grants will be made to states, local governments and non-profit entities.

Subtitle E -- Health Services for Medically Underserved Populations. Provisions to expand the Community and Migrant Health Centers funded under PHS is provided, including expansion of services and facilities. The National Health Service Corps is expanded to include Nurses Scholarship and Loan Repayment programs. A program is established to make payments to Hospitals which serve “vulnerable” patients.

Subtitle F -- Mental Health and Substance Abuse. Sets aside a portion of the Public Health Initiatives Fund for formula grants to States to enhance and improve mental health and substance abuse systems, and to establish a loan guarantee authority for private and public residential treatment providers for facility improvements.

Subtitle G -- Comprehensive School Health Education; School-Related Health Services. Establishes a comprehensive school health program for children in grades K-12 to address leading health problems and promote wellness. Grants are provided to States to conduct the planning and implementation. Subgrants to local governments and local educational agencies is allowed. Grants for delivering school based health care is provided either through States or through local community partnerships. Loan guarantees for capital costs is also provided.
Subtitle H -- Public Health Service Initiative. Sets out amounts to be appropriated by Congress toward these initiatives of $1.1 billion in FY95 growing to $3.6 billion in FY 2000.

Subtitle I -- Coordination With COBRA Continuation Coverage. Conforming language is provided to ensure health care reform changes are consistent with the continuation of coverage provisions in COBRA.

TITLE IV - MEDICARE AND MEDICAID:
Subtitle A -- Medicare and the Alliance System. Describes the enrollment of Medicare beneficiaries into the Regional Alliance Plans, providing individual options and encouraging Managed Care under the Medicare program. Includes quality management initiatives, anti-fraud and abuse provisions and extension of coverage for Medicare patients under Department of Defense and Veterans Affairs facilities.

Subtitle B -- Savings in Medicare Program. Reduces the existing rates under Medicare for certain services and calculations of payment, and amends formula calculations.

Subtitle C -- Medicaid. Limits the coverage under the Medicaid program to those listed in the Act as Comprehensive Benefits Package. Also expands eligibility for nursing facility services and long term care.

Subtitle D -- Increase in SSI Personal Needs Allowance. Increases the SSI allowances for personal needs effective January 1996.

TITLE V - QUALITY AND CONSUMER PROTECTION:

Subtitle B -- Information Systems, Privacy, and Administrative Simplification. Establishes the national data system for individual identifier numbers, health security cards, electronic data network and related provisions to ensure protection of privacy.

Subtitle C -- Remedies and Enforcement. Sets up procedures and rules for health plan claims, appeals, and mediation proceedings. Administrative and judicial review of claims and enforcement is provided.

Subtitle D -- Medical Malpractice. Amends federal tort law to provide for an alternative dispute resolution mechanism, places limitations on the amount of attorney's contingency fees and awards for recovery of health care related costs.

Subtitle E -- Fraud and Abuse. The section sets out an All Payer Health Care Fraud and Abuse Control Program with related monetary penalties and limitations on physician self-referral. Amendments to criminal law are also provided to cover health care fraud, false statements, bribery, etc.

Subtitle F -- McCarran Ferguson Reform. Extends certain federal laws to apply to the business of insurance.
TITLE VI - PREMIUM CAPS; PREMIUM - BASED FINANCING; AND PLAN PAYMENTS:

Subtitle A -- Computation of Targets and Accepted Bids. Sets out the formula and factors which may be taken into account by Regional Alliances in computing premiums and per capita rates.

Subtitle B -- Premium Related Financing. Sets out a multitude of channels through which to calculate individual and family based premiums depending upon the circumstances of the individual or family.

Subtitle C -- Payments to Regional Alliance Health Plans. Provides the computation for plan payments from per capita formula, and plan bid, AFDC and SSI proportions.

TITLE VII - REVENUE PROVISIONS

Subtitle A -- Financing Provisions. Provides for increases in taxes on tobacco products, assessments on Corporate Alliance employers, and recapture of certain health care subsidies received by high-income individuals, including some Medicare beneficiaries.

Subtitle B -- Tax Treatment of Employer-Provided Health Care. Establishes limitations on employer paid health benefits, eliminates cafeteria style plans, makes taxable as gross income any employer paid coverage which exceeds the Comprehensive Benefits Package.


Subtitle D -- Tax Treatment of Funding of Retiree Health Benefits. Establishes post-retirement medical and life insurance reserves, and health benefits accounts maintained by pension plans.

Subtitle E -- Coordination with COBRA Continuing Care Provision.

Subtitle F -- Tax Treatment of Organizations Providing Health Care Services and Related Organization. Exempts regional alliances from income tax, and makes provision for non-profit health care organizations.


Subtitle H -- Tax Incentives for Health Services Providers. Tax credit provided for specific medical providers practicing in certain areas.

Subtitle I -- Miscellaneous Provisions.

TITLE VIII - HEALTH AND HEALTH-RELATED PROGRAMS OF THE FEDERAL GOVERNMENT:

Subtitle A -- Military Health Care Reform. Keeps the military health delivery system intact as Uniformed Services Health Plans.

Subtitle B -- Department of Veteran Affairs. Establishes benefits and eligibility of the system under the VA, and organizes as an intact system as health plans, including supplemental services. No cost share is required.
Subtitle C -- Federal Employee Health Benefits Program. The FEHBP is repealed and a new system to cover federal employees established under the Health Security Act.

Subtitle D -- Indian Health Service. A separate, intact, delivery system for eligible Indians is provided covering IHS, tribal and urban Indian health programs. The IHS must provide all services under the Comprehensive Benefits Package to enrolled beneficiaries by January 1, 1999. Supplemental services beyond the Benefits Package are authorized to continue as currently exist under the IHS delivery system. No copayments are required for eligible Indians enrolling in the IHS system. Tribal governments and tribal organizations are exempt from employer payments of premiums for their employees (not restricted to only Indian employees). Services may be provided to non-Indian patients if it does not diminish care to Indian patients. Non-Indian family members of an eligible Indian may enroll, but will be responsible for payment of related copayments. The Indian delivery system may contract with health alliance providers to provide services. The Contract Health Services program is not affected by this provision. (A MORE DETAILED ANALYSIS OF THIS SUBTITLE IS ATTACHED TO THIS DOCUMENT)


Subtitle F -- Special Fund for WIC Program. Additional appropriations are authorized for the Women’s Infant and Children’s nutritional program.

TITLE IX - AGGREGATE GOVERNMENT PAYMENTS:
Provides for aggregate payments to States and Regional Alliances, and borrowing authority to cover cash-flow shortfalls.

TITLE X - COORDINATION OF MEDICAL PORTION OF WORKERS COMPENSATION AND AUTOMOBILE INSURANCE:
Provides for amendments covering other forms of insurance related to health care delivery such as Workers Compensation and Automobile.

TITLE XI - TRANSITIONAL INSURANCE REFORM:
Provides for protection of beneficiaries during the transition period, against violations of the Act by insurers, preserving current coverage, acceptance of new members, restrictions on premium increases, requirement for portability of health coverage, treatment of pre-existing conditions, and any reduction in benefits.

TITLE XII - TEMPORARY ASSESSMENT ON EMPLOYERS WITH RETIREE HEALTH BENEFIT COSTS:
Provides for a retiree subsidy beginning in 1998 for employers.
CONCLUSION

It is critical for tribes, urban Indian health providers and the Indian Health Service to begin to formulate the necessary positions and recommendations which will ultimately shape the final outcome of this health care reform debate. While the Presidents proposal may not be the final bill which is enacted, it is likely that much of the fundamental principles which shape the debate, such as consumer choice, managed competition, employer contribution, insurance reform and cost controls will emerge in some form or another.

We already know that the Indian Health Service meets less than 60% of the actual need for health services among the identified Indian beneficiary population. If the IHS/tribal/urban delivery systems seize this opportunity to expand significantly the amount of resources targeted for Indian health improvement, we may enhance the percentage of need met. There are inevitably risks involved in moving with the flow of health care reform, but there are also potential life-saving advances which could be achieved. In the course of developing Consensus Statements, Roundtable participants will be asked to discuss:

TRIBAL SOVEREIGNTY: Is there a negative impact on tribal sovereignty by guaranteeing the right of individual tribal members to a choice of health plans? How can the position of tribes be improved to better negotiate for appropriate risk adjustments for tribal patients enrolling in tribal and IHS systems? Is state and Regional Alliance involvement with tribes a benefit or disadvantage?

ELIGIBILITY AND ENROLLMENT: There is potential for mass exodus of Indian patients from the IHS/tribal/urban systems without proactive measures. Should Indian tribal members and Indian patients of urban clinics be automatically enrolled in the Indian system, until such time as they elect to enroll elsewhere? What are the advantages and disadvantages to enrolling non-Indians into the Indian delivery system?

GOVERNANCE AND STRUCTURE: The power base of Indian health will be substantially decentralized under this system. How can Indian delivery systems maintain a direct governance position over the Indian delivery system and have input into the National Health Board? A cost/patient ratio and a matrix for the scale of health services funded for any number of patients must be developed immediately to assist tribes in determining the structure, size, capacity and limitations of their systems. If funding is distributed on a capitated formula, what are the prototypes for shared services, inter-tribal alliances, and coordination with non-Indian alliances?
COMPREHENSIVE AND SUPPLEMENTAL BENEFITS: The Indian Health Service has made modest estimates to expand existing services for the entire IHS/tribal/urban system to meet 100% of all needs. IHS estimates an additional $700 million for the comprehensive benefits package and an additional $700 million for supplemental services. While appearing low, these figures are far greater than what is authorized for appropriations.

TRANSITION AND COMPETITION: The competitiveness of the Indian delivery system will be dependent upon the infusion of substantial resources to meet facility and direct care deficiencies. Without this infusion most of the Indian delivery systems will not be competitive and will lose patients to other plans. Indian plans have until 1999 to be able to guarantee the full range of comprehensive benefits and meet all standards. Until that time the Indian systems are vulnerable. With regard to services to non-Indians, it is still not clear how a well established and well equipped Indian plan can compete to enroll non-Indian patients in the larger community, as an economic enterprise of the tribe or urban center. In many rural areas, the Indian delivery system might be the only service available. The provisions under Section 3441 provide resources for Indian systems to join with other providers and alliances in serving federally designated medically underserved areas and populations, opening the door to increased capital.

FINANCING: Timely and quality data will be critical for local programs to acquire the necessary financing for the local centers. The comprehensive benefit fund will be administered by the local providers. For many smaller clinics, this may not produce the needed capital to operate, and may expose these programs to financial disaster due to high cost patients without an adequate reinsurance system or safety-net. Section 1541 provides for risk adjustment methodology for high cost patients, with special consideration for Indian systems. A means is also provided which will mandate health plans to purchase state reinsurance in the case where the plan requires risk adjustment but lacks the data to compute a higher rate.

FACILITY FINANCING: The revolving loan fund is not a totally new concept. Tribes have been requesting IHS and Congress to consider options for health facility construction such as tribal finance/buy-back or lease-back. The historical problems with the IHS Health Facility Construction Priority System has caused delays of many years, decades, for some facilities lucky enough to be on the list to finally be built. For smaller clinics, they will never have the numbers to compete on the IHS facility priority list. Yet, the amount of funds authorized for the revolving loan fund again appears small, in comparison with the IHS estimate of construction and replacement needs. Another option under the Act is Section 3441 which will provide for capital financing and grants to community health plans and practice networks. These are health plans, including Indian plans, which join together in a network to serve a medically underserved area or population.
REFERENCES


“Letter to President Clinton Re: Recommendation for Health Care to Native Americans and Alaskan Natives”. from National Indian Health Board, American Indian Health Association, and Association of American Indian Physicians. October 13, 1993.


Indian Health Service Application of Managed Care Approaches to Procuring and Dispensing Pharmaceuticals and Medical Supplies. Briefing Book by TCI, Incorporated, Washington, D.C. January 19, 20, 1994.


ATTACHMENTS

A. Text of Health Security Act

B. Section by Section Analysis of Indian Subtitle

C. Glossary
To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 20 (legislative day, NOVEMBER 2), 1993

Mr. MITCHELL (for himself, Mr. MOYNIHAN, Mr. KENNEDY, Mr. DASCHLE, Mr. ROCKEFELLER, Mr. RIEGLE, Mr. AKAKA, Mr. BAUCUS, Mrs. BOXER, Mr. BUMPERS, Mr. CAMPBELL, Mr. CONRAD, Mr. DODD, Mrs. FEINSTEIN, Mr. GLENN, Mr. GRAHAM, Mr. HARKIN, Mr. INOUYE, Mr. JEFFORDS, Mr. LEAHY, Mr. LEVIN, Mr. MATHIEWS, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mrs. MURRAY, Mr. PELL, Mr. PRYOR, Mr. REID, Mr. SIMON, and Mr. WOFFORD) (by request) introduced the following bill; which was read the first time

NOVEMBER 22, 1993

Read the second time and placed on the calendar
authority responsible for the administration of such provision.

(c) OMNIBUS BUDGET RECONCILIATION ACT OF 1993.—Effective as of the date of the enactment of this Act, section 11101(b)(3) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66; 107 Stat. 413) is amended by striking “September 30, 1998” and inserting “December 31, 1997”.

(d) EFFECTIVE DATE.—Except as provided in subsection (c), this section and the amendments made by this section shall take effect on the day after the FEHBP termination date.

Subtitle D—Indian Health Service

SEC. 8301. DEFINITIONS.

For the purposes of this subtitle—

(1) the term “health program of the Indian Health Service” means a program which provides health services under this Act through a facility of the Indian Health Service, a tribal organization under the authority of the Indian Self-Determination Act or a self-governance compact, or an urban Indian program;

(2) the term “reservation” means the reservation of any federally recognized Indian tribe, former Indian reservations in Oklahoma, and lands held by
incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.); 

(3) the term “urban Indian program” means any program operated pursuant to title V of the Indian Health Care Improvement Act; and 

(4) the terms “Indian”, “Indian tribe”, “tribal organization”, “urban Indian”, “urban Indian organization”, and “service unit” have the same meaning as when used in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

SEC. 8302. ELIGIBILITY AND HEALTH SERVICE COVERAGE OF INDIANS. 

(a) ELIGIBILITY.—An eligible individual, as defined in section 1001(c), is eligible to enroll in a health program of the Indian Health Service if the individual is—

(1) an Indian, or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the Indian community in which the individual lives, who resides on or near an Indian reservation or in a geographical area designated by statute as meeting the requirements of being on or near an Indian reservation notwithstanding the lack of an Indian reservation;
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(2) an urban Indian; or

(3) an Indian described in section 809(b) of the

Indian Health Care Improvement Act (25 U.S.C.

1679(b)).

(b) ELECTION.—An individual described in sub-
section (a) may elect a health program of the Indian
Health Service instead of a health plan.

c) ENROLLMENT FOR BENEFITS.—An individual
who elects a health program of the Indian Health Service
under subsection (b) shall enroll in such program through
a service unit, tribal organization, or urban Indian pro-
gram. An individual who enrolls in such program is not
subject to any charge for health insurance premiums,
deductibles, copayments, coinsurance, or any other cost
for health services provided under such program.

d) PAYMENTS BY INDIVIDUALS WHO DO NOT EN-
ROLL.—If an individual described in subsection (a) does
not enroll in a health program of the Indian Health Serv-
ice, no payment shall be made by the Indian Health Serv-
ice to the individual (or on behalf of the individual) with
respect to premiums charged for enrollment in an applica-
ble health plan or any other cost of health services under
the applicable health plan which the individual is required
to pay.
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SEC. 8303. SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS.

(a) IN GENERAL.—All individuals described in sections 8302(a) remain eligible for such benefits under the laws administered by the Indian Health Service as supplement the comprehensive benefit package. The individual shall not be subject to any charge or any other cost for such benefits.

(b) AUTHORIZATION OF APPROPRIATIONS.—In addition to amounts otherwise authorized to be appropriated, there is authorized to be appropriated to carry out this section $180,000,000 for fiscal year 1995, $200,000,000 for each of the fiscal years 1996 through 1999, and such sums as may be necessary for fiscal year 2000 and each fiscal year thereafter.

SEC. 8304. HEALTH PLAN AND HEALTH ALLIANCE REQUIREMENTS.

(a) COMPREHENSIVE BENEFIT PACKAGE.—The Secretary shall ensure that the comprehensive benefit package is provided by all health programs of the Indian Health Service effective January 1, 1999, notwithstanding section 1001(a).

(b) APPLICABLE REQUIREMENTS OF HEALTH PLANS.—In addition to subsection (a), the Secretary shall determine which other requirements relating to health
plans apply to health programs of the Indian Health Service.

(c) Certification.—Effective January 1, 1999, all health programs of the Indian Health Service must meet the certification requirements for health plans, as required by the Secretary under this section, as certified from time to time by the Secretary. Before January 1, 1999, all such health programs shall, to the extent practicable, meet such certification requirements.

(d) Health Alliance Requirements.—The Secretary shall determine which requirements relating to health alliances apply to the Indian Health Service.

SEC. 8305. EXEMPTION OF TRIBAL GOVERNMENTS AND TRIBAL ORGANIZATIONS FROM EMPLOYER PAYMENTS.

A tribal government and a tribal organization under the Indian Self-Determination and Educational Assistance Act or a self-governance compact shall be exempt from making employer premium payments as an employer under section 6121.

SEC. 8306. PROVISION OF HEALTH SERVICES TO NON-ENROLLEES AND NON-INDIANS.

(a) Contracts With Health Plans.—

(1) In General.—A health program of the Indian Health Service, a service unit, a tribal organi-
zation, or an urban Indian organization operating within a health program may enter into a contract with a health plan for the provision of health care services to individuals enrolled in such health plan if the program, unit, or organization determines that the provision of such health services will not result in a denial or diminution of health services to any individual described in section 8302(a) who is enrolled for health services provided by such program, unit, or organization.

(2) REIMBURSEMENT.—Any contract entered into pursuant to paragraph (1) shall provide for reimbursement to such program, unit, or organization in accordance with the essential community provider provisions of section 1431(c), as determined by the Secretary.

(b) FAMILY TREATMENT.—

(1) DETERMINATION TO OPEN ENROLLMENT.—A health program of the Indian Health Service may open enrollment to family members of individuals described in section 8302(a).

(2) ELECTION.—If a health program of the Indian Health Service opens enrollment to family members of individuals described in section 8302(a), an individual described in that section may elect
family enrollment in the health program instead of
in a health plan.

(3) ENROLLMENT.—

(A) IN GENERAL.—An individual who
elects family enrollment under paragraph (2) in
a health program of the Indian Health Service
shall enroll in such program.

(B) APPLICABLE INDIVIDUAL CHARGES.—
The individual who enrolls in such program
under subparagraph (A) is not subject to any
charge for health insurance premiums,
deductibles, copayments, coinsurance, or any
other cost for health services provided under
such program attributable to the individual, but
the family members who are not eligible for a
health program of the Indian Health Service
under section 8302(a) are subject to all such
charges.

(C) APPLICABLE EMPLOYER CHARGES.—
Employers, other than tribal governments and
tribal organizations exempt under section 8305,
are liable for making employer premium pay-
ments as an employer under section 6121 in the
case of any family member enrolled under this
subsection who is not eligible for a health pro-
gram of the Indian Health Service under section 8302(a).

(4) PREMIUM.—

(A) ESTABLISHMENT AND COLLECTION.—
The Secretary shall establish premiums for all family members enrolled in a health program of the Indian Health Service under this paragraph who are not eligible for a health program of the Indian Health Service under section 8302(a). The Secretary shall collect each premium payment owed under this paragraph.

(B) REDUCTION.—The Secretary shall provide for a process for premium reduction which is the same as the process, and uses the same standards, used by regional alliances for the areas in which individuals described in subparagraph (A) reside, except that in computing the family share of the premiums the Secretary shall use the lower of the premium quoted or the reduced weighted average accepted bid for the reference regional alliance.

(C) PAYMENT BY SECRETARY.—The Secretary shall provide for payment to each health program of the Indian Health Service, in the same manner as payments under section 6201,
amounts equivalent to the amount of payments that would have been made to a regional alliance if the individuals described in subparagraph (A) were enrolled in a regional alliance health plan (with a final accepted bid equal to the reduced weighted average accepted bid premium for the regional alliance).

(c) ESSENTIAL COMMUNITY PROVIDER.—

(1) HEALTH SERVICES.—If a health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program elects to be an essential community provider under section 1431, an individual described in paragraph (2) enrolled in a health plan other than a health program of the Indian Health Service may receive health services from that essential community provider.

(2) INDIVIDUAL COVERED.—An individual referred to in paragraph (1) is an individual who—

(A) is described in section 8302(a); or

(B) is a family member described in subsection (b) who does not enroll in a health program of the Indian Health Service.
SEC. 8307. PAYMENT BY OTHER PAYERS.

(a) Payment for Services Provided by Indian Health Service Programs.—Nothing in this subtitle shall be construed as amending section 206, 401, or 402 of the Indian Health Care Improvement Act (relating to payments on behalf of Indians for health services from other Federal programs or from other third party payers).

(b) Payment for Services Provided by Contractors.—Nothing in this subtitle shall be construed as affecting any other provision of law, regulation, or judicial or administrative interpretation of law or policy concerning the status of the Indian Health Service as the payer of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

SEC. 8308. CONTRACTING AUTHORITY.

Section 601(d)(1)(B) of the Indian Health Care Improvement Act (25 U.S.C. 1661(d)(1)(B)) is amended by inserting "(including personal services for the provision of direct health care services)" after "goods and services".

SEC. 8309. CONSULTATION.

The Secretary shall consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.
SEC. 8310. INFRASTRUCTURE.

(a) FACILITIES.—The Secretary, acting through the Indian Health Service, may expend amounts appropriated pursuant to section 8313 for the construction and renovation of hospitals, health centers, health stations, and other facilities for the purpose of improving and expanding such facilities to enable the delivery of the full array of items and services guaranteed in the comprehensive benefit package.

(b) CAPITAL FINANCING.—There is established in the Indian Health Service a revolving loan program. Under the program, the Secretary, acting through the Indian Health Service, shall provide guaranteed loans under such terms and conditions as the Secretary may prescribe to providers within the Indian Health Service system 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.

SEC. 8311. FINANCING.

(a) ESTABLISHMENT OF FUND.—Each health program of the Indian Health Service shall establish a comprehensive benefit package fund (hereafter in this section referred to as the “fund”).

(b) DEPOSITS.—There shall be deposited into the fund the following:
(1) All amounts received as employer premium payments pursuant to section 1351(e)(3).

(2) All amounts received as family premium payments and premium discount payments pursuant to section 8306(b)(4).

(3) All amounts appropriated for the fund for the purpose of providing the comprehensive benefit package to individuals enrolled in a health program of the Indian Health Service.

(4) Any other amount received with respect to health services for the comprehensive benefit package.

(c) Administration and Expenditures.—

(1) Management.—The fund shall be managed by the health program of the Indian Health Service.

(2) Expenditures.—Expenditures may be made from the fund to provide for the delivery of the items and services of the comprehensive benefit package under the health program of the Indian Health Service.

(3) Availability of Funds.—Amounts in the fund established by a service unit of the Indian Health Service under this section shall be available without further appropriation and shall remain

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available until expended for payments for the delivery of the items and services in the comprehensive benefit package.

SEC. 8312. RULE OF CONSTRUCTION.

Unless otherwise provided by this Act, no part of this Act shall be construed to rescind or otherwise modify any obligations, findings, or purposes contained in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) and in the Indian Self-Determination and Education Assistance Act.

SEC. 8313. AUTHORIZATIONS OF APPROPRIATIONS.

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subtitle, there are authorized to be appropriated $40,000,000 for fiscal year 1995, $180,000,000 for fiscal year 1996, and $200,000,000 for each of the fiscal years 1997 through 2000.

(b) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purposes of carrying out this subtitle.

SEC. 8314. PAYMENT OF PREMIUM DISCOUNT EQUIVALENT AMOUNTS FOR UNEMPLOYED INDIANS.

(a) DETERMINATION.—The Secretary shall determine (and certify to the Secretary of the Treasury) for
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(H.R. 3600 and S. 1757 p. 1249)

Section 8301. Definitions. This section defines the following terms for the purpose of this subtitle:

(1) The term "health program of the Indian Health Service" means a program which provides health services under this Act through a facility of the Indian Health Service, a tribal organization under the authority of the Indian Self-Determination Act or a self-governance compact, or an urban Indian program.

(2) The term "reservation" means the reservation of any federally recognized Indian tribe, former Indian reservations in Oklahoma, and lands held by incorporated Native groups, regional corporations, and village corporations under the provisions of the Alaska Native Claims Settlement Act.

(3) The term "urban Indian program" means any program operated pursuant to title V of the Indian Health Care Improvement Act.

(4) The terms "Indian", "Indian tribe", "tribal organization", and "service-unit" have the same meaning as when used in the Indian Health Care Improvement Act.

Section 8302. Eligibility and Health Service Coverage of Indians. An eligible individual is eligible to enroll in a health program of the Indian Health Service, and may elect a health program of the Indian Health Service instead of a health plan, if the individual is: (1) an Indian, or a descendent of a member of an Indian tribe who belongs to and is regarded as an Indian by the Indian community in which the individual lives, who resides on or near an Indian reservation or in a geographical area designated by statute as meeting the requirements of being on or near a reservation notwithstanding the lack of an Indian reservation; (2) an urban Indian; or (3) a Indian living in certain counties in California as described in section 809(b) of the Indian Health Care Improvement Act.

An individual described above who elects a health program of the Indian Health Service must enroll in the program. The individual is not required to pay any health insurance premiums or other cost sharing. If an individual chooses not to enroll in a health program of the Indian Health Service and instead enrolls in an alliance health plan, the Indian Health Service does not pay the premiums and cost sharing required by the health plan.

Section 8303. Supplemental Indian Health Care Benefits. All individuals described in section 8302 remain eligible for supplemental benefits offered by the Indian Health Service at no charge. $180,000,000 for fiscal year 1995 and $200,000,000 for each of the fiscal years 1996 through 1999 are appropriated for supplemental benefits.
Section 8304. Health Plan and Health Alliance Requirements. Beginning on January 1, 1999, all health programs of the Indian Health Service must provide the comprehensive benefit package. The Secretary of Health and Human Services will determine which other health plan requirements will apply to health programs of the Indian Health Service. Beginning on January 1, 1999, all health programs of the Indian Health Service must meet the health plan requirements that the Secretary determines apply to Indian health programs. Before January 1, 1999, all health programs must, to the extent practicable, meet these requirements. The Secretary must also determine which requirements relating to health alliances apply to the Indian Health Service.

Section 8305. Exemption of Tribal Governments and Tribal Organizations from Employer Payments. Tribal governments and tribal organizations under the Indian Self-Determination and Educational Assistance Act or a self-governance compact are not required to make employer premium payments.

Section 8306. Provision of Health Services to Non-Enrollees and Non-Indians. A health program or facility of the Indian Health Service may contract with a health plan to provide services to individuals enrolled in that health plan if the program or facility determines that the contract will not result in a denial or diminution of health services to Indians enrolled in a health program of the Indian Health Service. The health program or facility is reimbursed as an essential community provider based on an alliance fee schedule or Medicare payment methodology and rates, as determined by the Secretary.

A health program of the Indian Health Service may open enrollment to family members of individuals described in section 8302. If the health program opens enrollment to family members, family members who choose to join a health program of the Indian Health Service must enroll. Family members must pay premiums and other cost sharing. The Secretary of Health and Human Services must establish and collect premiums for family members enrolled in health programs of the Indian Health Service.

The Secretary must provide for a process for premium reduction which is the same as the process used by regional alliances for the areas in which family members reside, but in computing the family share of the premiums the Secretary must use the lower of the premium quoted or the reduced weighted average accepted bid for the reference regional alliance. The Secretary must pay to each health program the amounts that would have been paid to a regional alliance if the individual had enrolled in a regional alliance health plan (with a final accepted bid equal to the reduced weighted average accepted bid premium for the regional alliance).

If a health program or facility of the Indian Health Service elects to be an essential community provider, an individual described in section 8302 or a family member of the individual may receive health services from that essential community provider.
Section 8307. Payment By Other Payers. Indian Health Service programs will continue to receive payments from other Federal programs and third party payers. The Indian Health Service continues to be the payer of last resort for Indians eligible for contract health services under a health program of the Indian Health Service.

Section 8308. Contracting Authority. The Indian Health Care Improvement Act is amended to permit contracting for personal services for the provision of direct health care services.

Section 8309. Consultation. The Secretary must consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.

Section 8310. Infrastructure. The Secretary may expend funds appropriated under section 8313 for the construction and renovation of hospitals, health centers, health stations and other facilities for the purpose of improving and expanding these facilities to deliver the comprehensive benefit package. In order to enable health care facilities to deliver the package, the Secretary will establish a revolving loan program to provide guaranteed loans under terms and conditions determined by the Secretary to providers within the Indian Health Service.

Section 8311. Financing. Each health program of the Indian Health Service must establish a comprehensive benefit package fund. All employer premium payments, family premium payments and premium discount payments, appropriations for the purpose of delivering the comprehensive benefit package to enrollees in a health program of the Indian Health Service and any other amount received for the provision of the comprehensive benefit package must be deposited into the fund. Each fund is managed by the health program. Expenditures may be made from the fund for the delivery of the comprehensive benefit package. Amounts in the fund remain available without further appropriation and remain available until expended for payments for the delivery of the comprehensive benefit package.

Section 8312. Rule of Construction. Unless otherwise provided, no part of this act rescinds or modifies any obligations, findings or purposes contained in the Indian Health Care Improvement Act and in the Indian Self-Determination and Education Assistance Act.

Section 8313. Authorizations of Appropriations. For the purposes of carrying out this subtitle, there are authorized to be appropriated $40,000,000 for fiscal year 1995, $180,000,000 for fiscal year 1996, and $200,000,000 for each of the fiscal years 1997 through 2000. These appropriations are in addition to any other authorizations of appropriations that are available for carrying out this subtitle.

Section 8314. Payment of Premium Discount Equivalent Amounts for Unemployed Indians. The Secretary determines for each fiscal year beginning in fiscal year 1998 an amount equivalent to the total amount of premium discounts that would have been.
paid to an individual described in section 8302 who is unemployed. The Secretary certifies this amount to the Secretary of the Treasury who pays the amount to the Indian Health Service.
GLOSSARY OF HEALTH MANAGEMENT TERMS

All-payer System -- All insurers use same payment schedule.

Alternative Delivery System (ADS) -- A generic term for systems that are “alternatives” to the traditional fee-for-service (FFS) indemnity health insurance plans. ADSs usually involve significant integration between the payer and providers and are legally obliged to provide for (either directly or through a network of providers) and to manage care. Two well known examples of ADSs are Health Management Organizations (HMOs) and Preferred Provider Organization (PPOs). As ADSs rapidly become more mainstream, the term alternative has become somewhat of a misnomer and is less frequently used.

Bare-Bones Health Plans -- These no frills, low-cost policies are geared mainly for small businesses (who haven’t rushed to buy them). Many include only several days of hospitalization and all have huge deductibles, co-payments and low policy limits. Over half of the states have waived mandated health benefits to allow sales of these plans.

Canadian-Style System -- Commonly perceived as a single-payer system, nationalized health care or socialized medicine. But Canada's system actually provides national health insurance and 12 separate, single-payer systems with global budgets. Doctors are mainly self-employed, reimbursed under a negotiated fee schedule. Hospitals are about half government-owned, half publicly held non-profits, reimbursed in set lump sums. Provinces approve technology and facility investments. Patients choose their own doctors.

Carve-Out-Plan -- (See single benefit plan)

Case Management (CM) -- Defn. 1) A non-MD “case manager” (usually an RN or MSW) serving as a medical ombudsman responsible for coordinating the care process for selected consumers. Case-managers usually relate to patients with expensive conditions such as AIDs, premature neonates or cancer. This definition is suggested as the appropriate use of the term. Defn. 2) Sometimes used interchangeably with “managed” care. Defn. 3) A “gatekeeper” physician who must deliver or approve the delivery of all care. (See gatekeeper and coordinated care).

COBRA -- Consolidated Omnibus Budget Reconciliation Act of 1985. Entitles ex-employees of companies with 20 or more workers to continued coverage under the group plan for 18 months after leaving. Small companies are fighting the act.

Competitive Medical Plans (CMP) -- The Health Care Financing Administration (HCFA) uses this term to describe a sub-set of organizations that serve Medicare beneficiaries with “risk contracts” on a capititated payment basis, which is based on an adjusted average per capita cost (AAPCC). HCFA does not consider these organizations to be HMOs because they are not federally qualified (by HCFA's Office of Prepaid Health Care, OPHC). This term is sometimes used interchangeably with ADS.

Consumers -- Those persons who receive either direct medical care services, or reimbursement for the consumption of services, as part of an organized health benefits program. In the case of private plans, these persons generally are the employees or pensioned retirees of a firm and their dependents.
**Consumer Choice** -- This model gives consumers the opportunity and incentive to shop around for insurance prompted by a universal tax credit, which is given for the purchase of mandatory insurance. Companies that provide insurance do not receive a tax break but the poor get a tax refund. Also called a market-based approach.

**Coordinated Care** -- A generic term for managed care plans that frequently make use of gatekeepers.

**Cost-Shifting** -- This hidden tax for uncompensated care is passed on to the consumer through private insurance premiums to pay for the cost of treating the poor. This is the primary method of paying for indigent care in the United States, and some say it is the primary cause of health insurance inflation.

**Employer mandate** -- Requires employers to provide coverage or face stiff penalties. Nixon advocated it in the 1970s. Hawaii implemented it in 1974.

**ERISA** -- Employee Retirement Income Security Act of 1974. Exempts companies that self-insure, or fund their own insurance plans, from state regulations. Most large companies began to self-insure in the 1980s. Now, 70% of firms with 5,000 or more workers do it. Only Hawaii has an ERISA waiver, allowing it to regulated such plans. The act is a major roadblock to state health reform, since it means states cannot require their largest companies to provide insurance, pay premium taxes or cover mandated benefits.

**Exclusive Provider Organizations (EPO)** -- A type of PPO that requires a patient to “exclusively” use providers within the PPO. This characteristic is sometimes called a “lock-in” provision. If the EPO bears risk directly related to utilization of its enrollees, it can be categorized as Risk-sharing EPO or R/EPO.

**Fee For Service (FFS)** -- the traditional fee-for-service indemnity plan.

**Gatekeeper** -- A primary care physician (i.e. a family practitioner, internist or pediatrician) who is responsible for “coordinating” all services. In a gatekeeper plan, most elective specialist or hospital care cannot be delivered without the gatekeeper’s approval. This system is used by most HMOs and EPOs. The gatekeeper of an HMO is usually placed at financial risk for referral and hospital care, serving as a disincentive to “open the gate”. However, most non-HMO gatekeepers do not share risk and are paid separately for their services. State Medicaid programs use this approach fairly extensively and often label gatekeeper physicians as “case-managers” (See above). Some physicians form networks and offer their coordinating services to integrated delivery systems that choose to purchase them. These free-standing gatekeepers have sometimes been called “Primary Care Networks.”

**German-Style System** -- This model represents a regulated multi-payer system. In Germany, approximately 1,200 nonprofit insurance plans are organized by employers, labor unions and professional groups. They are funded by equal payroll taxes on employers and employees. Self-employed and wealthier workers can buy private insurance, but seldom do. Money is turned over to regional networks of doctors, who reimburse physicians in private practice and to hospitals, who pay staff physicians. The government oversees fee negotiations that set the global budget and cover the poor and unemployed. Physician networks police members’ utilization.
Global Budget -- State or national cap on total health care expenditures. Designed to force providers, patients and payers to cut costs and make hard choices.

Group Model HMO -- An HMO that uses a single large multispecialty group practice as the sole (or major) source of care for an HMO's enrollees. The group may or may not have existed prior to the formation of the corporately distinct HMO, and has an exclusive contract with the HMO. Some groups also see FFS or PPO patients, others are not allowed to do so. The term staff/group model HMO is also used for these large HMOs. (Also see HMO and Network HMO).

Health Care Financing Administration (HCFA) -- An agency within the Department of Health and Human Services (DHHS) that oversees Medicaid and Medicare programs. HCFA is responsible for assuring that health care services provided to Medicare and Medicaid beneficiaries meet professionally recognized and Federal standards of care and are delivered effectively and efficiently.

Health Insurance Purchasing Cooperatives (HIPC) -- Would be established under a managed competition model to aggregate the purchasing power of large populations and provide the economies of scale to small businesses and individuals.

Health Insuring Organization (HIO) -- (See Risk-sharing EPO)

Health Maintenance Organization (HMO) -- A prepaid organized delivery system where the organization and the primary care physicians assume some financial risk for the care provided to its enrolled members. Often, the physicians serving HMO patients are paid on a capitation basis. The HMO is legally committed to provide care to its enrollees. In a “pure” HMO, members must obtain care from within the system in order to be reimbursed. There are four basic HMO models (staff, group, network and IPA) and several related variants and hybrids. (Also see Group HMO Staff HMO, IPA, Network HMO, Mixed-Model HMO, S/HMO, O/HMO, and Risk-Sharing EPO).

Hybrid Health Plan -- (See Point-of-Service Plan)

Independent, or Individual, Practice Association (IPA) -- An “open-panel” type of HMO where individual physicians (or small group practices) contract to provide care to enrolled members. The primary care MD may be paid by capitation, or by FFS with a “withhold” risk-sharing provision. An IPA entity may or may not be legally distinct from the HMO entity with which the member enrolls. Physicians participating in IPAs retain their right to treat non-HMO patients on a FFS basis. Most of the early IPAs were developed by organized medicine to compete with large closed-panel HMOs. Many of these initial plans were sponsored by local medical societies and were known as Foundations for Medical Care (FMCs). (See HMO and Network HMO).

Indian Health Service (IHS) -- This department within the Department of Health and Human Services is responsible for providing care to approximately one and a half million American Indians and Alaska Natives living on or near reservations in 33 states. The IHS delivers preventative, curative, rehabilitative and environmental health programs to eligible Indians through three different mechanisms. It provides services directly through its own Federal facilities and staffing, which include 42 hospitals, 65 health centers, 4 school health centers and 52 smaller health stations. In cases where the IHS cannot provide care directly, the IHS
also administers a Contract Health Services (CHS) program which reimburses private providers for specialty and inpatient care provided to eligible Indians on a pre-approved, priority care basis. The second delivery system is tribally operated health services administered through contracts with IHS. Currently, tribes operate 8 hospitals, 93 health centers, 3 school health centers, 63 smaller health stations and 173 Alaska village clinics. The third health delivery system is the urban health program operated out of IHS via grants and contracts to 34 urban Indian organizations operating programs in 41 cities delivering outreach, referral and direct health care delivery services. Many of the tribally operated and urban Indian health programs also seek and secure funding from third party billing, other Federal funding, state or local support and private funds.

Informed Consumers and Providers -- Enforced government reporting requirements allow consumers and providers to make better informed choices. Health plans must report on consumer satisfaction, performance and other outcome indicators.

Integrated Delivery System -- See Alternative Delivery System.

Job-Lock -- Staying in a job out of fear of losing health insurance coverage. Pre-existing condition waiting periods, high rates and outright denials plague individuals applying for new policies.

Managed Care -- A generic term for all types of integrated delivery systems, such as HMOs and PPOs, implying that they “manage” the care received by consumers (in contrast to traditional FFS care which is “unmanaged”). The term denotes the entire range of utilization control “tools” and financial incentives used to manage the practices of physicians and others such as; persuading providers not to order unnecessary services, encouraging patients to use providers in the system and prompting the organization to keep patients as health as possible. These controls are used in all HMOs PPOs, EPOs and increasingly in conventional FFS indemnity plans (see Managed Indemnity Plan). Some of the methods used to manage the patient's care include: pre-admission certification, mandatory second-opinion before surgery, certification of “treatment plans” for discretionary services (such as mental health care), primary care physician gatekeepers and non-physician case-manager/ombudsman to monitor the care process of particular. The actual managing organization is often a separate entity from the payer or insurer, which is often called a care company or third party administrator (See TPA). The term managed care is sometimes used (especially among Medicaid agencies) to denote a “case manager” program. (Also see ADS, case-manager, coordinated care, MIP).

Managed Competition -- This regulated free-market approach holds down health costs through market competition among approved private health plans, as opposed to a single government payer for care or government regulated price controls. Managed competition also depends upon a third party intermediary to ensure that the plans compete on the basis of value rather than patient risk and that the plans are publicly scrutinized for outcome and performance. This proposal relies upon expanded coverage under approved private health plans rather than expanding public programs like Medicaid to achieve universal access. Generally funded by payroll tax on employers, employees. Insurers would get a fixed fee for each enrollee.

Managed Indemnity Plans (MIP) -- A type of health plan where the insurer (or its agent) uses a significant number of utilization controls to “manage” the practices of the providers it reimburses. These controls are more extensive than those used in traditional indemnity plans.
Providers are paid on a FFS basis and a variety of mechanisms may be used to determine rates of payment. A plan is not usually considered an MIP if it does not mandate pre-admission certification for elective hospitalizations. (Also see managed care).

**Mandatory assignment** -- Requires physicians to accept Medicare reimbursement as payment in full. (No balance billing).

**Medicaid Buy-In** -- Allows the uninsured to enroll in Medicaid by paying premiums on a sliding scale.

**Medical IRAs** -- The money employers and employees spend on health benefits is set aside in tax-free employee accounts. At year-end, workers might be allowed to withdraw unused money or earn vacation days. Also called medical savings accounts.

**Medicare Insured Group (MIG)** -- (See R/EPO).

**MeSH (Medical Staff and Hospital)** -- A "joint venture" where one or more hospital(s) and its private practice medical staff, or other body of independent MDs, form a corporation. This MeSH entity, as a unit, may then contract to provide in-patient and/or ambulatory care to patients enrolled in an HMO or PPO (which is corporately distinct from the MeSH). The MeSH can also become a PPO or HMO by directly negotiating with employer groups or payers and by relating to outside providers on a contractual basis.

**Mixed Model HMO** -- This HMO is a mixture of the relatively distinct staff, group, network or IPA varieties. For example, an HMO that serves a significant proportion of its enrollees within a staff model site, but also contracts with several other groups or IPA entities, may be of this type. An HMO can be a mixed model when assessed within a particular market area or across areas. These types of HMOs are becoming more common, as HMOs of one model acquire or merge with previously distinct HMOs of a different type. The results of such mergers are frequently known as "network model" HMOs. (Also see network HMO and O/HMO).

**Multipayer System** -- This model is similar to the German system where multiple payers, typically a private-public mix, reimburse providers. Vermont is studying a multipayer plan using existing insurers, with a state or quasi-state agency regulating costs and insurance fees.

**National Health Care** -- Government finances and delivers health care. This terms is often used a synonym for the Canadian style system, even though Canada does not deliver care.

**National Health Insurance** -- Government-paid health insurance for all. This system differs from nationalized health insurance, in which the government serves as a single payer.

**National Health Service** -- The government not only finances health care but also delivers it. The government typically owns the hospitals and puts doctors on salary. Sweden and the United Kingdom provide tow example of this system. Also known as nationalized health care.

**Negotiated Fee Schedule** -- Fees set through collective bargaining. Usually used to help determine global budget. Also called negotiated payment schedule.
Network Model HMO -- A type of HMO where a network of two or more existing group practices have contracted to care for the majority of patients enrolled in an HMO plan. A network model HMO sometimes also contracts with individual providers somewhat like an IPA whereby providers are usually free to serve FFS patients as well as those enrolled in other HMOs and PPOs. The term network/IPA is often used to encompass both this and IPA model HMOs. (Also see IPA and HMO).

Open-ended or Open HMO (O/HMO) -- A type of HMO where the enrollees are not locked-in and may leave the HMO without losing coverage of certain services. Such out-of-plan utilization is usually subject to a significant degree of cost-sharing (e.g. deductibles) unlike those services delivered within the plan. The out-of-plan segment of HMO use may fall within an existing non-managed indemnity plan, MIP or PPO run by the HMO or its parent corporation. To be considered an O/HMO: 1) the plan must retain all risk; and 2) the primary care physicians must share in this risk. This usually includes the risk associated with out-of-plan use. These plans are sometimes termed point-of-service (POS) HMOs, "hybrid-HMOs", HMO "swing-outs", and flexible-HMOs. (Plans using these labels often share some risk with employers.) Currently, this class of plan is still somewhat loosely defined. Many POS plans, that are not linked into an existing "pure" HMO, could more accurately be classified as PPOs or a type of Triple Option Plan (Also PPO, TOP).

Open enrollment -- Insurers take all comers, regardless of medical history or occupation.

Oregon Plan -- The state of Oregon has enacted sweeping changes to improve health care access and control costs. It requires a "play or pay" mechanism for employers. Medicaid is extended to all residents with incomes below the poverty level, and certain services in the Medicaid benefit package are eliminated. The plan also creates a "risk pool" to cover those individuals denied insurance due to pre-existing conditions.

Pay or Else -- See employer mandate

Pay or Play -- Employers pay for coverage for employees or contribute to a public program which would then insure non-covered workers and the unemployed poor. Many "Pay or Play" models also suggest a federal subsidy to assist in providing coverage to the uninsured.

Point-of-Service (POS) Plan -- A point-of-service plan is a hybridized managed care plan that offers the consumer a choice of options at the time he or she seeks services (rather than at the time they choose to enroll in a health plan). There are (at least) three types of POS plans: 1) An open-HMO; 2) A triple-option POS plan; and 3) a "unified" PPO. POS plans are also known as flexible health plans, mixed-model health plans, or hybrid model plans. (See Open/HMO, TOP and PPO).

Portability -- Allows workers to keep the same insurance policy when they change or lose a job.

Preferred Provider Arrangement (PPA) -- Similar to a PPO, except purchasers "selectively contract" directly with a provider usually without benefit of a comprehensive administrative entity like a PPO. Usually, no significant "managing" of care takes place in PPAs. (Also see PPO).
Preferred Provider Organization (PPO) -- A type of integrated delivery system where the PPO entity acts as a broker between the purchaser of care and the provider. In a PPO, consumers have the option of using the "preferred" providers available within the plan, or not. Consumers are channeled towards in-plan providers by incentives and disincentives (relating to cost-sharing provisions and benefit coverage). In return for the patient referrals, providers agree that their care will be "managed." Providers are usually paid a discounted FFS payment, e.g., 80% of their usual fee and they do not participate in financial risk-sharing. A "unified" PPO is a plan that bears risk for both in-plan and out-of-plan use. These plans are sometimes marketed as point-of-service plans. (Also see POS plan and EPO).

Providers -- the independent clinical professionals and institutions that furnish services to the consumer.

Reinsurance Pool -- Common fund to help insurers mitigate expected high losses from insuring high-risk groups and individuals. Only a handful of states have adopted these pools.

Single Benefit Plan -- An entity that sub-contracts with other organizations, e.g., HMOs, indemnity insurers or EPOs, (usually on a capitated basis) to provide health services only within a "single benefit" category. Single benefit plans have been set up to provide mental health, dental or eye care only. The providers in these plans may or may not participate in risk sharing arrangements, but the plan itself usually is at full risk for the services it contracts to provide. Often termed "carve out plans" because selected services are carved-out of the full array of coverage offered by the main insurer. (Also known as single benefit HMOs).

Single Payer -- A single entity, usually government run, reimburses all medical claims. Consumers typically pay a uniform tax rather than premiums. Money goes to a single health care trust fund, used only for health care expenditures.

Social HMO (S/HMO) -- A type of HMO developed mainly on a demonstration basis with HCFA funding. It is intended to expand traditional HMO medical services to provide social support and long-term care to elderly and disabled enrollees. The S/HMO arrangement may revolve around a conventional HMO that contracts with a long term care provider, a long term care agency that contracts with medical providers, or an independent broker that contracts with all providers. (Also see HMO).

Sponsors -- The employers (or sometimes unions) who sponsor group health benefit plans and pay the major portion of its ongoing costs, including administrative costs and direct expenditures for medical care.

Staff Model HMO -- A type of HMO were the majority of enrollees are cared for by physicians who are on the staff of the HMO. Although these physicians may be involved in risk-sharing arrangements, a majority of their income usually is derived from a fixed salary. The "group cooperative" consumer controlled HMOs are usually staff model plans. Because the physicians in these type of HMOs are also organized in groups, the label group/staff model is used to encompass both this and the group model HMO. (Also see HMO, Group Model HMO).

Third Party Administrator (TPA) -- A private firm that serves as the agent or intermediary of a health plan when dealing with providers. These firms can be distinct corporate entities
separate from the health plan or insurers. TPAs are responsible for at least some (if not all) administrative functions, but a TPA bears no financial risk associated with the insurance function. Some TPAs handle claims payment process. TPAs which manage the care paid for by the at-risk plan or employer are known as a managed care or utilization review company. TPAs are most frequently retained by self-insured employers, but nationally oriented MIPs, PPOs, IPAs and POS plans are also using their services. (Also see managed care).

**Triple Option Plan (TOP)** -- A "single" plan (or a collection of contractually linked free-standing plans) offers a consumer the choice of three health benefit options at the time of enrollment. TOPs offer an HMO, a PPO and a MIP (or a non-managed indemnity plan) under the same corporate umbrella. TOPs are often coordinated or owned by insurers who have formed or acquired free-standing HMOs or PPOs. To be considered a TOP plan, the risk for all plan options must be retained by a single entity. To an employer, a key advantage of a TOP (vs. non-linked plans offered to employees by separate insurers) is that the issue of biased selection, where healthier employees select one plan over another is avoided; the same insurer bears the risk regardless of which plan an employee chooses. A TOP that offers the consumer three choices at the point of service (rather than at the time of enrollment) is usually termed a point-service plan. (also see POS plan).

**Unified Health Care System** -- Includes health insurance, workers' compensation and health-related auto insurance under one rubric. Advocates say it will cut administrative costs.

**Universal Coverage** -- An all encompassing plan which would provide all 37 million uninsured Americans with health insurance.

**Waiver** -- Permission to circumvent Medicaid, Medicare and ERISA rules, vital to comprehensive health reform. HCFA recently thwarted Oregon's rationing plan by refusing to grant medicaid waivers.