National Native Network

Tobacco Control and American Indian Cancer Policy

Tobacco Control and American Indian Cancer Policy

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Professional activities include:

- Member, National Board of Directors, American Cancer Society
- Member, Minority Affairs Section and Association of American indian Physicians Representative to the American Medical Association
- Member, Advisory Committee on Rural Health and Human Services, US Department of Health and Human Services
- Member, National Institutional Review Board, Indian Health Service

Faculty Disclosure Statement

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Faculty Disclosure Statement

- Funding for this webinar was made possible by the Centers for Disease Control and Prevention DP13-1314 Consortium of National Networks to Impact Populations Experiencing Tobacco-Related and Cancer Health Disparities grant. Webinar contents do not necessarily represent the official views of the Centers for Disease Control and Prevention.
- No commercial interest support was used to fund this activity.

Accreditation

The Indian Health Service (IHS) Clinical Support Center is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. The IHS Clinical Support Center designates this live activity for 1 hour of *AMA PRA Category 1 Credit™* for each hour of participation. Physicians should claim only the credit commensurate with the extent of their participation in the activity. .

The Indian Health Service Clinical Support Center is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is designated 1.0 contact hour for nurses.

CE Evaluation and Certificate

- Continuing Education guidelines require that the attendance of all who participate be properly documented.
- To obtain a certificate of continuing education, you must be registered for the course, participate in the webinar in its entirety and submit a completed post-webinar survey.
- The post-webinar survey will be emailed to you after the completion of the course.
- Certificates will be mailed to participants within four weeks by the Indian Health Service Clinical Support Center.

Learning Objectives

By the end of this webinar, participants will be able to:

1. Identify patterns of AI tobacco use.

2. Identify patterns of AI cancer mortality.

3. Recognize the role of health care professionals working with tribal leadership in creating tobacco control policy.

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National Native Network Webinar
Inter Tribal Council of Michigan
January 26, 2016

Donald Warne, MD, MPH

Oglala Lakota

Chair, Department of Public Health

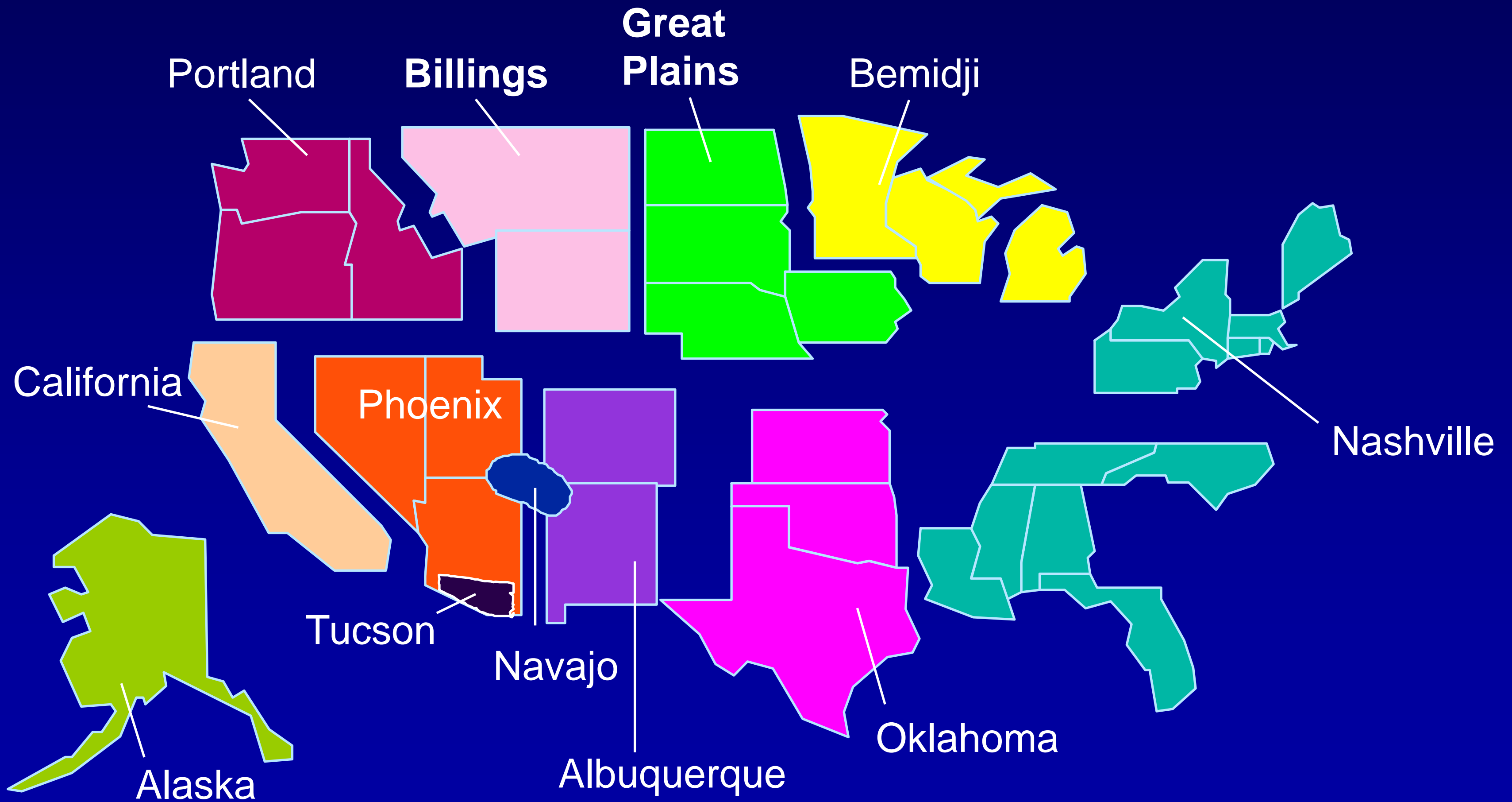
North Dakota State University

Pine Ridge Reservation

Kyle, S.D.

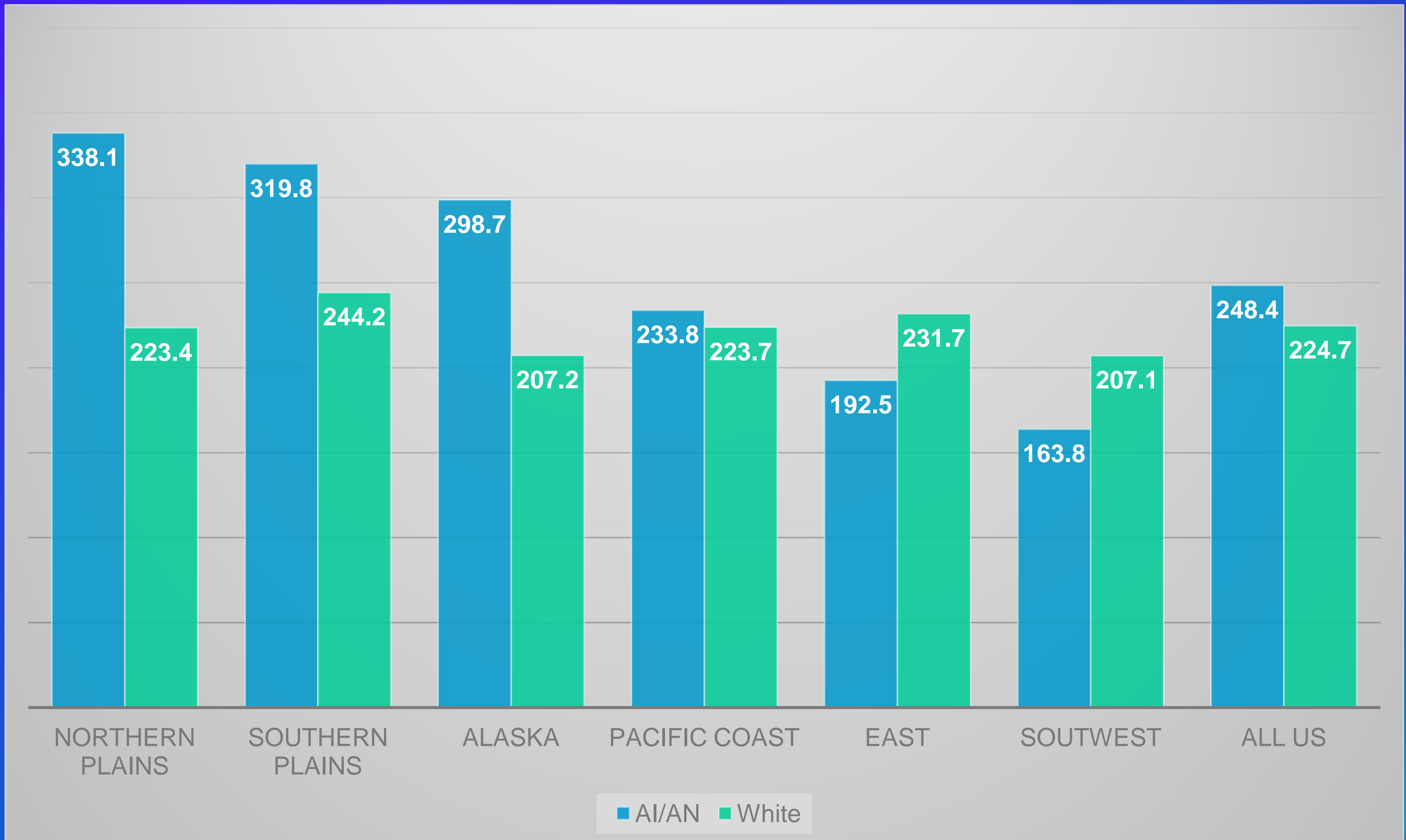
THE
FOOD STOP
CAFE
Kyle.SD
THE FOOD STOP
CAFE

IHS Areas



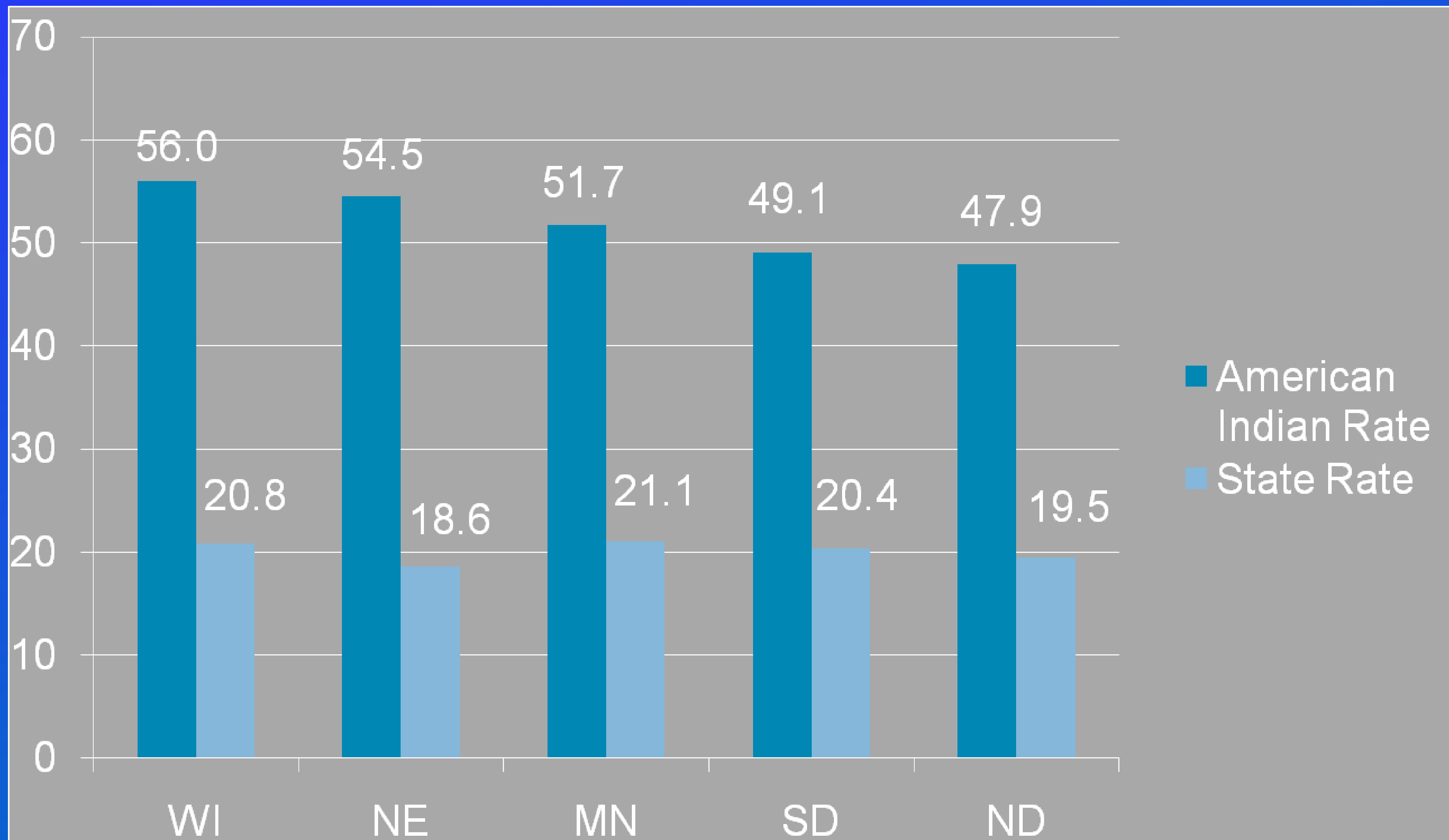
Cancer Death Rates

(Rate per 100,000 population)



White, Espey, Swan, et al. AJPH Supplement 3, 2014, (104): S377-S387

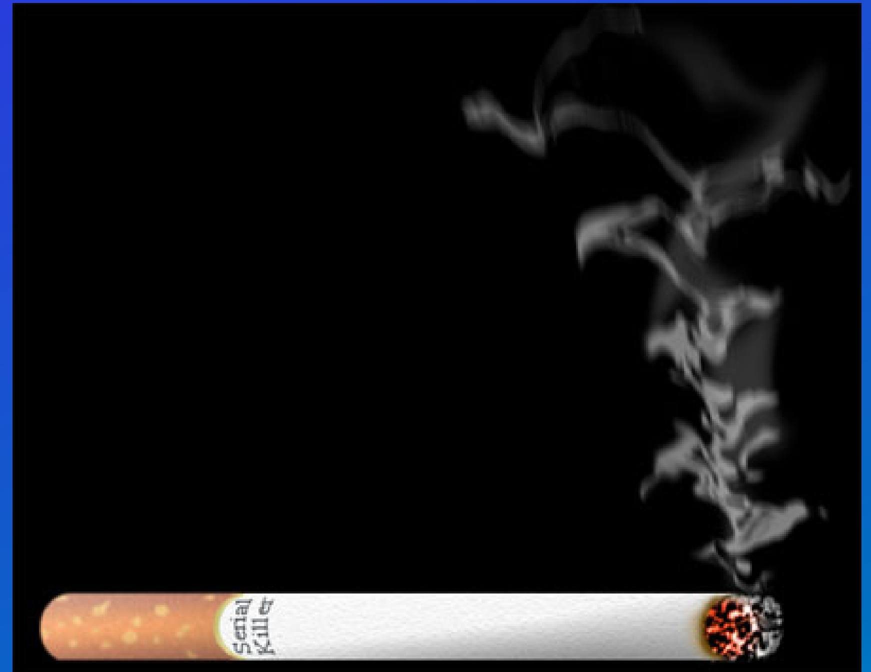
Smoking Disparities by State



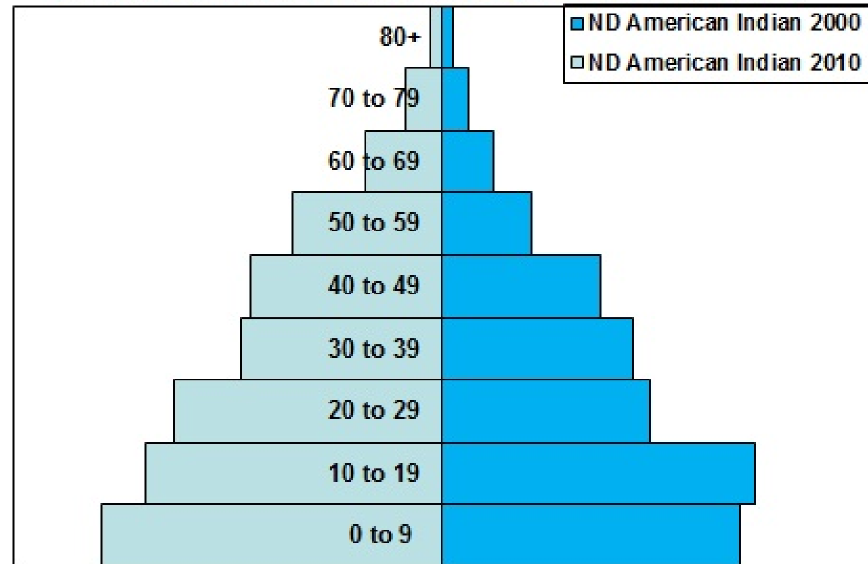
Traditional Tobacco ≠ Commercial Tobacco

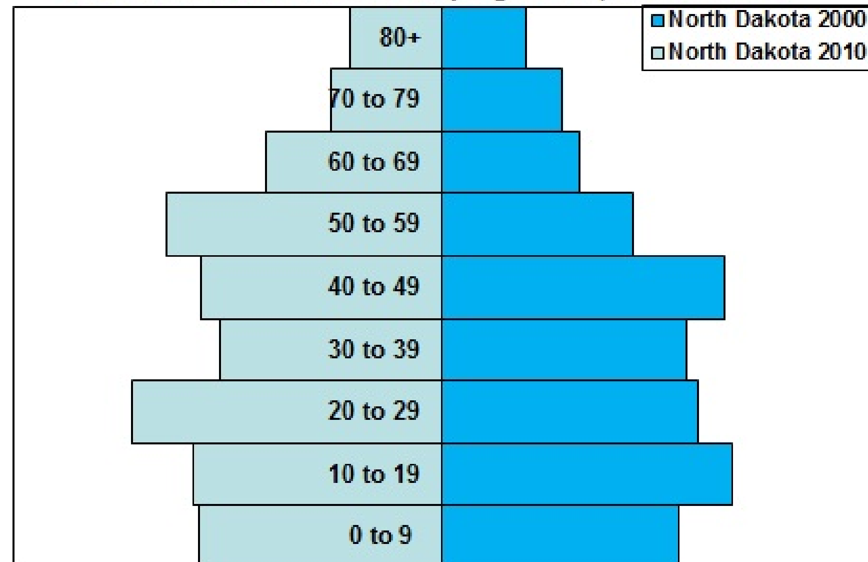
Traditional Tobacco

Commercial Tobacco



Comparison of 2000 and 2010 Age Pyramids for American Indians and the General Population in North Dakota





Death Rates in ND

(Rate per 100,000 population per year)

Deaths and Age Adjusted Death Rate by Cause, 2006-2010	American Indians	North Dakota
	Number (Adj. Rate)	Number (Adj. Rate)
All Causes	1,300 (6,589)	28,923 (687)
Heart Disease	227 (1,345)	7,121 (162)
Cancer	252 (1,337)	6,544 (162)
Stroke	34 (241)	1,696 (38)
Alzheimers Disease	21 (218)	1,936 (40)
COPD	50 (350)	1,607 (39)
Unintentional Injury	188 (589)	1,545 (42)
Diabetes Mellitus	91 (506)	1,072 (26)
Pneumonia and Influenza	17 (114)	702 (15)
Cirrhosis	85 (333)	289 (8)
Suicide	53 (143)	462 (14)

ND Department of Health

Average Age at Death in ND

Average Age at Death by Cause, North Dakota and		
	American Indian	North Dakota
All Causes	54	76
Heart Disease	63	80
Cancer	64	73
Stroke	71	82
Alzheimers Disease	83	88
COPD	70	79
Unintentional Injury	36	56
Diabetes Mellitus	65	77
Pneumonia and Influenza	65	83
Cirrhosis	48	57
Suicide	31	41

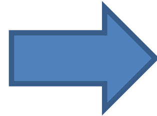
ND Department of Health

Cancer Control Model

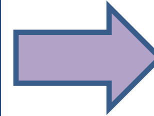
Public Health

Medicine

Primary Prevention: Tobacco & Obesity



PH / Medicine: Cancer Screening



Medicine: Diagnosis & Staging

Essential PH Services
Community Engagement
Tobacco Prevention
Health Education
Health Promotion
Obesity Prevention
Community Health Workers
Screening Access & Navigation

- Tobacco Cessation Therapy
- Obesity Treatment (medical/surgical)

Cancer Control Model

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Patient Navigation/ Care Coordination

Treatment
(Surgery, Radiation, Chemotherapy, etc.)

- Tobacco Cessation Therapy
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Cancer Control Model

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(Surgery, Radiation, Chemotherapy, etc.)

Survivorship / Follow up Care

- Tobacco Cessation Therapy
- Obesity Treatment (medical/surgical)

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(Surgery, Radiation, Chemotherapy, etc.)

- Tobacco Cessation Therapy
- Obesity Treatment (medical/surgical)

Palliative Care:
Family Support, Social Work, Hospice Care

Palliative Care:
Pain Management, Symptom Relief, etc.

AMERICAN INDIAN HEALTH POLICY

- Do people have a legal right to healthcare in the US?
- Approximately $3 trillion spent annually on healthcare in the US
- Over 45 million uninsured people in the US in 2010—over 18 million new enrollees under ACA (Marketplace & Medicaid expansion)

Legal Basis for Federal Services *to American Indians and Alaska Natives*

- United States Constitution
- The Snyder Act of 1921
- The Transfer Act of 1954
- Indian Sanitation Facilities and Services Act of 1959
- The Indian Self-Determination and Education Assistance Act (enacted 1975)
- Indian Health Care Improvement Act of 1976
- The Indian Alcohol and Substance Abuse prevention and Treatment Act of 1986
- The Indian Child Protection and Family Violence Prevention Act of 1990

This is not an all-inclusive list.

Wichetas:
To-sa-quas, (White Tail,)
Cho-wash-ta-ha-da, (Runner,)
Kow-wah, (Shirt Tail,)
Wich-qua-sa-is, (Contrary,)
His-si-da-wah, (Stubborn.)
Towa-karroes:
Ke-chi-ko-ra-ko, (Stubborn,)
Nes-ho-chil-lash, (Traveller,)
Na-co-ah, (Dangerfield,)
Ka-ra-ko-ris, (Deceiver,)
Ha-ke-di-ad-ah, (Gallant Man,)
Wha-cha-ash-da, (Looker-on,)
Wash-le-doi-ro-ka, (Don't you do so,)
Te-ah-kur-rah, (Lightman,)
Sar-rah-de-od-a-sa, (Straight Looker.)
Wacoes:
A-qua-gosh, (Short Tail,)
Ho-hed-orah, (Long Ways over the River,)
Chos-toch-ka-a-wah, (Charger,)
Cha-to-wait, (Ghost.)
Secretaries:
Thomas J. Wilson,
Isaac H. Du Val.
Witnesses:
Robt. S. Neighbsor,
Hugh Rose,
Jno. H. Rollins,
Thomas J. Smith,
E. Morehouse.
Interpreters:
Louis Sanches,
John Conner,
Jim Shaw.

(To each of the names of the Indians is affixed his mark.)

TREATY WITH THE POTAWATOMI NATION, 1846.

June 5 and 17, 18[...]
9 Stat., 853.
Ratified, July 1846.
Proclaimed, July 1846.

Whereas the various bands of the Pottowautomie Indians, known as the Chippewas, Ottawas, and Pottowautomies, the Pottowautomies of the Prairie, the Pottowautomies of the Wabash, and the Pottowautomies of Indiana, have, subsequent to the year 1828, entered into separate and distinct treaties with the United States, by which they have been separated and located in different countries, and difficulties have arisen as to the proper distribution of the stipulations under various treaties, and being the same people by kindred, by feeling, and by language, and having, in former periods, lived on and owned their lands in common; and being desirous to unite in one common country, and again become one people, and receive their annuities and other benefits in common, and to abolish all minor distinctions of bands by which they have heretofore been divided, and are anxious to be known only as the Pottowautomie Nation, thereby reinstating the national character; and

Preamble.

Whereas the United States are also anxious to restore and concentrate said tribes to a state so desirable and necessary for the happiness of their people, as well as to enable the Government to arrange and manage its intercourse with them:

Now, therefore, the United States and the said Indians do hereby agree that said people shall hereafter be known as a nation, to be called the Pottowautomie Nation; and to the following

Articles of a treaty made and concluded at the Agency on the Missouri River, near Council Bluffs, on the fifth day of June, and at Pottawatomie Creek, near the Osage River, south and west of the State of Missouri, on the seventeenth day of the same month, in the year of our Lord one thousand eight hundred and forty-six, between T. P. Andrews, Thomas H. Harvey, and Gideon C. Matlock, commissioners on the part of the United States, on the one part, and the various bands of the Pottowautomie, Chippewas, and Ottowas Indians on the other part:

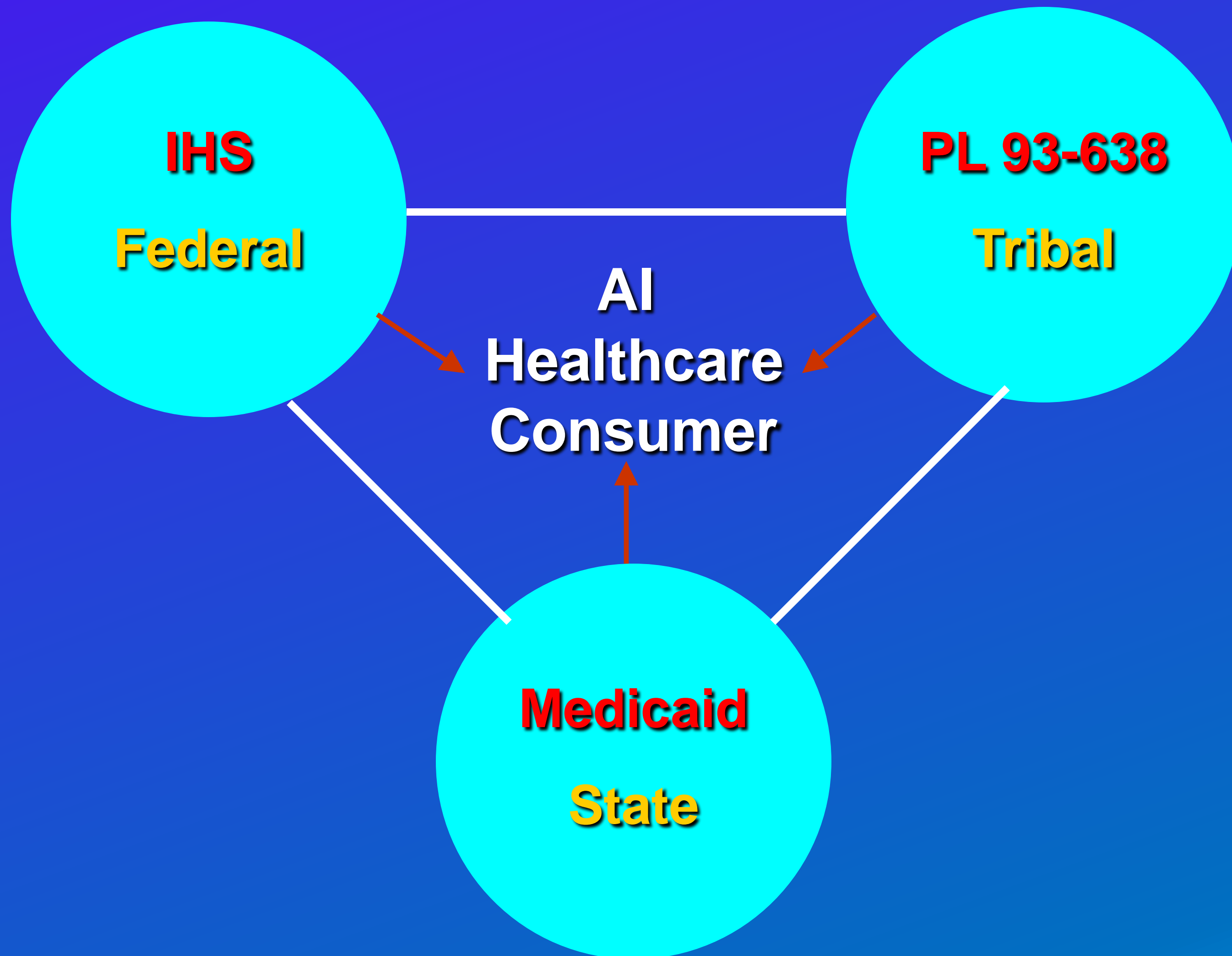
Peace and frien[d]ship to continue f[or]ever.

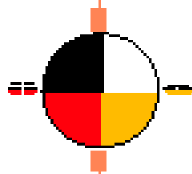
ARTICLE 1. It is solemnly agreed that the peace and friendship which so happily exist between the people of the United States and the Pottowautomie Indians shall continue forever; the said tribes of Indians giving assurance, hereby, of fidelity and friendship to the Government and people of the United States; and the United States giving, at the same time, promise of all proper care and parental protection.

Indian Health System 1955-1975

Indian Health System 1975-1985

Indian Health System





2012 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita

$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0

Per Capita spending in the year for which data are available– see base of each bar.

Year	Category	Amount
2011	Medicare spending per beneficiary	$12,042
2012	National health spending per capita	$7,535
2012	Veterans medical spending per patient	$6,980
2010	Medicaid spending per enrollee	$6,206
2009	FDI cost benchmark per enrollee (To be updated in 2013)	$4,817
2012	IHS spending per user	Medical $2,896; Other $555

See page 2 notes on reverse for data sources and extrapolation assumptions.

1/8/2013

2014 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita

Year	Category	Per capita spending
2013	Medicare spending per beneficiary	$11,910
2014	National health spending per capita	$8,097
2014	Veterans medical spending per patient	$7,036
2010	Medicaid spending per enrollee	$5,563
2014	FDI benchmark per user (inflated)	$5,296
2014	Actual IHS spending per user	Medical* $3,107; Other $499

Per Capita spending in the year for which data are available–see base of each bar.

$0, $2,000, $4,000, $6,000, $8,000, $10,000, $12,000

*See page 2 notes on reverse for data. *The extent of payments by other sources for medical services provided to AIANs outside IHS is unknown.*

2/13/2015

- **AI/ANs face some of the worst health disparities with significant regional differences in cancer disparities.**
- Insurance companies could discriminate against up to 129 million Americans with pre-existing conditions.
- Premiums had more than doubled over the last decade, while insurance company profits were soaring.
- Nearly 50 million Americans were uninsured and tens of millions more were underinsured.
- **IHS does not have the resources needed to address the AI/AN cancer burden—CHS/PRC dependence.**

Ten Titles: the Architecture of ACA

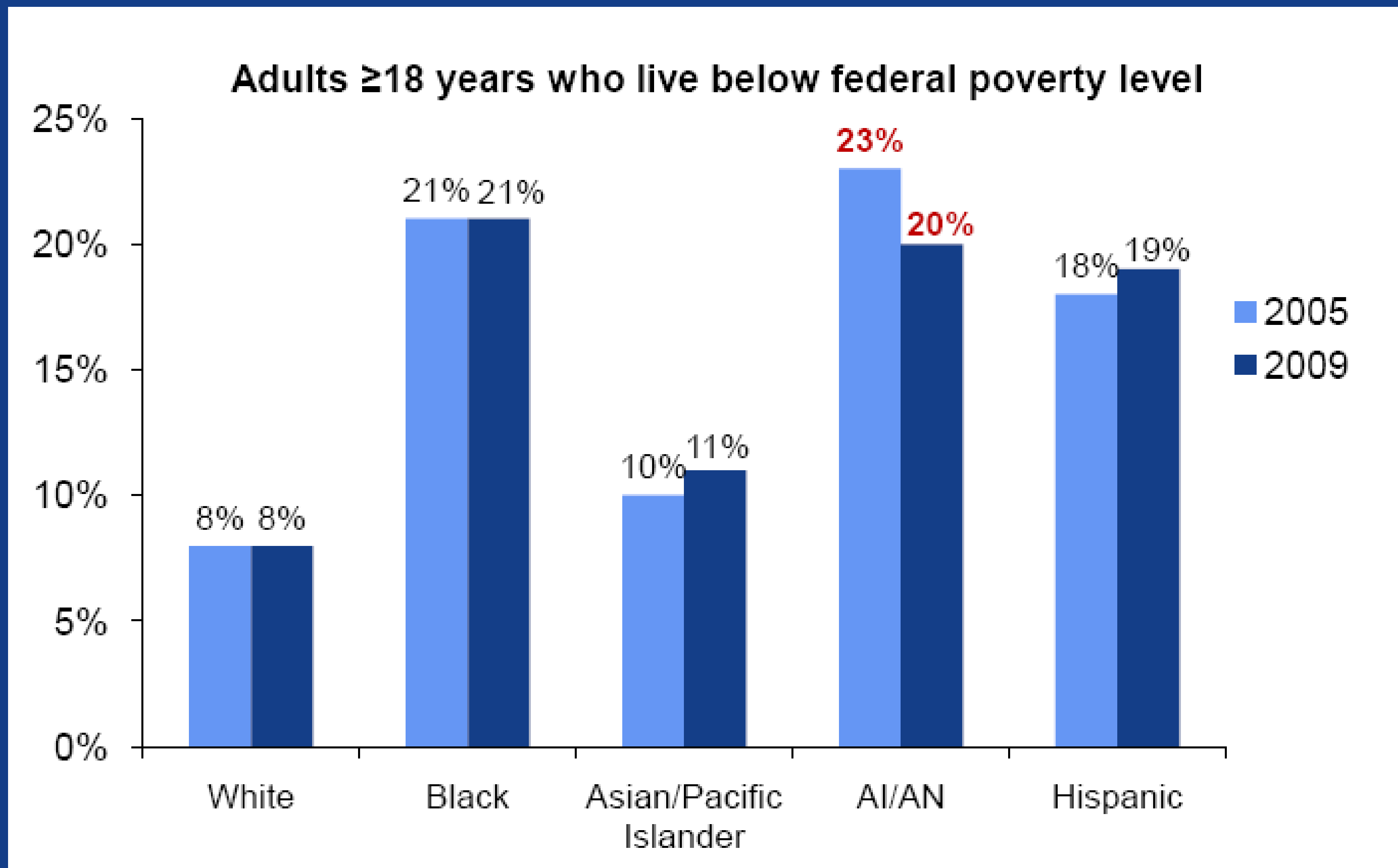
I. Affordable and Available Coverage
II. Medicaid and CHIP
III. Delivery System Reform – Medicare plus
IV. Prevention and Wellness
V. Workforce Initiatives
VI. Fraud, Abuse and Transparency
VII. Pathway for Biological Similars
VIII. CLASS – Community Living Assistance Services & Supports
IX. Revenue Measures
X. Indian Health Care Improvement Act

Title I and II

- **I: Affordable and Available Coverage**
  - The Three-Legged Stool
    - Insurance Market Reform
    - Individual Mandate/Responsibility
    - Premium & Cost Sharing Subsidies
  - State Insurance Exchanges, “Marketplace”
  - Employer Responsibility (>50 employees)

- **II: Medicaid & CHIP**
  - National Eligibility floor of 138% FPL (Medicaid Expansion)
  - Federal Financing 90% plus (FMAP)
  - Uniform Eligibility and Enrollment Standards
  - CHIP Extension through 2019

2.5 times as many AI/ANs as whites live below poverty level



Source: CDC Health Disparities and Inequalities Report 2011, MMWR, Vo. 60

Current Status of State Medicaid Expansion Decisions, 2014

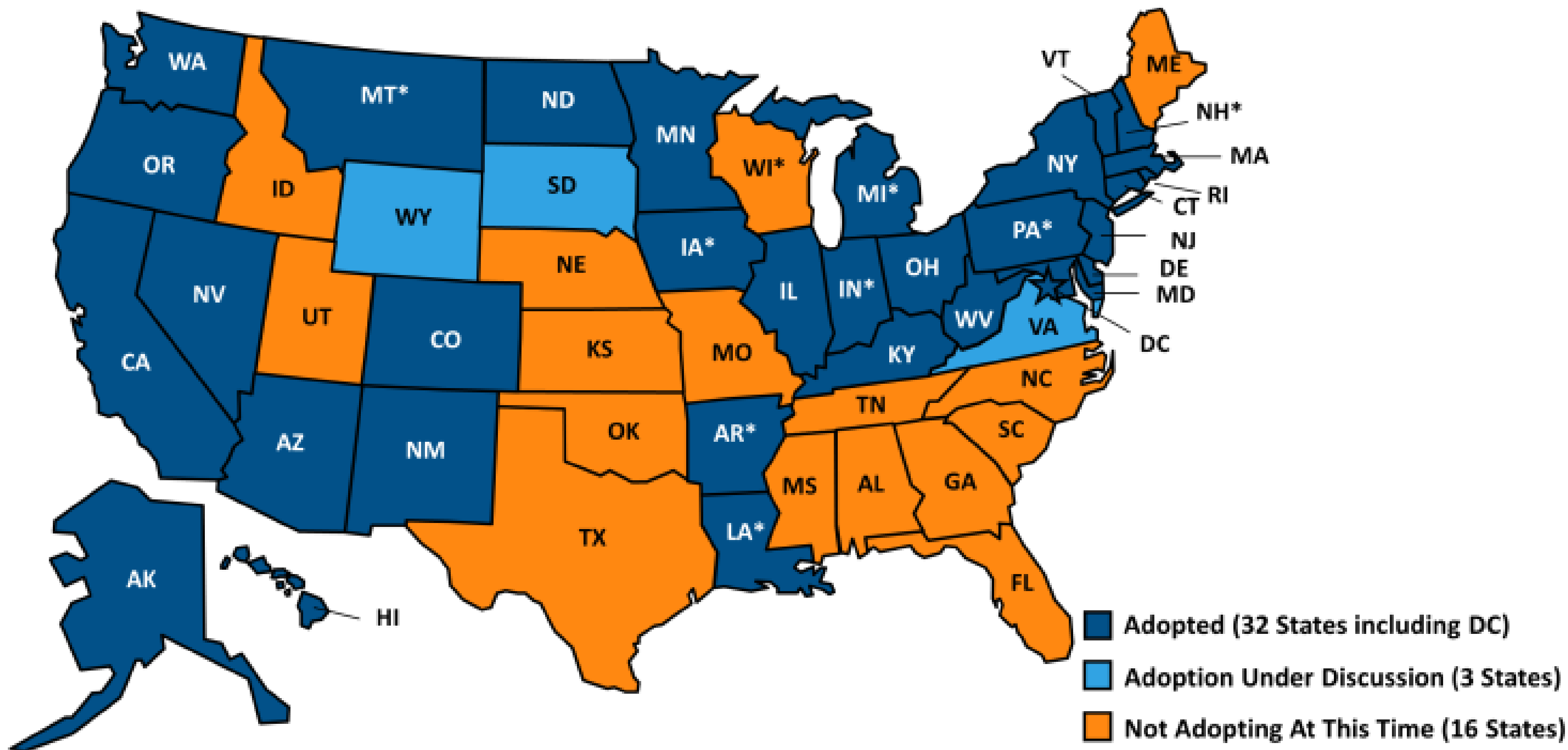
- Implementing Expansion in 2014 (27 States including DC)
- Open Debate (3 States)
- Not Moving Forward at this Time (21 States)

NOTES: Data are as of June 10, 2014. *AR and IA have approved waivers for Medicaid expansion. MI has an approved waiver for expansion and implemented in Apr. 2014. IN and PA have pending waivers for alternative Medicaid expansions. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. NH has passed legislation approving the Medicaid expansion in Mar. 2014; the legislation calls for the expansion to begin July 2014.

SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS here. States noted as "Open Debate" are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.

THE HENRY J. KAISER FAMILY FOUNDATION

Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, NH and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it has transitioned coverage to a state plan amendment. Coverage under the MT waiver went into effect 1/1/2016. LA's Governor Edwards signed an Executive Order to adopt the Medicaid expansion on 1/12/2016, but coverage under the expansion is not yet in effect. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion. See source for more information on the states listed as "adoption under discussion."

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 12, 2016. http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

THE HENRY J. KAISER FAMILY FOUNDATION

Title IV

- **IV: Prevention and Wellness**
  - Prevention and Wellness Commission
  - Prevention & Wellness $15B Trust (e.g. CTG)
  - Calorie Labeling in Chain Restaurants
  - **Inclusion of Clinical Preventive Services in insurance plans**
    - **Including CRC screening**
    - **Is FOBT as good as colonoscopy?**
    - **Is IHS “insurance”?**

Contract Health Services / Purchased and Referred Care

Before the law, contract health dollars ran out too soon.

"Don't get sick after June"

Now, with additional options for health insurance, more contract health dollars will be available to meet the health care needs of Indian Country.

But, we need AI/ANs to enroll…

PRC Medical Priorities

- **Level I** —Emergent/Acutely Urgent Care Services
- **Level II** —Acute Primary and Preventative Care Services (including cancer screening)
- **Level III** —Chronic Primary and Secondary Care Services
- **Level IV** —Chronic Tertiary Care Services
- **Level V** —Excluded Care Services

Subsidies

2 Kinds

- **Premium tax credit** (subject of Appeals Court rulings)
- **Cost sharing subsidies**

- No cost sharing for American Indians up to 300% FPL
- No open enrollment timeframes for AIs

Premium Tax Credit

- Amount of credit based on expected family income
- Determined upon enrollment
- Credit is in form of advance payments
- Tax credit sent directly to the insurance company and applied to premium
- 138% to 400% FPL
- ***The New "Doughnut Hole"*—No Medicaid Expansion and Income under 138% FPL and NOT eligible for Medicaid**

2016 Federal Poverty Levels

Size of Household	Household Annual Income					
	138%	150%	200%	250%	300%	400%
1	$16,105	$17,505	$23,340	$29,175	$35,010	$46,680
2	$21,708	$23,595	$31,460	$39,325	$47,190	$62,920
3	$27,311	$29,685	$39,580	$49,475	$59,370	$79,160
4	$32,913	$35,775	$47,700	$59,625	$71,550	$95,400
5	$38,516	$41,865	$55,820	$69,775	$83,730	$111,640

If your total annual household income is within these levels you may qualify for premium subsidy (discounted health insurance premium)

Cost Sharing Subsidies

- Reduces deductibles, co-pays, co-insurance and sets limits on out of pocket spending
- For incomes at or below 250% FPL (~$59,000 / year for a family of four)

Tribal Sponsorship

- Tribes can purchase on behalf of Tribal members
- They will have to work directly with plans
- Tribes can decide which plan they wish to sponsor

Why would American Indians choose to participate in Exchange?

- Save CHS / PRC Dollars
- I/T/Us can bill and collect—increase 3rd party resources
- Offers Individuals Options
- Expands access to services, including cancer screening and treatment

A Path Forward for Indian Health in Northern Plains

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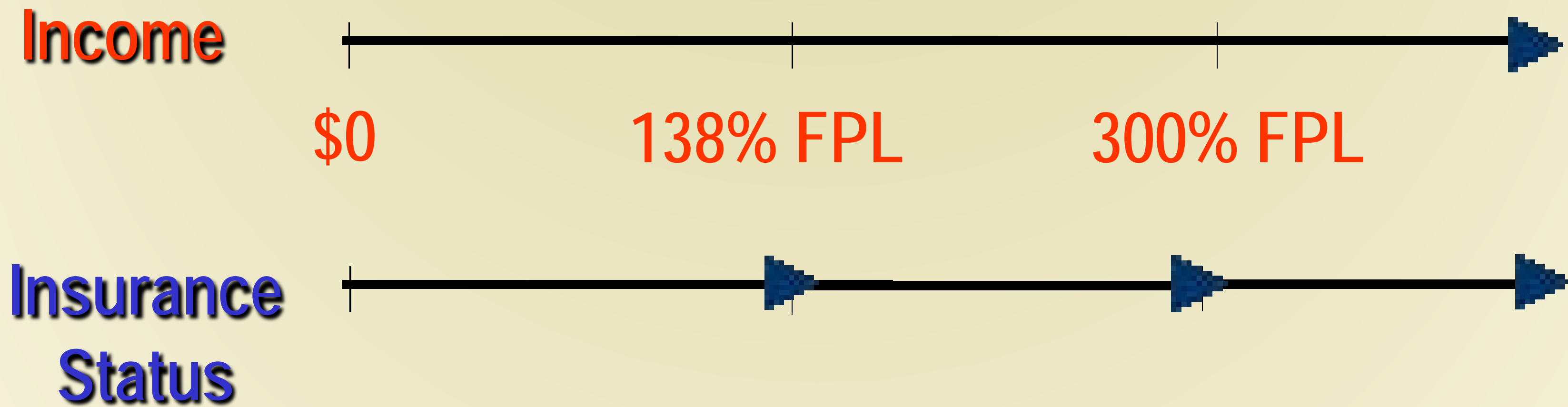

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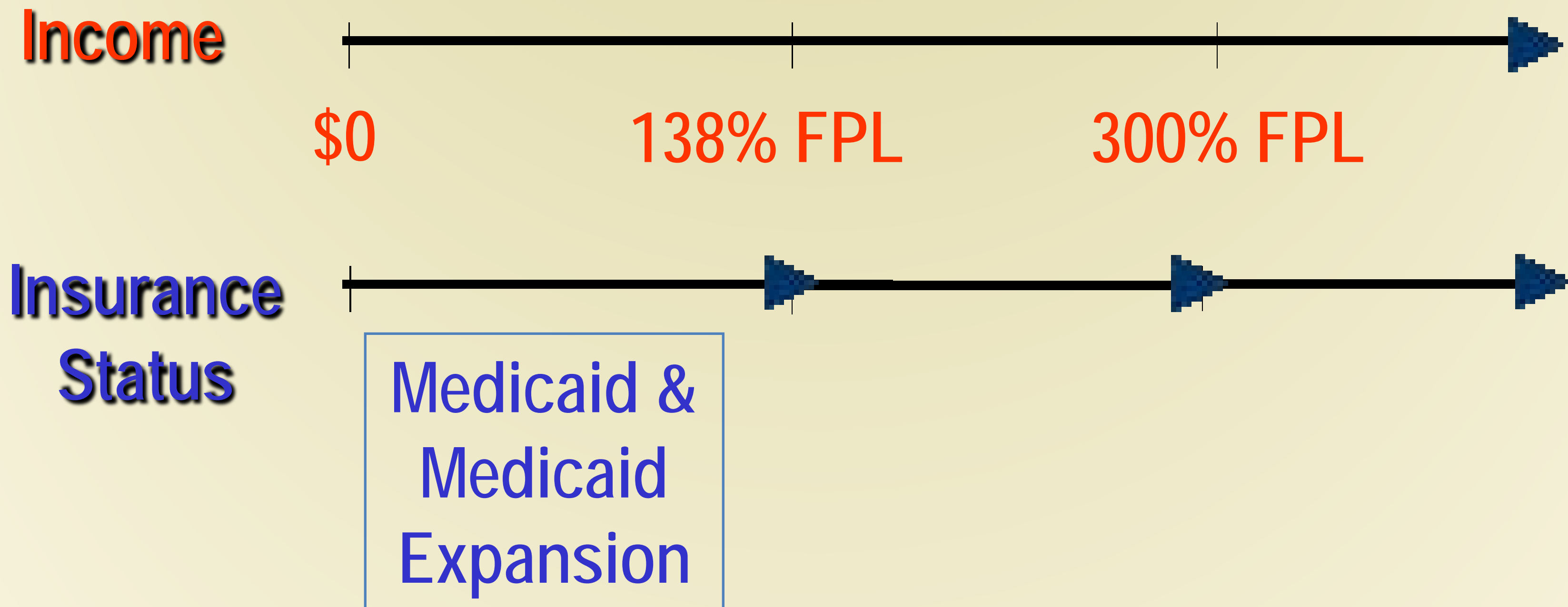

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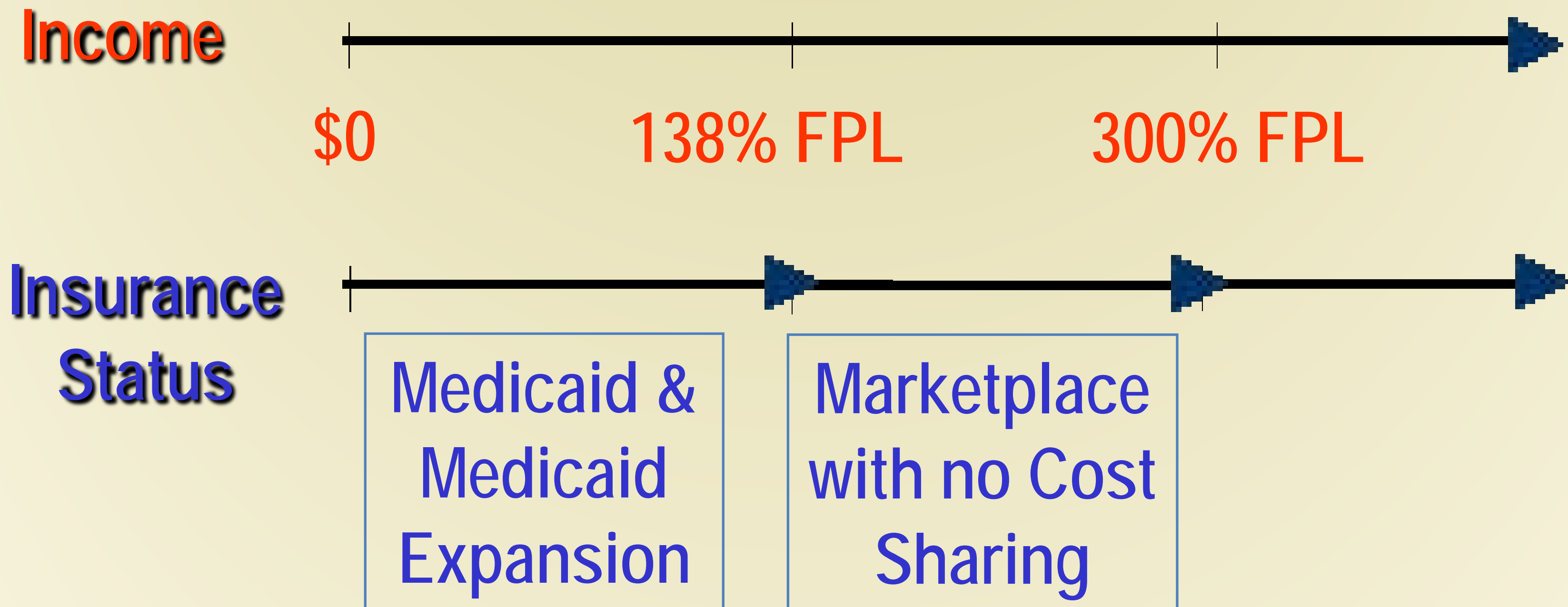

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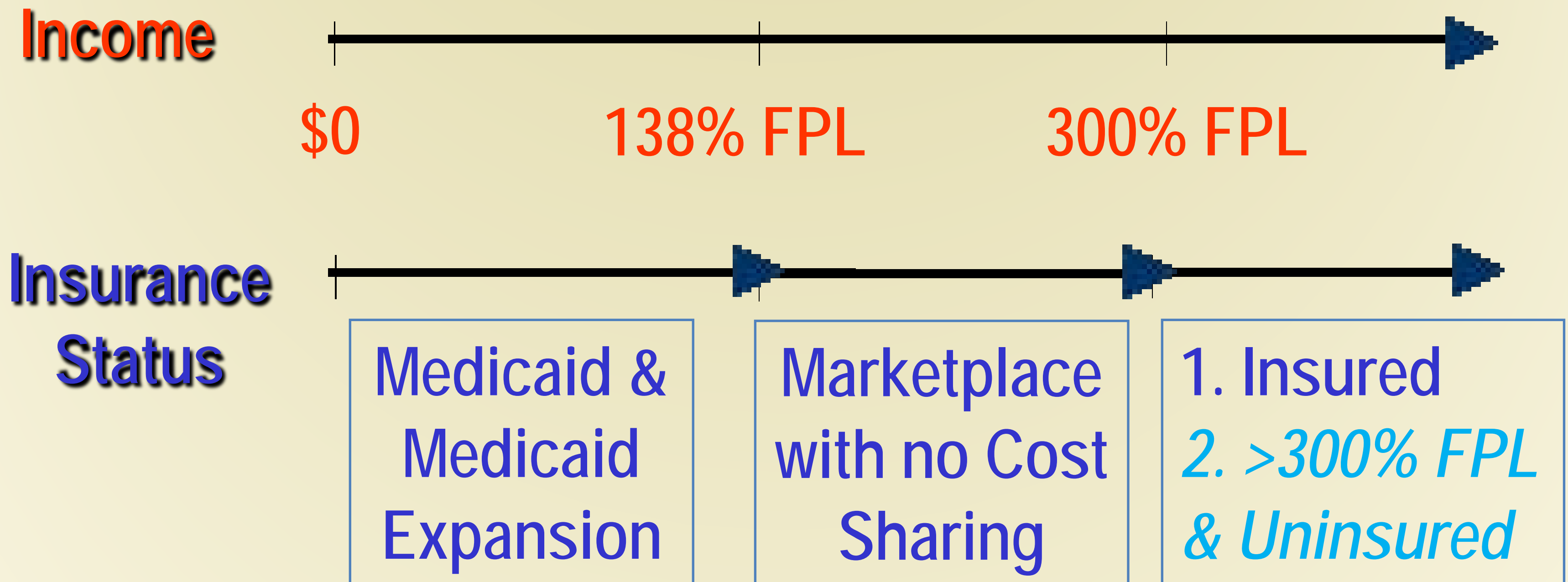

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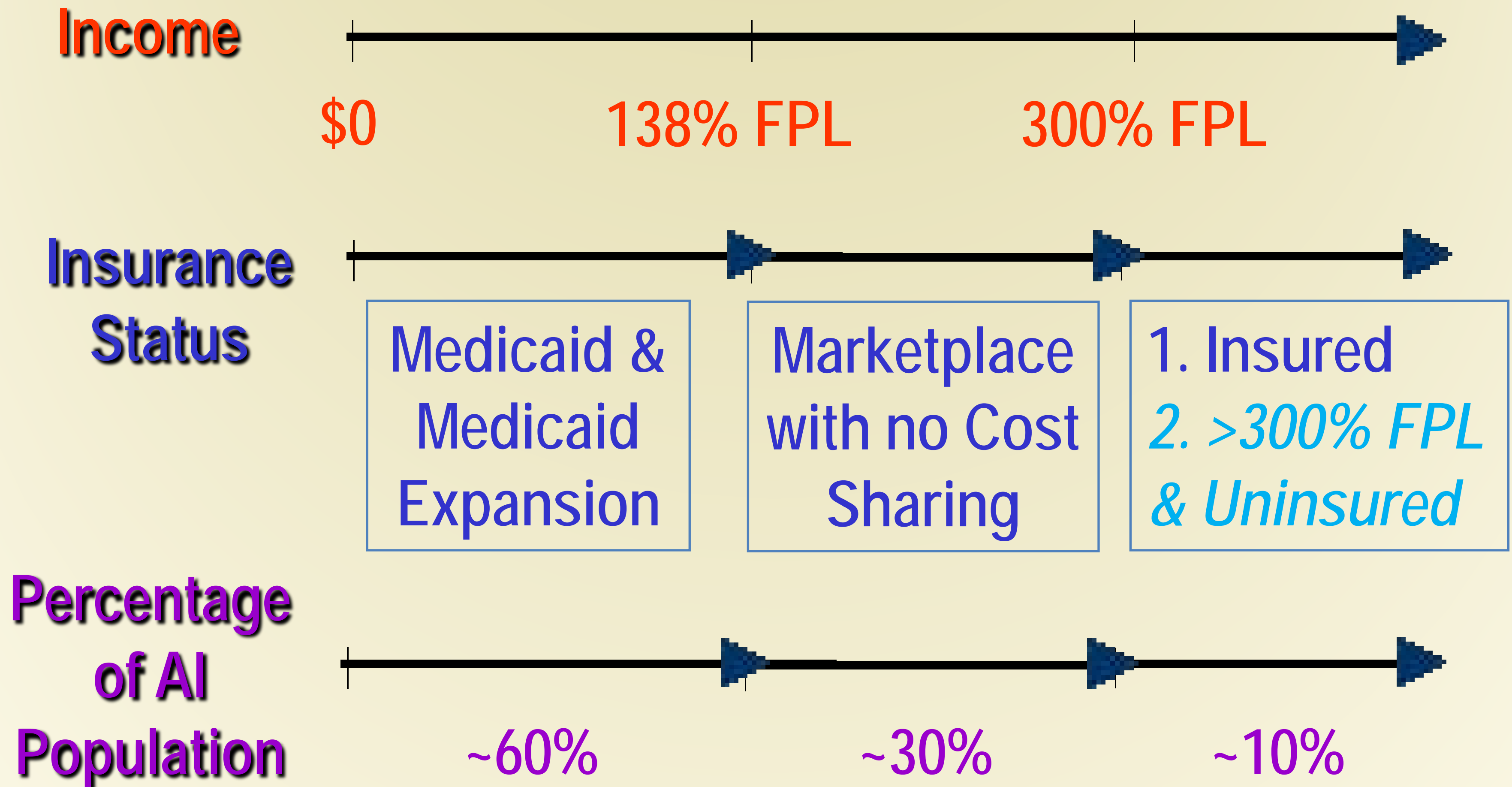

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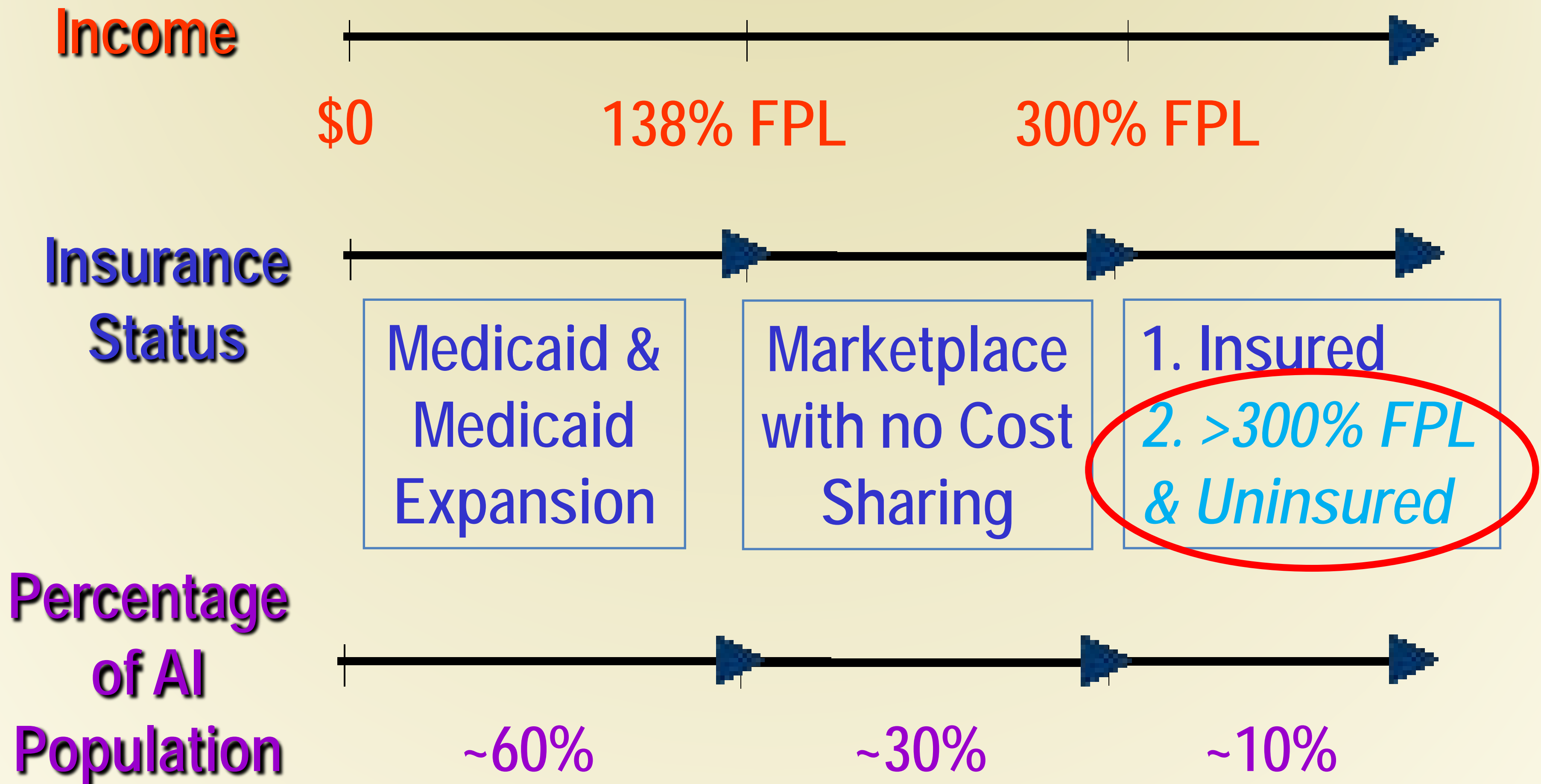
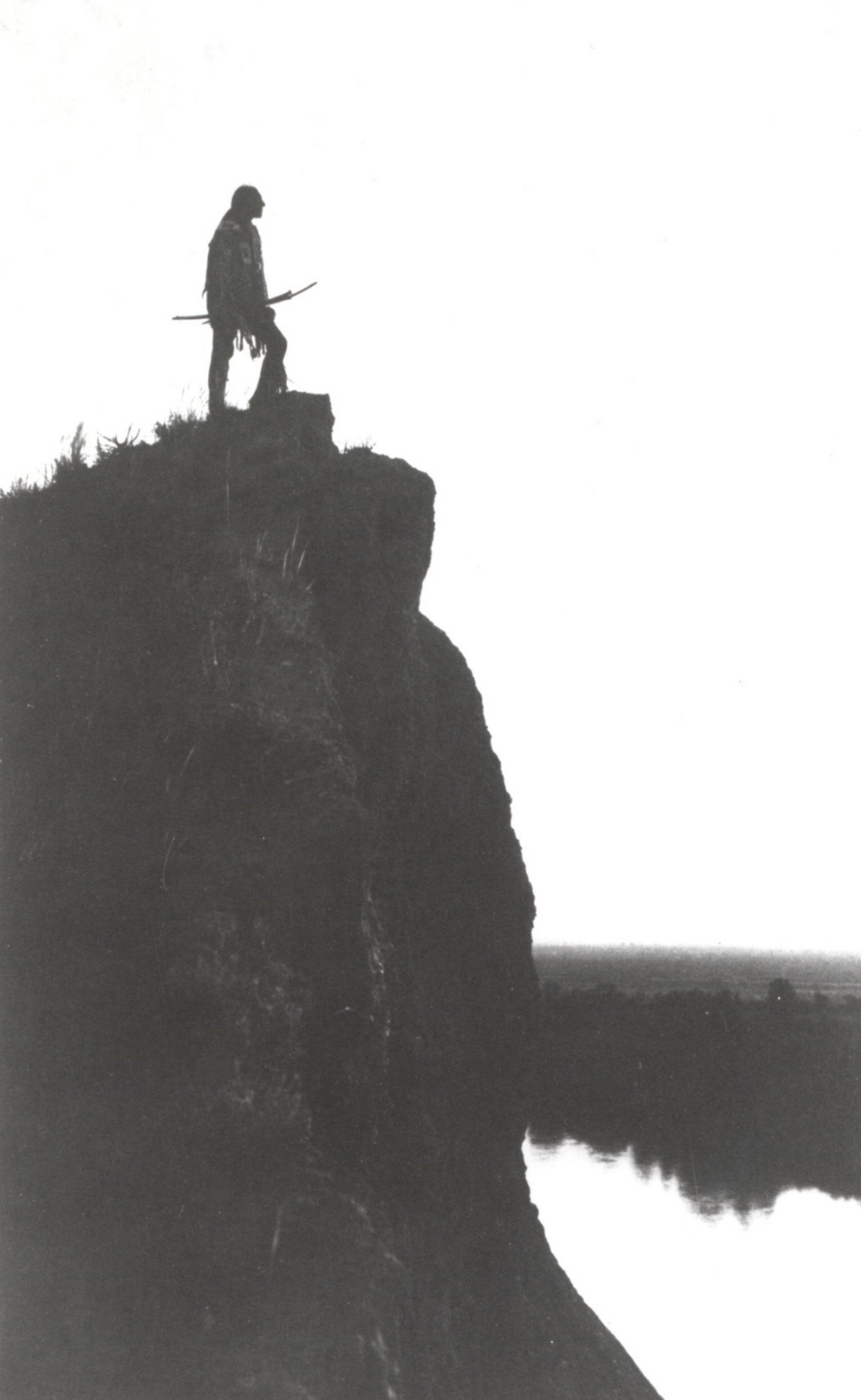


Tribes can "638" PRC funds to pay for cost sharing—eliminating the need for PRC in the State of ND

Opportunities to Consider
Tribal Leaders and Health Services Providers

- Consider "Feasibility Study of using 638-contracted PRC funds for Marketplace cost-sharing for tribal members"
- Encourage enrollment in ACA programs!
- Establish evidence-based / best practices in AI Cancer Policy
- May ***eliminate*** the need for PRC in some tribes!
- CRC Disparities Research
- Lung Cancer Screening Clinical Trial



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