HEALTH SECURITY ACT—PART I

HEARING

BEFORE THE

SUBCOMMITTEE ON
NATIVE AMERICAN AFFAIRS

OF THE

COMMITTEE ON
NATURAL RESOURCES
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

H.R. 3600

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

HEARING HELD IN WASHINGTON, DC
FEBRUARY 28, 1994

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APPENDIX

February 28, 1994

H.R. 3600, HEALTH SECURITY ACT

MONDAY, FEBRUARY 28, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON NATURAL RESOURCES,
SUBCOMMITTEE ON NATIVE AMERICAN AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10:17 a.m., in room 1324, Longworth House Office Building, Hon. Bill Richardson (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. BILL RICHARDSON

Mr. RICHARDSON. The committee will come to order.

This morning we will be taking testimony on H.R. 3600, the President's Health Security Act. I don't need to remind anyone of the importance of the subject of health care reform. What we will be discussing specifically is the impact of this plan on our Native American population.

I probably do need to remind you, though, that special health care needs of Indian people need to continue, as well as the unique relationship with the Indian tribes. There is a solemn trust responsibility that flows to the Indian tribes from the United States to provide health care.

The responsibility comes from treaties and statutes and has a solid foundation in the law. In spite of this obligation, the responsibility of the United States to provide decent health care to Indian people has always fallen somewhat short of the mark. Native Americans have the highest rates of diabetes, tuberculosis, and fetal alcohol syndrome, teen suicides, and among the shortest life spans. The funding is never adequate and the provisions of services never meets the needs of Indian country.

As we examine this new plan, we must ask ourselves several questions on behalf of the Indian people. Two questions come to mind immediately. The first is: Will this plan improve the provision of health care to the Indian people? The second is: Does this plan enhance the trust responsibility of the United States to the tribes and respect the sovereignty of the Indian Nations?

We will try to get those answered today and in the days and weeks ahead as we go forward with this bill.

I ask that all witnesses summarize their statements. Your full written statements will be made a part of the record which will remain open for two weeks.

At this time, I ask is that the Indian title to the bill, section-by-section analysis and the background be made part of the record.

[The information follows:]

I

103D CONGRESS
1ST SESSION

H. R. 3600

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 HOUSE OF REPRESENTATIVES

NOVEMBER 20, 1993

Mr. GEPHARDT (for himself, Mr. BONIOR, Mr. HOYER, Mr. FAZIO, Mrs. KENNELLY, Mr. LEWIS of Georgia, Mr. RICHARDSON, Mr. DINGELL, Mr. ROSTENKOWSKI, Mr. FORD of Michigan, Mr. WAXMAN, Mrs. COLLINS of Illinois, Mr. STARK, Mr. WILLIAMS, Mr. CLAY, Mr. BROOKS, Mr. MOAKLEY, Mr. ABERCROMBIE, Mr. ACKERMAN, Mr. ANDREWS of Maine, Mr. BARRETT of Wisconsin, Mr. BERMAN, Mr. BILBRAY, Mr. BLACKWELL, Mr. BORSKI, Mr. BROWN of California, Ms. BROWN of Florida, Mr. CARDIN, Mr. CLYBURN, Mr. COYNE, Mr. DE LUGO, Ms. DELAURO, Mr. DEUTSCH, Mr. DICKS, Mr. DIXON, Mr. DURBIN, Mr. EDWARDS of California, Mr. ENGEL, Ms. ENGLISH of Arizona, Ms. ESHOO, Mr. FALEOMAVAEGA, Mr. FILNER, Mr. FLAKE, Mr. FOGLIETTA, Mr. FRANK of Massachusetts, Mr. GEJDENSON, Mr. GIBBONS, Mr. HASTINGS, Mr. HILLIARD, Mr. HINCHEY, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSTON of Florida, Mr. KANJORSKI, Mr. KREIDLER, Mr. LAFALCE, Mr. LANTOS, Mr. LEVIN, Ms. LONG, Mr. MARTINEZ, Mr. MATSUI, Ms. MCKINNEY, Mrs. MEEK, Mr. MINGE, Mrs. MINK, Mr. MURPHY, Mr. MURTHA, Ms. NORTON, Mr. OBERSTAR, Mr. OBEY, Mr. OWENS, Mr. PASTOR, Mr. PAYNE of New Jersey, Mr. RAHALL, Mr. RANGEL, Mr. REYNOLDS, Mr. ROMERO-BARCELÓ, Mr. RUSH, Mr. SABO, Mr. SAWYER, Mr. SCOTT, Mr. SERRANO, Ms. SHEPHERD, Mr. SKAGGS, Ms. SLAUGHTER, Mr. SMITH of Iowa, Mr. STOKES, Mr. STRICKLAND, Mr. STUDDS, Mr. SWIFT, Mr. SYNAR, Mr. THORNTON, Mrs. THURMAN, Mr. TRAFICANT, Mr. UNDERWOOD, Mrs. UNSOELD, Mr. VENTO, Mr. WATT, Mr. WHEAT, Mr. WISE, and Mr. YATES) introduced the following bill; which was referred jointly to the Committee on Energy and Commerce, to the Committee on Ways and Means, and to the Committee on Education and Labor for consideration of such provisions in titles I, III, VI, VIII, X, and XI as fall within its jurisdiction pursuant to clause 1(g) of rule X; and concurrently, for a period ending not later than two weeks after all three committees of joint referral report to the House (or a later time

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;

(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 subsection (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 program. 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 ENROLL.—If an individual described in subsection (a) does not enroll in a health program of the Indian Health Service, no payment shall be made by the Indian Health Service to the individual (or on behalf of the individual) with respect to premiums charged for enrollment in an applicable health plan or any other cost of health services under the applicable health plan which the individual is required to pay.

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 payments 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

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

each fiscal year (beginning with fiscal year 1998) an amount equivalent to the aggregate amount of the premium discounts (established in section 6104) that would have been paid to individuals described in subsection (c) if such individuals had been enrolled in regional alliance health plans.

(b) PAYMENT.—For each fiscal year for which an amount is certified to the Secretary of the Treasury under subsection (a), from the funds available under section 9102, such Secretary shall pay the amount so certified to the Indian Health Service for the purpose of providing the comprehensive benefit package.

(c) INDIVIDUAL DESCRIBED.—For purposes of this section, an individual described in this subsection is an individual described in section 8302(a) who is not a qualifying employee or a family member of such an employee.

Subtitle E—Amendments to the Employee Retirement Income Security Act of 1974

SEC. 8401. GROUP HEALTH PLAN DEFINED.

Section 3 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002) is amended by adding at the end the following new paragraph:

"(42) The term 'group health plan' means an employee welfare benefit plan which provides medical care (as

SECTION BY SECTION ANALYSIS OF H.R. 3600, THE NATIONAL HEALTH SECURITY ACT

TITLE VIII, SUBTITLE D - INDIAN HEALTH SERVICE

SECTION 8301. DEFINITIONS.

Section 8301 sets out the definitions used in Subtitle D.

SECTION 8302. ELIGIBILITY AND HEALTH COVERAGE OF INDIANS.

Subsection (a) provides that an eligible individual may enroll in an IHS program if the individual is an Indian; or a descendant of a member of an Indian tribe who is regarded as an Indian by the Indian community; or an urban Indian; or an Indian described in section 809 (b) of the Indian Health Care Improvement Act.

Subsection (b) provides that an eligible Indian may elect to be served by an Indian health program instead of a health plan.

Subsection (c) provides that an Indian who elects an Indian health program shall be enrolled through a service unit, tribal organization, or urban Indian program. An Indian enrolled in an IHS program shall not be subject to charges for health insurance premiums, deductibles, copayments, coinsurance, or any other cost for health services.

Subsection (d) states that individuals who do not enroll in the IHS program shall be subject to premiums charged by the health plans and any other costs for health services under the applicable health plan.

SECTION 8303. SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS.

Subsection (a) provides that all Indians enrolled in an IHS program shall remain eligible for supplemental benefits which are outside the comprehensive benefit package. Supplemental benefits shall be provided without charge or cost to eligible Indians.

Subsection (b) authorizes $180,000,000 for fiscal year 1995, $200,000,000 for fiscal years 1996-1999, and such sums as may be necessary for fiscal year 2000 and each fiscal year thereafter to carry out the purposes of this section.

SECTION 8304. HEALTH PLAN AND HEALTH ALLIANCE REQUIREMENTS.

Subsection (a) requires the Secretary to ensure that the comprehensive benefit package is provided by all IHS programs as of January 1, 1999.

Subsection (b) directs the Secretary to determine what other requirements of health plans will apply to the IHS health plan.

Subsection (c) requires all health programs of the IHS to meet certification requirements for health plans by January 1, 1999. Prior to January 1, 1999, IHS health programs shall meet certification requirements to the extent practicable.

Subsection (d) directs the Secretary to determine which requirements of regional health alliances shall apply to the IHS.

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

Section 8305 exempts Indian tribes and tribal organizations from making employer premium payments.

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

Subsection (a) provides that an IHS or tribal health program may enter into a contract with a health plan to provide health care to individuals enrolled in the health plan so long as provision of such services will not result in a diminution of services to enrolled and eligible non-Indians. An IHS or tribal program shall be treated as an essential community provider pursuant to Section 1431 (c) and reimbursed for services accordingly.

Subsection (b) authorizes an IHS health program to provide health care to family members of enrolled Indians. An eligible Indian may enroll his/her family in an IHS or tribal health program. It also provides that eligible Indians shall not be subject to charges for health insurance premiums, deductibles, copayments or coinsurance for health services provided. Non-eligible family members are subject to all such charges.

It also provides that employers are liable for employer premiums for any non-eligible family member enrolled in an IHS or tribal health program. The Secretary is directed to establish and collect premiums for non-eligible individuals enrolled in IHS or tribal programs. The Secretary is also directed to establish a process for premium reduction in the same manner as regional health alliances. The Secretary is further directed to use the lower of the premium quoted or the reduced weighted average accepted bid for the regional health alliance when calculating the family share of the premium. Finally, the Secretary is directed to provide payment to IHS or tribal programs in the same manner as payment is made to a regional health alliance.

Subsection (c) provides that if an IHS or tribal health program elects to be an essential community provider then an eligible Indian or family member who is not enrolled in the IHS or tribal program may receive health services from the IHS or tribal program as essential community provider.

SECTION 8307. PAYMENT BY OTHER PAYERS.

Subsection (a) provides that nothing in the Act, shall be construed to affect sections 206, 401, or 402 of the Indian Health Care Improvement Act regarding payments from third party payers.

Subsection (b) provides that nothing in the Act shall be construed to affect the status of IHS as the payer of last resort for enrolled Indians.

SECTION 8308. CONTRACTING AUTHORITY.

This section amends section 601 of the Indian Health Care Improvement Act to include personal services for the provision of direct health care services in the term "goods and services".

SECTION 8309. CONSULTATION.

This section directs the Secretary to annually consult with Indian tribes and tribal organizations regarding health care reform impacts on Indian communities.

SECTION 8310. INFRASTRUCTURE.

Subsection (a) authorizes the Secretary to expend funds appropriated under this subtitle for construction and renovation of health facilities to enable such facilities to deliver the full range of services in the comprehensive benefit package.

Subsection (b) establishes an IHS revolving loan program to provide guaranteed loans to expand and improve tribal health care facilities to provide the full range of services in the comprehensive benefit package, under such terms as the Secretary may prescribe.

SECTION 8311. FINANCING.

Subsection (a) requires each IHS or tribal health program to establish a comprehensive benefit package fund.

Subsection (b) provides that employer premium payments, family premium payments, premium discount payments, funds appropriated to provide comprehensive benefit package to enrolled Indians, and any other amount received for services under the comprehensive benefit package shall be deposited in the comprehensive benefit package fund.

Subsection (c) provides that the comprehensive benefit package fund shall be managed by the IHS or tribal health program and that expenditures from the fund may be made for services provided under the comprehensive benefit package by the IHS or tribal health program. Funds shall be available without further appropriation and shall remain available until expended.

SECTION 8312. RULE OF CONSTRUCTION.

This section provides that no part of this Act shall be construed to rescind or otherwise modify any obligations, findings, or provisions contained in the Indian Health Care Improvement Act and the Indian Self-Determination Act, unless specifically provided for in this Act.

SECTION 8313. AUTHORIZATIONS OF APPROPRIATIONS.

Subsection (a) provides that 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 fiscal years 1997 through 2000 to carry out the provisions of this Act.

Subsection (b) provides that the authorization of appropriations in this section are in addition to any other authorizations of appropriations available to carry out the purposes of this subtitle.

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

Subsection (a) requires the Secretary to determine and certify to the Secretary of the Treasury each fiscal year an amount equal to the amount of premium discounts that would have been paid to an eligible Indian who is unemployed if such individual had been enrolled in a regional health alliance.

Subsection (b) provides that for each fiscal year that an amount is certified to the Secretary of the Treasury, the Secretary shall pay to the IHS the certified amount for the purpose of providing the comprehensive benefit package.

BACKGROUND FOR HEARING ON H.R. 3600, THE NATIONAL HEALTH SECURITY ACT

H.R. 3600, the National Health Security Act was introduced by Congressman Gephardt on November 20, 1993. The National Health Security Act represents an attempt to restructure the health care system across the nation. The bill creates a network of regional health alliances which would provide health care coverage to consumers. The states would determine the number of regional health alliances in their state. The alliances would collect employer premiums and distribute the funds to health providers within the state. The Act provides that employers will pay up to 80% of the cost of insurance premiums. The Act also provides that no employer will be required to pay more than 7.9% of its payroll in health insurance premiums. The government will pay for retired employees and will subsidize costs for low wage employees and unemployed individuals. The Act will Medicare and Medicaid largely intact.

The Act provides that no consumer would be required to contribute more than 3.9% of his or her salary. It also provides that consumers are responsible for making copayments and paying premium deductibles. The Act also creates a National Health Board which will have 7 members who are appointed by the President and confirmed by the Senate. The National Health Board is responsible for regulating health insurance premiums, setting national quality standards, and determining what benefits are included in the comprehensive benefit package. Health benefits that would be provided as part of the comprehensive benefit package include inpatient and outpatient services, ambulatory care, clinical preventive services, comprehensive inpatient mental health services and substance abuse counseling, prenatal care and family planning services, hospice care and home health care, ambulance services, outpatient rehabilitation services, laboratory and diagnostic services, and dental services for children. While states will have to develop the health care alliances and offer the comprehensive benefit package to all citizens by January 1, 1998, the Indian Health Services will have until January 1, 1999 to provide the level health care required under the comprehensive benefit package.

NATIONAL HEALTH CARE REFORM AND INDIAN HEALTH CARE

The National Health Security Act will provide American Indian and Alaska Natives the opportunity to choose between a health plan offered by the Indian Health Service or a regional health alliance. American Indians and Alaska Natives will be eligible for the same level of coverage as any other American. If an eligible Indian elects to receive services from an IHS or tribal health provider, then they are entitled to services under the comprehensive benefit package at no charge. If an eligible Indian elects to receive services from a regional health alliance, then they must pay any of the costs or copayments required under the plan. All Indians would be eligible to receive supplemental health services from the IHS regardless of where they are enrolled. Supplemental services are those

services and programs currently administered by the Indian Health Services that fall outside those services provided as part of the comprehensive benefit package. They include adult dental care, community health representatives, public health nursing, environmental health services, and water and sanitation facilities. IHS and tribal health programs would be able to provide health care to no-eligible family members of eligible Indians. Non-eligible family members will be responsible for any deductibles, copayments, and coinsurance charges. In addition, at the election of an IHS or tribal program, they may be treated as an essential community provider by a regional health alliance and provide health care to non-Indians so long as services to Indians are not diminished.

The Act requires IHS or tribal health programs to provide the same level of services under the comprehensive benefit package by January 1, 1999. This deadline is one year later than the deadline for the rest of the country. The Secretary will develop certification requirements for IHS and tribal health programs which each Indian program must meet by January 1, 1999. The Act authorizes $40 million in FY 1995, $180 million in FY 1996, and $200 million each year thereafter to enable the IHS to provide all the health services required under the comprehensive benefit package. These funds shall be used to construct and renovate IHS and tribal facilities and to provide basic services under the comprehensive benefit package. The Act also authorizes a revolving loan fund to help finance costs of construction or renovation of Indian health facilities. Finally, the Act authorizes $180 million in FY 1995, $200 million in FY 1996, and such sums as are necessary for each year thereafter to provide supplemental services through the IHS.

HEARING

The Subcommittee will receive testimony from the Administration and Indian tribes and tribal organizations on the potential impacts of national health care reform on the delivery of health care to American Indians and Alaska Natives. Some of the testimony will focus on the Administration's FY 1995 budget proposal and its implications on health care reform of the IHS.For example, the Administration has proposed no funding for construction of IHS health and sanitation facilities, a reduction of 460 FTE within the IHS, proposed cuts of $10.4 million in administrative costs, and inflated projections of third party collections (560% of last years collections). Indian tribes are also concerned that the proposed FY 1995 budget may result in a shortfall of $385 million for FY 1995. Indian tribes are concerned that the IHS system will not have adequate resources to be competitive with other health providers and regional health alliances. Indian tribes are also concerned that the Administration has provided transitional funding for the states, the Veteran's Administration and other health care delivery systems but has not provided similar transitional funding for the IHS.

Mr. RICHARDSON. I recognize the gentleman from Wyoming.

OPENING STATEMENT OF HON. CRAIG THOMAS

Mr. THOMAS. Thank you. I am glad to be here.

I have been very interested, and continue to be, in the overall health reform that is before us. And I have been very interested also in the Indian health program. As you know, I come from Wyoming and we have unique problems there, just because of our low population, and so on. So we are trying to see how we fit in this proposition as well, as you must take a look at that.

One of the difficulties is, of course, that this thing is not what we will see when it is all over, in my judgment. So now you are talking about how do you fit in this, and you also have to say, well, what is it going to be in the final analysis? It won't be this. But it is important that you do evaluate it and I am anxious to hear your evaluation.

I am also anxious to hear what the Health Service has to say. We had several hearings on that. My inclination is that there have been some improvements in terms of the Indian Health Service. I hope so.

So, I look forward to hearing the witnesses and thank you for calling this hearing.

Mr. RICHARDSON. I thank the gentleman. And as usual, I commend him and his very able staff for the very effective oversight that I believe our subcommittee conducts.

I would like to recognize our first witness, the Honorable Michel Lincoln, acting director, Indian Health Service, United States Department of Health and Human Services.

He is accompanied by Robert Van Hook, executive officer, Health Care Reform Office of the Assistant Secretary for Planning and Evaluation.

Director Lincoln, welcome. Please proceed. We look forward to your testimony.

STATEMENT OF MICHEL LINCOLN, ACTING DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DR. ROBERT VAN HOOK, EXECUTIVE OFFICER, HEALTH CARE REFORM, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

Mr. LINCOLN. Thank you, Mr. Chairman. It is a pleasure to be in front of the committee today.

I would like to mention that in the audience today we have a number of distinguished people, tribal leaders and Indian people of various organizations. We also have with us today Dr. Michael Trujillo who is the Indian Health Service Director designate. And Dr. Trujillo is seated directly behind me.

Mr. RICHARDSON. Why isn't he testifying?

Mr. LINCOLN. Basically, Dr. Trujillo has not been through the final confirmation process in front of the Senate.

Mr. RICHARDSON. Oh, well, that is all right with us. I understand.

Mr. LINCOLN. Mr. Chairman, Congressman Thomas, it is indeed a pleasure to be here. We have submitted testimony for the record. That testimony is organized in a manner that describes the histori-

cal background and justification for health services for Indian people. It discusses the legal relationship, and political relationship, that exists within treaty, within various acts of Congress and other legal doctrine of this country. It is important that we start at that point as we talk about the existing program and as we plan for Indian health services within the Health Security Act.

In addition, the document that has been submitted for the record points out some of the continuing health needs that exist within Indian country. As the Chairman mentioned, in many areas, fetal alcohol syndrome, fetal alcohol effect, tuberculosis, and now as we move toward for more chronic and behavioral disease problems, Indian people lag behind the U.S. general population in these areas.

There is diversity among disease in Indian country. The document probably doesn't adequately point that out, but I would like to point out to the committee that cancers primarily associated with smoking affects people in the northern plains more than it affects Indian people in the southwest. There are extraordinarily high diabetes rates, depending on which region of the country one lives in.

The Health Security Act, I believe, does offer an answer to improving health care—access to health care for Indian people. I will briefly cover some of the outstanding provisions within the Health Security Act as it has been identified in Title VIII, Subtitle D for Indian programs.

The Indian health programs will operate outside of the State alliance structure that has been defined within the rest of the act. Indian people testified throughout this country and provided strong statements that they would expect that the Indian Health Programs, the Indian Health Service, Tribal Health Service Programs could be continued out of the State alliance structure but that it would not be the same program. This new program would be a program that guaranteed or assured the comprehensive benefits package that is to be assured to all Americans as part of the Health Security Act.

In addition, the Subtitle D, the Health Security Act provides that existing legislation that guides the Indian Health Service continue. The Indian Self-Determination and Education Assistance Act in 1975 and the Indian Health Care Improvement Act and its amendments of 1976 continue to apply to the Indian health programs.

Therefore, maintaining the tribes's rights under Public Law 93-638, to exercise as much control as the tribe chooses to exercise, including the contracting for health programs, will continue under the Health Security Act.

Indian people under Subtitle D of the Health Security Act—Title VIII of the Health Security Act, will be offered a choice, as all Americans will be offered a choice. Individual Indians will be asked on an annual basis to choose a health plan. If an Indian chooses to enroll in an Indian health program; the Indian Health Service Federal program, a tribal 638 program or an urban program, their care will be assured. The comprehensive benefits package will be assured without any individual cost to that individual Indian person.

If an Indian person chooses to enroll in an alliance, that Indian person will be treated as any other citizen in this country. The in-

dividual will be expected to pay for the copays and deductibles and the 20 percent of the premium that any citizen would be asked to pay.

In closing, Mr. Chairman, I would like to point out that there are significant government-to-government features. I will mention two of them in closing: The first government-to-government feature is that tribal government employers are exempt from paying the 80 percent personal premiums as tribal governments for their employees. This is a provision that is mentioned in Subtitle D. There continues to be a need for providing language that will describe how this is to occur. But it is an acknowledgment of the role of tribal government in this act.

The last point, Mr. Chairman, is that the act requires consultation by the Secretary of the Department of Health and Human Services on a regular basis, on an annual basis with Indian tribes and Indian organizations in order that they be more involved in shaping the health care system of the future.

Mr. Chairman that, concludes my opening statement. And Mr. Van Hook and I are available to answer questions.

[Prepared statement of Mr. Lincoln and attachment follow:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

FOR RELEASE UPON DELIVERY

STATEMENT OF

MICHEL LINCOLN

ACTING DIRECTOR

INDIAN HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

NATURAL RESOURCES SUBCOMMITTEEE ON
NATIVE AMERICAN AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

February 28, 1994

Good Morning.

I am Michel Lincoln Acting Director of the Indian Health Service (IHS). This morning I will discuss how the Health Security Act proposes to deal with American Indians and Alaska Natives, the health care system currently in place to serve them, and tribal governments which have a unique status within our Constitutional system.

There are a number of principles affecting Indian concerns which the framers of this bill have adopted in drafting this legislation. These principals are: individual Indians should not have to pay for services that they now receive without charge; supplemental services guaranteed by earlier legislation should continue under health care reform; and the rights of tribes to assume operations of Federal programs through the Indian Self-Determination and Education Assistance Act, Public Law (P.L. 93-638) must be maintained and affirmed. The specifics should be evaluated with these principals in mind.

First, I will describe what the Health Security Act offers to American Indian and Alaska Natives (AI/AN) as individual health care consumers. Second, I will describe the proposed Indian health services delivery system and how it interrelates with alliances. Third, I will describe those provisions that relate to Tribal governments and tribal organizations. I will conclude with a brief description of the consultation process IHS has undertaken with Indian tribes, Indian organizations, and Indian people.

I will begin by providing a very brief summary of the historic Federal health care obligations to Indian Tribes and the health conditions and needs of Indian people. Any reconfiguration of health care services and/or financing for AI/AN people must appropriately address the Federal government's historic responsibility to provide adequate health care to Indian people. The basic legislation encompassing this responsibility is the 1921 Snyder Act which grew out of the historical and Constitutional relationship.

The 1921 Snyder Act was the culmination of the historical provision of services to Federally recognized Indians which grew out of the Constitutionally based primacy of Congress over Indian affairs.

The close involvement of the Public Health Service (PHS) with the Indian health program began in 1926 and was based on the Indian program's need for medical personnel and health service expertise, particularly in communicable disease. The 1955 transfer of programs to the PHS was based on these needs, coupled with the benefits of being located in an agency focusing exclusively on health.

The IHS has developed a health care delivery system and model that combines clinical services for individuals with community and public health programs. Within the limits of IHS' annual funding base, the service delivery system includes the integration of:

* comprehensive, curative, preventive and rehabilitative health care
* supplemental services to improve access and appropriate utilization
* public health, community and population-based programs
* capacity-building programs
* traditional AI/AN beliefs and approaches to personal, spiritual and community health.

The 1990 Census identified approximately two million American Indians and Alaska Natives. This population is growing 2.3 percent annually. Indians live throughout the United States, in urban areas, and on or near rural reservations. The current total AI/AN service population of the IHS is 1.3 million spread throughout 33 states. Services are delivered under circumstances that are overwhelmingly rural and isolated, focusing on relatively small numbers of people in any given area.

According to national estimates, approximately 28 percent of the IHS service population is covered by private health insurance (this figure includes employer provided insurance), and this proportion includes those holding both supplemental policies (e.g., medigap, long-term care, etc.) as well as those with more comprehensive policies. Among AI/ANs in the IHS service population who are employed full time, it is estimated that only 47 percent have employment related insurance. Financial, cultural, and language barriers frequently reduce access to, use of and acceptability of private health care facilities available near Indian reservations and communities.

Health reform will not change the need these small communities have for: public health and other services not part of health care reform proposals; training, recruitment and retention of health professionals.

The IHS addresses the needs of this diverse population through a partnership with more than 500 federally recognized tribes and 34 urban Indian organizations, collectively operating 50 hospitals, 140 service units, 164 health centers, 7 school health centers, 112 health stations, 172 Alaska village clinics, and 28 urban clinics. Services funded by IHS in urban areas range from provision of outreach and referral services to deliver of comprehensive ambulatory health care.

The Indian population is poorer and more disadvantaged than most Americans. More than thirty percent of Indian households live below the poverty level. Indians experience elevated risk for disease and injury that accompanies conditions associated with poverty and cultural dislocation. This risk is reflected in higher rates of illness and death for many diseases and injuries. Despite remarkable gains in the last 35 years, disproportionate numbers of Indian people die prematurely compared to the US all races average.

Indian people experience significant barriers that limit their access to health care services. Low incomes and high rates of unemployment push affordable private insurance out of the reach for many Indian households. Seventy-two percent of the IHS service population have no private

insurance (this figure includes employer provided insurance). Many depend on the IHS and other public insurance such as Medicaid as their sole source of health care.

Many Indian people live in remote and isolated areas. Many reservations are located in the most remote and harshest environments in the United States. Many Indians in these areas must travel long distances to reach a health care facility. Indian people often do not have reliable means of personal transportation and public transport is virtually non-existent in most rural areas. Harsh weather and impassable roads prevent travel altogether during parts of the year.

Indian tribes and Indian people are culturally and linguistically diverse. Non-Indian health care professionals frequently need translators to communicate with Indians who maintain their native language. Trained indigenous members of Indian communities are needed to blend western scientific medical practice with traditional cultural beliefs and ways.

To open my discussion of the Health Security Act, it is worth noting that American Indians and Alaska Natives receive unique treatment under the Health Security Act in recognition of the historic obligations of the government-to-government relationship that exist between the Federal government and Indian tribes. Other health care reform proposals before the Congress contain few, if any, references to Federal health care programs for Indians.

The Health Security Act offers significant new benefits to Indians, as it does for all Americans. Under the Health Security Act, Indian individuals and families receive the same guarantees of universal coverage for comprehensive benefit services as other Americans. Universal coverage will expand health insurance coverage to many Indian people who are currently not covered by any form of private health insurance. Universal coverage is especially beneficial to those Indians who do not reside near IHS facilities.

Like other Americans, Indians will choose a health plan. Eligible Indians may elect to enroll with a health program of the IHS or with a health plan offered through an alliance. An Indian eligible to enroll with a health program of the IHS is the same as defined in the Indian Health Care Improvement Act. It also extends full coverage to Indians living in urban areas in which urban Indian health programs are offered. Indians residing in a geographic area in which a health program of the IHS is not offered must enroll in an alliance health plan.

Consistent with existing Federal policy, the Health Security Act preserves free health care for Indians electing a program of the IHS. Indians enrolled with a program of the IHS will receive the comprehensive benefit package services at no cost. Cost sharing provisions in the Act will apply to Indians enrolling in an alliance health plan. Indians electing alliance plans will be eligible for cost sharing discounts on the same basis as other Americans.

A health program of the IHS may open enrollment to non-Indian family members if enrolled as a family unit by an eligible Indian. Non-Indian family members must pay normal premiums and other cost sharing.

Other non-Indians may not enroll in a program of the IHS. However, IHS programs may optionally serve non-enrollees by entering into contracts with alliance health plans to serve their enrollees if the local IHS program determines that services to enrolled Indians will not diminish and the alliance plan reimburses the Indian program as an essential community provider. This is especially important for Public Law 93-638 contractors who wish to compete more broadly in the health care market place.

The comprehensive benefits package defined in the Health Security Act assures a range and scope of medical care that exceeds what the IHS is currently able to provide. While enhancing preventive and curative medical services, the Health Security Act also preserves supplemental IHS programs that are not included in the comprehensive benefits package. Examples of these vitally important programs are public health nursing, community health representatives, environmental health services, and safe water and sanitation facilities. Indians retain their eligibility for supplemental programs regardless of which plan they elect.

I will now turn to the health care delivery system proposed to serve enrolled Indians. The Health Security Act proposes Indian Health Service programs that are distinct and separate from State or alliance control. Programs of the IHS would be operated by the IHS, or under contract with a Tribe or tribal organization or an Urban Indian program.

Indians enrolled with an IHS, tribal, or urban Indian program will receive comprehensive benefit package services either directly from the program's providers or from other providers under contracts arranged by the program. Conversely, the local IHS, tribal, or Urban Indian program may contract with alliance plans to serve their Indian or non-Indian enrollees under conditions I described earlier.

All health programs of the IHS must offer the comprehensive benefits package by January 1, 1999. Many states are proceeding on a faster health care reform track. To assure the financial viability of the IHS programs under reform, the health programs of the IHS should be able to offer the benefit package as states implement reform.

Because the programs of the IHS operate outside of the normal alliance framework, financing for the comprehensive benefits package is somewhat different from that described elsewhere in the Health Security Act. Revenues to fund the comprehensive benefit package will consist of a blend of employer premiums collected by alliances, non-Indian family member premiums, cost sharing discount equivalents for low-income non-employed Indians, reimbursements for services provided to other plans, and Federal appropriations for the comprehensive benefits package.

The Health Security Act authorizes new appropriations of $40 million in FY 1995, $180 million in 1996, and $200 million thereafter for enabling services such as transportation, outreach, translation, and for construction and renovation of facilities to enable the delivery of the comprehensive benefits package. Additionally, the Health Security Act authorizes a new revolving loan program and/or loan guarantees to finance capital improvements and other infrastructure development.

I will turn next to provisions relating to tribes and tribal governments. The Health Security Act recognizes and expressly preserves health related Federal Indian law. This includes the rights of tribes and tribal organizations to contract or compact for Federal Indian programs under the Indian Self-Determination and Education Assistance Act.

The government-to-government principle is recognized and retained. The federal framework is retained by organizing the programs of the IHS outside the jurisdiction of the States and regional health alliances. Whether IHS operated, operated by a tribe or tribal organization, or operated by an Urban Indian program, basic Federal jurisdiction flows through the Secretary of Health and Human Services (HHS). The Secretary of HHS will determine which health plan requirements of the Health Security Act will apply to the programs of the IHS. Health programs of the IHS must meet health plan certification requirements specified by the Secretary by January 1, 1999.

Another principle underlying these provisions is that health care reform will not shift health care costs that are now borne by the federal government to tribal governments. Consequently, the Health Security Act waives employer contributions for Tribal governments and tribal organizations.

Finally, I want to briefly describe a process of consultation that the IHS has undertaken with regard to health care reform. The Health Security Act requires the Secretary of HHS to consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities. Up to now, the IHS has focused on providing information about the Health Security Act throughout Indian country. These efforts have included special presentations to tribes, tribal organizations, and Indian communities throughout Indian country. Health reform has been on the agenda and discussed at virtually every business meeting and conference for 6 months. Additionally, IHS has contracted with the National Indian Health Board to publish an ongoing newsletter and analysis of health reform proposals that affect Indian communities. These are distributed through a mailing list of over 800 tribes, Indian organizations, and Indian leaders.

Recently, Dr. Philip Lee, Assistant Secretary for Health has scheduled a series of public meetings with tribal leaders in four different regions. These 3 day sessions began February 2 in Albuquerque, New Mexico. Similar forums are scheduled for March in Portland, Oregon, for April in Billings, Montana and for Washington, DC in May. Together with senior HHS and IHS officials, Dr. Lee will consult intensively with tribal leaders regarding their views on national health care reform and other issues affecting Indian tribes and Indian people.

This concludes my remarks. I will be pleased to answer any questions that you may have. Thank you.

Provisions for Indians in the HEALTH SECURITY ACT

GENERAL PROVISIONS

- American Indians/Alaska Natives ("Indians") receive special treatment under the Health Security Act in recognition of the historic obligations of the government-to-government relations that exist between the Federal government and Indian tribes

- Indians receive the same guarantees of universal coverage for comprehensive benefit services as other Americans

- The Secretary of the Department of Health and Human Services is required to consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities.

ELIGIBILITY, CHOICE AND COVERAGE

- Eligibility as an Indian remains the same as in the Indian Health Care Improvement Act

- Eligible Indians may choose to enroll with a health program of the Indian Health Service (IHS) or with a health plan offered through an alliance

- Health programs of the IHS are those that provide services under the Act through:
  -- a facility of the IHS
  -- a tribal organization under the Indian Self-Determination Act or a self-governance compact, or
  -- an urban Indian program

- Indians enrolling in a health program of the IHS will receive benefit package services through Indian/Tribal/Urban (I/T/U) facilities or elsewhere by arrangement with the health program

- Indians remain eligible for supplemental health services guaranteed under the Indian Health Care Improvement Act regardless of which type of plan they choose

ENROLLMENT – FINANCIAL RESPONSIBILITIES

- Indians enrolling with a health program of the IHS will receive comprehensive benefit package services with no cost sharing
- Cost sharing provisions in the Act will apply to Indians enrolling with an alliance health plan, and Indians so electing will be eligible for cost sharing discounts the same as other Americans

ASSURANCE OF BENEFITS AND QUALITY

- All health programs of the IHS must provide the comprehensive benefit package by 1/1/1999
- At that time, all health programs of the IHS must meet health plan certification requirements specified by the Secretary

NON-INDIAN FAMILY MEMBERS

- A health program of the IHS may open enrollment to non-Indian family members of eligible Indians
- Non-Indian family members who enroll pay normal premiums and other cost sharing, and they are eligible for appropriate discounts

SERVICES TO NON-ENROLLEES

- I/T/U programs may enter into contracts with alliance health plans to serve their enrollees (whether Indian or non-Indian)
- The local I/T/U program must determine that providing services to non-enrollees will not diminish services to enrolled Indians
- Alliance health plans contracting with I/T/U programs must pay them as essential community providers

ESSENTIAL COMMUNITY PROVIDERS

- I/T/U programs may elect to be essential community providers and may provide services to Indians and non-Indian family members who do not enroll in a health program of the IHS

- Alliance health plans must pay essential community providers at a negotiated rate, or at the election of the ECP, at an appropriate Medicare rate (e.g., FQHC, RHC, or Medicare capitation rate) or on the alliance fee schedule

FINANCING FOR COMPREHENSIVE BENEFIT PACKAGE SERVICES

- The Act establishes a comprehensive benefit package fund for each health program of the IHS (I/T/U) to assure access to those services

- There are five sources of deposits into the funds:
  - -- employer shares of premiums for Indians employed by non-tribal employers
  - -- premium and other cost sharing payments from non-Indian family members
  - -- amounts equivalent to premium discounts for low income, non-employed Indians if they in alliance health plans
  - -- reimbursements from alliance health plans for services to non-enrollees
  - -- Congressional appropriations

TRIBAL EMPLOYER EXEMPTION

Tribal governments and tribal organizations are exempted from making employer premium payments

AUTHORIZATION OF APPROPRIATIONS

The Act authorizes new appropriations of $40 million in FY 1995, $180 million in FY 1996, and $200 million in FY 1997-2000 for the purposes of:

- supplemental health services (e.g., transportation, outreach, translation, and other enabling services) and
- construction and renovation of facilities to enable the delivery of the comprehensive benefit package
- establishment of a revolving loan program for infrastructure development

Mr. RICHARDSON. Mr. Van Hook, did you wish to say anything, or are you ready to answer questions?

Dr. VAN HOOK. No, sir, I would just as soon answer questions.

Mr. RICHARDSON. The Chair recognizes the gentleman from Wyoming for questions.

Mr. THOMAS. Okay. I think you mentioned in your statement, Mr. Lincoln, that the proposed program offered under the Health Security Act program has greater benefits than is offered by the Health Service; is that correct?

Mr. LINCOLN. That is correct, sir.

Mr. THOMAS. Substantially greater?

Mr. LINCOLN. In the area of medical care services and long-term care, yes, we believe substantially greater services. The Indian health program in terms of preventive health care, is perhaps a little bit broader when you take into account our sanitation facility construction program and other services provided by our community health representatives and our public health nurses, as examples. But when you look at the medical care program and the services covered under the comprehensive benefits package, we believe those services are broader and deeper.

Mr. THOMAS. What, then, would you expect would be the outcome, assuming that most tribal members would stay with the Indian Health Service? Would you see changes then being requested?

I can't imagine that if these benefits were put into place that others would be happy to have less benefits.

Mr. LINCOLN. From our discussions and our consultation with Indian organizations and with tribal governments, what has been clearly stated by Indian people is that they would expect to have assured the same benefits as a result of the Health Security Act that the U.S. population in general would be assured. In addition to that, they would expect those supplemental programs, those public health programs of which I briefly spoke, to be continued because it is the combination, from what I have been told, of the medical benefits and the benefits assured in the comprehensive benefits package, and the public health services that will improve health status. And so I think Indian people are looking for an enhancement to the services that are currently available to them.

Mr. THOMAS. So, you don't see it as a choice, but rather that those who would choose to stay with the Indian Health Service, the caveat would be that those services would be increased; is that what you are saying?

Mr. LINCOLN. I believe that to be the case, yes, sir.

Mr. THOMAS. What about—and this, as I understand it, the proposal that we are talking about here is on an individual basis, by individual tribal members?

Mr. LINCOLN. Yes, it is, sir. Individual tribal members, as any citizen would be asked on an annual basis to choose who their provider of care would be.

Mr. THOMAS. What impact would that have, let's say, on the Wind River Reservation if half of the tribal members decided to do one thing and the other half decided to do the other, in terms of volume of facility use and that kind of thing?

Mr. LINCOLN. I believe that is one of the more important unknowns as a result of having individual choice and not dealing with

the issue of what in the Indian country is known as "dual eligibility." In this instance, with the Health Security Act fully in effect, the resources, the per capita payment, if you will, identified with various enrolling units and an individual, as an example, would follow the individual. So if 50 percent of the existing people who use the Wind River Service Unit were to enroll through an alliance in a health plan, those resources would follow those individuals.

We have not completed an analysis of the impact on the system. But in general, I think if we were looking at this kind of pattern, it obviously would lessen the ability of the Wind River Service Unit to continue to provide the scope of services it provides.

Mr. THOMAS. You mentioned that there are six principles, and one is individual Indians should not have to pay for services. That would not be consistent, then, with belonging to an alliance; wouldn't it?

Mr. LINCOLN. That is true. The way the Health Security Act was organized and is being formulated and being discussed, it was anticipated that the government-to-government relationship, including individual Indian rights associated with being a member of a federally recognized tribe would continue. One way to continue providing care to eligible Indian people, free of charge, was to build that into the act itself.

One of the six principles of the administration's Health Security Act in general, though, is one of individual choice. Decisions were made at the highest levels within the administration to preserve individual choice, even within Subtitle D. We were aware that the health system that is in place would need to be stable——

Mr. THOMAS. What do you mean by "individual choice"?

Mr. LINCOLN. That individual Indian persons, just like a non-Indian person in this country, would be able to choose who their provider would be, is what I mean by individual choice.

Mr. THOMAS. Individuals do not have a choice between Indian Health Services and alliances. I don't have a choice. I have to belong to an alliance under this arrangement.

Mr. LINCOLN. Indian people, based upon the Health Security Act, will have a choice.

Mr. THOMAS. Yes, I understand. So that is unique, however. That isn't applied to everyone over the country?

Mr. LINCOLN. That is correct, sir.

Mr. THOMAS. It is my hunch, frankly, that most of the VA, medicare, Indian Health Service, these others are pretty much going to stay as they are. It seems to me that there is enough problem trying to deal with the remaining issues that those are generally going to stay pretty much as is.

Do you see great change in the Indian Health Service?

Mr. LINCOLN. Congressman Thomas, I would see two—at least two significant changes. One of them is that the Health Security Act, at least as far as the Indian health portion is concerned, would guarantee and assure the comprehensive benefits budget, and that is different than what occurs now. What occurs now is that the Indian Health Service uses appropriations that are provided to the Indian Health Service to provide health services, but there is not a guaranteed or assurance of a comprehensive benefits package for each individual. That is a significant difference.

The second difference would be in the revenue streams that might be generated as a result of the Health Security Act. Currently, the Indian Health Service depends on appropriations, primarily, and some collections, primarily from Medicare and Medicaid reimbursements. The Health Security Act, as it is currently written, would provide a third revenue stream for the Indian health programs and those would be employer-based premiums of some kind.

Mr. THOMAS. And also individual payments?

Mr. LINCOLN. No—well, the Health Security Act does not envision any individual Indian payments to come to the Indian health programs as a result of it.

Mr. THOMAS. But tribal members, if they joined the alliance, would have some obligation to pay for it then?

Mr. LINCOLN. That is correct.

Mr. THOMAS. And you are not suggesting that be changed?

Mr. LINCOLN. The Health Security Act is, as you described, an individual Indian enrolling in a non-Indian program would pay their 20 percent of the premium and other deductibles as any other citizen would pay.

Mr. THOMAS. Do you have any idea—you know, each year, the appropriation for Indian Health Service is also a hassle. If you change the Indian health services to be equal to what is suggested here, what would it cost? Any idea?

Mr. LINCOLN. Congressman Thomas, we have a number of studies that are ongoing, with two that are significant. One of them is an actuarial-based study that is to do two things: Determine what the costs would be and estimate the costs associated with providing the comprehensive benefits package.

And the second component of that study would be using the models in the Health Security Act and determine what revenue one could expect to generate based upon the Health Security Act. We have a preliminary report in that regard, but we are still in the process of validating and verifying the data and understanding the economic model that was used by our actuarial people. That information generally is available.

The second, though, is increasing the capacity of the existing programs from a facility standpoint. And in this record, the Indian Health Service on an annual basis, for the last half a dozen years, publishes or makes available to the general public a document that has been expanded to take into account some Health Security Act information. That number is approximately $3.3 billion over a long period of time to upgrade the capacity of various facilities throughout Indian country.

Mr. THOMAS. I don't have any more questions, but there really are some difficult issues here. We talk on the one hand of seeking to have health care for everyone, and then trying to do something about reducing the cost. So then on the other hand, we say, well, but we will leave this apparatus in place, which is obviously more costly than not leaving it in place. And these things are conflicting.

The Indian Health Service is not the most inexpensive way to deliver health in the world. And I see you don't agree with me, but I don't think that it is. I think it is very expensive, as a matter of fact, for what it provides, so that is a little inconsistent, in my

view, with the idea of trying to reduce costs. And I don't have an opinion on it particularly, but I do think that there are some contradictions in this decision in terms, overall.

Thank you for your responses.

Thank you, Mr. Chairman.

Mr. RICHARDSON. Mr. Lincoln, the VA system is being provided a large percentage or amount of funding for transitional costs as they move into implementing this new plan. Is there any transitional funding for the IHS under the plan?

Mr. LINCOLN. Mr. Chairman, within the Health Security Act, there are some authorized amounts identified. In fiscal year 1995, the Act identifies $40 million of funds that could be authorized. And in 1995, it identifies $180 million and in 1996 through the year 2000, I believe, sir, it authorizes $200 million per year. These funds could be used for a variety of supplemental services, capacity building, to name two.

Mr. RICHARDSON. Now, do you have an estimate as to how much it will cost to provide all the benefits raised in the comprehensive benefits package for the Indian people? Say, an estimate of all the benefits listed?

Mr. LINCOLN. Mr. Chairman, the information we have from the actuarial study that we commissioned many months ago identifies cost somewhere in the neighborhood in general of about $2.8 to $3 billion. One of the difficulties, though, is that as we have reviewed the database associated with those numbers, we have a number of questions. The Indian Health Service will need to work with the Department, with the Office of Management and Budget, and with Indian tribes and representatives in order to fully understand how our actuarials came up with that number.

Mr. RICHARDSON. Is there funding under the plan to bring the IHS into compliance with the facilities requirement that is established in the bill?

Mr. LINCOLN. Mr. Chairman, the dollar amounts of $40 million in 1995, $180 in 1996 and $200 million in the years after that, it was envisioned that a certain portion of those funds, if appropriated, would be available to increase the facility capabilities. In addition, the Act identifies a guaranteed loan repayment loan in Subtitle D that is designed to assist those tribes and those Indian organizations, both tribally based and urban based, with access to low-interest, guaranteed loans so they improve their facilities.

Mr. RICHARDSON. Okay. The staff is telling me that while the VA gets $3.4 billion for transitional costs, the Indian Health Service gets $40 million; is that accurate?

Mr. LINCOLN. The—$40 million is authorized in 1995, that is correct sir.

Mr. RICHARDSON. It is a little bit of a disparity; isn't it?

Mr. VAN HOOK. Mr. Chairman, I don't think the $3 billion for VA is in 1995, so it is spread out a little bit. But there clearly are not the same provisions for transition for the Indian health services as for the veterans in the bill.

Mr. RICHARDSON. Let's take Section 8310 and 8311; what are the estimated costs for the expansion and renovation of Indian Health Service and tribal facilities under those sections?

Mr. LINCOLN. Mr. Chairman, under 8310(a) which talks about facilities and authorizes the Secretary through the Indian Health Service to expend appropriations for construction or renovation of hospitals or health centers and other facilities, in order that the services guaranteed in the comprehensive benefits package could be provided, the number that I mentioned before of approximately $3.3 or $3.4 billion is the current estimate of what it would cost to upgrade the existing facilities within the Indian health programs. And that is it on a national basis. That includes both federally operated facilities, tribally operated and built facilities and urban Indian health facilities.

This information, indeed, is preliminary. This is an analysis that has been performed on facility modernization and repair for half a dozen years. But we did update our latest estimates.

Mr. RICHARDSON. How much does the IHS expect to collect in employer premium payments and third-party collections?

Mr. LINCOLN. Based on actuarial work that has been performed over the last three months, again, we have not had a chance to verify and validate the data. We are continuing to work with the actuarial organization that we entered into a contract with. It estimates that in employer-based premiums, nontribal government employer-based premiums, would be somewhere in the neighborhood of $340 million. That number is very preliminary, Mr. Chairman, and we would ask that there be the opportunity to completely review the study and understand those numbers before we started relying on numbers like that. They are preliminary and it has been just one week since we received our first report from the actuarial studies.

Mr. RICHARDSON. You know how important third-party collections are to tribes. Over the years the IHS has significantly undercounted and has been unable to collect those revenues. This is a critical source of revenue. I think if the IHS plan in the national health care initiative is going to work, we have got to make sure those third-party collections work.

Now, what happens to medicare and medicaid payments which tribes currently collect under the plan?

Mr. VAN HOOK. Mr. Chairman, the medicare payments will continue. The medicare program continues unchecked in most areas under the Health Security Act. Medicare for acute—medicaid, excuse me, for acute care services will essentially go away and will be folded into the overall health plan.

There is—it will be easier to collect payments—premium payments, than it will be to collect fee-for-service payments. Fee-for-service payments are part of what is wrong with our health care system today, so we hope that the premium payments and the sources of funding that are available to Indian providers will be a lot more regularized and routine than that trying to collect third-party payments.

Mr. RICHARDSON. What about Section 8314, the premium discounts; how much does the Indian Health Service intend to collect?

Mr. LINCOLN. Mr. Chairman, we do not have an estimate as to what we would anticipate to collect from premium discount equivalents for unemployed Indians. We will be asking our actuarial firm to make an estimate based upon the data they have.

Mr. RICHARDSON. Okay. Needless to say, you have heard the concern and outrage in Indian country over the levels of funding for the Indian Health Service. I hear it in my State. The issue is how can you provide adequate health care without adequate resources? As we move into this national plan, we are not just talking about new construction. I am talking about essential services, ensuring that there are people right now to staff IHS hospitals.

When you make an announcement that a high percentage of the hospital is going to be laid off and at the same time you say that the Indian Health Service is going to adequately provide care for Native Americans, it is kind of a difficult argument to make.

Let me ask you this, will you be requesting a sufficient level of funding to meet the requirements of a comprehensive benefit package, the funding needed to provide the same level of supplemental services as you are currently providing as well as meeting the requirements of Section 8310?

Mr. LINCOLN. Mr. Chairman, the Health Security Act requires the Secretary by 1999, to assure the comprehensive benefits package. The Indian Health Service is not in a position today to comment on, and project out, what resources might be requested by the Department, by the administration, so I could not provide that assurance today as the Acting Director of Indian Health Service.

What I can say is that the Indian Health Service will make sure that the costs of providing and assuring the comprehensive benefits package is known. We will develop those numbers co-jointly with the Indian tribes, with the Department and with the Office of Management and Budget; and we are pursuing that vigorously.

Mr. RICHARDSON. Well, before we mark up this bill, H.R. 3600, in this subcommittee, would you provide the Secretary with the current estimates for, one, levels of funding needed to provide all services in the comprehensive benefits package; two, renovation and construction needs; and three, funding needed to provide the same level of supplemental services as are currently available.

Mr. LINCOLN. Yes, sir.

[EDITOR'S NOTE.—The information was not received at the time of printing.]

Mr. RICHARDSON. I think that is important.

Dr. Van Hook, you were involved in the development of the plan; is that right?

Dr. VAN HOOK. Yes, sir.

Mr. RICHARDSON. You know, I am a cosponsor and vigorous supporter of the plan. What do I tell my Indian constituents? Are we going to fix this? How much flexibility in the administration position is there, especially on the funding issue to fix this?

Dr. VAN HOOK. Again, I think I have to be a little bit like Mr. Lincoln on this. I don't think I can answer for the Office of Management and Budget, or for the administration, any further than the documents that have been submitted. We are continuing to review and to provide updated information and to get better understanding of what the costs will be for Indian people. And I am sure they are going to be given a lot of consideration, both in the administration and the Congress over the next month or so.

Mr. RICHARDSON. Well, in Congress, you certainly will. We are going to change this. We can't, obviously, accept all of these numbers.

Now, one policy issue that is bothering me is do you think that this plan penalizes small tribes or individual Indians who are not living near an IHS or tribal provider? Would these regional health alliances victimize those possible recipients because they would be required to pay the cost of deductibles and copayments for services that they now receive without cost? Is this a potential danger?

Mr. LINCOLN. Mr. Chairman, in the way that you described it, that is a potential danger. What the plan does, though, is that it acknowledges the need to build capacity at a local level more than any other proposed piece of legislation or current act. And in that, if the local capacity can be built to such an extent that Indian people could enroll locally and still be assured the comprehensive benefits package, then I do not believe it will penalize individuals. I think the key to assuring the comprehensive benefits package is ensuring the capacity at the facility and at the enrollment point exists.

Dr. VAN HOOK. Mr. Chairman, may I comment on that?

As you describe the situation, I think in fact an Indian person who lives away from the reservation that would be able to enroll through a health alliance, may actually end up with a better plan, because they would be assured the comprehensive benefits package, they would still be eligible for all the premium discounts that any other American would be entitled to, so if they are low income, they would be able to have the family share taken care of. And, you know, if they are living far away from Indian Health Service services now, they wouldn't have very good access to even those services that are available now, much less the comprehensive benefits package services, so I think it could be an improvement for Indian people that live away from the reservation.

Mr. RICHARDSON. Well, we need to fix this, because this, in my judgment, would run counter to the Federal Government's trust obligations if all of a sudden somebody is disqualified for federal services.

Does my colleague have additional questions?

Mr. THOMAS. Just one general question, and I have sort of forgotten the answer to this.

Do you know, offhand, with the Indian Health Service and the participating tribal members, what is the cost per member?

Mr. LINCOLN. For the existing number of people who use Indian Health Service on an annual basis, the per capita cost of hover between $1,250 and $1,300 a person for medical and health services.

Mr. THOMAS. That is not eligible, those are participating? That is it?

Mr. LINCOLN. For the 1.3 million Indian individuals who use the Indian health programs.

Mr. THOMAS. Thank you.

Dr. VAN HOOK. Mr. Chairman, may I add one further thing about the difference between having—between an Indian person's responsibility for the copayments, the cost sharing if they enroll in an alliance health plan?

One of the reasons why there is that difference is that it provides a terrific incentive for Indian people to enroll with the Indian health plan sponsored by the Indian Health Service. Without that incentive, one kind of situation, that I think Congressman Thomas discussed, about 50 percent of the people going into a health alliance and 50 percent staying with the Indian Health Service, might be a problem that programs of the Indian Health Service might encounter in the future.

Mr. RICHARDSON. I think as we move ahead and we mark this bill up, we need to talk. I would like those figures as soon as possible, because I think the IHS plan as submitted needs some radical surgery, not just on the resource component. I think your goals are the same as ours, but I think we have a trust obligation that we need to fulfill.

We want to make health care more efficient. We want to provide access to everyone. We want to cover everyone. We want to make it more efficient and less bureaucratic, but I just wonder if we have achieved all of these goals in this plan that has been submitted. So, let's work together in the days ahead to try to make sure that we are making positive changes that will benefit all American Indians and Alaska Natives.

Mr. THOMAS. Let me say that I hope that you take a look at some other alternatives. I am not a sponsor of H.R. 3600, as a matter of fact, I am not a supporter of this plan, which is immaterial here, except that that is not the only plan that there is. So I think you have to take a look at it on the basis that there are some other plans out there.

I know that you are supporters of this, that is your job. But I am not, and so all I am saying is that if you want to really deal with the Native American needs, I hope we take a look at it broader than just what might come out of this bill.

Mr. RICHARDSON. Thank you. I want to thank both of you for appearing.

PANEL CONSISTING OF HON. PHILLIP MARTIN, CHIEF, MISSISSIPPI BAND OF CHOCTAW INDIANS, PHILADELPHIA, MISSISSIPPI, ACCOMPANIED BY JIM WALLACE, DIRECTOR, CHOCTAW HEALTH DEPARTMENT; HON. JULIE BARTON, SECRETARY, ONEIDA TRIBE OF INDIANS OF WISCONSIN, ACCOMPANIED BY DEANNA BAUMAN, DIRECTOR, GOVERNMENTAL SERVICES DIVISION; LYDIA HUBBARD-POURIER, DIRECTOR, HEALTH SERVICES DIVISION, NAVAJO NATION, WINDOW ROCK, ARIZONA; AND, PAMELA E. IRON, EXECUTIVE DIRECTOR, HEALTH SERVICES DIVISION, CHEROKEE NATION, TAHLEQUAH, OKLAHOMA

We now move on to our second panel. The Honorable Philip Martin, the Tribal Chief of Mississippi Band of Choctaw Indians, Philadelphia, Mississippi, who is accompanied by Mr. Jim Wallace, Director the Choctaw Health Department; the Honorable Julie Barton, Secretary Oneida Tribe of Indians of Wisconsin, and she is accompanied by Ms. Deanna Bauman, Director of Governmental Services Division; Ms. Lydia Hubbard-Pourier, Director, Division of Health for the Navajo Nation, Window Rock, Arizona; and Ms.

Pamela Iron, Executive Director of Health Services Division for the Cherokee Nation, Tahlequah, Oklahoma.

I want to welcome all of you to our hearing.

As I mentioned earlier, your full statements will be submitted in the record. We would ask you to summarize your statements within our allotted five-minute time period.

We will start first with Honorable Philip Martin, the Chief of the Mississippi Band of Choctaw Indians.

STATEMENT OF HON. PHILLIP MARTIN

Mr. MARTIN. Thank you, Mr. Chairman.

We are happy that you gave us an opportunity to say a few words about the health care. I am the elected chief. I have been working with the tribe for over 35 years. And one of the things that our goals and objectives have been is to bring health care opportunity to the Choctaw people, raise the level of income for our people, and manage the reservation as a tribal government. And we have done real well in those areas.

We operate our own schools and health care. We contracted the health care in 1983. We have industry that we brought in on the reservation. We have about eight different kinds of industries that bring employment. We have created over 3,000 jobs. One of the largest employers in the State of Mississippi.

We have over $80 million in sales on manufactured items that we do. And we do a lot of work for the automotive industry and AT&T, many other Fortune 500 businesses. So we have a comprehensive community development program going on on the reservation and it has been very successful.

Health needs are a part of the community. You have got different elements of the community. Health care is very vital. If you don't have healthy people, you can have all kinds of jobs but you won't find people that work. So, in 1983 we contracted our IHS health facility which was built in 1976 over 52,000 square foot of space.

We started with a 40-bed hospital then. And a comprehensive community health program; inpatient and outpatient. So—and we have had problems with running a comprehensive program because we are only funded 70 percent of need. And if—that is a big concern of us, of what is going to happen to our funding.

We don't understand all of the issues here. We just got into it here recently. And we are concerned about the sovereignty issue, but this whole thing. We are very leery about going through State programs, because State does not have any trust responsibility to us. So we are just another citizen in a State situation. And we would probably not benefit at all.

And so we would like to see a program where reservation—tribal governments have the option of running a comprehensive health program. We can do that with a little more money. We got practically everything that is needed there except major operations but it is underfunded, so we would have to have more money to upgrade the facility to do that.

Jimmy Wallace here, who is the Health Director, he manages all the health program. We have a health department, and he handles a day-to-day operation of the department.

He is familiar with the problems that he faces everyday. That is why I wanted him to come here and raise some questions with you on the health care reform.

One of the other things that we are doing might be of interest. We built a 120-bed nursing home. We went to the State legislature and the State government and obtained a certificate of need. And we were lucky I guess, they had a moratorium on nursing homes but they gave us a 120-bed nursing home authority for that.

But the reason why you don't see a lot of nursing homes in Indian country is because of financing. If tribes had financing to build nursing homes, then they can come under the State medicare and medicaid program or private funding to manage those. And we have one of the best in the State.

We just had a review by an accreditation agency. I don't remember the name of that one. But our nursing home received no deficiencies. That means that we are doing a good job and we are following all of the Federal and State regulations pertaining to nursing homes. And I believe that long-term care—we can't find anything in the information we have received about long-term care. So I think somebody needs to look into that as well.

I think I have said all I need to say and I am going to let Jimmy come up with some specific questions that we have written down.

[Prepared statement of Mr. Martin follows:]

TESTIMONY

on

THE INDIAN HEALTH SERVICE CARE SYSTEM IN THE NATIONAL HEALTH CARE REFORM

Presented to:

HONORABLE BILL RICHARDSON, CHAIRMAN
HOUSE NATURAL RESOURCES SUBCOMMITTEE ON
NATIVE AMERICAN AFFAIRS
1522 Longworth House Office Building
Washington DC 20515

by:

PHILLIP MARTIN, CHIEF
MISSISSIPPI BAND OF CHOCTAW INDIANS
Box 6010 Choctaw Branch
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February 28, 1994

My name is Phillip Martin, and I am the elected Chief of the Mississippi Band of Choctaw Indians, a 5,500-member tribe occupying 21,000 acres of reservation lands in east central Mississippi. I have been in the tribal leadership for nearly 40 years, and am in my fourth consecutive four-year term as Chief. The tribe operates all Indian Health Services programs on the reservation under Self-Determination contract, including a 35-bed hospital.

As a recompense for the taking of tribal lands in the 18th and 19th centuries, the United States pledged, through treaties and statutes later condensed in the Snyder Act, to provide special services to American Indian people and their tribal governments, with which the Constitution had established a special government-to-government relationship. Among the services to be provided were health care services. These were delivered initially through the Bureau of Indian Affairs, and later, after 1953, by HEW, now HHS.

Indian health care was the first great national public health care system -- and there are to this day only two, the other being the services made available to veterans of the armed forces. Each has a long tradition of dedicated professional staff working in remote and difficult conditions, of appropriated resources that fall far short of assessed levels of need, and of top-down decision-making and a trickle-down approach to funding.

The Indian Health Service bureaucracy has had, and continues to have, major difficulties in providing quality health care to the people it is supposed to serve. But, in part because it is a system of *public* health care, these problems are different in scope and in kind from those afflicting the country's prevailing *private* health care system. Each of the health reform proposals before the Congress is aimed at correcting inequities in the nation's private, fee-for-service health care system.

It is our belief that inclusion of public health care systems in private health care reform can only result in their being treated as stepchildren, and in placing inappropriate burdens on the people for whom the public systems were designed, in this case, American Indian people.

If I may, let me briefly describe what the Mississippi Choctaw tribe has been able to do over the past 20 years to bring federal public health resources under local control, and to leverage additional resources to bring the level of health care services up to IHS-determined levels of need.

After several years of contracting for the operations of the smaller IHS programs under the auspices of the Buy Indian Act, and later the Self-Determination Act, the Mississippi Band of Choctaw Indians contracted for total IHS operations in 1984. This established a mechanism of full local control of health care delivery, especially important on the Choctaw reservation, where 95 per cent of Choctaw families speak the Choctaw language.

Around the same time, we established a self-funded health insurance system for tribal and tribal enterprise employees (now totaling around 2,900 people) with a dual purpose: 1) providing quality health care to all persons in the insurance system, Indian and non-Indian, and 2) providing a pool of resources to defray some of the costs of treating the Indian employees in the tribal health care system, in order to bring the level of services up higher than 70 per cent of minimum need, where IHS funding currently stands.

In addition to the hospital facilities, the tribe operates a 120-bed nursing home, community clinics (the reservation is scattered over six counties), and, in conjunction with Kidney Care of Mississippi, a kidney dialysis unit serving both Indians and non-Indians. An organizational chart of our Health Department is attached to my testimony. Meanwhile, however, some basic health care services once available to people on the reservation, including surgery and obstetrics, have been curtailed by the IHS; and we have had to turn to contract medical care to supply them. Our IHS allocation is $5.6 million for 68,000 ambulatory visits per year. After ten years of effort, we have been able to supplement this per visit figure by $1.3 million per year, using payments from the tribal self-funded insurance, a relatively few other third-party payments, and Medicaid and Medicare reimbursements.

I must emphasize that while this tribal health care system is, despite the requirement for contracting out some basic services, a fairly unitary one with some insurance reimbursements, and may be compared in some respects to an HMO, it is definitely not a fee-for-service set-up -- and insofar as low levels of funding preclude our concentration on needed preventive activities, in many ways it is more akin to an emergency room than an HMO.

American Indians think it's pretty humorous that many of the critics of the President's and First Lady's health proposal complain that it will subject the American people to unnecessary social experimentation. Of course, we American Indians have been the objects of ongoing health-related social experiments for the last 100 years or more. My primary reason, in this context, for being here this morning is to pose a few questions to the Subcommittee, the answers to which, if made available, would help ascertain how the newer social experiment would impact those of us in the older.

The most important question is this: Can the health-realted constitutional and treaty obligations of the United States to Indian people be maintained intact if they are made to choose between public and private care? I think the answer is no -- especially if the choice is posed in the way proposed in the President's bill, which provides no mechanism for improving the quality of IHS care prior to the choice, and actually gives the states an advantage by requiring an earlier date (compare sections 1006[c] and 8304[a]) for states to provide full benefits. It is apparent that the states will have such a marketing advantage over IHS facilities that it will be next to certain that public health care for Indians would lose nearly all its constituency.

Secondly, if public health care is to be forced to compete with private health care, what can be done in a short time to make the quality of such care comparable? I believe that the only solution is a massive infusion of dollars into the IHS budget, which is not likely as long as the national debt situation remains the first priority of the Congress.

Third, how can Indian health care, a manifestation of the *exclusive* relationship between the federal government and tribal governments, be jammed into an organizational structure in which the states make many of the vital health care decisions, both directly and indirectly?

I think the only reasonable answers that would preserve the position of tribal governments and their citizens within the federal framework is to provide for dual participation in both the private and public health care systems. This situation would be

similar to that provided for under the Job Training Partnership Act, wherein job training services are available to Indian people from both state-run programs and Indian organizations.

We also have some implementational questions on the President's proposal, and the other bills, which do not go to such fundamental relationships, but are important to those of us providing Indian health services on a daily basis, who soon may have to sort out how we might fit in the new system:

1. How can a tribal government, such as that of the Mississippi Band of Choctaw Indians, which provides full employer-funded health insurance to employees (though not their dependents -- an employee-funded option under the plan), maintain vital non-Indian participation (ours stands at a level of 1,200) in such a program in the face of the tempting choices available through the alliances?

2. If the President's plan is to be maintained generally in its proposed form, is there not some way that provisions can be added to raise the capabilities of IHS facilities, within the next four years, so as to make them able to compete on an equal basis with private providers of care for the patronage of non-Indians in the local area?

3. What can be done to prevent IHS from perceiving itself as being forced to divert its funding from "supplemental benefits" to Comprehensive Benefit Package items, 1) as required by section 8304(a) of the President's bill, and 2) in order to make its facilities more competitive with private providers?

4. The IHS is currently without any program emphasis on geriatric care whatsoever. Is it possible, or even conceiveable, that such care could be geared up on the vast majority of reservations that have no nursing home facilities, prior to 1998?

I have attached some additional, more detailed questions to my written testimony, each of which requires an answer before American Indian people can have some comfort about the future of their health care situation.

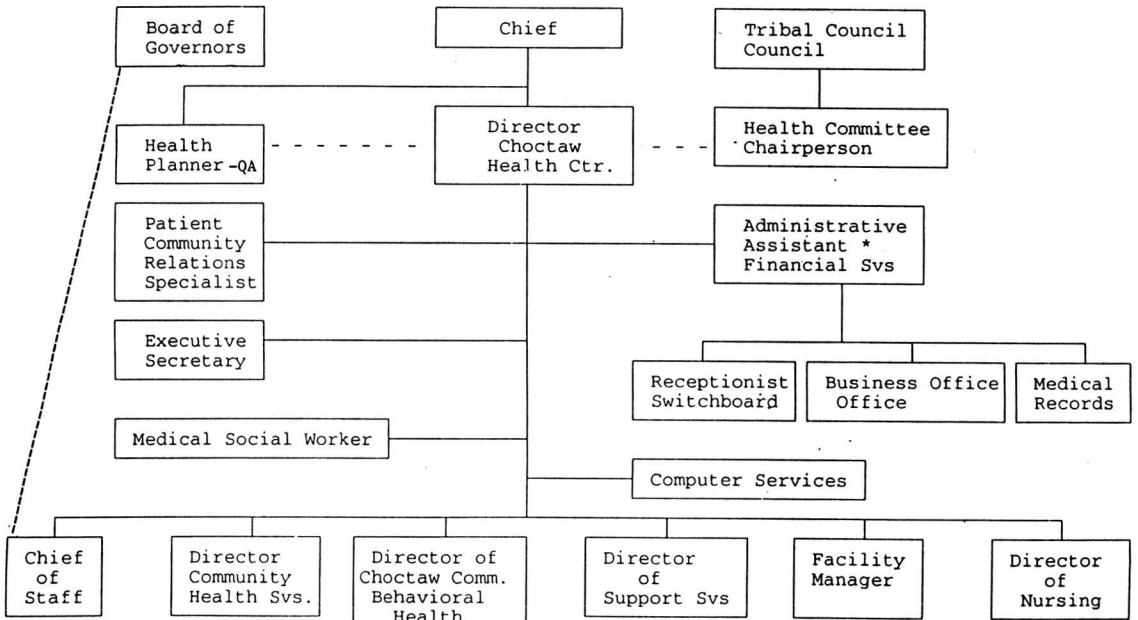
It is my understanding that the President's health reform bill is the only one making specific provisions for Indian health services; and of course whatever legislation the Congress adopts on this issue must have specific Indian language. But even the President's bill does not specifically address the special relationship of Indian tribal governments and the federal government, a fundamental tenet of constitutional law.

I believe a factor contributing to this lack may have been a confusion on the part of the Presidential planning group on how the status of American Indian citizens changes depending on where they reside. The constitutional health obligations to Indians are for those Indians who choose to remain on or near their reservation; that is, within IHS service areas. Indians who choose to emigrate to cities and other areas do not receive any services (with the exception of a few discretionary programs) over and above those of other citizens. For those urban Indians, the President's plan, and the other proposals, would represent a definite improvement in health services delivery opportunities.

But for the constituents of tribal governments, the residents of IHS health service

areas, health reform that is based exclusively on the private fee-for-service model could, and I believe would, perhaps unwittingly, result in the abandonment of federal obligations because of a mass exodus from the system by those to whom the system is obligated.

Thank you.



APPROVED: Phillip Martin 10/18/93

PHILLIP MARTIN
TRIBAL CHIEF

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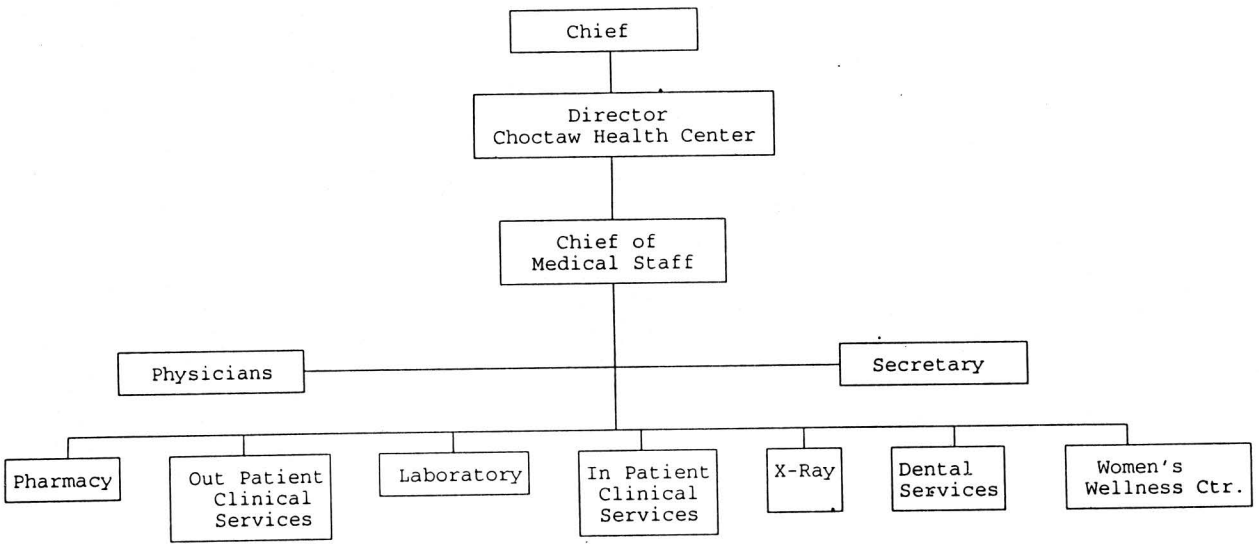
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Choctaw Health Center
Chief of
Medical Staff
Physicians
Secretary
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Out Patient
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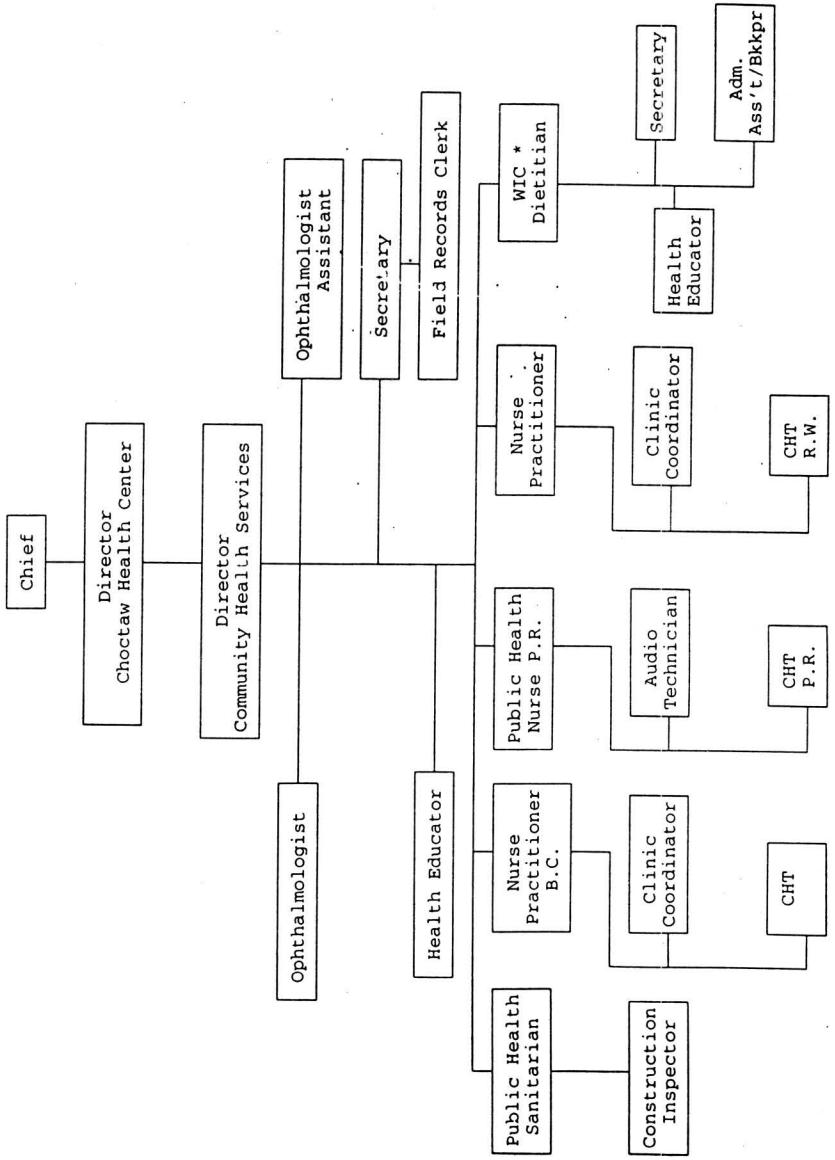
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Choctaw Health Center
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Community Health Services
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Secretary
Field Records Clerk
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Public Health
Sanitarian
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Nurse
Practitioner
B.C.
Clinic
Coordinator
CHT
Public Health
Nurse P.R.
Audio
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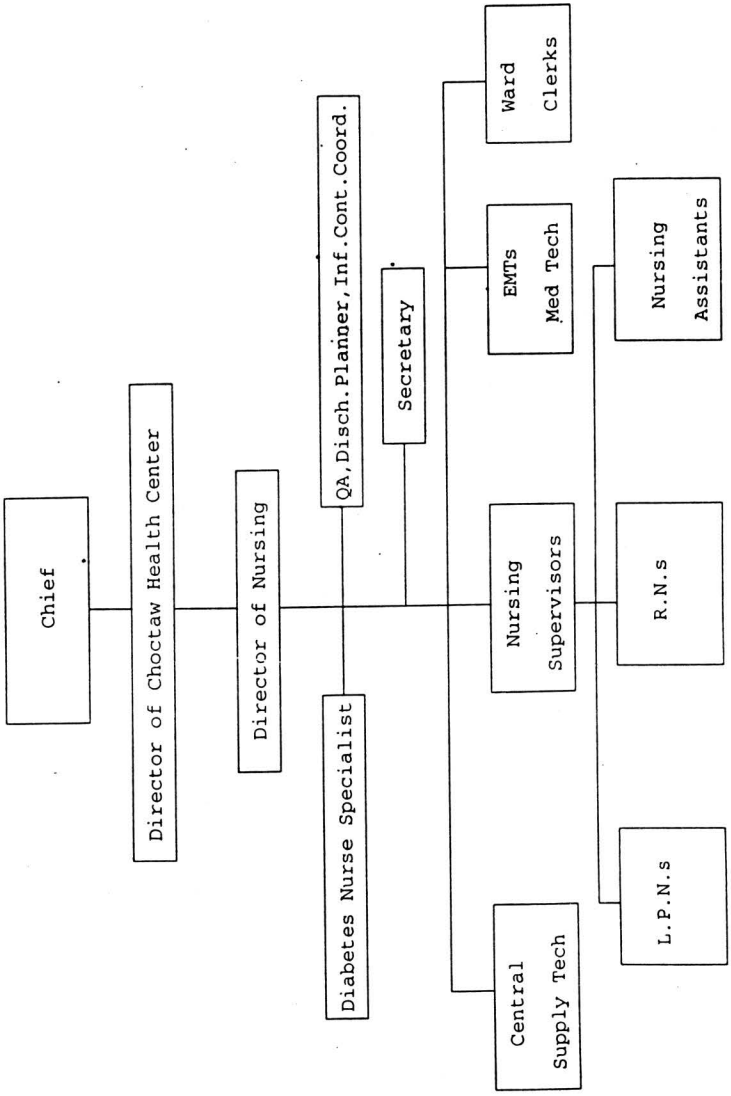
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Director of Choctaw Health Center
Director of Nursing
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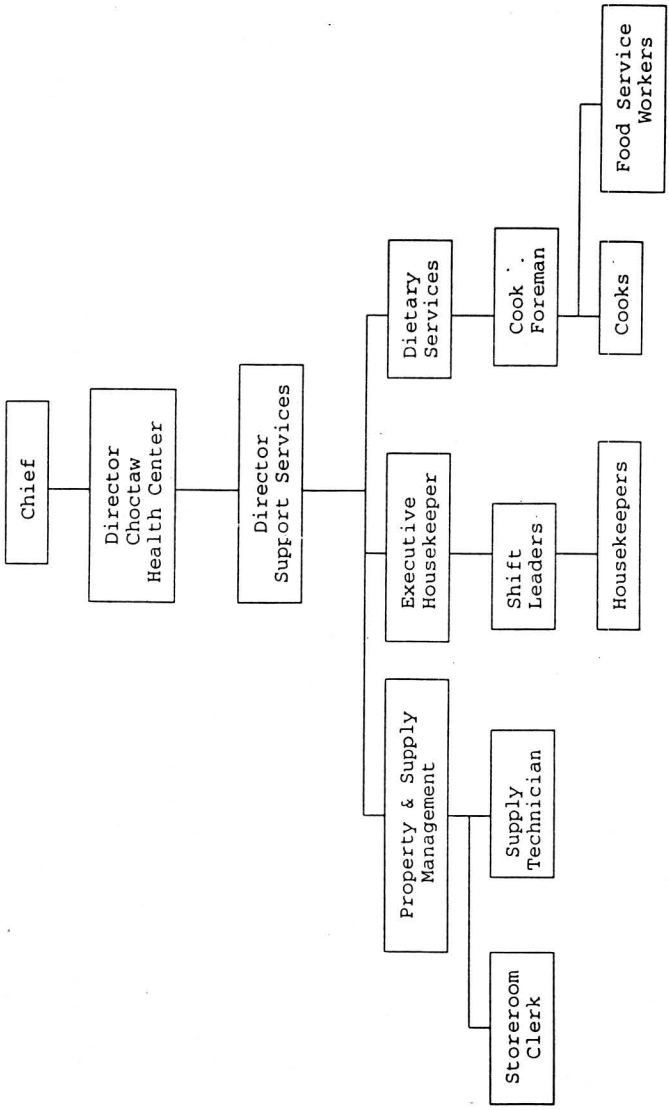
Secretary
Diabetes Nurse Specialist
Central Supply Tech
Nursing Supervisors
Ward Clerks
EMTs Med Tech
R.N.s
Nursing Assistants
L.P.N.s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Director Choctaw Health Center
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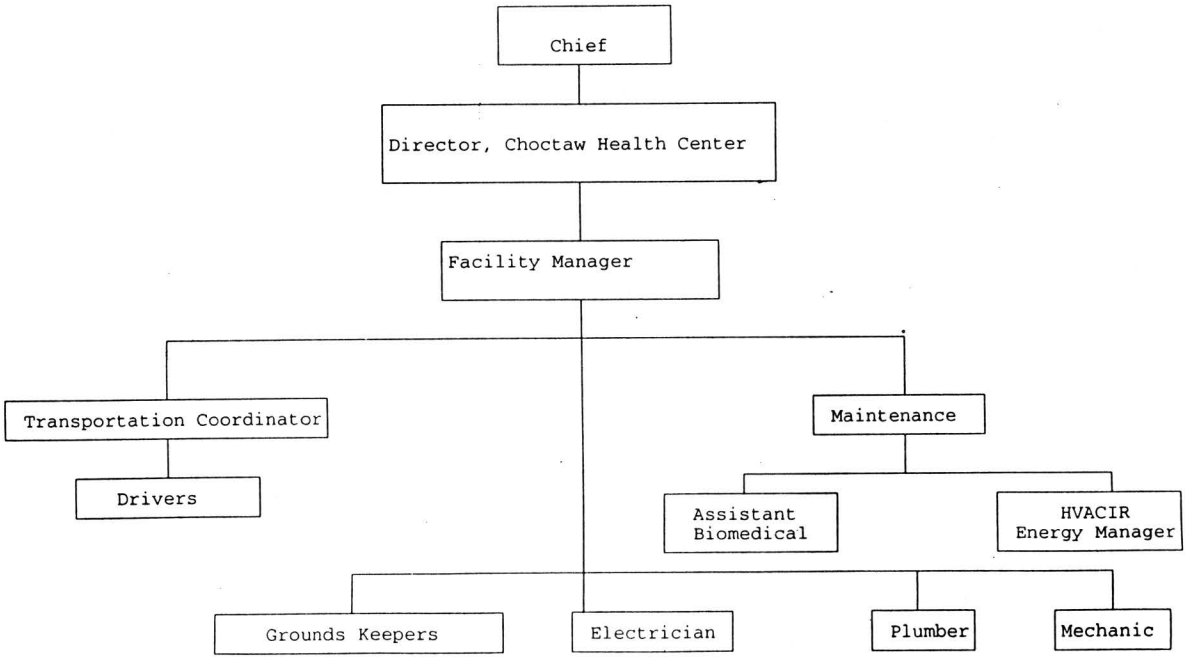
Dietary Services
Cook Foreman
Food Service Workers
Cooks
Executive Housekeeper
Shift Leaders
Housekeepers
Property & Supply Management
Supply Technician
Storeroom Clerk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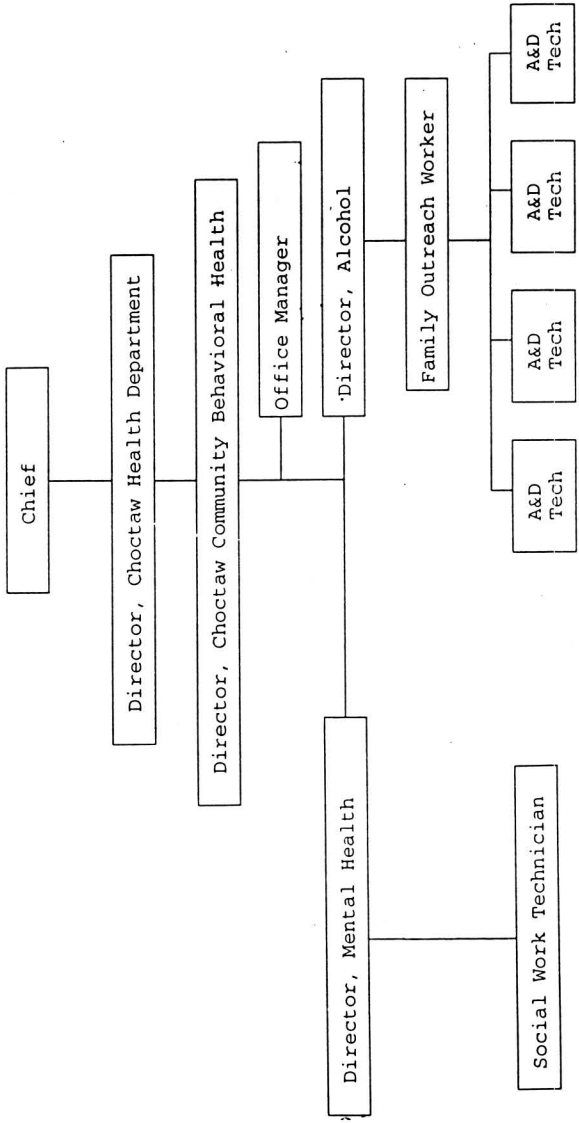
Maintenance
Assistant Biomedical
HVACIR Energy Manager
Grounds Keepers
Electrician
Plumber
Mechanic


Chief
Director, Choctaw Health Department
Director, Choctaw Community Behavioral Health
Office Manager
Director, Alcohol
Family Outreach Worker
A&D Tech
A&D Tech
A&D Tech
A&D Tech
Director, Mental Health
Social Work Technician

Senate Indian Affairs Committee
Oversight Hearing on Health Care Reform
January 31, 1994

Questions Submitted by the
Mississippi Band of Choctaw Indians

Introduction

There is no question that the Administration's health care reform bill, the National Health Security Act (the "Act"), S. 1757, would have a significant effect upon the relationship between the Indian Health Service ("IHS") and the Indian tribes which it serves. Our major concern is that the Administration does not fully understand the effect of its own proposal upon Indian tribes. In order to gain our support, as well as the support of every other Indian or Alaska Native tribe across the country, it is imperative that the Administration provide us, and all other Indian tribes, with the information that is necessary to weigh the merits of the President's proposal. We have divided our questions into the following major categories: financing, the government-to-government relationship, and other general questions.

I. FINANCING

We believe that financing of the initiatives contained in the Act will determine whether or not the Administration's plan will benefit or harm Indian and Alaska Native tribes. Presently, we are quire skeptical of the level of financial support that the Administration intends to extend to Indian tribes and the IHS. Thus, while the Act contains many worthwhile objectives, without proper financing, none of those objectives can be attained. In fact, inadequate funding will almost certainly lead to a reduction in the level of benefits currently provided by the IHS. As a tribe which has assumed the responsibility of delivering health care to our own members pursuant to an Indian Self-Determination Act contract, we have a special duty to ensure that none of the changes proposed in this Act

detrimentally affect our ability to serve our own members. We also believe that the Administration, in light of its own special trust relationship with Indian tribes, has the same responsibility. Therefore, we believe that the Administration must provide Indian tribes with concrete data that will enable us to evaluate the Act.

The Act would require the IHS and tribes operating programs pursuant to 638 contracts and Self-Governance compacts to provide a core level of benefits, the Comprehensive Benefit Package, to all Indians (and other eligible beneficiaries as described in section 8306) who enroll in the IHS system. The Act would also require the IHS and tribes operating programs pursuant to 638 contracts and Self-Governance compacts to provide supplemental benefits, i.e. those benefits and services which the IHS currently provides in addition to those contained in the CBP such as community health representatives and environmental and sanitation services, to all eligible Indian beneficiaries, whether or not they enroll in the IHS system.

Questions:

1. How much will it cost to provide all of the benefits listed in the Comprehensive Benefit Package ("CBP")?

    a. How much will it cost to expand the scope of IHS services to include long-term care?

2. How much will it cost to maintain the same level of supplemental benefits which the IHS currently provides?

3. What is the user population that the Administration has used for calculating the cost of providing (a) the CBP; and (b) supplemental benefits?

4. What is the current level of need funded ("LNF")?

5. What is the LNF that the Administration has used for calculating the cost of providing (a) the CBP; and (b) supplemental benefits?

6. What is the cost of renovation and expansion of IHS and tribal facilities called for in section 8310?

7. What is the amount that the Administration expects to spend on facilities renovation and expansion? Conversely, how much does the Administration expect tribes to spend on renovation and expansion through the revolving loan program?

8. What are the revenue projections for the IHS and tribes under section 8311?

   a. How much does the IHS expect to collect in employer premium payments?

   b. How much does the IHS expect to collect in family individual and employer premium payments under section 8306(b)?

   c. How much of the IHS project will be appropriated by Congress for (1) the CBP; and (2) supplemental benefits?

   d. How much does the IHS expect to collect in third-party payments?

   e. What will happen to Medicare and Medicaid payments which tribes currently collect under the Act?

   f. How much does the IHS expect to collect in section 8314 premium discounts?

   g. How much does the IHS expect to collect in payments from non-Indians under contracting arrangements (§ 8306(a)) and essential community provider arrangements (§ 8306(c))?

9. Isn't it unrealistic to assume that the IHS can provide the expected level of core and supplemental benefits with the limited amount of direct funding contained in section 8313 (funding for both core and supplemental benefits of $40 million in FY '95, $180 million in Fy '96, $200 million in FYs '97-2000) and section 8303 (funding for

supplemental benefits of $180 million in FY '95, $200 million in Fys '96-'99, and such sums as necessary thereafter)?

10. What can be done to ensure that the IHS will not divert funding from supplemental benefits in order to fully fund the CBP as required by section 8304(a)?

11. Will the Administration and the IHS commit to seeking a sufficient level of funding necessary to provide (a) the CBP; (b) at least the same level of supplemental benefits as currently exist; and (c) for the renovation and expansion of facilities as required in section 8310?

II. GOVERNMENT-TO-GOVERNMENT RELATIONSHIP

The tribe is also concerned that the Act does not properly take into account the government-to-government relationship between Indian tribes and the federal government.

For instance, the Act provides a number of incentives to states which opt to undergo reform prior to the January 1, 1988 deadline. No such incentives, however, are extended to tribes or the IHS. To the extent that the Act provides states, but not tribes, with the financial, logistical, and infrastructural support necessary to provide the benefits guaranteed under the Act, tribal members will doubtless be tempted to opt out of the IHS system for better coverage under private health plans. This will be especially true if (1) the Act provides significant subsidies for low-income individuals; and (2) the IHS remains responsible for the continued provision of supplemental services to eligible Indians even if they opt out of the IHS system. Combined with the fact that the Act encourages states to undergo reform prior to 1998, but requires the IHS and tribes to wait until 1999 for reform, there is no question that Indian tribes and states will not be competing on a level playing field. The problem this raises is that if there is a mass exodus of Indian beneficiaries from the IHS system, then Congress will likely reduce the IHS and tribal funding. We cannot overstate the damage to the integrity of Indian tribal governments that such a reduction in funding would cause. In addition, many tribes, such as ourselves, rely heavily on the income provided from third-party income.

Taken as a whole, the Act may place tribes at such a disadvantage as to violate the federal trust, and thus the government-to-government relationship, with Indian tribes and their members.

Questions:

12. What can the Administration do to place tribes and the IHS on an equal footing with states so that tribes and states can undergo reform at roughly the same time?

13. Will the Administration agree to provide the same incentives to tribes that it is currently offering to states?

14. If the Administration is not willing to provide economic incentives, as well as financial, logistical and infrastructural support on the same basis as the states, would this not constitute a violation of the federal trust relationship?

Undermining of the government-to-government relationship also occurs with respect to services to non-Indians. Under section 813 of the Indian Health Care Improvement Act, tribes presently have the authority to prevent the IHS from unilaterally extending services to non-Indians. The Act would strip the tribes of that authority. See section 8306.

Question:

15. Would the Administration support restoration of the requirement of tribal consent prior to the extension of IHS and tribal services to non-Indians?

In addition, the Act guarantees that all Americans, except Indians, will receive the Comprehensive Benefit Package by 1998. Compare section 1006(c) with section 8304(a). It seems the Administration is not committed to providing equal services to Indians.

Question:

16. What is the basis for requiring Indians to wait until 1999 to receive

the CBP when all other Americans are guaranteed the CBP by 1998?

Many Indian tribal governments, such as ourselves, presently purchase insurance for their own employees. Thus, tribal employees presently have the option of visiting a physician covered under our insurance plan or an IHS physician. In other words, they may choose to visit both private physicians and IHS physicians. The Act would remove that option. Under the Act, our employees would have to choose between physicians covered by our insurance plan or else IHS physicians. They could no longer visit both.

Question:

17. Has the Administration carefully considered the effect of the Act on tribal employees who now have the option of visiting both a private physician (covered by insurance) and an IHS physician (covered by the IHS-tribal relationship? Is there anything the Administration is willing to do to restore that choice?

Under the Act, it is likely that some tribal members will elect health care coverage through a private plan rather than the IHS. It is also likely, given the geography of Indian country, that those tribal members will have to travel long distance, off-reservation, to seem care from the primary provider. Following treatment, however, the tribal member will be in a position where he or she must repeatedly travel long distance to receive follow-up care or else hope that his or her insurance plan provides for the delivery of follow-up care back on the reservation. We are concerned that, as is often the case now, the primary provider will seek to shift the burden of providing follow-up care back to the IHS (or the tribe in the case of tribes operating pursuant to 638 contracts or Self-Governance compacts). This can be done under the claim that the IHS remains responsible for supplementary benefits and services under the Act.

Question:

18. How does the Administration expect the IHS to coordinate the provision of supplemental services with non-residential primary providers?

The federal government, by virtue of treaties, executive orders, statutes, and judicial opinions, has assumed a special responsibility to provide health care to American Indians and Alaska Natives. Yet, Indian tribal members generally lose the benefit or guaranteed health care when they leave their reservation. The Administration's plan stresses portability of benefits as a major goal. Yet, section 8302 (a)(1) restricts Indian eligibility in the IHS system to those Indians who reside on or near Indian reservations. Otherwise, tribal members who have elected to remain in the IHS system will nonetheless be forced to enroll in a private plan if the choose to move out of an IHS service delivery area.

Question:

19. Does the Administration or the IHS support extended coverage under the IHS system to tribal members who no longer reside on or near an Indian reservation?

The Act would exempt tribal governments, 638 contracts and Self-Governance compactors from making employer contributions on behalf of their employees. Section 8305.

Questions:

20. In view of the federal policy of Self-Determination and tribal economic development, would the Administration support an extension of that exemption to Indian-owned businesses?

21. Does that exemption apply only with respect to employees who enroll in the IHS system?

III. OTHER GENERAL QUESTIONS

22. What will the Act do to actually increase the quality of care which American Indians and Alaska Natives receive?

23. What will the Act do to actually increase the health status of American Indians and Alaska Natives?

24. Given the fact that the House Energy and Commerce Committee expects to mark up the Act by late March, what is the point in having the four-part IHS/PHS consultations with Indian tribes extending into late May?

25. Under section 8306(c) of the Act, will IHS and tribal programs which elect Essential Community Provider status be required to serve non-Indians in addition to those beneficiaries designated in section 8306(c)(2)?

Questions:

Role of tribal governments: Tribal governments, especially those such as the Choctaw, who operate their own health care systems, are held accountable by their constituents for health care. Yet, there doesn't seem to have been any opportunity for them to participate in the development of the plan. Will there now be a chance for the tribal governments to be heard and is there provision for the plan to be changed in response to their concerns?

The Choctaw tribe currently employs over 1,200 non-Indians who are covered by the tribal self-insurance program. How will they receive health care coverage under the plan?

Mr. WALLACE. Thank you, Mr. Chairman.

You expressed some of our concerns in talking to Mr. Lincoln a few minutes ago, some of the concerns that we have. I want to raise a unique question that I think maybe has not been discussed and that is the situation of choice. Either you belong to IHS system or you belong to the health alliance.

And let me give you a little background on this, and I can only speak specifically for the Choctaw Indians. At our place we have a self-insurance that provides health insurance for our people, if they are tribally employed. So when we have to transfer a patient out of our facility to another facility or to a high level of care, in that health insurance helps provide pay that we otherwise would have to pay out of Indian Health Service since we are the last payor. So under the Health Reform Act, if we are given a choice, either/or, then I can see our expenses and our cost providing an IHS facility probably doubling if we were not able to provide for every need that an individual had?

Do you understand what I said? We are using the health insurance now to supplement the cost for IHS facilities. If we didn't have that in place, then we would double our cost.

I think it is a unique thing we need to look at and let's not leave that out. It would be fine with us if we could be assured that the financing was going to be there to take care of our people. Then we wouldn't care if you had a choice. But under the present system that we had, as Chief Martin said, we are only about 70 percent financed. And we are down there literally prioritizing who gets care and who doesn't get it under the priority one program. So we wonder, will we be funded for infrastructure, for facilities, equipment, to provide a comprehensive benefits package? And those are our questions and our concerns.

We believe that we have the capabilities of doing that. But we can't do it on a shoestring budget. It seems real strange to me. And what we heard last week at a meeting here that Washington, Indian Health Services is planning on cutting budgets next year in 1995, and then we are talking about spending billions and billions of dollars on the private sector to enhance their health care and we are cutting the IHS budget. It is real strange to me.

So in the Health Care Reform Act that I see, what is written down there, hey, guys, we are going to improve your health delivery system, but we have to be assured that the finances are going to be there before we can do that.

Thank you.

Mr. RICHARDSON. Thank you.

Honorable Julie Barton.

STATEMENT OF JULIE BARTON

Ms. BARTON. Good morning, Mr. Chairman, and Members of the committee. My name is Julie Barton and I am currently Secretary for the Oneida Tribe of Indians of Wisconsin. I have served as an elected member of the Oneida Business Committee for 7 years and have worked for the tribe for almost 30 years.

With me today is Ms. Deanna Bauman, Governmental Services Director for Oneida. Ms. Bauman also Secretary of the National In-

dian Health Board and the National Indian Health Board representative for the Bemidji Area.

On behalf the tribe, I would like to thank you very much for inviting us to testify before your committee H.R. 3600 and its potential impact on the health care delivery for the Oneida Tribe. We appreciate your strong commitment to addressing the special health care needs for American Indians.

My oral testimony today will focus on the impact of the proposed fiscal year 1995 Indian Health Service budget and legislative recommendations to the Health Security Act.

Oneida's relationship with the Federal Government dates back to 1777, when the Revolutionary War campaign came to an end and General George Washington took his weary army to Valley Forge. Chief Skenandoah was an unwavering friend of the Americans and fought against the British invaders. It was he and his Oneidas who saved Washington's starving army at Valley Forge by bringing them corn; the Oneida white corn.

Despite our economic successes, we must keep in mind that it is quite recent in nature, in fact, only in the last two-and-a-half years, that we have started to catch up. And regardless of how successful our economic development efforts are, the Federal Government still needs to honor its treaty responsibilities to the tribe.

Mr. Chairman, as you may recall from your last visit to our reservation last summer, the Oneida Tribe Indians is located on the outskirts of Green Bay, Wisconsin, or as we would like to say, Green Bay is located on the outskirts of the Oneida Reservation. We have more than 11,000 enrolled members, with approximately 40 percent living on or near the reservation. Over the past few years, our tribe has experienced a rapid growth, with an average of a thousand newly enrolled members each year.

In addition, there are approximately 5,000 to 6,000 members of other federally recognized tribes residing within our health service delivery area.

Only 10 years ago our unemployment rate was 70 percent, today we employ approximately 3,000 people, with an unemployment rate of approximately 14.9, which is totally unacceptable in most other areas, other than for tribes that we have tried to improve.

As our tribe becomes more successful with the economic development, more and more tribal members are coming back to the reservation, which increases the demand for services, particularly in the areas of housing and health care.

Oneida is committed to providing quality, comprehensive health services to improve the health status of our members. We operate a JCAHO-accredited ambulatory patient care facility under Public Law 93–638, a contract with the Indian Health Service. The Oneida tribe also owns and operates a State-licensed skilled nursing home, inpatient services that are provided on site, such as specialist services, and they are obtained by our members through the contract health services.

According to the latest IHS health service priority methodology, our level of funding is 69.8 percent for fiscal year 1994. IHS provides 55.8 percent of this funding for the Oneida Health Center through third-party payments which total 39.2 percent. The remainder is funded by the tribe and the State.

Oneida does not totally depend on IHS for the provision of health care, and every attempt is made to utilize all available resources. During the past year alone, we experienced a 26 percent increase in our active user patients, providing over 34,000 outpatient visits and nearly 7,500 dental visits. Of our 10, 167 active patients, 42.6 are Oneida, 31.2 percent are members of other federally recognized tribes, and 26.2 percent are non-native family members.

The Anna John Nursing Home provides skilled nursing care services to all who suffer from debilitating illnesses regardless of age. The ages of our nursing home population are 29 years to 104 years. The nursing home relies heavily on the tribal contribution of nearly 50 percent. Medicaid accounts for 34 percent and 22 percent is private pay.

With the advent of health care reform, we expect the demand for services to increase. We have plans to begin construction on a new health care facility this summer, a nursing home and community-based residential facility.

However, our immediate concern is with the administration's fiscal year 1995 budget, administrative cost reductions and FTE ceilings instead of reductions, we need 100 percent of our health delivery needs funded now to avoid termination of our unique health services delivery system on the reservation.

While we commend the administration for taking on the enormous task of reforming America's health care system, we are outraged by the administration's proposed budget cuts for the Indian Health Service. Although I recognize that I was asked to specifically address H.R. 3600, I urge this committee to closely examine the President's proposed fiscal year 1995 budget and its implication for health care reform.

The fiscal year 1995 Indian Health Service budget proposal would result in a total shortfall for the Indian health care delivery system of $385 million in 1995 alone. Oneida echoes the grave concerns expressed by the National Indian Health Board regarding the following budget issues:

With respect to IHS facilities, the administration proposes to fully cut funding for sanitation and construction facilities. Cutting the budget for sanitation services for Oneida means no water and septic systems for any new homes to meet our housing needs, nor the replacement of over 100 failing septic systems.

The unrealistic estimate of the Indian Health Service third-party collections of more than a $100 million will inevitably be funneled down to Oneida and every other tribal program in the form of budget cuts from the IHS. At Oneida, although many people are now working, they are still considered the working poor and are unable to purchase health insurance and many have preexisting conditions which preclude them from qualification for insurance.

We still have a relatively high unemployment rate of 14.9 percent. Ultimately, this third-party provision will result in the reduction of health care services to American Indians and Alaska Natives.

With respect to administrative cost reductions, there are inconsistencies in the definition and the application of it as it applies to IHS versus other Public Health Service agencies. This will result in reduced training and technical assistance which will signifi-

cantly impede our ability to compete with the private sector in the health care reform area.

Ms. BARTON. We would like to go on and try to persuade the committee here to recognize the need for the Federal Government to recognize us as sovereign governments; that we have paid our dues with our land; that we will significantly impact the services to the people, basic services that are afforded to all people. And our concern, then, is that we have input in the changes that are being made and the consultation.

Thank you.

Ms. Bauman and I will answer any questions you have.

Mr. RICHARDSON. Thank you.

[Prepared statement of Ms. Barton follows:]

Onedas bringing several hundred bags of corn to Washington's starving army at Valley Forge, after the colonists had consistently refused to aid them

Oneida Tribe of Indians of Wisconsin

Post Office Box 365

Phone: 869-2214

Oneida, WI 54155

UGWA DEMOLUM YATEHE
Because of the help of this Oneida Chief in cementing a friendship between the six nations and the Colony of Pennsylvania, a new nation, the United States, was made possible

TESTIMONY

of

JULIE BARTON

SECRETARY
ONEIDA TRIBE OF INDIANS OF WISCONSIN

before the

HOUSE SUBCOMMITTEE ON NATIVE AMERICAN AFFAIRS

on the

HEALTH SECURITY ACT (H.R. 3600)

FEBRUARY 28, 1994

Good morning, Mr. Chairman and Members of the Committee. My name is Julie Barton. I am currently Secretary of the Oneida Tribe of Indians of Wisconsin and have served on the Oneida Business Committee for a total of seven years. For 10 years, I worked for the Tribe in Education and for three years I worked in our Language Program. With me is Ms. Deanna Bauman, Governmental Services Division Director for Oneida. Ms. Bauman is also Secretary of the National Indian Health Board (NIHB) and the NIHB Representative for the Bemidji Area which includes Wisconsin, Minnesota, and Michigan.

On behalf of the Tribe, I would like to thank you very much for inviting us to testify before your committee on H.R. 3600 and its potential impact on health care delivery for the Oneida Tribe. We truly appreciate your strong commitment to address the special health care needs of American Indians and Alaska Natives. In addition to providing you with information regarding Oneida and the current health status of our members, my testimony will focus on both the impact of the proposed FY 95 Indian Health Service (IHS) budget and legislative recommendations to the Health Security Act.

Brief History and Background

Our relationship with the Federal government dates back to 1777 when the Revolutionary War campaign came to an end and General George Washington took his weary army to Valley Forge. Chief Skenandoah (The Deer) was an unwavering friend of the Americans and fought against the British invaders in all the wars along the Mohawk River and surrounding territory. It was he and his Oneidas who saved Washington's starving army at Valley Forge by bringing them several hundred bushels of Oneida white corn.

Mr. Chairman, as you may recall from your visit last summer to our reservation, the Oneida Tribe of Indians is located on the outskirts of Greenbay, Wisconsin. We have more than 11,000 enrolled members, with approximately 40% living on or near the reservation. In addition, there are approximately 5,000 - 6,000 members of other Federally recognized tribes residing within our health service delivery area.

According to our latest survey (March 1993), the unemployment rate was 14.9%. Households whose income was provided solely or in part by State or Federal (non-employment) sources were at 12.1%. These figures have probably improved in conjunction with the Tribe's economic development ventures, particularly when one compares the rate of growth over the past few years. At this same period of time in 1988, the Oneida Tribe employed approximately 450 people. Today we employ approximately 3,000 people, and by the end of FY 1994, this figure should be 3,400.

Within the boundaries of the Oneida reservation, 1003 tribal member households were surveyed: 46% were owner occupied, 25% renter occupied, and 25% homeless (89% of the 25% homeless living with extended family, 11% homeless living in available shelter). Outside the boundaries of the Oneida reservation, but within the health service delivery area, another 1,068 tribal member households were surveyed: 33% were owner occupied, 50% renter occupied, and 17% homeless (82% of the 17% homeless living with extended family; 18% of the 17% homeless living in available shelter).

As the Tribe becomes more successful with its economic development, more and more tribal members are coming back to the reservation, which increases the demand for

services, particularly in the areas of health care and housing. However, despite these successful economic ventures, we must keep in mind that they are quite recent in nature, and that we still have a lot of "catching-up" to do.

Health Services at Oneida

Oneida is committed to providing quality, comprehensive health services to improve the health status of our members. We operate a JCAHO Accredited ambulatory patient care facility under a P.L. 93-638 Indian Self-Determination Contract with the Indian Health Service. The Oneida Tribe also owns and operates a State licensed skilled nursing home.

The Oneida Community Health Center provides a full range of services: out-patient ambulatory care, dental, optometry, pharmacy, physical therapy, audiology, OB/GYN, pediatric, podiatry, preventive health programs (community health nursing, occupational health and safety, CHR, health promotion/disease prevention, women's health, pre-natal, HIV/AIDS prevention, nutrition) and the Community Options Program (COPS). Inpatient and services that we are unable to provide on-site -- i.e. specialists services -- are obtained by our members through Contract Health Services, which is operated and managed by the tribe under the P.L. 93-638 Contract with IHS. Services are provided during regular scheduled clinic hours, Monday through Friday, 8:00 a.m. - 4:30 p.m. After hours services are available 7-days per week via an on-call Registered Nurse, with physician back-up (a summary of the history of our health center is attached).

Funding sources for FY 1994 are: IHS - 55.8%; 3rd Party - 39.2%; State - 1.6%; Tribal Contribution - 3.4%. According to the IHS FY 1992 Health Service/Priority Systems methodology, our Level of Need Funded is 69.8%. Our sources of Third Party Revenue are: 40% - Medicare/Medicaid; 10% - Private Pay (non-eligible - no insurance); 20% - Insurance; 30% - IHS Eligible, but Uncompensated. Oneida does not totally depend on the IHS for the provision of health care, and every attempt is made to utilize all available resources.

During the past year we have experienced a 26% increase in our active user patients. We provided 34,557 outpatient visits and 7,437 dental visits in FY 1993. Out "Active Chart Total" is 10,167 patients: 42.6% - Oneida; 31.2% - members of Other Federally Recognized Tribes; 26.2% - Non-Indian family members.

The Anna John Nursing Home (AJNH) is a 50-bed skilled nursing care facility providing nursing, dietary, activities, social services, housekeeping and laundry services. The Health Center provides physical therapy, dental, audiology, podiatry, and ophthalmology services. In addition, the nursing home contracts with a geriatric specialist and a nutritionist who specializes in geriatrics. Speech and occupational therapy is provided through a local Curative Workshop Rehabilitation Center.

The AJNH provides approximately 13,870 patient days, 7,393 skilled nursing care patient days, and 6,477 intermediate nursing care patient days per year, which averages 38 patients. Ages of our nursing home population range from 29 years to 104 years. The nursing home provides skilled nursing care services to all who suffer from debilitating illnesses, regardless of age. Funding sources for the AJNH are: 34% - Medicaid; 22% - Private Pay (includes private pay residents and the Medicaid patient liability portion); 1% - Other (i.e. employee, guest purchased meals, bake sales); 43% - Tribal Contribution.

At Oneida, the major health problems in our adult population are: 1) diabetes; 2) complications as a result of diabetes (i.e. amputations, diabetic retinopathy, renal failure); 3) hypertension; 4) Arteriosclerotic Heart Disease (hardening of the arteries); and 5) upper respiratory (i.e. asthma). For children, the major health problems are: 1) injuries, 2) Chronic Otitus Media, and 3) upper respiratory.

Fortunately, we have had the ability and resources to address most of our health care needs. With the advent of health care reform, we certainly expect the demand for services to increase. At Oneida, we have plans to begin construction this summer on a new health facility, nursing home, and community based residential facility. However, we are very concerned about the Administration's FY 95 budget, Executive Order No. 12837 (2/10/93), and Executive Order No. 12839 (2/10/93). *Instead of reductions, we need 100% of our health delivery needs funded NOW to avoid termination of the unique health services delivery system on our reservation.*

Fiscal Year 1995 Budget

While we commend the Administration for taking on the enormous task of reforming America's health care system, we are outraged by the Administration's proposed budget cuts for the Indian Health Service. Although I recognize that I was asked to specifically address H.R. 3600, I urge this committee to closely examine the President's proposed FY 95 budget and its implications for health care reform. The FY 95 IHS budget proposal could result in a total shortfall for the Indian health care delivery system of $385 million in 1995 alone.

Oneida echoes the grave concerns expressed by the National Indian Health Board regarding the following budget issues: 1) IHS facilities and third party reimbursement; 2) Administrative cost reductions; 3) Full-Time Equivalent (FTE) reductions.

With respect to IHS facilities, the Administration proposes to fully cut funding for sanitation and construction facilities. Cutting the budget for sanitation services for Oneida means no water and septic systems for the planned construction of new homes to meet our housing needs, nor the replacement of septic systems for the over 100 failing systems. The unrealistic estimate of the IHS third party collections of more than $100 million (an increase of more than 560%) will inevitably by funneled down to Oneida and every other Tribal program in the form of budget cuts from the IHS. Ultimately, this results in the reduction of health care services to American Indians and Alaska Natives.

With respect to administrative cost reductions, the Administration proposes to cut funding by $10.4 million. This will result in inequitable reductions throughout the IHS. There are inconsistencies in the definition and application of administrative costs as it applies to IHS versus other PHS agencies. For example, the current definition of administrative costs for IHS includes: travel costs related to the delivery of health services, and contractual services which directly support the delivery of health services. These are just two examples. This could result in reduced training and technical assistance from the Area Office, which would significantly impede our ability to compete with the private sector in the health care reform arena. Any reduction will result in a shift in health service delivery emphasis from the overall population needs to the immediate acute care demands of individual patients.

With respect to FTE reductions, the Administration has imposed a ceiling on the IHS, which is primarily being accomplished by attrition. The IHS does not have the appropriate authorities to reorganize or consolidate otherwise. Within the IHS system, high levels of attrition take place at the local level, thereby directly impacting the delivery of health care services. This provision is not only unfair, but is in direct conflict with the intent of the Indian Self-Determination Act (P.L. 93-638) as it forces Tribes to choose to contract whether they want to or not, with no consideration for their capabilities. This could create a loss of services associated with the FTEs should a Tribe refuse to contract.

At Oneida, we currently have two FTEs, a dentist and a community health nurse. Since the tribes in our area primarily operate their health programs under P.L. 93-638 contracts, the FTE reductions would occur at the Area Office and the two IHS operated facilities.

While we certainly recognize the need for the Federal government to exercise measures to control the budget deficit, we do not believe that American Indians and Alaska Natives should have to carry the burden of balancing the Federal budget. We would not necessarily be opposed to the FTE ceilings or the administrative cost reductions if, and only if, the savings achieved would be passed on directly to the Tribes. We have already "paid our dues" with our land.

Mr. Chairman and Members of this committee, I truly hope that you will work with the Administration in addressing these budgetary concerns. *If the Administration and Congress do not adequately fund the current health system for American Indians and Alaska Natives NOW, we do not see how the expansive health care reform proposal presented in H.R. 3600 will ever be available to American Indians and Alaska Natives.*

H.R. 3600 - Legislative Recommendations

As I indicated earlier, we commend the Administration and the Congress for embarking on this landmark legislation. We certainly endorse the principles of the President's plan. I think we would all be hard pressed to find anyone who did not support the principles of universal coverage, guaranteed comprehensive benefits, insurance reform, administrative simplification, consumer protection, and quality assurance. We are also encouraged by the Administration's commitment to retain a Federal health program for American Indians and Alaska Natives by enhancing the IHS system. However, these principles will mean absolutely nothing if they are not backed by adequate funding and not put into practice in a timely manner.

It is our hope that by working with the Congress and the Administration, you will heed our concerns so that we may take advantage of this tremendous opportunity to improve the health care delivery system for our people. The following are legislative recommendations to the Health Security Act which must be adopted in order improve the quality of health care available to our tribal members.

First, the sovereignty of tribes needs to be recognized in the language of health care reform legislation. Within the preamble of the Act, there should be a statement of policy regarding the legal obligation of the Federal government to elevate the status of American Indian and Alaska Native health to the highest level based on treaties and statute. It is

important to include language which makes it very clear that American Indians and Alaska Natives have a unique relationship with the Federal government. We have already paid for our health care with our land, minerals and other natural resources. We are not "other" minorities, nor are we a special interest group.

Moreover, because of the government-to-government relationship that Indian tribes have with the Federal government, we must be consulted regarding the development of this legislation while it is being debated, not after the fact. For example, Dr. Philip Lee, Assistant Secretary for Health, is participating in three regional meetings in Indian country to consult with Tribal leaders about the plan. To date, only one of them has taken place, with five of the 12 IHS Areas being represented. The second regional meeting (for three IHS Areas) will be held in Portland, Oregon on March 9-11, and the final regional meeting for our area (and two other IHS areas) is scheduled for April 6-8 in Billings, Montana. These regional meetings will culminate in a national meeting in Washington, D.C. at the end of May.

My concern is that Congress, particularly the House of Representatives, is quickly moving ahead with subcommittee mark ups scheduled for March, and that by the time Indian country has had a chance to consult with the Administration, it will be too late for input. We need assurances that we will have access to this process and to the information needed to make informed recommendations.

Second, in recognition of the treaties and agreements we made in exchange for our land, the Federal government must authorize and appropriate sufficient funds to fulfill its obligation of providing health care to American Indians and Alaska Natives. We are very concerned that while the Health Security Act contains many worthwhile objectives, the funding will not be there to make them a reality. The government's track record on this speaks for itself. As I stated earlier, the FY 1995 IHS budget proposal could result in a total shortfall for the Indian health care delivery system of $385 million in 1995 alone. These cuts will occur before health care reform is supposed to take place. With the proposed funding levels, we simply cannot see the feasibility of providing the Comprehensive Benefits Package and Wrap-Around services, as described in the Health Security Act, being delivered to our tribal members in 1999 or even in 2099.

Third, language needs to be included in the Health Security Act that treats Tribes and States the same with respect to benefits provided to States for transition and implementation. The Act should ensure that Tribes are able to provide the Comprehensive Benefits Package at the same time as that of the State in which they are located. Without these assurances for a competitive and comparably equipped health care delivery, the Health Security Act will result in the termination of a unique health delivery system for American Indians and Alaska Natives. As we stated earlier, one hundred percent (100%) of our health delivery needs must be funded now to avoid termination of the unique health services delivery system on our reservation.

Fourth, the Act should expand the definition of long term care to include skilled nursing home care. Community-based residential facilities and home-based care programs do not necessarily meet the needs of all patients. For most Tribes, particularly the Oneida Tribe, long term care is not just an "elderly" issue. We have "young" persons who require skilled nursing care as a result of diabetes, diseases of the heart, cancers, automobile accidents, and other debilitating diseases such as Multiple Sclerosis and AIDS.

There are a number of other issues that we also believe must be addressed in the context of health care reform, but we believe that for Oneida, the issues of sovereignty, funding, transition and implementation, and long-term care are paramount. Regardless of what shape the health care reform legislation eventually takes, Congress must ensure that the Federal government upholds its promise -- based on hundreds of treaties -- to provide health care to American Indians and Alaska Natives. The Oneida Tribe of Indians of Wisconsin wants to work closely with you and the Administration to ensure that this promise is realized.

Thank you very much for listening to our concerns. I would be happy to answer any questions the Committee may have at this time.

HISTORY OF THE ONEIDA COMMUNITY HEALTH CENTER

Many years ago, a handful of Oneida women had a vision and a dream. Thus, our present day Oneida Community Health Center was conceived and born.

It began in a small suite of rooms at the Norbert Hill Center with a director, a secretary and two Community Health Representatives. Health services evolved and a move was made to the Civic Center where a small laboratory was added. The medical staff consisted of volunteer doctors, a nursing staff, the first alcohol and other drug abuse counselors and a social worker. Dental services were provided by volunteer dentist on weekends in a small office at the Tribal building. Most health services were contracted out to local area providers.

The services grew and expanded. In May 1978, the present Oneida Community Health Center opened it's doors to the Oneida Community. The present facility has expanded twice to meet the needs of the growing community.

Services were provided by Indian Health Service doctors and Indian Health Service Commission Corps personnel. Commission Corps personnel staffing was provided in the following areas: Medical Clinic, Pharmacy, Dental Clinic, Community Health and Sanitarian Departments. Over the years an increasing number of these positions have been filled by Tribal employees.

Services in all area have grown and expanded over the years to include full medical, dental and community health services. Optical, nutrition, audiology, pharmacy, and physical therapy services are also provided on-site. Services were established to provide comprehensive family practice and outpatient medical services to Native American people living on or near the Oneida Reservation situated in Brown and Outagamie Counties. Services are provided during regular clinic hours:

MONDAY THROUGH FRIDAY FROM 8:00 A.M. to 4:30 P.M.
AFTER HOURS SERVICES ARE AVAILABLE 7-DAYS PER WEEK SIMPLY BY CALLING THE HEALTH CENTER NUMBER:
869-2711 / 833-7536 / 788-6692

Care is provided by full-time physicians, a physician assistant, nurse practitioners, a staff of registered nurses, licensed practical nurses and various ancillary personnel. In addition, several physicians are contracted part-time to provide care in specialized areas of internal medicine, obstetrics, pediatrics, podiatry, allergy, asthma and otorhinolaryngology (ENT). Appointments to the specialists are accepted by referral only to facilitate appointment scheduling.

Appointments are available for diagnosis, treatment, well child care, immunization, family planning, minor surgical procedures, Women's Reproductive Health and preventive care. In order to best meet the needs of the community and provide the most efficient services, appointments in all areas of service are strongly encouraged.

The Oneida Community Health Center received accreditation through the Joint Commission of Health Care Organizations in ambulatory care in 1988. We have continued to maintain this accreditation through our continual process of providing the highest quality of care based upon the standards of the Joint Commission of Health Care Organizations. Very few of the major clinics in the area have achieved this accreditation.

MISSION STATEMENT

The Oneida Community Health Center strives to provide the best and highest quality of health care by considering the whole person and family in a holistic manner. We provide the opportunity to maximize the health status and total well-being of the patient. We seek to serve the entire Oneida community with mutual respect, consideration and dignity.

The Oneida Community Health Center responds to the guidance of the governing body and individual tribal member needs.

Our goal is to create a unique health delivery environment based upon individual needs. We strive to incorporate traditional Native American values into our services to the best of our abilities.

Mr. RICHARDSON. Ms. Lydia Hubbard-Pourier, director of the Division of Health, Navajo Nation, Window Rock.

STATEMENT OF LYDIA HUBBARD-POURIER

Ms. HUBBARD-POURIER. Good morning, Mr. Chairman, Members of the subcommittee, I am executive director of the Navajo Nation, Division of Health, and I am testifying on behalf of President Peterson Zah of the Navajo Nation.

The Navajo Nation generally supports the initiatives and principles of the Health Security Act but has some specific concerns that will be addressed in this testimony.

The Navajo Nation, under health care reform, supports a separate Federal health care delivery system for American Indians and Alaskan Natives through the Indian Health Service, however, we urge the Indian Health Service to upgrade its delivery of health care services to American Indians and Alaskan Natives in compliance with the Health Care Improvement Act and the Indian Self-Determination and Education Assistance Act, which affirms the Federal trust relationship.

The bill we are discussing gives the Indian Health Service, under its present form, the responsibilities for providing all eligible Indians the same comprehensive benefits package provided to all Americans. However, the primary issue in this instance is whether or not the Indian Health Service will have sufficient resources, especially funding, to accomplish its task of providing basic and adequate health care to American Indians and Alaskan Natives under the health care reform and under its existing Federal trust, in particular, the mounting pressures over FTE cuts, budget limits and downsizing of government and its affect on IHS to provide these basic services now.

These reductions will impede the Indian Health Service's present duty of providing basic and adequate health care needs as well as affecting its future ability to perform under the proposed health care reform.

The Navajo Nation is the largest Indian tribe in the United States, with citizenship of over 219,198 enrolled members, constituting more than 13 percent of all Indians. The Navajo Nation spans more than 17 million acres within the States of Arizona, New Mexico and Utah. This constitutes 36 percent of all Indian lands in the lower 48 States. This size is comparable to the State of West Virginia, and the median age of our population is 19 years old.

The Navajo population is also growing at twice the national rate. Like most Indian reservations, we are affected by problems associated with a seriously depressed economy. Forty-six percent of Navajo families live below the poverty level, and our unemployment rate is 36 percent, or more than 50 percent, depending on the season. Our per capita income averages $4,106 annually, in comparison to the United States per capita income of $19,082.

The Navajo Nation is a sovereign Nation with a sophisticated three-branch government; executive, judicial and legislative. The Navajo Nation has a president, vice president and an 80-member council elected by the Navajo people. We have a speaker of the

council chosen by the council members, we have a chief justice appointed by the president and confirmed by the council.

The Navajo Division of Health, of which I am the Executive Director, is the lead tribal division that is responsible for planning health care services, while the Indian Health Service provides direct health care services to the Navajo people as well. The Navajo division of health is analogous to a State health department with responsibilities both for individual and community services, as well as regulation and planning and coordination of health services to its people.

The Navajo Nation has been very active in the process of developing the proposed Health Securities Act. The Navajo Nation has expressed its concerns and recommendations in varying forms, but more officially as a sovereign Indian Nation via the Navajo Nation Council resolution approving and endorsing the Navajo Nation's recommendations for development of President Clinton's proposed legislation, the Health Securities Act of 1995.

The resolution No. CO–76–93, a copy of that important Navajo Nation resolution is attached as Appendix A of this testimony.

I wish to point out that the wording and phrasing of the specific recommendations of this Navajo Nation Council resolution are of critical importance and should be read as such. Concerning the comments and representations under Subtitle D, of Title VIII of H.R. 3600, the Health Securities Act, the following are the Navajo Nation's specific recommendations:

There are a number of specific recommendations listed in our testimony, which we have written testimony which we will submit, however, I would like to go over a few of them, which are of importance and are critical.

Under eligibility and health service coverage for Indians, this provision, Subsection B of Section 8302, this provision permits Indians to choose local health alliances rather than the Indian Health Service. As noted earlier, there is some concern Indians located in areas where there are alternate delivery services will choose to leave IHS, particularly if they qualify for premium payments and other out-of-pocket costs.

Without adequate appropriations now, to make the IHS system marketable and competitive, Congress will ensure the exodus of Indian clients from the Indian Health Service and their capitated premiums will be diverted to those alliances that provide health care services to these former IHS Indian clients.

Again, under open enrollment, Subsection C, Section 8302, this section provides for enrollment in the Indian Health Service through a service unit, tribal organization or Indian urban program. This may actually limit consumer choice of providers in such areas as Navajo country, where the reservation is divided up into more than one service unit, however, services primarily Navajos in all eight service units.

Under—and I will go forward—under redefining supplemental Indian health care benefits, Subsection A, this section provides that all Indians eligible for participation in the IHS system remain eligible under current law and legislation for any benefits beyond the comprehensive benefits package as a supplemental service, and

they shall not be subject to any charges for these supplemental benefits.

Clearly, there should not be any retrenchment of eligibility for additional services as a consequence of health care reform. However, the key issue in this section will be in defining what benefits are supplemental to the basic benefits package. The supplemental benefits should not be less than those currently available under the present legislation to American Indians and Alaska Natives.

Again, under health care and health alliances requirements, these sections give the—Subsection B and D of Section 8304—these sections give the Secretary the discretion to decide which alliance and plan requirements are applicable to IHS programs. There are some alliance and plan requirements that Indian tribes may want to require the Indian Health Service to implement. These should be carefully reviewed in consultation with Indian tribes and allow for this discretionary decision by the Secretary.

Again, under exemption of tribal governments and tribal organizations from employer payments, the language needs clarification in this subsection——

Mr. RICHARDSON. Lydia, I am going to ask you to please summarize.

Ms. HUBBARD-POURIER. Coming to the basic underlying issue, the Navajo Nation expresses great concern for the fact that under the present budget cuts, FTE cuts as well, that the Federal Government and OMB are looking at reducing the capacity of Indian Health Service to perform, under health care reform now, only under the transitional costs at a later point in time, as was mentioned by Mr. Lincoln, to attempt to bring the Indian health service system back up to a level that would allow them to be marketable and competitive under health care reform.

The Indian people express great concern for this and feel that any change in the benefits of the present system really need to be negotiated with the Indian tribes.

In conclusion, we wish to thank you for the opportunity to provide our comments, written as well as verbal, and that we wish to go in a partnership with the Federal Government to look at the present restructuring and the reformation of the Indian Health Service to perform under health care reform.

And I thank you very much.

[Prepared statement of Mr. Zah and attachments follow:]

TESTIMONY
OF THE
NAVAJO NATION PRESIDENT,
PETERSON ZAH

BEFORE THE

HOUSE SUBCOMMITTEE ON
NATIVE AMERICAN AFFAIRS
(CHAIRPERSON RICHARDSON, D-N.M.)

FEBRUARY 28, 1994

WRITTEN TESTIMONY OF LYDIA HUBBARD-POURIER
EXECUTIVE DIRECTOR
OF THE NAVAJO DIVISION OF HEALTH

ON BEHALF OF PETERSON ZAH
PRESIDENT OF THE NAVAJO NATION

BEFORE THE SUBCOMMITTEE ON NATIVE AMERICAN AFFAIRS
OF THE HOUSE NATURAL RESOURCES COMMITTEE

HEARING ON SUBTITLE D OF TITLE VIII
OF H.R. 3600, THE HEALTH SECURITY ACT

FEBRUARY 28, 1994

Mr. Chairman and members of the House Subcommittee on Native American Affairs, the Navajo Nation appreciates this opportunity to express concerns and recommendations on Subtitle D of Title VIII on H.R. 3600, the Health Security Act, which would provide for a universal health care for citizens of the United States. My name is Lydia Hubbard-Pourier, Executive Director of the Navajo Division of Health. I am testifying on behalf of President Peterson Zah of the Navajo Nation. The Navajo Nation generally supports the initiatives and principles of the Health Security Act, but has some specific concerns that will be addressed in this testimony.

This testimony is divided into five parts: (1) Introduction; (2) Overview of the Navajo Nation; (3) Comments on H.R. 3600; (4) Comments on IHS Restructuring; and (5) Conclusion.

INTRODUCTION

The Navajo Nation supports a separate federal health care delivery system for American Indians and Alaskan Natives through the Indian Health Service; however, we urge the Indian Health Service to upgrade its delivery of health care services to American Indians and Alaskan Natives in compliance with the Indian Health Care Improvement Act and the Indian Self-Determination and Education Assistance Act which affirms the federal trust relationship. The bill (H.R. 3600) gives IHS the responsibility for providing all eligible Indians the same comprehensive benefit package provided to all Americans. The primary issue is whether IHS will have sufficient resources, especially funding, to accomplish its task of providing basic and adequate health care to American Indians and Alaskan Natives. In particular, the Navajo Nation is concerned with the mounting pressures of FTE cuts, budget limits and downsizing of government and its affect on IHS to provide health care services. These reductions impede IHS' present duty of providing basic and adequate health care needs to American Indian and Alaskan Natives as well as affecting its future ability to perform under the proposed Health Care Reform.

THE NAVAJO NATION

The Navajo Nation is the largest Indian tribe in the United States. With a citizenship of over 219,198 enrolled members (constituting more than thirteen percent of all Indians), the Navajo Nation spans more than 17 million acres within the states of Arizona, New Mexico, and Utah (36 percent of all Indian lands in the lower 48 states), comparable in size to the state of West Virginia. The median age is 19 years of age. Our Navajo population is growing twice the national rate.

Like most Indian reservations, we are affected by problems associated with a seriously depressed economy. Fifty-six percent of Navajo families live below the poverty level and our unemployment rate is thirty-six percent to more than fifty percent, depending on the season. Our per capita income averages $4,106 annually in comparison to the United States per capita income of $19,082.

The Navajo Nation is a sovereign nation with a sophisticated three branch government: executive, judicial and legislative. The Navajo Nation has a President, Vice-President and an eighty-member Council elected by the Navajo people. We have a Speaker of the Council chosen by the Council members. We also have a Chief Justice who is appointed by the President and confirmed by the Council.

The Navajo Division of Health is the lead tribal division that is responsible for managing health care services while the Indian Health Service provides direct-health care services to the Navajo People.

The Navajo Nation has been very active in the process of the development of the proposed Health Securities Act. The Navajo Nation has expressed its concerns and recommendations in varying forms but more officially as a sovereign Indian Nation via the Navajo Nation Council resolution, "Approving and Endorsing the Navajo Nation's Recommendations for the Development of President Clinton's Proposed Legislation, The Health Securities Act of 1993," CO-76-93, (11/01/93). A copy of that important resolution is attached as Appendix A of this testimony.

COMMENTS AND RECOMMENDATIONS ON SUBTITLE D OF TITLE VIII OF H.R. 3600, HEALTH SECURITY ACT

The following are the Navajo Nation's specific recommendations on H.R. 3600, Title VIII, Subtitle D:

Redefine "Health Program" (Section 8301 of Subtitle D of Title VIII of H.R. 3600)

The definition of "health program" is unclear. The Navajo Nation recommends the definition specify those programs which need certification by the Secretary in order to deliver comprehensive benefit package under Section 8304 of Subtitle D of H.R. 3600.

Eligibility and Health Service Coverage of Indians (Subsection (b) of Section 8302 of Subtitle D of Title VIII of H.R. 3600)

This provision permits Indians to choose local health alliances rather than the IHS system. As noted earlier, there is some concern that Indians located in area where there are alternative delivery systems may choose to leave the IHS system, particularly if they can qualify for financial assistance in meeting premium payments and other out-of-pocket costs. Without adequate appropriations now to make the IHS system "marketable and competitive", Congress will assure the exodus of Indian clients from IHS and their "capitate" premiums will be diverted to those alliances that provide health care services to former IHS Indian clients.

Open Navajo Enrollment to all Navajo Area Service Units (Subsection (c) of Section 8302 of Subtitle D of Title VIII of H.R. 3600)

This sections provides enrollment in the IHS system shall be through a service unit, tribal organization, or urban Indian program. The language could be interpreted to limit the scope of the IHS plan to geographic boundaries of existing service units which presents problems for the Navajo Nation because it spans into three states and the reservation is divided into its own service units. This may actually limit consumer choice of providers in areas such as Navajo country, where the reservation is divided up into more than one service unit. Subsection (c) also provides that eligible individuals enrolling in the IHS system shall not be charged for premiums, deductibles, copayments, coinsurance, or other costs. This language is consistent with trust responsibilities of the United States government and is critical to ensuring that individuals have incentives to use the IHS system.

Provide a better incentives package to Indians (Subsection (d) of Section 8302 of Subtitle D of Title VIII of H.R. 3600)

This section prohibits IHS payments for premiums and other costs associated with eligible individuals who choose to seek care outside the IHS system. This section is very important to ensuring that IHS resources are not diverted to supporting other alliance activities. However, it is possible that some Indians will argue that the federal commitment to providing health care services to Indians should not be limited to the IHS system and that Indians should receive the equivalent to a health care voucher that could be applied to cover their out-of-pocket costs associated with the regional alliances.

Redefine "Supplemental Indian Health Care Benefits" (Subsection (a) of Section 8303 of Subtitle D of Title VIII of H.R. 3600)

This section provides that all individuals eligible for participation in the IHS system remain eligible under current law and legislation for any benefits beyond the comprehensive benefit package as a supplemental service and they shall not be subject to any charges for these supplemental benefits. Clearly, there should not be any retrenchment of eligibility for

additional services as a consequence of the health care reform legislation. However, the key issue in this section will be defining what benefits are supplemental to the basic benefit package. The supplemental benefits should not be less than those currently available to American Indians and Alaskan Natives.

Supplemental Indian Health Care Benefits (Subsection (b) of Section 8303 of Subtitle D of Title VIII of H.R. 3600)

This section provides two hundred million ($200,000,000) in FY 1996 for supplemental health care services. It is clear that this authorization is NOT based on current appropriations adequate to cover the necessary supplemental services. Moreover, as previously stated this is simply an authorization, not an entitlement.

American Indians Receive Comprehensive Benefit Package by January 1, 1998 (Subsection (a) of Section 8304 of Subtitle VIII of H.R. 3600)

This section requires all health programs of the IHS to provide the comprehensive benefits package by January 1, 1999, one year later than all other health programs required to provide the basic benefits package. The Navajo Nation recommends the effective date of January 1, 1999 be changed to read January 1, 1998, the same as other American citizens. By changing the effective date, this will ensure the IHS and tribal programs to remain competitive with regional health alliances and preventing an American Indian exodus from IHS to private health plans or regional health alliances.

Health Plan and Health Alliances Requirements (Subsection (b) and (d) of Section 8304 of Subtitle D of Title VIII of H.R. 3600)

These sections give the Secretary the discretion to decide which alliance and plan requirements are applicable to IHS programs. There are some alliance and plan requirements that Indian tribes may want to require the IHS to implement. These should be carefully reviewed and in consultation with Indian tribes to allow consultation for the discretionary decision.

Health Plan and Health Alliance Requirements (Subsection (c) of Section 8304 of Subtitle D of Title VIII of H.R. 3600)

This section requires all IHS plans to meet clarification requirements determined by the Secretary. It is unclear what happens if the IHS plan is not certified, given the fact that on many reservations the IHS is the only service provider and that adequate resources to raise level of care may not be forth coming.

Exemption of Tribal Governments and Tribal Organizations from Employer Payments (Section 8305 of Subtitle D of Title VIII of H.R. 3600)

This is an important provision. It exempts tribal organizations from employer premium payments. This language appears to be drafted to eliminate any requirement to make payments for either Indian or non-Indian employees. This language needs clarification so that Indian and non-Indian employees.

Payment by Other Payers (Section 8307 of Subtitle D of Title VIII of H.R. 3600)

This section ensures that the IHS continues to be the payor of last resort. This section helps to ensure that IHS continues to be the payor of last resort. This section helps to ensure that IHS funds conserved for those cases where there is no other health insurance coverage for the eligible individual.

Contracting Authority (Section 8308 of Subtitle D of Title VIII of H.R. 3600)

This section eliminates any ambiguity regarding the authority of IHS to contract for personal services for the provision of direct health care services.

Consultation (Section 8309 of Subtitle D of Title VIII of H.R. 3600)

This important section requires Secretarial consultation with representatives of Indian tribes concerning health reform affecting Indian communities.

Clarify IHS authorization to grant direct expenditures for construction and renovation of health care facilities (Section 8310, of Subtitle D of Title VIII of H.R. 3600)

There are a number of major concerns regarding this section. The first subsection appears to authorize IHS to make grants or direct expenditures for the construction and renovation of health care facilities. However, when compared with subsection (b) and Section 8313, the Secretary may be only permitted to make loans under subsection (b). If so, it is difficult to see how this section will be of any real benefit to Indian country.

Redefine "comprehensive benefit package fund" (Section 8311 of Subtitle D of Title VIII of H.R. 3600)

There are a number of unresolved issues created by this section. First, the geographic scope of the benefit package funds is ambiguous as well as the phrase "each program of the IHS". These funds could be as narrow as a single service unit or as broad as IHS. This ambiguity ought to be clarified. Second, the bill should provide for Indian control or governance. The Navajo Nation recommends an Indian board and representation in its council resolution. Third, as stated earlier in this subsection, it should be revised to include an additional source of revenue -- an assessment received from other alliances. This assessment could be set at a level to ensure that IHS funding was at least equivalent or greater to the average individual health plan payment.

Rules of Construction (Section 8312 of Subtitle D of Title VIII of H.R. 3600)

This provision preserves existing statutory provisions unless they are expressly modified by this Act. This means that existing authorization and statutory responsibilities for IHS will continue.

Authorization Regarding Public Health Service Initiatives Fund (Section 8313 of Subtitle D of Title VIII of H.R. 3600)

This section authorizes up to $200,000,000 for infrastructure development. Subsection (b) specifies that this authorization is in addition to other authorization that are currently available for investment in these types of projects. There are three major issues to consider. First, Navajo and other tribes need to assess the extent of current authorization for infrastructure development and determine whether this additional authorization will provide enough additional authority to compete the facility construction necessary to provide comprehensive benefit package to all Indians. We stand ready to assist in that analysis. Second, this authorization is only for loans, a comparable authorization is needed for direct capital expenditures. Finally, since this is only an authorization, funding is dependent on the annual budget process. Consequently, there is no assurance that the comprehensive benefit package will be provided. Once again, alternatives should be developed to make this an entitlement consistent with the trust responsibilities of the government.

Although the Navajo Nation supports the initiatives of the legislation, the Navajo Nation has several general concerns on H.R. 3600, the Health Security Act. The Navajo Nation should have access to public health initiatives such as school health clinics and we do agree they should be administered by the State Alliances. The Navajo Nation is particularly concerned with whether Navajos and other Indians will have direct access to these state-administered health care and related health care services. We recommend that there be set-asides or federal grants in these public health initiatives specifically for American Indians and Alaskan Natives population.

We also recommend that specific language be inserted into the bill that would allow Indian tribes the option of participating as a "health care plan." The present language could be deemed ambiguous.

COMMENTS ON IHS RESTRUCTURING

In the midst of budget reduction and downsizing of the federal government, IHS as a federal agency, is compelled to conform to these administrative initiatives. However, the Navajo Nation also is compelled to remind the Administration that the IHS is unlike other agencies in DHHS as it carries out the trust and treaty obligation for health care to American Indians and Alaskan Natives. The resources provided the IHS are a part of the first pre-paid health plan and those resources should not be changed without consultation or renegotiation. In Fiscal Year 1995, IHS will incur a budget cut of approximately $10 million. Undoubtedly,

this budget cut coupled with an underfunded IHS, which is nationally funded at 68 percent of the total health care need, will adversely impact the delivery of health-care to American Indians and Alaskan Natives. These proposed reductions are contrary to the Administration comprehensive health care plan outlined in the Health Security Act and focus on restructuring of the IHS functions while ignoring the impact of direct health-care services. Moreover, these cuts foster unemployment on the Navajo Indian reservation which has an unemployment rate of 36 to 50 percent, depending on the season.

Full-Time Equivalent (FTE) Reduction

The Executive Order for reduction of 100,000 Federal positions including IHS will negatively impact the delivery of health care to American Indians. Preliminary indications from the provisional FTE ceiling numbers indicate the loss of up to 500 positions in the Navajo Area. The Navajo Nation is not overserved. It is currently funded at 68 percent of need. Navajos have no alternative outpatient or inpatient resources available at which to seek health care. NO PRIVATE INSURANCE COMPANIES, PHYSICIANS, OR HEALTH CARE PROVIDERS SERVE THE NAVAJO RESERVATION COMMUNITIES AFFECTED BY THESE CUTBACKS.

Presently, at IHS facilities, patient waiting lists are extensive. It is not uncommon for severely injured or ill patients to be transported on dirt roads up to a hundred miles to be seen at these facilities, which are now scheduled for huge reductions. If these reductions occur, the additional staff required for the new Shiprock Hospital would be understaffed at 54 percent and the Tohatchi clinic. There is simply no logic nor humanity in reducing health care services to those who desperately need them. Nor in expending millions of dollars to construct a needed 60-million dollar hospital only to have it stand half vacant due to staff cuts.

The Navajo Nation will be unable to recruit and fill senior level positions for physicians. Consequently, the Navajo Area IHS will utilize more Fiscal Year 1994 contract health care funds usually left utilized for those patients with critical health care needs.
Consolidation of Area IHS Offices

In response to increasing pressures for budget, employment, and government reductions, the IHS has begun its restructuring effort. Though the Navajo Nation recognizes a need for examination and restructuring of IHS, these proposed reductions of staff in the only health care system for Indian reservations mean that many Native American Health care professionals now serving their communities will become unemployed.

One of the "downsizing" options being aggressively considered under the IHS Restructuring Plan is the consolidation of the Navajo Area IHS office with the Albuquerque and Phoenix IHS Area offices. This consolidation would put the agency out-of-touch with the very people it serves. At this time, the Navajo IHS Area addresses the needs of the people and facilities through frequent interaction with local Navajo health boards and communities.

The recent Hantavirus or "mystery illness" which devastated primarily Navajo citizens accentuates the need for increased, not decreased, funding and staff to address our underserved population. Life expectancy among Navajos is well under the overall U.S. population. It is predictable that if the IHS budget is reduced, as proposed, the resulting cost of the failure to address health needs in their early stages, and already at deficient levels, will result in an increase in serious illnesses and untold costs which eventually must be borne by the U.S. federal government, the trustee of its Indian citizens.

CONCLUSION

In conclusion, despite the progress begun over the last several years in delivering and meeting critical health care needs, the IHS has been directed, under the guise of FTE cuts, budget limits, and downsizing government to implement these astounding cuts with no appeal, no recourse and no alternative source of services. The U.S. government's promises to its American Indian citizens would be irreversibly breached if these cutbacks are allowed to occur. I assure you that other American Indian leaders will join me to advocate for the Federal government to meet its federal obligation to deliver adequate and quality health care services to our Indian people and to prepare for transformation under Health Care Reform.

Appendix A

Resolution of the Navajo Nation Council

(CO-76-93)

CO-76-93

Class "C" Resolution
No BIA Action Required.

RESOLUTION OF THE
NAVAJO NATION COUNCIL

Approving and Endorsing the Navajo Nation's Recommendations for the Development of President Clinton's Proposed Legislation, the Health Security Act of 1993.

WHEREAS:

1. Pursuant to 2 N.T.C. Section 102 (a), the Navajo Nation Council is the governing body of the Navajo Nation; and

2. Pursuant to 2 N.T.C. Sections 822 (2) and 824 (b)(2) and (3), a purpose of the Intergovernmental Relations Committee is to ensure the presence and voice of the Navajo Nation; and is authorized by the Navajo Nation Council to review and continually monitor federal programs and activities, assisting in the development of those programs through intergovernmental relationships between the Navajo Nation and such departments; and

3. Pursuant to 2 N.T.C. Sections 451 and 454 (b)(1) and (8), the Health and Social Services Committee is a standing committee of the Navajo Nation Council with oversight authority over the Division of Health and is vested with the authority to represent the Navajo Nation in matters relating to health and social services; and

4. Pursuant to 2 N.T.C. Sections 1601, et seq., the Navajo Division of Health Improvement Services (now the Navajo Division of Health) is authorized by the Navajo Nation Council to plan and deliver health services and programs on the Navajo Nation; and

5. The United States Government, through the Indian Health Service, is responsible for providing a comprehensive health services delivery system for American Indians and Alaska Natives as provided for by the Snyder Act; P.L. 94-437 and Treaties; and

6. As appointed by the Clinton Administration, a National Task Force was appointed to make legislative recommendations for National Health Care Reform; and

7. Based on the recommendations forwarded to President Clinton, his National Health Care Reform Proposal was formally presented to the Joint Session of Congress on September 22, 1993 and said Proposal will be introduced in Congress later this year as the Health Security Act of 1993; and

8. On October 6-7, 1993, a Technical Workgroup comprised of representatives of the three national Indian health organizations - the National Indian Health Board, the American Indian Health Care Association, the Association of American Indian Physicians - and other Indian health professionals met to review the elements of the Health Security Act of 1993 proposal and provided its recommendations (attached as Exhibit "C") which will be addressed at the National Indian Health Board Conference; and

9. The Technical Workgroup does not intend to forward its recommendations without tribal consultation; thus, the Division of Health has produced a position paper, attached as Exhibit "A".

10. The Health and Social Services Committee has reviewed and endorsed this position paper by Resolution HSSC-OCT-98-93, attached as Exhibit "B".

NOW THEREFORE BE IT RESOLVED THAT:

1. The Navajo Nation Council approves and adopts the Health Security Act of 1993 Recommendations attached hereto and incorporated herein as Exhibit "A" to be presented to the appropriate Federal agencies, Congressional committees and National Indian organizations.

2. The Navajo Nation Council hereby authorizes the Navajo Division of Health to represent the Navajo Nation and the interests of the Navajo People and their health services and programs in the on-going process for the proposed national Health Care Security Act of 1993.

3. The Navajo Nation Council further solicits support of the Arizona, Utah and New Mexico Congressional Delegations to ensure the incorporation and passage of the Navajo Nation Recommendations in Exhibit "A" in the final Act.

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Navajo Nation Council at a duly called meeting at Window Rock, Navajo Nation (Arizona), at which a quorum was present and that same was passed by a vote of 57 in favor, 1 opposed and 5 abstained, this 28th day of October 1993.

Speaker
Navajo Nation Council
November 1, 1993
Date Signed

Motion: Johnny Descheny
Second: Wallace Charley

ACTION BY THE EXECUTIVE BRANCH

1. Pursuant to 2 N.T.C. Section 1005 (c)(1), I hereby sign into law the foregoing legislation on this 2 day of November 1993:

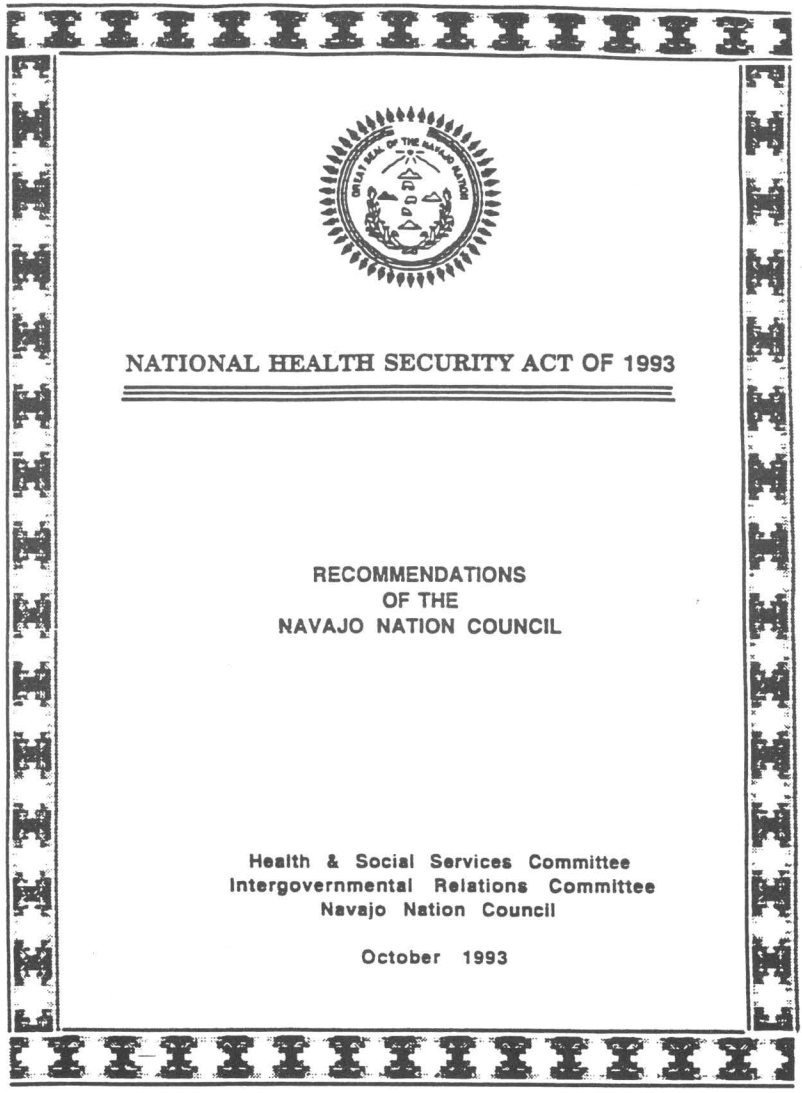
Peterson Zah, President
Navajo Nation

* * * *

2. Pursuant to 2 N.T.C. Section 1005 (c)(10), I hereby veto the foregoing legislation this ____ day of _____ 1993 for the reason(s) expressed in the attached letter to the Speaker:

Peterson Zah, President
Navajo Nation

EXHIBIT "A"



NATIONAL HEALTH SECURITY ACT OF 1993

RECOMMENDATIONS
OF THE
NAVAJO NATION COUNCIL

Health & Social Services Committee
Intergovernmental Relations Committee
Navajo Nation Council

October 1993

RECOMMENDATIONS OF THE NAVAJO NATION ON THE NATIONAL HEALTH SECURITY ACT OF 1993

INTRODUCTION

As duly elected members of the Navajo Nation Council and as Native American Indians, we support the initiative and principles of President Clinton's actions to reform the Nation's health care system. The principles of uniform benefits, access, cost containment, quality and simplicity are worthy goals to implement to guarantee all Americans' health care.

However, the unique legal status of sovereign Indian nations and their relationship with the United States Government for Native American Indians, through treaties and secession of native lands, must not be ignored during the process of national health care reform.

We, therefore, actively support the retention of a separate federal health care delivery system for American Indian/Alaska Native people and request that the continued reform of the Indian Health Service system occur within the framework of the unique government-to-government relationship, federal policy of self-determination, self-governance, tribal consultation, and the maintenance of the federal trust responsibility to American Indian/Alaska Native People.

The Navajo Nation Council, therefore, submits the following recommendations to the drafters of the American Health Security Act of 1993 to be addressed in the proposed legislation.

1. POLICY

The Navajo Nation Council has identified the following policy concerns and requests that they be incorporated in the Policy Section of the Act:

* **An express declaration that the Act implements the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of American Indians and Alaska Natives (AI/ANs) in such programs.**

* **An express declaration that this Act reaffirms the policy of the United States, in fulfillment of its special responsibilities and legal obligations to AI/ANs, to assure the highest possible health status for AI/ANs and to provide all resources necessary to effect that policy.**

* **An express declaration that all existing authorities governing the provision of health services to AI/ANs remain unaffected unless expressly modified by this Act.**

2. DEFINITIONS

The Navajo Nation Council recommends the following definitions be included in the Definition Section of the Act:

* **Define the "Indian Health Service" to include the IHS system, Tribal programs operated under the Indian Self-Determination Act and Urban Indian health programs (collectively referred herein as (I/T/U).**

* **The definition of "health professional" should be expanded to include Native traditional healers.**

* **The definition of "Essential Community Provider" should be expanded to include I/T/U providers.**

3. GOVERNANCE

The Proposal establishes a special Fund that supplements appropriations to the Indian Health Service. The Navajo Nation Council recommends the establishment of an independent Federal Indian Health Security Fund (FIHSF) Board to provide governance and oversight of the Fund for the distribution and management of funds.

* **The President shall appoint an independent nine (9) voting member Board comprised of a majority of representatives of federally recognized tribes to reflect the government-to-government relationship of the Indian Health Service as a federal agency with tribal governments.**

  Five (5) members at-large shall be designated by the President from nominations submitted by federally recognized tribal governments.

The Navajo Nation due to its population and geographical size will have two (2) designated positions on this Board.

Two (2) members shall be selected from nominations provided by each of the following organizations:

National Congress of American Indians (NCAI)
National Indian Health Board (NIHB)

Two (2) ex-officio (non-voting) members shall be selected from the following agencies:

Public Health Service (PHS)
Indian Health Service (IHS)

* **The Board shall elect a Chairman from its voting members who shall serve on the National Health Board.**

* **Within six months following the date of enactment of this Act, the President shall establish the FIHSF Board.**

4. SERVICES

The Proposal calls for the provision of a guaranteed Comprehensive Benefits Package (CBP) to improve access and establish equity within the I/T/U system. Supplemental services are those services currently provided through the Indian Health Service system but are not included in the CBP. The Navajo Nation Council recommends that:

* **Federally recognized Tribes have responsibility for the identification of those Native traditional healers who will be designated as "health professionals".**

* **A mechanism should be established which provides for the integration of Native traditional healers into the I/T/U system and insures that they are compensated for their services.**

* **An Indian Health Service or tribally-operated facility may serve non-Indians enrolled in a regional health alliance on a contract basis, only with the consent of the impacted tribe.**

* **Under the authority of Health Care Access Initiative, Tribal consent is required in order to expand population-based public health services to non-Indians.**

* **A provision be included which ensures funding for costs associated with public health epidemics.**

* **The Adolescent and School-Aged Youth Initiative expressly include Bureau of Indian Affairs funded schools and public schools serving a significant Indian population. Tribes should be authorized under this Initiative to receive formula grants focusing on the reduction of risk behaviors.**

* **Funding of the CBP must not affect the continued provision of current supplemental services of Indian Health Service.**

* **Because long-term care is a guaranteed component of the CBP, the Indian Health Service be required to provide sufficient funding and a coordinated planning effort necessary to establish long-term care services.**

* **I/T/U providers be exempted from the provisions of the Anti-Deficiency Act until full coverage of of the CBP is provided for all eligible AI/ANs.**

5. INFRASTRUCTURE

The Proposal requires the Indian Health Service to renovate and expand I/T/U facilities during a five-year transition period. In addition, the Proposal establishes a flexible grant and guaranteed loan program to facilitate capital infrastructure development in order to expand access to care in underserved areas. The Navajo Nation Council recommends:

* **The Indian Health Service continue to bear the primary responsibility for capital costs associated with the construction, expansion and renovation of I/T/U facilities.**

* **Payments be provided for all transportation costs associated with the referral of AI/AN people to non-I/T/U providers. Transportation costs include equipment, vehicles, airline tickets and any other means of transportation necessary to provide services in remote locations.**

* **Stable funding and adequate reimbursement be provided for basic emergency medical services, advanced transportation systems, first responder training, and start-up services.**

* **I/T/U providers located in remote locations be exempt from new Federal Aviation Administration regulations governing air ambulance services.**

* **The Indian Health Service and other responsible federal agencies shall meet the public health responsibility in the**

expansion, renovation and new construction of sanitation and environmental health facilities and systems.

6. MANPOWER

The Proposal calls for an increase in the recruitment, preparation and retention of AI/ANs into medical, nursing, public health and other health professions. The Proposal also calls for the expansion of the Indian Health Scholarship Program and Loan Repayment Program to fund all eligible applicants. Although AI/ANs comprise 0.8 percent of the total United States population, AI/AN physicians account for only 0.1 percent of the physician workforce. In order to reach parity, the number of AI/AN enrollments in medical schools would have to increase by 800 percent. The Navajo Nation Council recommends that:

* The National Health Service Corps (NHSC) and related programs be expanded and incentives be included to attract and retain AI/AN health professionals to serve in I/T/U programs.

* A minimum of 25 percent of NHSC professionals be placed in the I/T/U system.

* Health recruitment and retention programs be funded to focus on Indian and other rural communities.

7. FINANCING

The Proposal calls for the establishment of a number of funding sources to support health services to AI/AN people. The Proposal, however, does not identify a funding source or payment system for these new and expanded services. The Navajo Nation Council recommends that:

* The Proposal expressly state the responsibility of the Indian Health Service and the federal government to provide the CBP to all eligible AI/ANs.

* Eligible AI/ANs not be subject to co-payment requirements within the I/T/U system.

* Funding of the FIHSF include adjustments related to family size, low health status, geographic location, poverty and cultural barriers.

* I/T/U providers which contract with other providers of health plans for services to non-Indians be reimbursed at the full cost of those services.

* **The Authority which exempts federally recognized Tribal governments from the obligation to pay the employer's share include all tribal employees.**

* **The Authority which exempts federally recognized Tribal governments from the obligation to pay the employer's share be expanded to clearly cover tribal council established enterprises and entities.**

* **I/T/Us be funded in a timely manner and at a level which ensures that they are competitive with other local alliances.**

* **Tribal governments must participate in the public health activity administered by the state/alliance.**

8. HEALTH RESEARCH INITIATIVES

The Proposal calls for new funding for health research, focusing on prevention and health services research. The Navajo Nation Council recommends that:

* **A separate title for AI/AN populations be established within each category of the Health Research Initiatives to address unmet health needs and health status outcomes.**

* **The Internal Review Board process be maintained and Tribal/Indian governments approve all proposed research involving AI/AN communities.**

* **All research entities hire and train AI/ANs for all proposed projects.**

9. MEDICAID/MEDICARE

The Navajo Nation Council recommends that:

* **Medicaid/Medicare collections for care provided eligible AI/ANs by I/T/Us under the existing provisions of P.L. 93-437 as amended continue to revert to the source of collection for use providing quality health services.**

* **Any expansion of benefits to the Federally Qualified Health Center program apply equally to Tribal and Urban health programs.**

Mr. RICHARDSON. Thank you.

Ms. Pamela Iron, executive director of the Health Service Division of the Cherokee Nation.

STATEMENT OF PAMELA E. IRON

Ms. IRON. Thank you, Mr. Chairman.

As stated, my name is Pamela Iron, and I am the executive director of the Cherokee Nation, which is a sleepy little tribe in northeastern Oklahoma.

Chief Wilma Mankiller has asked me to come today to share with you issues involving the impacts of President Clinton's Health Securities Act on Indian health services and vulnerable populations within the Cherokee Nation and among all tribes in this country.

Indians are served, for the most part, within rural Indian health services where both primary and specialized health services are difficult to obtain because they are located long distances from rural Indians.

Finally, funding for health services is wholly inadequate, leading to fragmentation of services and overcrowded health facilities.

While the package of health care benefits is guaranteed under the President's plan, it is meaningless to many rural Indians if they are unable to gain access to services because of lack of transportation. It is not enough to provide health services, they must be assessable. Therefore, it is essential under the President's plan that mechanisms for establishing and funding transportation services for rural areas be developed.

The President's plan also lacks a strong health promotion and disease prevention component, which is essential for decreasing the vulnerability of Indian populations. We believe these programs form the cornerstone of any effective health system. Indians are at a seven times greater risk of death from tuberculosis than the population at large, six times greater risk of death from alcoholism and two-and-one-half times greater risk of death from diabetes and accidents.

We ask that Congress mandate that health promotion and disease prevention programs be included in any guaranteed package of health benefits and that sufficient funds be appropriated for this purpose.

Within an already vulnerable Indian population, certain groups face additional hardships. Elderly Indians and Indians with disabilities are particularly vulnerable. President Clinton's health care offers improved long-term care services largely due to provisions which greatly enhance home- and community-based services, particularly for the severely disabled. The administration is to be commended for this, however, it is unclear in reviewing the President's plan where Indian programs fit into this system.

Currently, States fund long-term care services for low-income Indians through the medicaid program. It is unclear if this would continue in a reformed system. If it does not, mechanisms need to be clearly identified within the President's plan for funding the portions of the various long-term care programs for Indians which would otherwise be paid as part of the State matching funds.

In addition, expansion of home- and community-based services for the less seriously disabled should be considered as part of the long-term strategy for improving care for the elderly and disabled.

The Cherokee Nation is very concerned about one provision of President Clinton's American Health Security Act which could have a significant impact on the ability of tribes to structure their health plans to ensure the economic health of their service delivery system. This section of the Act provides that tribal health plans should be required to contract with health plans offered through regional health alliances in order to serve non-Indians.

The Cherokee Nation has made no decision about whether service delivery in a reformed system would be extended to non-Indians. However, for tribes to have the greatest flexibility to structure a cost-effective system, if regional health alliances are adopted by Congress as a component of any health system, tribes which desire to serve non-Indians must have the option to operate through health alliances while serving Indians outside the alliances.

Failure to give the tribes the option to serve non-Indians within the health alliances could leave tribes which desire to serve non-Indians or rural communities without sufficient providers at the mercy of regional health plans.

As the American Health Security Act is currently written, health plans within the regional alliances could decide not to contract with a tribe to serve non-Indians in the region, even if it was in the best interest of non-Indians within the alliance to join tribal plans and both the non-Indian potential enrollees and tribes desired to do so.

In many underserved population areas, services could be provided more cost effectively per capita with integrated populations of Indians and non-Indians due to the economies of scale.

I have enclosed for your consideration, draft legislation to modify language in the President's proposal addressing service delivery in Indian health programs for non-Indians.

Finally, the President's plan provides that a guaranteed badge of health benefits be available to most Americans by 1998. However, it would not be required for Indian health plans until 1999. Many tribes are deeply concerned that they will lose their tribal members to health plans offered through regional health alliances if mechanisms are not established to assist tribes and the Indian Health Service to establish the package of Indian health programs at the same time it is mandated to be provided to everyone else.

This could be very detrimental to the abilities of tribes to maintain systems which have been developed under self-determination contracts and self-governance compacts.

In conclusion, I would just like to make one statement about the proposed budget. It is my understanding that the 1995 budget is again being proposed to be balanced on the backs of Indian people. The FTE cuts proposed will cut into patient care, and in talking with individuals and especially our tribal members, they are looking at self-governance, they are looking at the health care reform package, and then when they see the President's budget come out with these cuts, it is incomprehensible how all these things fit together when we are trying to work at providing better, more efficient care and then the budgets are cut right out from under us.

So I really thank you and appreciate this opportunity to be here. And I would like for you to consider the need to maintain the budget at least the current level.

Thank you.

[Prepared statement of Ms. Iron follows:]

TESTIMONY OF PAMELA IRON
EXECUTIVE DIRECTOR, HEALTH SERVICES DIVISION
CHEROKEE NATION
BEFORE THE SUBCOMMITTEE ON NATIVE AMERICAN AFFAIRS
OF THE HOUSE COMMITTEE ON NATURAL RESOURCES

Mr. Chairman. My name is Pamela Iron. I am the Executive Director of the Health Services Division of the Cherokee Nation, the second largest Indian tribe in the United States. The Cherokee Nation was one of the first tribes in the nation to enter into a Self-Governance compact with the United States government under 1988 amendments to the Indian Self-Determination and Education Assistance Act. I am here today to share with you issues involving the impact of President Clinton's Health Security Act on Indian health care services and vulnerable populations within the Cherokee Nation and among all tribes in this country.

Indian populations as a whole within the United States are vulnerable, largely for three reasons. First, they are poorer and less educated, on average, than comparably-situated White populations. This is even more of a hardship for many Indian patients, particularly elderly Indians, who speak primarily Indian dialects and use little or no English. Second, Indians are served for the most part within rural Indian health systems where both primary and specialized health services are difficult to obtain because they are located long distances from rural Indians. Finally, funding for health services is wholly inadequate, leading to fragmentation of services and overcrowded health facilities.

While a package of health care benefits is guaranteed under the President's plan, it may be meaningless to many rural Indians if they are unable to gain access to services because of lack of transportation. It is not enough to provide health services; they must be accessible. Therefore, it is essential under the President's plan that mechanisms for establishing and funding transportation services for rural areas be developed.

The President's plan lacks a strong health promotion and disease-prevention component, which is essential for decreasing the vulnerability of Indian populations. We believe these programs form the cornerstone of any effective health system. Indians have seven times greater risk of death from tuberculosis than the population at large, six times greater risk of death from alcoholism and two and one-half times greater risk of death from diabetes and accidents. We ask that Congress mandate that health promotion and disease prevention programs be included in any guaranteed package of health benefits and that sufficient funds be appropriated for this purpose.

Within an already vulnerable Indian population, certain groups face additional hardships. Elderly Indians and Indians with disabilities are particularly vulnerable. President Clinton's health care offers improved long-term care services, largely due to provisions which greatly enhance home and community-based services, particularly

for the severely disabled. The Administration is to be commended for this. However, it is unclear in reviewing the President's plan where Indian programs fit into this system. Currently, states fund many long-term care services for low-income Indians through the Medicaid program. It is unclear if this would continue in a reformed system. If it does not, mechanisms need to be clearly identified within the President's plan for funding the portions of the various long-term care programs for Indians which would otherwise be paid as part of state matching funds. In addition, expansion of home and community-based services for the less seriously disabled should be considered as part of a long-term strategy for improving care for the elderly and disabled.

The Cherokee Nation is very concerned about one provision of President Clinton's American Health Security Act of 1993 which could have a significant impact on the abilities of tribes to structure their health plans to ensure the economic health of their service delivery systems. This section of the Act provides that tribal health plans would be required to contract with health plans offered through regional health alliances in order to serve non-Indians. The Cherokee Nation has made no decision about whether service delivery in a reformed system would be extended to non-Indians. However, for tribes to have the greatest flexibility to structure a cost-effective system, if regional health alliances are adopted by Congress as a component of any health system, tribes which desire to serve non-Indians must have the option to operate through health alliances, while serving Indians outside the alliances.

Failure to give tribes the option to serve non-Indians within health alliances could leave tribes which desire to serve non-Indians or rural communities without sufficient providers at the mercy of regional health plans. As the American Health Security Act is currently written, health plans within regional alliances could decide not to contract with a tribe to serve non-Indians in the region even if it was in the best interest of non-Indians within the alliance to join tribal plans and both the non-Indian potential enrollees and tribes desired to do so.

In many underserved population areas, services could be provided more cost effectively per capita with integrated populations of Indians and non-Indians, due to economies of scale. In addition, many services which could not be justified if smaller populations were served separately could be justified if Indian and non-Indian populations were combined. I have enclosed for your consideration draft legislation to modify language in the President's proposal addressing service delivery in Indian health programs for non-Indians. This would give Tribes the greatest flexibility to design and implement effective delivery systems.

Finally, the President's plan provides that a guaranteed package of health benefits be available to most Americans by 1998. However, it will not be required for Indian health plans until 1999. Many tribes are deeply concerned that they will lose their tribal members to health plans offered through regional health alliances if mechanisms are not established to assist tribes and the Indian Health Service to establish the package for Indian health programs at the same time it is mandated to be

provided to everyone else. This could be very detrimental to the abilities of tribes to maintain systems which have been developed under self-determination contracts and self-governance compacts. Based on projections developed by the Indian Health Service, amounts appropriated to them to be used for the development of systems capable of delivering the full package of services is wholly inadequate to ensure the availability of the guaranteed benefit package, even by 1999. Yet under the Act, funds would be available to specifically assist states to develop the infrastructure necessary to support such a system, with incentives for states to act quickly. We ask that funds be appropriated to tribes to support early development of effective systems which could provide the benefit package. It is essential that sufficient funding to fully support services for Indians be available, consistent with the government's trust obligations to Indian peoples. However, funding for Indian health programs within the American Health Security Act appears to be inadequate to support the costs of delivering the guaranteed benefit package to Indians. We are concerned that the President's plan continues a long history of underfunding of Indian programs. For example, the expressed commitment by Congress in the Indian Health Care Improvement Act to promoting the highest level of health care for Indians and acknowledging the responsibility of the federal government to ensure that these services are available has failed to produce adequate funding to carry out the clearly-stated purposes of the Statute.

The standing of Indian tribes as sovereign governments, engaged in government-to-government relationships with the United States, places a heavy responsibility on both the tribes and the federal government to ensure that health services to Indians are wholly sufficient to meet the needs and enhance the health status of all persons served within the Indian health system. We applaud efforts by the President and Congress to ensure that all Americans receive basic health services. However, we implore Congress to ensure that any health plan which is enacted ensures that funding for Indian health care is adequate to truly meet the needs of all Native Americans. Thank you for your consideration.

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

New Section (c) -- (the previous section (c), "Essential Community Providers" is renumbered to section (d))

(c) Notwithstanding any provisions of this Act addressing eligibility for enrollment in regional or corporate health alliances or eligibility for enrollment in Indian health programs for individuals described in section 8302(a) or section 8306(b), any health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program may offer health services to individuals not eligible for enrollment under section 8302(a) or section 8306(b) as a health plan through a regional health alliance 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.

Mr. RICHARDSON. Thank you.

All of you have given very compelling testimony, and I understand your concerns.

Let me just ask one question, maybe each one of you could take a stab at it.

Do you think the tribes could compete with other regional health alliances? Do you see that as being a problem?

Let's start with the Navajo Nation.

Ms. HUBBARD-POURIER. Under the current wording in the proposed legislation, it is not clearly established whether or not the Navajo Nation could serve as a health plan. Because of our size, we would be able to probably cover this and provide a wide range of services as required under the uniform benefits package.

But to do so, the Navajo health care system, which is predominantly composed of IHS facilities and service providers now, would have to be greatly upgraded. It is only currently funded at about a 68 percent level for individual personnel health care costs. So, consequently, it would be difficult for the present system to be marketable, as it were, or competitive as a plan which Navajo people would choose.

Under the present wording in the legislation, it is anticipated that people who are employed could go outside the IHS system. For us it would be very difficult for those people in the interior of the Navajo Reservation, primarily because they do not have access to other private providers or other health care plans. The people in the border town and border regions of the Navajo Reservation would have more of an opportunity to have this access to other health care plans.

The Navajo Nation has yet looked at the possibility of becoming a separate health plan, and this is a decision that will be made by the Navajo Nation Council who must make this policy decision.

Mr. WALLACE. The question is whether we could offer the comprehensive benefit package in our facility at Choctaw. The answer would be yes, if several things happen, and those things are that in the language of the Health Securities Act that the proper financing are put into place for the upgrading of our system.

We know that we deliver good health care already at our facility. We are Choctaw-Commission accredited. But with the proper equipment, proper facilities, we believe that we could compete and possibly compete on a regional level, that would not only give our Choctaw Indians the proper health care but we could give non-Indians that proper health care also.

In fact, we have looked at the financial situation and that may be the only way that we can come out, is if we have those resources coming in to help provide for the care of our people.

Ms. BAUMAN. The answer for Oneida would be yes, that we could compete with the appropriate financing. Our concern is also if it does not come through by—if it is not available by 1999 and everything else is available by 1998, being where our location is, we will find a lot of people walking or going to Green Bay, and so by 1999, we would not have—we wouldn't have to worry about it.

Mr. RICHARDSON. Okay.

Ms. IRON. The Cherokee Nation has formed the Cherokee Rural Health Network and in two of our facilities we already serve non-

Indians adopted by the tribal council for two communities that came onto the Cherokee Nation.

We do feel that we can compete within the alliance and we want to underline that. We do believe that the Indian population should be served outside of the alliance; not that the Indian population—it should be an option written into the language that tribes could participate at their own option, because there are some tribes that need—the tribes need to have the choice of whether they are going to offer a health plan to non-Indians or not, whether Indian Health Service is going to continue to deliver services, and then advise them, or a combination of those.

Mr. RICHARDSON. I want to thank this panel for appearing. You have made some very good points. The subcommittee encourages your continued participation as we look at H.R. 3600 and try to improve it. I think you have all made some very good statements on how we can improve it, and the subcommittee thanks you.

PANEL CONSISTING OF JULIA A. DAVIS, VICE-CHAIRPERSON, NEZ PERCE TRIBE OF IDAHO, CHAIRPERSON, NATIONAL INDIAN HEALTH BOARD, AND CHAIRPERSON, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD; ALIDA MONTIEL, HEALTH PROJECT COORDINATOR, INTER TRIBAL COUNCIL OF ARIZONA; AND CHRISTOPHER T. STEARNS, ESQUIRE, ON BEHALF OF BRISTOL BAY AREA HEALTH CORP., AK

Mr. RICHARDSON. We will now move on to the third panel, the Honorable Julia Davis, vice-chairperson of the National Indian Health Board; Ms. Alida Montiel, health project coordinator, Inter Tribal Council of Arizona, and Mr. Christopher Stearns, on behalf of the Bristol Bay Area Health Corporation.

Ms. Davis, please begin.

STATEMENT OF HON. JULIA A. DAVIS

Ms. DAVIS. Good morning, Chairman. It is good to be here, even though we are a three-hour difference, I am glad to be here.

I need to make some general comments to the committee, to all of you, to let you know that I am here on behalf of the National Indian Health Board and we have presented written testimony and also the Northwest Portland Area Indian Health Board, of which we have presented testimony.

Because you have that written testimony, what I would like to do is just make some general comments to you, but I would like to highlight certain areas of the testimony that I think are important.

As stated, my name is Julia Davis, and I am the vice chairwoman of the Nez Perce Tribe of Idaho, and we have our Nez Perce delegation here today, and I would like to recognize them. If they would please stand.

These are tribal council members from the Nez Perce Tribe.

Mr. RICHARDSON. Welcome and thank you for coming.

Ms. DAVIS. I would also like to let you know that it is an honor to be here and I am glad to see that the committees are having these hearings.

My first comments are on the budget, and I did hear a few comments by people that testified previously. The fiscal year 1995 IHS

budget proposed by the administration is disgraceful and disheartening to all American Indians and Alaska Natives.

Tribes vividly recall the President's State of the Union address in January of 1994. The themes that he presented provided a sense of optimism and encouragement to Indian communities, including myself.

I was here for the inauguration, and I felt that he was going to do what was right for not just all people but Indian people. The President talked about investing in America's most important resource, its people. He spoke passionately about investing in America's children, intensifying the fight against HIV–AIDS, enhancing biomedical and behavioral research, increasing treatment and prevention of substance abuse and making significant investments in America's infrastructure. All of these issues are important to Indian communities.

Now that the tribes have seen and analyzed the budget that followed that speech, we are appalled by the hypocrisy of his message. How is it possible that the first Americans are not only forgotten but targeted for unpardonable harm?

How is it possible that the Health and Human Services Department, the parent organization of Indian Health Service, proudly proclaims that its overall budget, increased by 7 percent, and discretionary funding by 10 percent, while the tribes health programs are hit with a 12 percent decrease in budget authority?

This Department has some explaining to do, not just only to the tribes but to Congress. This is the worst health budget the tribes have ever encountered.

I needed to make that comment to you, Mr. Chairman, because the fiscal year 1995 budget is very appalling, and that goes hand-in-hand with these testimonies that we are presenting here on behalf of our Indian people and on behalf of the Indian organizations across the United States. If our budgets are going to be cut, how does President Clinton expect to incorporate the Clinton's health security plan without adequate funding even in the health plan, let alone the fiscal year 1995 IHS budget?

Some of the tribes have commented to you about not having funding for certain areas of their concern, facilities, construction, long-term care needs, but also where is that funding for Indian tribes for the health security plan?

There is funding available for State health plans and some of them have already implemented that, the States of Washington and Oregon. They have monies for that, including some of the other agencies, but the Indian tribe health boards have not seen any funding to incorporate any of President Clinton's health initiatives in his plan.

Title VIII, Section D has been analyzed by the Northwest Portland Indian Health Board and, for the record, I would like to let you know and the recorder know that we will submit that analysis for your information.

[EDITOR'S NOTE.—The information was not received at time of printing.]

Ms. DAVIS. I just very strongly feel, not only as a tribal leader to Indian people, but to all tribes across the United States, that we really do need to have a consultation.

And to you, Mr. Chairman, I would like to request and hope that you would support the tribal leaders meeting with President Clinton and Vice President Gore, because at that time, I think the tribal leaders could let the President know about how they feel about the budget and about the health security plan. That needs to be done very soon.

One other quick comment I would like to make. The Indian people have endured. We have survived and we will be here today and we will be here tomorrow and it is my hope that you as Chairman of this subcommittee, will take all of the testimonies that were presented here today to heart, not just as a piece of paper and set it aside and have somebody else look at it. Take the time to read through what we have honestly said with our hearts and our feelings and take that message to Congress when they talk about the Indian Health Service and the Indian people.

Thank you.

Mr. RICHARDSON. Let me say for the record that we have already prepared our recommendations and concerns to both the Budget and the Appropriations Committees and many of the statements that we heard here today, good suggestions, including your passionate statement, is reflected in that and that will be reflected in our actions. But I thank you for being so eloquent.

[The prepared statements of Ms. Davis follows:]

NATIONAL INDIAN HEALTH BOARD

Statement of
Julia A. Davis, Chairperson
National Indian Health Board
before the
Subcommittee on Native American Affairs
on
H.R. 3600, Health Security Act
February 28, 1994

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Good afternoon, Mr. Chairman and members of the Committee. I'd like to thank you for this opportunity to address you on health care reform and how it affects American Indian and Alaska Native (AI/AN) consumers. My name is Julia Davis. I am the Vice-Chairperson of the Nez Perce Tribe of Idaho. I am also the Chairperson of the Northwest Portland Area Indian Health Board, which is an aggregate organization of 40 tribes from Washington, Oregon, and Idaho. I am here today as the Chairperson of the National Indian Health Board (NIHB). I have held this position since November 1993 and prior to that I held the position of Vice-Chairperson for three years.

As you may know, the National Indian Health Board is the oldest national representative body for AI/AN health concerns in the United States. The NIHB carries the mission to conduct, engage in, and carry on activities and programs which are exclusively of benefit to the health of AI/ANs. The NIHB is a member of the National Indian Coalition on Health Care Reform.

I would like to acknowledge the efforts in the Health Security Act to preserve the tribal sovereignty of Indian nations. Although it is not expressly stated in the bill, the separate but enhanced system and the exemptions from employer premiums to tribal governments and organizations under P.L. 93-638 contracts and self-governance compacts are acknowledgements of our government-to-government relationship.

We applaud this acknowledgement of the Federal responsibility to AI/ANs based on moral obligations, historical obligations, and legal obligations stemming from treaties, federal legislation, and court decisions. However, it is time for the Federal government to act on this acknowledgement. We do not have definitive figures on the cost of providing the comprehensive benefits package, the cost of the guaranteed supplemental services, or the cost of transitioning into our separate but enhanced system. We do know that these numbers will be at least four times greater than the current appropriations. These appropriations will be the definitive factor in whether the Health Security Act actually fixes what is broken with the Indian health system.

The current appropriations trends are in direct conflict with the Health Security Act. The result of these trends will be the erosion of the tribal right to health care and tribal sovereignty in providing this care to their people. Our programs are not being provided the wherewithal to provide adequate care and will lose in the market driven system without the critical mass to support programs.

In this vein, there are five topics which I would like to

discuss today related to the Indian health programs in the Health Security Act. These include transition issues, financing, governance, eligibility and some specific programmatic concerns.

Transition Issues

In areas where there are options in health plans, competition will be the key. Sections of the Health Security Act put the Indian health programs at a further disadvantage in competing than they currently are with the historic levels of underfunding and the current appropriations trends. The bill gives special incentives to alliances to enroll disadvantaged populations and states are given incentives to begin early. Indian health programs are to begin a year later, giving other health plans opportunity to enroll eligible Indians.

If the individual Indian person is not allowed a reasonable choice between an Indian health facility or another general-population facility, then the federal government has doubly failed, in its trust responsibility in providing health care to AI/ANs and in the neglect of the right to choose under the Health Security Act, which, in the case of eligible Indians, must include the option of an Indian health plan.

The bill allows for individual Indians to enroll in a health alliance plan or an Indian health program. The "vote with your feet" concern has fed worries about the inability of Indian health programs to compete in the larger environment. Indians shouldn't have to be competitive in this environment because of the federal trust responsibility but the reality is that they are and by losing, it's a de facto termination. We realize the requirement for volume of users as opposed to straight dollars in the new system but the Indian health programs must be made more attractive than other plans in a particular area to gain these users. The augmentation of services from their current level must take place in a timely manner, as with the Veterans Administration, where transition funds are already being spent.

Financing

The cost of delivering the services to AI/ANs in H.R. 3600 is unknown. The IHS has not released their latest figures based on an actuarial study but the roughest estimates of the situation indicate that concern is warranted. The items that need review are: 1) the cost of providing the comprehensive benefits package, 2) the cost of supplemental services, 3) the cost of enabling the Indian health program to provide the required services, and 4) the expected revenues.

The cost of providing the comprehensive benefit package is unknown. The current user population of 1.3 million at the current per capita spending rate of $3,127.94 in the general U.S.

population gives us a total just over $4 billion dollars for basic health care. This overly crude figure is, of course, unreliable but it ballparks the great needs which the Indian health programs would have under the Health Security Act. Having to rely on such a figure to gain perspective also points to the need for valid studies of what it might cost to provide adequate services to the AI/AN population.

The IHS has estimated that the cost of upgrading their facilities to provide the comprehensive services is $3.4 billion with an ongoing cost of $400,000 per year. Regardless of the number, no viable IHS facilities should be closed under the Health Security Act, particularly in underserved areas. Further options must be explored.

One option the IHS is currently exploring is using the authorized appropriations of Title VIII, Subtitle D to leverage guaranteed loan in the capital finance market. First, I think that any plan should include built in fairness. The current priority systems award larger programs with facility dollars and accompanying expansions of programs. The bigger, the better. The smaller programs across the country are doubly jeopardized. Second and more fundamental, I ask you why Indian people should take out loans to finance federal responsibilities.

According to the IHS, there are five sources of revenue for the new system: Medicare and other program reimbursements, comprehensive benefits package appropriations, non-Tribal employers premiums, non-Indian family member premiums, and medical assistance premiums from an entitlement fund for low income and medically needy. None of these will be guaranteed levels of funding for the Indian health programs and the ramifications are unsettling once the budget process comes into play. We cannot assume that the Indian health program is going to be funded at 100 percent of the comprehensive benefit package. Further, the employer exemptions for tribal governments and organizations necessitate a budget add-on to cover these dollars. This authorization must be in the legislative language.

Indian people have expressed concern over how the comprehensive benefit package will be delivered in the antiquated and inadequate system and how they will fare in an arena in which there are other plans which may well have a competitive edge in the proposed market-driven system. The Public Health Initiative dollars, if any flow to the Indian health program, and the Section 8313 funds will not be enough. In short, the current version of the bill would leave the Indian health programs underfunded by billions of dollars.

Governance

A national independent Indian Board should provide governance and oversight for the distribution and management of such funds as are involved in the delivery of services in the Indian health care system under the enacted Health Security Act. The Chairperson of this Board would report to the National Health Board and the Indian Board would be established within six months following the date of enactment of this Act. The Indian Board will consult closely with the Secretary on the determination of which requirements relating to health alliances apply to the Indian health programs, on reimbursement criteria for contract with health plans for the provision of health service to non-enrollees and non-Indians, on the establishment of premiums and premium reductions for non-eligible enrollees into the Indian health programs, and on all other Secretarial authorities in Title VIII, Subtitle D of the Act. Tribes must be consulted closely regarding the membership to this Board.

Eligibility

The Health Security Act states that Indian health programs provide services to the current users. It cannot be assumed that this will be the number of users. Estimates of the user population should take into consideration whether the Indian health programs will be enabled to be competitive with other health plans; the upgrading of IHS facilities; changing membership criteria by tribes; impending federal acknowledgement of new tribes; population growth; and inclusion of the portion of the 900,000 Indians not currently served by the IHS who choose to opt in; and the provision of the supplemental services to all AI/ANs regardless of residence.

The Health Security Act allows service to non-Indians at the discretion of local tribal governments. There are ways that the Act is contradicts itself. For instance, in the election of essential care provider status, providers are required to serve non-Indian family members. Since this is a requirement of all Indian health programs, it opens the door for the IHS to make determinations of providing services to non-Indians, without consideration of tribal decisions, in its direct operations. This is in conflict with section 8306 which states that services to non-eligible individuals shall be at the discretion of local tribal governments. All references to services to non-eligible individuals in H.R. 3600 should include the explicit requirement of local tribal consent.

Other

Indian tribes should be fully eligible to take advantage of the Public Health Initiatives in Title III of the Bill, including the national health promotion and disease prevention initiative

(section 3331), health care access initiatives for urban and rural medically-underserved populations (section 3411), grants and contracts enabling services (section 3461), and school health education grants (section 3651-3692).

On the issue of recruitment and retention, Indian people support the major increases in the National Health Services Corps under the Health Security Act. We seek to have one quarter of this increased program placed in service within the Indian health programs, directly delivering services and not in administrative positions.

And related to manpower issues, the comprehensive delivery of services translates, in Indian Country, to a holistic view of health. The use of traditional healers is an integral part of this definition in our minds and no definition of a health care provider can go forward without incorporating the traditional healers. This must also give attention to a mechanism of identification of the healers at the local level and a plan to integrate these healers into the medical model delivery system.

Long-term care was a growing concern in Indian Country prior to the current debate. As the Health Security Act and other national health care reform bills are introduced in Congress, long term care is typically addressed in fragmented, uncoordinated statutory provisions. The Act discuses long-term care in at least ten different places -- without clarification of how long-term care provisions would effect Indian Health Service, tribal, and urban Indian health care providers.

Since the IHS has never provided any type of long-term care, Indian health care providers will need immediate access to and inclusion in other provisions of the Health Security Act, such as demonstration grant funding for acute and long-term care integration. Indian health programs will also need an equivalent to the new state long-term care integration option, with full access to all available Medicare and Medicaid resources.

Indian health providers cannot offer integrated long-term care without more access to existing federal long-term care funding, as well as new funding under the Health Security Act. Federal funds to Indian health care providers should, at a minimum, equal the amount of state and federal funds spent under comparable non-Indian programs. They should be paid directly to Indian health care providers. Indian health programs must be authorized -- on an equal basis with states and health plans -- to access federal funding sources for long-term care. They must have sufficient additional funding to offer the full range of long-term care services available from non-Indian providers.

Finally, this largely state driven system must not give states the latitude to drop their responsibility because they

view the provision of health services the AI/ANs as a federal concern.

Conclusion

In conclusion, the Indian health programs must be allowed to govern their own separate and enhanced system. Regardless of the course of national health care reform, there must be reform for the Indian health system. It currently represents a unique preventive care model that the Health Security Act mirrors. It is a system that works whose major flaw is the egregious underfunding.

If AI/ANs do not have the choice of a fully funded Indian health program at enrollment time under the Health Security Act, they have been denied their right because the federal government failed to live up to its responsibility in enabling Indian health programs to be competitive. We ask that this Committee give this issue primary concern as you consider H.R. 3600 in the coming months.

Testimony of Julia A. Davis, Chair
Northwest Portland Area Indian Health Board
on the
Health Security Act, H.R. 3600

Before the

House Subcommittee on Native American Affairs
February 28, 1994

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INTRODUCTION

The Northwest Portland Area Indian Health Board is a tribal organization which, for the past 22 years has represented the 40 Federally-recognized Indian tribes in Oregon, Washington, and Idaho on health-related issues. As Chair of this tribal organization, it is an honor for me to appear before you today to provide testimony on H.R. 3600, the Health Security Act.

The NPAIHB is pleased that the President and Congress are about to address the issue of health care reform. For many years, the Indian health care system has felt the impact of the problems of the health care system of this country. As more and more Indian people were without private health insurance, the population served by the Indian health care system increased. Double digit medical inflation decreased the services Indian health services could both provide and purchase resulting in deferred medical services, extremely long waits for appointments, and a lack of capacity to serve all those needing care. Indian people know about rationed health care. So, while we have serious concerns about how the new system will work and specific language in the Bill, the opportunity for Indian people to have a guaranteed comprehensive health benefit package is one we vigorously support.

The NPAIHB has prepared a full analysis and will provided that document to the Committee. Today, I will address a few critical issues which must be addressed for this bill to meet the needs of the Indian health care system.

We are extremely pleased that the President has understood the importance of maintaining the Indian Health care system as a separate system. When we read Title VIII, Subtitle D, we believed the Administration understood and was committed to honor the Federal responsibility to provide health care to Indian people, health care which was secured by treaties and prepaid for with millions of acres of land and resources of untold value. However, now that we have seen the Administration's FY 95 Budget proposal for the Indian Health Service with its 12% decrease in overall budget authority, exaggerated revenue projections, and requirements to absorb mandatory increases, our confidence in that commitment has been shaken.

FINANCING AND APPROPRIATED FUNDING

Consequently, our greatest concern is that inadequate funding will be appropriated to the Indian Health Service so that it will be unable to provide the comprehensive benefit package and the supplemental services authorized under this and other Indian health care legislation.

While the cost of providing the comprehensive benefit package has not been clearly identified, we do not believe that the $180 million authorized for FY 96 and the $200 million in following years will be adequate for the needed expansion of services and infrastructure development. We have no way at this time to determine if this shortfall will be made up with employer and individual premiums. If the funding provided to the Indian Health

Service remains inadequate, patients will be unable to get timely appointments, services will be deferred, and patients forced to leave the system, justifying further cuts. We are also concerned that funding for supplemental programs such as sanitation and prevention projects will be robbed to pay for the comprehensive benefit package. The FY 95 proposed budget has intensified this fear as it zeros out funding for both sanitation and new facility projects.

We do not know the amount needed to be authorized and appropriated to insure that the Indian health care system can provide the comprehensive benefit package and the supplemental health program. That is the Administration's task, and it is one that should be done away from the politically-charged budget spotlight so that the true need is not distorted and the Indian Health Service program irreparably harmed. It is a complex issue and many things need to be considered. As an example, our area will continue to have to purchase all inpatient and specialty care from private providers. We are concerned that the capitated rate received from insurance premiums and Medicaid will not be adequate to pay for the primary care we will provide plug the care we will be required to purchase.

Northwest tribes are also concerned that the Bill allows IHS to provide the comprehensive benefit package one year later than is guaranteed for all other American citizens. It is intolerable that Indian people be singled out and for one year not be entitled to the same benefit package as all other Americans. Delaying the

availability of the comprehensive benefit package at Indian health programs may also result in individuals leaving in order to get a comprehensive benefit package. Will this temporary loss of patients be used to justify reduced funding?

Sufficient funding must be provided and it must be provided early to allow Indian programs to meet the certification requirements in order to provide the comprehensive benefit package by 1998 along with the states. Indian health programs must be made eligible for the incentives and financial assistance given to states to provide the comprehensive benefit package early. State health care reform is already in effect in Washington and Oregon so this is an immediate and critical concern, especially now that we have seen the Indian Health Service budget proposed for FY 95.

FACILITIES AND INFRASTRUCTURE

To enable the Indian health system to provide the comprehensive benefit package, significant investment in infrastructure is needed. Clearly the funding levels authorized at Section 8313 are not sufficient for infrastructure development. Adequate funds must be specifically authorized for the Indian Health Service to invest in the future of Indian health care by building modern, well-equipped community health centers in Indian communities. In conjunction with tribes, IHS through various mechanisms should be building or replacing a minimum of 10 community health centers annually.

The ways in which tribes can build health centers should be expanded. Northwest tribes wholeheartedly support the revolving loan program authorized in the Bill. But we believe a less expensive and more appropriate proposal is a guaranteed loan program that allows tribes to utilize private financing to construct needed facilities. Tribes can build facilities faster and for less money than can Indian Health Service with its complex and burdensome acquisition regulations. In these time of budget constraint, giving tribes the authority and resources to construct needed clinics will produce the best value for the Federal dollar.

ENROLLMENT

Northwest tribes are concerned that for many reasons, both historical and cultural, many Indian people will not proactively enroll in a health care plan and will be assigned to a plan other than an Indian health program. They will have to pay copayments and deductibles, so will continue to come to the Indian program for care. Indian programs will be obligated morally, if not legally, to continue to provide care to these individuals. Language must be included to allow Indian health programs to assist individuals to enroll in Indian health care programs, and to continue to bill for services provided to Indians enrolled in other programs at least through a reasonable transitional period.

SERVICE TO NON-INDIANS

Northwest tribes are in agreement that Indian health programs should continue to have the opportunity to provide services to non-Indians, particularly family members, if the capacity to provide service exists. However, tribes firmly believe that the decision to extend services should always be that of the affected tribe and can not be a decision of the IHS alone.

CONSULTATION WITH TRIBES

Northwest tribes are pleased to see the requirement at Section 8309 that the Secretary consult with tribes annually concerning health care reform initiatives. We suggest that this language be expanded to require the Secretary to regularly consult with tribes on a government-to-government basis on all initiatives which will impact Indian health care.

ELIGIBILITY

Under the very broad definitions currently contained in the Act the number of individuals eligible for the comprehensive benefit package to be provided by the Indian Health Service will significantly increase. Northwest tribes believe now is the time to deal with eligibility for Indian health care. Eligibility should not be tied to residency (urban or reservation), but rather to tribal membership. Being American Indian or Alaskan Native is not simply one of racial identity but is primarily one of political identity. It is a basic right of all governments to determine who

is a citizen, and as sovereign governments, tribes maintain the fundamental right to determine their membership. It is tribal governments who have the right and the obligation to face the eligibility issue through their decisions on membership just as you determine who becomes a citizen of this country.

CONCLUSION

Once again, thank you for the opportunity to share the concerns of the 40 Federally-recognized Indian tribes of Oregon, Washington, and Idaho on the Health Security Act. As tribal leaders, we know the difficulty of meeting the needs and addressing the concerns of all parties who have an interest in an issue. But, we urge you not to forget Indian people. Our grandparents gave up a great deal to secure health care for Indian people living today. We hope you will not forget their sacrifices by failing to address the inequities and inadequacies in both the national health care system and the Indian health care system.

Mr. RICHARDSON. Ms. Alida Montiel, Intertribal Council of Arizona.

STATEMENT OF ALIDA MONTIEL

Ms. MONTIEL. Chairman Richardson, I appreciate that you did not demolish my name.

Mr. RICHARDSON. Did I say it right?

Ms. MONTIEL. You said it great; Alida Montiel.

I am here today to represent Chairman Dale Phillips. He is the chairman of the Cocopah tribe and the president of the Inter tribal Council of Arizona. Myself, I am the health project coordinator of the Inter tribal Council of Arizona.

For your information, I am a member of the Pascua Yaqui Tribe of Tucson, Arizona. Well, Tucson is there now.

This morning the content of the testimony of the Inter tribal Council of Arizona will be with regard to three areas. One, the recommendations to the subcommittee to revisit IHS policy and enhance the IHS budget to implement the Health Securities Act provisions.

The second area is recommendations to clarify specific provisions of the Health Securities Act, title VIII, subtitle D, and additional concerns not identified in the Health Securities Act.

The H.R. 3600 is receiving critical attention by the tribes because it is the only health reform proposal which recognizes and proposes the continuation of IHS and the relationships of tribal governments and the Indian Health Service to the new system. We are encouraged that the President is proposing new dollars into the Indian health system to provide the comprehensive benefits package to enhance existing services and upgrade facilities.

The President's plan also creates new public health initiatives and tribal communities are eligible to participate in these initiatives. The administration included representatives from IHS and Indian tribes who provided direct input into formation of the 13 provisions pertaining to IHS.

The President's working group should be commended for recognizing the importance of the IHS and tribal health care systems in the formation of this proposed legislation.

With regard to recommendations on Indian health care policy, the Subcommittee on Native American Affairs should urge the Clinton administration to coordinate its approach to Indian health care policies. On the one hand, the administration has taken positive steps to work with tribes to ensure that the Indian Health Service and tribal governments are recognized in the Health Securities Act. However, the Clinton administration's proposed reductions for clinical services and Indian health facilities in the 1995 IHS budget is not consistent.

Clearly, the Clinton administration's reduction of funding, staffing and facilities resources will result in the IHS and tribal governments lack of ability to implement the Health Securities Act. It appears that the policy side of the White House recognizes the need to improve IHS resources and capacity, however, the Office of Management and Budget proposes devastating cuts. The White House needs to reconcile its Indian health care budget with its Indian health care policies.

The Committee on Natural Resources needs to ask the Clinton administration to describe the administration's views on the implementation of title VIII, subtitle D, given the administration's proposed reductions in IHS funding, staffing and facilities. The Subcommittee on Native American Affairs should urge the Clinton administration to approve a waiver under Executive Order 12839 to exempt the IHS from FTE reductions.

The Inter Tribal Council of Arizona requests that the subcommittee also write to President Clinton and urge the President to approve a waiver to the IHS. If the administration does not approve a waiver, the Congress should reinstate statutory language in the Interior Appropriations Act prohibiting the administration from reducing IHS FTEs without the approval of the Committee on Appropriations.

For many years, the Interior Appropriations Act contained language protecting the staffing levels of the Indian Health Service. The Subcommittee on Natural Resources should direct the administration not to propose unrealistic increases in medicare, medicaid and third-party collections that would offset appropriations for Indian health services. It is our perspective that the purpose of having collected medicare and medicaid payments is to enable the IHS and tribal facilities to meet and maintain accreditation standards.

Title IV of the Indian Health Care Improvement Act authorizes IHS to collect these medicare-medicaid reimbursements, and it specifically states that medicare and medicaid collection shall not be used to offset IHS appropriations.

With regard to specific provisions of the Health Securities Act, this is included in our testimony, and I will briefly state that we are requesting membership representation of tribal government in the Indian Health Service on the National Health Board.

With regard to the expansion of the National Health Service Corps, we are requesting that the Act include a study to determine the best utilization of commissioned corps and health care facilities.

With regard to school-related services, we are requesting that you expressly include Bureau of Indian Affairs, BIA tribal and tribal schools. Presently, school health and referral services are not uniformly provided by the IHS. Due to limited personnel, these schools lack nursing staff, health education courses and in-service training.

With regard to the section on health plan and health alliance requirements, the comprehensive benefits package, the tribes—the member tribes of the Intertribal Council of Arizona are concerned that a number of people may enroll in another health plan unless they are assured that IHS is able to restructure in a timely manner.

What we are proposing is that it become an essential activity of the Indian Health Service to effectively communicate new and existing services, enrollment procedures and eligibility requirements to Indian people defined in the act.

We are concerned that the Arizona State Medicaid Agency, the Arizona Health Care Cost Containment System, known as AHCCCS, is one of the models for health care reform. And if AHCCCS is one of the models for health care reform, the difficulty in implementing medicaid-covered benefits or the on-reservation

population in Arizona should be recognized. These difficulties have included the lack of a direct funding relationship with the Health Care Financing Administration, the lack of intergovernmental agreements, inadequate payment systems, lack of funding for administrative and start-up costs, and lack of clear policies governing State, Federal and tribal relationships.

The difficulties have been pronounced because the State government assumes authority to direct the delivery of federally and tribally operated health services. There should be a direct relationship between the Indian Health Service, HCFA and tribal governments with regard to the Health Securities Act, with no requirements for involvement with State alliances.

In addition, the tribes in Arizona are concerned that the Health Securities Act be able to provide the full range of comprehensive benefits. Funding should include start-up costs for establishing emergency medical services, long-term care, home- and community-based services, and public health prevention strategies.

The Health Securities Act needs to clearly state that IHS and its contracted health programs are authorized to provide or arrange for the provision of the comprehensive benefits package.

With regard to infrastructure financing and appropriations, there must be concrete appropriations for upgrading facilities to support the delivery of services. The small tribes should not be expected to compete with the larger tribes for funding facilities improvements. There should be separate funds with timely consistent approval processes built into the act.

With regard to the direct relationship with the fiscal intermediary, and I am not sure who that is at this point yet, whether if it is a transformed Health Care Financing Administration or what the specific Department is going to be called, but there should be a direct relationship with the fiscal intermediary to Indian Health Service and tribal health departments to provide the comprehensive benefits package, public health initiatives and medicare-medicaid services.

With regard to provision of health services to nonenrollees and non-Indians, the Health Securities Act allows provision of services to non-Indian families with approval of the program unit or organization, and we would ask that this section include the word "tribe."

With regard to participation in public health initiatives, we endorse expanding public health initiatives, but we ask that they be established by the initiative of the tribes themselves; that the tribes identify what their public health initiatives should be.

The last two items I have is tribal concerns not identified in the Health Securities Act. At this time, the tribes have indicated to the staff of the Inter tribal Council that they are concerned that native traditional healers are not defined in the bill in a definition of health care provider or in relation to program delivery.

And also, to summarize, effective IHS restructuring should meet Indian Health Care Improvement Act year 2000 goals and objectives, the Health Securities Act requirements, and specific tribal strategic planning. Restructuring and improving the Indian Health Service will continue to be addressed by the tribes regardless of and in conjunction with national health care reform and in light of individual State efforts at health care reform.

These are my comments today.
Thank you.
Mr. FALEOMAVAEGA [presiding]. Thank you, Ms. Montiel.
[The prepared statement of Inter Tribal Council follows:]

INTER TRIBAL COUNCIL of ARIZONA

TESTIMONY TO THE
SUBCOMMITTEE ON NATIVE AMERICAN AFFAIRS
COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES
ON HR 3600, THE HEALTH SECURITY ACT

February 28, 1994

Submitted by:
Dale Phillips, Chairman, Cocopah Tribe
President, Inter Tribal Council of Arizona

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TESTIMONY TO THE
SUBCOMMITTEE ON NATIVE AMERICAN AFFAIRS
COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES
ON HR 3600, THE HEALTH SECURITY ACT

February 28, 1994

Submitted by:
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In behalf of:
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President, Inter Tribal Council of Arizona

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Outline of the Testimony

I. Recommendations to the Subcommittee to revisit IHS policy and enhance the IHS budget to implement the Health Security Act provisions.

   A. The need for coordinated approaches to Indian health care policies.
   B. Request for a waiver for IHS from FTE reductions.
   C. Request to reinstate statutory language regarding FTE reductions for IHS.
   D. Request to clarify the National Performance Review in relation to IHS and the BIA.
   E. Unrealistic increases in Medicare/Medicaid and third party collections discussed.

II. Recommendations to clarify specific provisions of the Health Security Act, Title VIII, Subtitle D.

   A. Inclusion of tribal government and IHS representation on the National Health Board.
   B. Better utilization of the National Health Service Corps in IHS and tribal programs.
   C. Inclusion of Bureau of Indian Affairs and tribal schools in school health initiatives.
   D. Additional funding and coordination needed to deliver the comprehensive benefits package.
   E. Needed facilities infrastructure improvements.

F. Tribal government approval of the provision of services to non-enrollees and non-Indians.
G. The need to maintain the alternate resource rule.
H. Participation in public health initiatives to address tribal concerns.

III. Additional concerns not identified in the Health Security Act.

A. Inclusion of the formation of a traditional healing policy at the local level.
B. Effective IHS restructuring in light of health care reform.

TESTIMONY
TO THE SUBCOMMITTEE ON
NATIVE AMERICAN AFFAIRS
COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES

H.R. 3600, The Health Security Act of 1993

Dale Phillips, Chairman - Cocopah Tribe
President, Inter Tribal Council of Arizona

February 28, 1994

I. INTRODUCTION

HR 3600, the Health Security Act is receiving critical attention by the tribes and tribal organizations because it is the only health reform proposal which recognizes and proposes the continuation of the Indian Health Service (IHS) and the relationship of tribal governments and the Indian Health Service to the new system. The prospect of adding new dollars into the Indian health system to provide the comprehensive benefits package to enhance existing services and upgrade facilities is encouraging. The President's plan also creates new public health initiatives and tribal communities are eligible to participate in many of the initiatives. The Administration included representatives from the IHS and Indian tribes who provided direct input into the formation of the thirteen provisions pertaining to IHS (Title VIII, Subtitle D). The President's Working Group should be commended for recognizing the importance of the IHS and tribal health care systems in the formation of national health care policies.

The tribes have encouraged the Administration to become more fully acquainted with Indian health issues and have requested consultation with the tribal leadership. Most recently Dr. Phillip Lee, Assistant Secretary of Health, and IHS officials began a series of regional forums on Indian health care reform. Specific health concerns identified by the member tribes of the Inter Tribal Council of Arizona were presented at this meeting. In addition major concerns about the FY 1995 budget proposal were identified and discussed. This opportunity to provide testimony to the Subcommittee on Native American Affairs allows the tribes additional opportunity to address these concerns to the Congress.

II. RECOMMENDATIONS ON INDIAN HEALTH CARE POLICY

A. The Subcommittee on Native Americans should urge the Clinton Administration to coordinate its approach to Indian health care policies.

On one hand, the Administration has taken positive steps to work with Indian

tribes to ensure that the Indian Health Service and tribal governments are recognized in the Health Security Act in Title VIII, Subtitle D. However, the Clinton Administration is proposing a reduction of five percent for Clinical Services and a 70 percent reduction in Indian health facilities in the FY 1995 IHS budget. The Clinton Administration is also proposing a reduction of seven percent for IHS full time employees (FTEs). Clearly, the Clinton Administration's reduction of funding, staffing and facility resources will result in the Indian Health Service and tribal governments lack of ability to implement Title VIII, Subtitle D of the Health Security Act.

Section 8303(b) of the Health Security Act contains language that would authorize appropriations of $180 million for FY 1995 and $200 million each year for fiscal years 1996 through 1999. The appropriations would be in addition to "amounts otherwise authorized to be appropriated". It appears that the policy side of the White House recognizes the need to improve IHS resources and capacity. However, the Office of Management and Budget proposes devastating budget cuts. The White House needs to reconcile its Indian health care budget with its Indian health care policies.

The Committee on Natural Resources needs to ask the Clinton Administration to describe the Administration's views on the implementation of Title VIII, Subtitle D, given the Administration's proposed reductions in IHS funding, staffing and facilities.

B. The Subcommittee on Native Americans should urge the Clinton Administration to approve a waiver under Executive Order 12839 to exempt the IHS from FTE reductions.

Executive Order 12839 allows: "...exemptions necessary for the delivery of essential services and compliance with applicable law." Clearly, the Indian Health Service meets the two tests for a waiver. The ITCA and many tribal governments have written to President Clinton to request that the President approve a waiver for the Indian Health Service.

The entire Department of Health and Human Services (DHHS) has been ordered to reduce its staff by 5,200 FTEs (-4%) by FY 1995. The IHS has been ordered to reduce its staff by 1,099 FTEs (-7%). In other words, the IHS has been ordered to absorb one-fifth (21%) of the entire DHHS FTE reduction. This is clearly inequitable.

The ITCA requests that the Subcommittee on Native Americans also write to President Clinton and urge the President to approve a waiver for the IHS.

C. If the Administration does not approve a waiver, the Congress should reinstate statutory language in the Interior Appropriations Act prohibiting the Administration from reducing IHS FTEs without the approval of the Committees on Appropriations.

> For many years the Interior Appropriations Act contained language that protected the staffing levels of the Indian Health Service:
>
> Provided further, That personnel ceilings may not be imposed on the Indian Health Service nor may any action be taken to reduce the full-time equivalent level of the Indian Health Service by the elimination of temporary employees, by reduction in force, hiring freeze or any other means without the review and approval of the Committees on Appropriations.

The language was originally included in the Interior Appropriations Act in recognition of the fact that the Federal government has a clear legal obligation to provide health care services to Indian tribes.

D. The Subcommittee on Native American Affairs should ask the Clinton Administration to explain the relationships between the National Performance Review and the proposed budget and FTE reductions.

The proposed FTE reductions and related restructuring for the Indian Health Service and the Bureau of Indian Affairs (BIA) are purportedly justified based upon the National Performance Review that was conducted by Vice-President Al Gore. However, the National Performance Review report does not contain any recommendations specific to the Indian Health Service or the Bureau of Indian Affairs.

The Clinton Administration should not justify budget cuts or FTE reductions based on the National Performance Review. If the Administration persists in justifying changes for the BIA and the IHS based on the National Performance Review, then the Administration should also address how the budget reductions and the FTE reductions would result in

- o improved delivery of health services to Indian tribes;
- o improved "customer satisfaction" on the part of Indian people with regard to IHS services;
- o empowering IHS service unit personnel to improve the delivery of health services to Indian people.

The proposed FTE reductions for the IHS will not achieve any of the objectives described in the National Performance Review.

E. The Subcommittee on Natural Resources should direct the Administration not to propose unrealistic increases in Medicare/Medicaid and third-party collections that would offset appropriations for Indian health services.

The Clinton Administration's proposed FY 1995 budget for the Indian Health Service projects an increase in Medicare/Medicaid and third party collections from $234 million in FY 1994 to $276 million in FY 1995. This is an increase of 18 percent (+$43 million). The Subcommittee on Native American Affairs needs to ask the Administration how it justifies the basis for increased Medicare/Medicaid and third party collections by the IHS.

The Clinton Administration needs to be reminded that the delivery of health care services to Indian tribes is a serious, and not a frivolous, matter. The planning and delivery of health care services to rural and remote Indian communities is made more difficult when the Administration does not propose budgets that are based upon realistic assumptions.

The purpose of having the Indian Health Service collect Medicare/Medicaid payments is to enable IHS and tribal facilities to meet and maintain accreditation standards. Title IV of the Indian Health Care Improvement Act, which authorizes the IHS to collect Medicare/Medicaid reimbursements, specifically states that Medicare /Medicaid collections shall not be used to offset IHS appropriations.

III. RECOMMENDATIONS TO SPECIFIC PROVISIONS OF THE HEALTH SECURITY ACT

A. Membership on the National Health Board

The membership of the National Health Board should include tribal government and Indian Health Service representation and participation to ensure recognition of the direct relationship between the tribal and federal governments and to ensure coordination of services. This is needed due to the need by IHS and tribal health programs to interface contractually with the health plans to be able to provide the full range of comprehensive benefits that may not be directly provided in an IHS or tribal facility.

B. Expansion of the National Health Service Corps

The Health Security Act does not address the expansion of the National Health Service Corps in relation to Indian health programs. A study is needed to determine what the impact has been of utilizing Commissioned Corps in the delivery of health care services to Indian people. The information generated would be important to IHS and tribal programs to determine expansion at the most critical locations. The results of the study should be disseminated to tribal leaders. Recommendations of the study should be used in individual tribal and IHS program planning to determine a conscientious approach in the utilization of Commissioned corps in Indian health

programs.

C. Comprehensive School Health Education: School Related Services

School aged youth initiatives do not expressly include Bureau of Indian Affairs (BIA), tribal schools and public schools with significant Indian populations. These schools need to be included. Presently school health and referral services are not uniformly provided by the IHS. Due to limited personnel these schools lack nursing staff, health education courses and in-service training. These duties are normally assigned to Community Health Representatives.

D. Health Plan and Health Alliance Requirements: Comprehensive Benefits Package

This section of the Health Security Act addresses the relationship of Indian health Programs with respect to health alliance requirements and verifies the ability of IHS to contract with other health plans. However the inability of the IHS to compete in a market environment with other local plans has not been addressed. The tribes are concerned about delivering the core benefits package in antiquated and inadequate facilities and systems while other plans have a competitive edge in a market driven system. The tribes are concerned that a number of Indian people may choose another health plan unless they are assured that IHS is able to restructure and acquire essential personnel in a timely manner consistent with the timeframes identified in the Act for the rest of the nation. In many areas where IHS is the sole provider, it will be imperative for IHS to provide comparable services to that of any health plan. It will be an essential activity of the IHS to effectively communicate new and existing services, enrollment procedures and eligibility requirements to Indian people defined in Section 8302 of the Act.

It is requested that if the Arizona state Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS), is one of the models for health care reform that the difficulty in implementing Medicaid covered benefits for the on-reservation population in Arizona be recognized. These difficulties include the lack of a direct funding relationship with the Health are Financing Administration, lack of intergovernmental agreements, inadequate payment systems, lack of funding for administrative and start up costs, and lack of clear policies governing state/federal/tribal relationships. The tribal experience in implementing acute care and long term care services for tribes in Arizona may prove beneficial in identifying the difficulties in implementing the comprehensive benefits package for IHS and tribal prgrams. The difficulties are pronounced when state government assumes it has authority to direct the delivery of federally and tribally operated health services. There should be a direct relationship between the Indian Health Service, the Health Care Financing Administration and tribal governments with regard to the Medicaid or publicly financed populations, with no requirements for involvement with State

Alliances.

In addition, the tribes are concerned that the Health Security Act provide adequate funding to secure the full range of comprehensive benefits and new public health programs. Funding should include start up costs for establishing new services including emergency medical services, first responder training, transportation services, long term care, home and community based services and public health prevention strategies. Notably lacking on Indian reservations are skilled nursing facilities, adult inpatient alcohol treatment centers, partial and residential mental health treatment, and hospice care facilities. Furthermore, there are no Medicaid certified home health care agencies serving on reservation developmentally disabled clients. The Act needs to clearly authorize all of these services in the comprehensive benefits package for the IHS and tribes.

E. Infrastructure, Financing and Appropriations

The Congress should support funding necessary to provide the comprehensive benefits package, including long term care and home and community based services while seeking to maintain and enhance supplemental public health services, sanitation and environmental services provided by the IHS. There must be concrete appropriations for upgrading facilities to support the delivery of services. The small tribes should not be expected to compete with larger tribes for funding facilities improvements. There should be separate funds with timely consistent approval processes. Authorized amounts in Subtitle D are not adequate to address the facilities backlog to renovate existing buildings and increase construction of needed hospitals and clinics. The Congress should support increased funding for improvements to facilities infrastructure, including sanitation and environmental health facilities in undeserved areas.

The Health Security Act provides that each IHS Service Unit, tribal program or urban Indian program will manage a local comprehensive benefits fund. The formula for the distribution of the fund should take into consideration an accurate assessment of unmet need factors including lack of facilities infrastructure, inadequate staffing and transportation needs. The open enrollment policies of some tribes for the provision of health services greatly diminish the allocation of resources. It is requested that resources follow the patient and not be transferred to the "home of record" indicated on the patients registration form if the patient no longer utilizes the "home" facility. Combined workload units should be credited to the location where the services are provided. It is also requested that IHS and the Congress include in the distribution of the comprehensive benefits fund special consideration for the status of Indian medical centers. Specialty services, acuity of care and other special requirements as referral centers should be identified and accounted for in all appropriations.

The Act should outline a direct relationship with the fiscal intermediary to IHS and tribal health departments to provide the comprehensive benefits package, public health initiatives and medicare/medicaid services. Indian set asides are needed in block grant funding proposed in the Health Security Act.

Furthermore IHS needs to quickly revisit policy interpretations which directly impact the ability of the tribes to collect federal reimbursements. This refers to differing policy interpretations by IHS and the Health Care Financing Administration which limits 100 percent federal pass-through reimbursement to programs operated by tribes or tribal organizations. In Arizona, all IHS facilities and three tribes have been approved to collect the reimbursement. There have been adverse decisions against tribally operated programs because they did not meet the "at, in or through" test, despite the fact that the tribes are providing a service within the scope and definition of IHS services.

F. Provision of Health Services to Non-Enrollees and Non-Indians

The legislation allows provision of services to non-Indian family members if the program, unit or organization determines that the provision of such services will not result in a denial or diminution of health services to eligible Indian enrollees. The section should include the word "tribe".

G. Payment by other Payers

Section 8307 (a), (b) relating to IHS as the payor of last resort should be maintained. The alternate resource rule and the payor of last resort policy should not be eliminated. The role and legal obligations of the federal government are paramount. Moreover the legal role of the states has been clarified. A practice in several states to deny state funded services to American Indians based on the special legal relationship of the tribes with the federal government has been declared a discriminatory practice. American Indian as citizens of the states in which they reside are eligible to receive state funded services.

H. Participation in Public Health Initiatives

It should be stated in the bill that Indian tribes are eligible to participate in Public Health Initiatives including health promotion disease prevention, access initiatives for urban and rural medically undeserved populations, plus grants and contracts enabling services and school health education grants. Critical concerns of the tribes reported to the IHS and the Public Health Service include:

- Establish community prevention and education activities to promote long term healthy life styles which target identifiable tribal concerns.
- Expand Early Periodic Screening Diagnostic and Treatment (EPSDT)

Services to all children served by IHS. Certification of providers needs to be expanded. Coordination is needed with the Health Care Financing Administration to enable children to receive the full range of preventive and treatment services.

IV. ADDITIONAL TRIBAL CONCERNS NOT IDENTIFIED IN THE HEALTH SECURITY ACT

A. Native traditional healers are not defined in the bill in a definition of health care provider or in relation to program delivery.

On April 14, 1992, the IHS announced the creation of a Traditional Medicine Program. The purpose of the program is to analyze current IHS interactions with traditional medicine practices, assess the knowledge base of IHS service providers, and provide training and orientation to IHS service providers and "others outside of IHS" about the uses and principles of traditional practices. This program was created to 1) meet policy provisions within the Native American Religious Freedom Act to preserve and protect the ongoing practice of health ceremonies and 2) evaluate IHS policy on payment for healing ceremonies; unless a medical doctor includes traditional medicine services in a patient's treatment plan, the IHS will not pay for related costs.

Recommendations to the Health Security Act include:

- The IHS should involve participation from traditional medicine people, healers and similar traditional leaders in the formation of a traditional healing policy and practice at each Service Unit. It should be recognized that some tribes may be willing to share information and others may choose not to discuss specific healing practices.
- IHS and other contracted providers should recognize the significance of traditional medicine and institute policy which accepts a patient's right to incorporate tribal healing practices in a treatment plan. Traditional healers, at the patients request, should be provided the opportunity to coordinate treatment plans with medical personnel.

B. Effective IHS restructuring should meet Indian Health Care Improvement Act Year 2000 goals and objectives, Health Security Act requirements, and specific tribal strategic planning. Restructuring and improving the Indian Health Service will continue to be addressed by the tribes regardless of and in conjunction with national health care reform and in light of individual state efforts at health care reform.

ITCA, Inc.
2/24/94

Mr. FALEOMAVAEGA. The Chairman had to leave this morning because he has a meeting with the leadership of the House, but I want to emphasize for the record that his absence does not mean he is not concerned about the testimonies and trying to address the problems raised in this record as it relates to the Health Security Act that has been introduced by Congressman Gephardt.

We have also Mr. Christopher Stearns.

Your testimony this morning, please.

STATEMENT OF CHRISTOPHER T. STEARNS

Mr. STEARNS. Good morning. My name is Chris Stearns, and I am an attorney with Hobbs, Straus, Dean and Wilder, and am here today on behalf of the Bristol Bay Area Health Corporation.

Bristol Bay Corporation is a tribal nonprofit corporation organized by the 32 villages of the Bristol Bay and Alaska Native villages of Alaska.

Before I go into a summary of my remarks, I wanted to remark on two things the gentleman from the administration had mentioned. The first was Dr. Robert Van Hook's statement that an Indian who lives away from an IHS facility may actually experience an improvement in health services under the Health Security Act. And I think that is probably pretty bad, or seems pretty scary to me, because that implies there are really two different levels or kinds of services within the IHS and services outside of the IHS. And he seemed to be stating that the ones outside the IHS are definitely going to be better.

The second thing I wanted to remark on was Michel Lincoln's statement that funding under Section 8313, the $40 million in fiscal year 1995, for instance, can be used for transitional funding. In theory, that is true, but there are really two things going against that: One is, first, they have not even asked for any of their money. If you look at the budget request, it is not there.

Secondly, that money is also supposed to be used for upgrading facilities, which is going to cost $3.4 billion, and for the delivery of supplemental and core benefit services. So while it is there in theory, I don't think it is realistic to think they are actually going to ask for it.

I am going to try to make this pretty quick, since I think everyone has been here for a long time.

In terms of cost, it has already been mentioned that there are three important questions: How much is it going to cost, where is the money going to come from and, probably most importantly, what happens when the cost exceeds the revenues.

In terms of cost, I guess what we are really worried about is no one at the administration seems to know how much it is going to cost. As Mike Lincoln said, they actually commissioned the study in November, and Lord knows, where all our money has been going to, but they have not even come up with a result and they are asking us to bear with them to give them some time, but we are running out of time.

You guys are going to mark up the bill soon, other people in the House are going to mark up the bill soon, and we are sort of in a very tough position. We have no idea how much it is going to cost.

And the problem that raises is that under the act, the core benefit package is an entitlement to individual Indians. And the Secretary is actually required, he is not authorized but he is required, to make sure that all IHS and tribal facilities under the 638 Act provide the core benefit package.

On the other hand, supplemental services, which as Mike Lincoln mentioned, really are public health services and probably are the backbone of the IHS system, they are not guaranteed. So the problem that we are really worried about is if there is not enough money in the system, we will have to divert funding from supplemental services just to meet the act's requirements that we guarantee full funding of the comprehensive benefit package.

I think that would definitely be disastrous. For one thing, you are going to destroy the unique balance that the IHS system has, which is a balance between clinical and preventive services. That is really unique in this country and sets the IHS system apart from everything else. Because the act requires full funding of the comprehensive benefit package and, in a sense, neglects the supplemental benefit package, I think you are going to destroy that balance.

Secondly, if you start cutting back in the key services like sanitation, like facilities, like community health representatives, you really—I just don't see any other way, but you are going to have to destroy—you are going to have to lower the health status of American Indians. You are going to reduce the status of services.

You are definitely not going to improve the IHS system. I think that would constitute a violation of the trust responsibility or of at least the Federal Government's policy as stated in the Indian Health Care Improvement Act of raising Indian health status to the highest possible level.

In summary, what I would like to suggest is that there are two things that the committee could do. One is build in a guarantee of funding into the act for provision of the comprehensive benefit package. I think that is fair. To the extent that the government wants to impose additional requirements on tribes, it should at least provide the money to do so, instead of shifting the burden back to Indian tribes.

Secondly, if you can't do that, then what I think you are going to have to do is essentially de-entitle the comprehensive benefit package. That is to give the tribes and the IHS the flexibility to allocate money between the comprehensive benefit package at something less than 100 percent level need. That would also enable the tribes to ensure that supplemental benefits are not cut or reduced. That is all I am going to talk about for the time being.

I will be glad to answer any questions that you have.

Thanks.

[Prepared statement of Mr. Stearns and attachment follow:]

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Statement of the
BRISTOL BAY AREA HEALTH CORPORATION
Submitted to the
HOUSE SUBCOMMITTEE on
NATIVE AMERICAN AFFAIRS

Hearing on the
HEALTH SECURITY ACT, H.R.3600

February 28, 1994

Presented By

CHRISTOPHER T. STEARNS
Hobbs, Straus, Dean & Wilder

Statement of the

BRISTOL BAY AREA HEALTH CORPORATION

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HEALTH SECURITY ACT, H.R.3600

February 28, 1994

The Bristol Bay Area Health Corporation ("BBAHC") is a private, non-profit corporation organized in June, 1973, by the Alaska Native villages of the region. BBAHC provides a wide variety of health services including hospital services, family medicine, mental health, dental, optometry, substance abuse treatment services, health education, and other preventive and community health services. BBAHC serves more than 7,000 year-round residents and 32 villages within the Bristol Bay and Calista regions, two of the twelve regions into which Alaska was divided under the Alaska Native Claims Settlement Act in 1971. The Bristol Bay region encompasses a portion of southwest Alaska that is approximately the size of Ohio. In 1980, BBAHC became the first tribal organization in the United States to take over the operation of a hospital from the Indian Health Service ("IHS") under the authority of the Indian Self-Determination and Education Assistance Act. The Kanakanak Hospital has been accredited by the Joint Commission on the Accreditation of Healthcare Organizations since 1973.

While we support the Administration's efforts to control national health care spending and to provide universal health care coverage, we are seriously concerned that the Health Security Act (the "Act"), if enacted by Congress as it is presently written, may actually do more harm than good in Indian country. Due to the number of issues raised by the Act and the limited space available within the record, we will direct our testimony to the following issues:

- Financing
- Competition with regional alliance plans
- Services to non-Indians
- Benefits
- Eligibility
- Risk sharing
- Trust responsibility

In preparing our testimony, we analyzed the Act in terms of policy and implementation. For instance, among the policy issues raised are: (1) does the Act contain measures that will actually raise the health status of American Indians and

Alaska Natives; (2) will the Act improve the quality of health care delivery within Indian country, i.e. improve the IHS system; (3) will the Act uphold the federal trust responsibility towards American Indian and Alaska Native tribes and individuals; and (4) will the Act strengthen the government-to-government relationship and promote tribal self-determination? As for implementation within Indian country, the Act contains a number of laudable goals, but does not appear to be structured in such a way as to attain those goals. For instance, the Act's guarantee of the delivery of the comprehensive benefit package through the IHS system is certainly desirable, but without proper funding, the consequences of that guarantee -- diversion of funding from equally-important "supplemental" services -- will likely be disastrous.

1. FINANCING

In theory, the Act is quite simple. The Act provides that all eligible Indians and Alaska Natives will be entitled to the benefits contained in the comprehensive benefit package ("CBP") by 1999. In addition, the Act assumes that the IHS will continue to provide at least some level of supplemental services, i.e. those services and benefits which are not part of the CBP but which the IHS currently provides. Supplemental services thus include such fundamental programs as community health representatives, public health nursing, facilities construction, and environmental health services. The use of the term "supplemental services" is highly misleading since it tends to minimize the importance of services which set the IHS system apart from all other health care systems in the country.

Since the CBP will include some services which the IHS does not currently provide, such as long-term care, or services which are provided on a demonstration project basis, such as home health and hospice care, IHS funding will have to increase, both in terms of start-up costs, and on an annual basis thereafter, in order to provide these services. The Act also provides that all Indians, whether or not they choose to enroll in the IHS system, will remain eligible for supplemental services. In addition, the Act also directs that the Secretary of Health and Human Services (the "Secretary"), through the IHS, may spend amounts appropriated under section 8313 of the Act for the construction and renovation of IHS and tribal facilities in order to ensure that such facilities can actually deliver the CBP by 1999. The IHS has stated that only 15 of the 505 facilities in the IHS system have that capability now.

At the risk of oversimplifying the debate, we believe that tribal support for the Act may rest on the answers to three very simple questions -- (1) how much will all of additional requirements in the Act cost; (2) where will the money come from; and (3) and what will happen to Indian tribes if projected costs exceed projected revenues? The Act tells us very little about what revenues the IHS and tribes can expect to receive under the Act, and tells us even less about the costs of providing the CBP and supplemental services. The Act, however, does give us a clear picture of what will happen if costs exceed revenues, and that picture is very disturbing.

a. **Costs**

The cost to the IHS and Indian tribes of providing health care under the Act will likely be staggering. In FY 1994, Congress appropriated a little more than $1.9 billion to the IHS. At the same time, the IHS has acknowledged that it is only meeting 49% of the level of need within Indian country. Furthermore, the IHS has acknowledged that a serious backlog, in excess of $1.6 billion, in sanitation needs exists. As previously mentioned, only 15 of the 505 facilities within the IHS system have the capacity to provide all of the services contained within the CBP. In order to upgrade IHS and tribal facilities so that all eligible Indians could receive services to which they would be entitled under the CBP, the IHS has conservatively projected a cost of $3.4 billion, which does not include an additional annual maintenance cost of $400 million. In what looks like an attempt to cut back the federal government's trust responsibility, the Act asks that tribes shoulder the lion's share of construction and renovation costs through a revolving loan fund, since (1) federal outlays are limited to $1.02 billion over a six year period, and (2) those same outlays must also help pay for the cost of the delivery of the CBP as well as supplemental benefits. The fact that the Administration's FY 1995 budget request seeks zero dollars in construction funding (despite section 8313(a)'s authorization of up to $40 million), makes us wonder whether the Administration ever intends to spend any money on facilities construction and renovation.

Perhaps the greatest problem, however, that we have with the Act is that no one within the IHS nor anywhere else in the Administration seems to know how much it will cost to provide the guaranteed level of CBP services as well as adequate, if not enhanced, level of supplemental benefits to Indian country. We have been told that the IHS contracted with an actuarial firm to conduct a study of the costs and that the actuarial firm has briefed the IHS on its preliminary analysis. The IHS, however, refuses to share those figures with Indian country. We are also concerned that the actuarial study will only address the cost of providing the CBP -- which is only half of the equation. Indian country, and the Subcommittee, needs to know how much the provision of the CBP *and* supplemental services will cost.

Nevertheless, we understand that recent IHS estimates place the cost of providing CBP services at approximately $4.2 billion a year. This figure is based on an assumption that only 80% of presently eligible Indians will elect to stay in the IHS system. Given the fact that IHS is currently only meeting 49% of the level of need across Indian country, we believe that actual costs may run far higher. In addition, earlier IHS estimates placed the cost of providing supplemental services at $800 million per year. Unfortunately, that IHS figure was not based on an actual calculation but was simply the amount which the IHS believed would be left over after funding of the CBP. After a review of the Administration's FY 1995 budget justification, we believe that simply maintaining the present level of supplemental services in the IHS system would cost at least $1.1 billion annually. Even if we assume that tribes will bear the financial responsibility (through the revolving loan fund in section 8310(b)) for one-half of $3.4 billion cost necessary to upgrade IHS

facilities, there still remains an additional annual maintenance cost of $400 million, as well as the $1.6 billion backlog in sanitation deficiencies. Thus, it is apparent that simply meeting the requirements of the Act -- that the IHS and tribes ensure the delivery of services under the CBP -- while still maintaining the present level of supplemental services, would require the IHS to receive a massive infusion of funding within the next five years, at least $3.3 billion, followed by annual appropriations of at least $5.7 billion. Where will the money come from?

b. Revenues

The Act specifically sets forth nine sources of revenues, which must fund both the delivery of the CBP and supplemental benefits. Revenues consist of:

Two continued sources —

- IHS appropriations
- Third-party payments

Seven new sources —

- Section 8303 funding for supplemental benefits ($180 million in FY 1995; $200 million in FYs 1996-1999; such sums as necessary thereafter)
- Section 8313 funding for CBP and supplemental benefits ($40 million in FY 1995; $180 million in FY 1996; $200 million in FYs 1997-2000)
- Employer premium payments (§1351(e)/§ 6121)
- Premium discount payments (§ 8314)
- Contractual arrangements with private plans (§ 8306(a))
- Family premiums and other charges (§ 8306(b))
- Essential Community Provider arrangements (§ 8306(c))

With the exception of specified funding amounts under sections 8303 and 8313, no one seems to have any idea how much revenue will be brought in by any of the new funding sources. Given the enormous costs of health care reform within Indian country, the limited funding authorized in sections 8303 and 8313 seems quite paltry, especially in light of the fact that the Secretary may use some or all of the section 8313 funding for the upgrade of IHS and tribal facilities, at cost of $3.4 billion. Furthermore, appropriations under section 8313 are authorized only through FY 2000.

As for third-party reimbursements, reality dictates that these will not significantly increase over the next ten years. The IHS estimates that private third-party collections will bring in slightly under $19 million in FY 1994. The IHS also estimates that Medicare and Medicaid collections for FY 1994 will total slightly more

than $154 million. Thus, even under the most optimistic of scenarios, it is unlikely that third-party collections would provide a significant portion of the revenues necessary to fund the CBP and supplemental services under the Act.

We also expect that revenues from section 8306(a) contractual arrangements, section 8306(b) family premiums and co-charges, and section 8306(c) essential community provider arrangements will not significantly add to the IHS funding base because: (1) such arrangements are not required under the Act; (2) such arrangements will vary from region to region; and (3) the revenues from these arrangements will only cover the costs of serving non-Indians.

As for the two other sources of revenue -- employer premium payments and federal premium discount payments -- we are very skeptical that these sources can be relied on in order to make up a significant portion of the large gap between needed revenues and actual costs. Because the Act requires that employer premium payments be deposited in local CBP funds, the flow of these funds to Indian country will vary greatly, depending, of course, on the level of employment within particular service areas. In other words, tribes with high levels of unemployment will experience minimum benefits while tribes in areas with high levels of employment will likely receive larger employer premium payment revenues.

Section 8314 federal premium discounts may provide a significant source of new revenues to the IHS, but in order for such revenues to even reach $1 billion, the Secretary must determine that nearly the entire IHS population is entitled to substantial individual or family premium assistance if enrolled in private plans. We note that earlier IHS estimates placed premium discount payments at $532 million. Unfortunately, premium assistance is somewhat limited under the Act. The Act provides that only families receiving benefits from Aid to Families with Dependent Children or Supplemental Security Income and people whose incomes are below a very low threshold ($1,000 in 1994, inflated by CPI thereafter) would not have to pay the family or individual portion of plan premiums. CBO calculates that individual and family premiums would range between $420 to $2,532. A family's obligation would rise with income so that a family with income at 150% would only have to pay 20% of the family portion of weighted average premium or 3.9% of income, whichever is lower. Premium assistance is capped at 3.9% of income for all families with incomes less than $40,000. Given these figures, we do not believe that premium discount payments pursuant to section 8314 will create a new funding source sufficient to make up the gap between expected costs and expected revenues.

Thus, even under the most optimistic of scenarios, the viability of health care reform under the Act probably rests upon Congress' ability to more than double IHS appropriations. Given the budget caps under which the Appropriation committees operate, we are skeptical that this will happen. Given the FY 1995 IHS budget request, it appears that the Administration is not even willing to ask Congress to try.

c. When Costs Exceed Revenues

The Act, for all of its ambiguities, is very clear on one point -- the Secretary must ensure that all IHS health programs provide the CBP by January 1, 1999. The Act would thus entitle Indians and Alaska Natives to CBP services. Indians and Alaska Natives, however, would not be entitled to supplemental services, such as the community health representatives and sanitation programs which are critical to the delivery of health care in Indian country. Thus, should costs exceed revenues, the IHS will have no choice but to reduce spending on supplemental services in order to ensure that the CBP can be delivered. Tribal organizations, such as ourselves, providing health services under the Indian Self-Determination Act will be similarly forced to cut supplemental services in order to fully fund CBP services. Thus, the Act may actually destroy the unique balance which the IHS has struck between clinical and preventive services, by requiring that financial resources be first devoted to the provision of CBP services. More importantly, should funding levels be inadequate, there is no question that the quality of health care delivery to Indians will diminish, that services to Indians will be restricted, that access to health care will be reduced, and Indian health status will decline. Such a result would violate the federal trust responsibility to Indians and Alaska Natives in the field of health care as affirmed by the Indian Health Care Improvement Act.

In order to avoid such a disaster, we propose two alternative solutions. The purpose of both solutions is to ensure that the delivery of present IHS and tribal programs are not diminished under the Act. While the first solution would ensure both the delivery of the CBP and at least the present level of supplemental services, the second solution would not guarantee full funding of the CBP. The first solution would be for Congress to amend section 8313 to guarantee that appropriations pursuant to section 8313 are sufficient to ensure the delivery of the entire CBP. We prefer this approach. *See* Amendment No. 1. The federal government's unique trust obligation to provide health care to American Indians and Alaska Natives dictates that when the federal government chooses to impose additional service requirements on the IHS and tribes, as the Act does, it must provide sufficient funding for those additional services. Otherwise services will be cut, or else tribes will be forced to spend their own funds to pay for the costs of the additional requirements.

If the federal government cannot guarantee sufficient funding necessary to ensure delivery of the CBP and a beneficial level of supplemental services, Congress should remove the requirement that all health programs of the IHS must provide the CBP by January 1, 1999. This amendment would provide the IHS and tribes with the flexibility to allocate whatever limited resources they would receive under the Act between CBP and supplemental services in a way which would not jeopardize the continued existence of critical supplemental services. Such flexibility would also defer to the tribal authority in health care which has been fostered in the Indian Self-Determination Act and the Indian Health Care Improvement Act. *See* Amendment No. 2.

2. COMPETITION WITH REGIONAL ALLIANCE PLANS

The Act would guarantee that all Americans receive the comprehensive benefit package by January 1, 1998, but would require American Indians and Alaska Natives to wait until January 1, 1999, in order receive the same benefits. The Act would also provide states with a number of financial incentives to establish regional health alliances or single-payer systems before 1998. For instance, states may receive large planning grants and may provide further risk adjustments and extra health care services in order to attract population groups with limited access to care because of geographic location, income levels, or racial and cultural differences. The IHS and tribes would receive no such support. We believe that this arrangement would put the IHS and tribes at a clear disadvantage in meeting the obligation to provide the comprehensive benefit package.

We are concerned that if the IHS and tribes will not be able to offer the comprehensive benefit package prior to 1999, then they may lose many of their members to private plans that can offer the comprehensive benefit package by 1998. Many tribal members might be willing to pay the additional costs necessary to receive health care through a private plan offered through a regional alliance, especially if: (1) the private plan offered the comprehensive benefit package at a time when the IHS or tribe did not; (2) the additional cost of enrolling in the private plan would be substantially reduced by federal low-income subsidies; and (3) tribal members enrolling in private plans would still receive all of their current supplemental benefits from the IHS. If tribal members opt to leave the IHS system, then the resulting reduction to the tribes' user population base would likely lead to a proportionate reduction in IHS funding and, more importantly, to a loss of tribal autonomy. Tribes have fought long and hard for the right to assume control of federal programs and serve their own members, especially in the field of health. We feel that if the Act remains as written, it would deal a major setback to the federal policy of tribal self-determination.

The most effective way to prevent a mass exodus from the IHS system may be to ensure that IHS and tribal programs remain competitive with the regional alliance plans. Thus, the federal government should take steps to ensure that IHS and tribal programs will be in a position to offer the comprehensive benefit package at the same time that the surrounding states do. Accordingly, we suggest that the Act be amended to provide the IHS and tribes with similar incentives and financial assistance to that given the states. These include technical assistance from the National Health Board pursuant to section 1503 (f)(3); planning grants pursuant to section 1515(a); grants for start-up support pursuant to section 1515(b); and transitional assistance in an amount similar to that granted to the Department of Veterans Affairs in section 8102(a)(2). *See* Amendment No. 3.

3. SERVICES TO NON-INDIANS AND NON-ENROLLEES

The Act, in some instances, would authorize the IHS to offer services to non-beneficiaries without tribal authorization, thus abrogating the terms under which such services can now be provided under section 813 of the Indian Health Care Improvement Act. While tribal authorization for such services would still be required if IHS services are provided by a tribe or tribal organization pursuant to an Indian Self-Determination Act contract or Self-Governance compact, tribes which receive services directly from the IHS will lose the right to object to the expansion of services to non-Indians. The loss of this right stands in contradiction to the principles inherent in a government-to-government relationship and the federal policy of Indian self-determination. Furthermore, the Act requires the IHS to make a finding that the extension of services to non-Indians will not reduce services to Indians before entering into contracts with private plans, but does not require the IHS to make a similar finding before serving non-Indian family members or entering into essential community provider arrangements.

The Act provides that a "health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program may enter into a contract" with a private health plan in order to provide services to individuals enrolled in that plan. Section 8306(a). In order to preserve tribal rights vested under section 813 of the Indian Health Care Improvement Act, and to prevent the IHS, where it directly operates a health program or service unit, from unilaterally entering into contracts with private health plans to serve non-Indians, section 8306(a) should be amended to require tribal authorization. *See* Amendment No. 4.

Section 8306(b) of Act provides that a "health program of the Indian Health Service may open enrollment to family members" of eligible Indians. If a health program is directly operated by the IHS, then the IHS will have the authority to unilaterally open services to non-Indian spouses and children without the consent of the tribes served by the program. Since this provision of the Act is inconsistent with section 813 of the Indian Health Care Improvement Act, which authorizes the delivery of services to non-eligible spouses only if authorized by tribal resolution, we suggest that section 8306(b) be amended to require tribal authorization. *See* Amendment No. 5.

The Act provides that a "health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program" may elect essential community provider ("ECP") status. Sections 8306(c) and 1582(a). ECP status is designed primarily to ensure that private health plans do not purposely avoid contracting with clinics or facilities serving remote or other underserved populations. As with subsections 8306(a) and (b), we believe that the decision to elect ECP status must rest with the tribes themselves. Therefore, we propose that section 8306(c) be amended to require tribal authorization prior to election of ECP status. *See* Amendment No. 6.

4. BENEFITS

While the Act provides that the Secretary must ensure that all IHS and tribal health programs offer the CBP by January 1, 1999, the rest of the United States population, however, would be entitled to the CBP a year earlier. We are unsure why Indians are singled out as the only population which will not receive the benefits of the CBP by 1998. Unfortunately, this provision gives the appearance that the Administration is not as fully committed to the delivery of health care to Indians and Alaska Natives as it is to the rest of the United States population. In order to ensure that American Indians and Alaska Natives are treated equally with all other Americans, section 8304(a) of the Act be amended to provide for an effective date of January 1, 1998. *See* Amendment No. 7.

Section 8301(1) defines a health program of the IHS (including tribally-operated programs and urban Indian programs) in terms of facilities. This definition, however, creates certain ambiguities in other sections of the Act. For example, a tribe operating a program pursuant to the Indian Self-Determination Act that includes a number of facilities or clinics would, under the Act, be operating several "programs". This may lead to administrative problems given that the Act allows for election of services to non-Indians on a program-by-program basis, and further provides for the establishment of comprehensive benefit package funds on a program-by-program basis. We recommend that the term "facilities" be deleted from the definition in order to eliminate these ambiguities. *See* Amendment No. 8

5. ELIGIBILITY

We believe that the geographic residency requirement which now limits eligibility for IHS services should be eliminated. Residency requirements have resulted in the loss of services to Indians who, for various reasons, no longer reside within Indian country or in areas in which an urban Indian program is located. We do not read a residency requirement into the United States' unique trust obligation to provide health care to American Indians and Alaska Natives. In addition, elimination of the geographic residency requirement would accomplish one of the Administration's major goals -- portability of benefits. Therefore, we recommend that section 8302(a) of the Act be amended to eliminate the geographic residency requirement. *See* Amendment No. 9

6. RISK SHARING

Section 8301 defines IHS and tribal health programs on a facility-by-facility basis. Section 8311 calls for the creation of a comprehensive benefit package fund for each health program, consisting of revenues obtained from a number of sources, described in the financing section above. The danger of creating individual CBP funds on a facility, tribal, or even service unit basis, however, is that the amounts deposited in each CBP fund would, in many instances, be insufficient to absorb the

costs of a major health catastrophe. In other words, the Act would create dangerously small risk-sharing pools, especially in the case of smaller tribes.

For non-Indian plans, the Act mandates minimal capital standards which plans must meet in order to participate in the alliance system. For instance, plans would have to maintain at least $500,000 of capital in order to participate. Section 1551. The National Health Board could also establish additional standards, including standards based on the projected number of plan enrollees and the extent and nature of risk-sharing with participating providers. In general, the Act anticipates that risk will be shared on a regional or state-wide basis. The Act, however, would not set such minimum standards for IHS and tribal programs. While the drafters probably did not intend to create risk-sharing pools with less than 1,000 members, small tribes may find themselves in just that situation.

We suggest that the Act include a broader-based risk distribution system which spreads risk among Indian tribes on an area-wide basis in conjunction with a federally-funded reinsurance program for Indian health programs similar to that created for state plans under section 1541(c) of the Act. *See* Amendment No. 10.

7. TRUST RESPONSIBILITY

The federal government's trust responsibility for the delivery of health care to American Indians and Alaska Natives is a unique commitment arising out of treaties, statutes, the United States Constitution, case law, and the government-to-government relationship between Indian tribes and the federal government. For instance, through treaties, Indian tribes agreed to cede to the United States millions of acres of land holdings and other resources. In exchange, the United States promised to provide health care to the Indian tribes in partial compensation for the ceded lands and other resources. Through statutes, such as the Snyder Act, the Indian Health Care Improvement Act, and the Indian Self-Determination and Education Assistance Act, Congress has unambiguously stated the unique obligation of the federal government to provide health care to all Indian and Alaska Native tribes. The courts have affirmed this obligation. We believe that the Act should clearly set forth the federal government's trust obligation to provide health care to American Indians and Alaska Natives. *See* Amendment No. 11.

CONCLUSION

We are concerned that the Health Security Act may unintentionally result in a reduction in critical health services to American Indians and Alaska Natives. Therefore, we ask that the Subcommittee on Native American Affairs give careful consideration to the amendments we have presented before taking action upon H.R. 3600. We thank the Subcommittee for the opportunity to present this testimony and offer our assistance in the revision and further drafting of the Act.

Amendment No. 1

Page 1261:

"**SEC. 8313. AUTHORIZATION 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~~ --

(1) guaranteeing the delivery of federal health care services to American Indians and Alaska Natives in fulfillment of the federal government's unique trust responsibility and legal obligation to the American Indian and Alaska Native people;

(2) guaranteeing sufficient funding for the provision of the comprehensive benefit package at one-hundred percent level of need to all eligible beneficiaries under this subtitle;

(3) raising the health status of American Indians and Alaska Natives to the highest possible level;

(4) raising the quality of health care delivery to American Indians and Alaska Natives to the highest possible level; and

(5) ensuring that the federal government delivers health care services to American Indians and Alaska Natives in such a way that is consonant with and effectuates this Nation's recognized Indian self-determination policy,

there is hereby authorized to be appropriated for each fiscal year a sum sufficient to provide the comprehensive benefit package at one-hundred percent level of need to all eligible beneficiaries under this subtitle.

(b) RELATION TO OTHER FUNDS.-- The authorization 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."

Amendment No. 2

Page 1252:

"**SEC. 8304. HEALTH PLAN AND HEALTH ALLIANCE REQUIREMENTS.**

(a) COMPREHENSIVE BENEFIT PACKAGE. -- The Secretary shall ensure, subject to the requirements of paragraph (b), that the comprehensive benefit package is provided by all health programs of the Indian Health Service effective January 1, ~~1999~~ 1998,* notwithstanding section 1001(a).

(b) SUPPLEMENTAL BENEFITS. -- The Secretary shall ensure that the requirements of this subpart do not result in a reduction of the level of supplemental benefits provided within the Indian Health Service system."

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* See Amendment No. 7

Amendment No. 3

Page 261:

"(f) PARTICIPATING STATE REQUIREMENTS. -- Consistent with the provisions of subtitle C, the Board shall --

(1) establish requirement for participating States,

(2) monitor State compliance with those requirements, and

(3) provide technical assistance to States and programs of the Indian Health Service, ~~and~~

in a manner that ensures access to the comprehensive benefit package for all eligible individuals."

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Page 273:

"**SEC. 1515. FEDERAL SUPPORT FOR STATE AND TRIBAL IMPLEMENTATION**

(a) PLANNING GRANTS. --

(1) IN GENERAL. -- Not later than 90 days after the date of the enactment of this Act, the Secretary shall make available to each State and programs of the Indian Health Service a planning grant to assist a State or a program of the Indian Health Service in the development of a health care system to become a participating State under subtitle C or, in the case of a program of the Indian Health Service, to ensure the delivery of the services described in Title VIII, subtitle D of this Act."

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Page 274

"(b) GRANTS FOR START-UP SUPPORT. --

(1) IN GENERAL. -- The Secretary shall make available to States, upon their enacting enabling legislation to become participating States, and at the same time, to programs of the Indian Health Service within those States, grants to assist in the establishment of regional alliances, or in the case of programs of the Indian Health Service, to assist in the delivery of the services described in Title VIII, subtitle D of this Act."

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Page 1262:

"**SEC. 8315. TRANSITIONAL ASSISTANCE.**

In addition to the assistance provided to the Indian Health Service, tribes and tribal organizations, and urban Indian programs pursuant to sections 1503 and 1515 of this Act, there are authorized to be appropriated $350,000,000 for fiscal year 1995, $750,000,000 for fiscal year 1996, $950,000,000 for fiscal year 1997, and $850,000,000 for fiscal year 1998 for the purpose of assisting health programs of the Indian Health Service deliver the comprehensive benefit package at the same time as the states in which the health programs of the Indian Health Service are located."

Amendment No. 4

Page 1253:

"**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 organization, 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 only if --

(A) The ~~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 by such program, unit, or organization; and

(B) The program, unit, or organization obtains the authorization of the tribe or tribes which it serves."

Amendment No. 5

Page 1254:

"(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) only if the health program obtains the authorization of the tribe or tribes which it serves."

Amendment No. 6

Page 1257:

"(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)~~ (3) 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) TRIBAL AUTHORIZATION. -- In order to make the election described in paragraph (1), the health program, service unit, tribal organization described in paragraph (1) must first obtain the authorization of the tribe or tribes which it serves."

Amendment No. 7

Page 1252:

"**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~~ 1998~~, not withstanding section 1001(a)~~."

Amendment No. 8

Page 1249:

"**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 including programs operated by ~~through a facility of~~ the Indian Health Service, a tribe or tribal organization under the authority of the Indian Self-Determination Act or a self-governance compact, ~~or an~~ and urban Indian programs;"

Amendment No. 9

Page 1250:

"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~~;"

Amendment No. 10

Page 1259:

"**SEC. 8311 FINANCING.**

(a) ESTABLISHMENT OF FUND. -- Each ~~health program~~ area of the Indian Health Service shall establish a comprehensive and supplemental benefit package fund (hereafter in this section referred to as the 'fund')."

Page 1260:

"(c) ADMINISTRATION AND EXPENDITURES. --

(1) MANAGEMENT. -- The fund shall be managed by the health program of the Indian Health Service, as defined in section 8301(1).

(2) EXPENDITURES. -- Expenditures may be made from the fund to provide for the delivery of the items and services of the comprehensive benefit package, and for any other items and services described in this subpart, under the health program of the Indian Health Service."

(3) AVAILABILITY OF FUNDS. -- Amounts in the fund established by a ~~service unit~~ health program of the Indian Health Service under this section shall be available without further appropriation and shall remain available until expended for payments for the delivery of the items and services ~~in the comprehensive benefit package~~ described in paragraph (2).

(4) REINSURANCE. -- The Secretary shall establish a reinsurance program under which health programs of the Indian Health Service may make payments to the reinsurance program for the purpose of reinsuring all or part of the health care expenses for items and services included in the comprehensive benefit package and other items and services described in paragraph (2)."

Amendment No. 11

Page 1249:

"SEC. 8301 CONGRESSIONAL DECLARATION OF POLICY

The purpose of this subchapter is --

(1) to guarantee the delivery of federal health care services to American Indians and Alaska Natives in fulfillment of the federal government's unique trust responsibility and legal obligation to the American Indian and Alaska Native people;

(2) to guarantee sufficient funding for the provision of the comprehensive benefit package at one-hundred percent level of need to all eligible beneficiaries under this subtitle;

(3) to raise the health status of American Indians and Alaska Natives to the highest possible level;

(4) to raise the quality of health care delivery to American Indians and Alaska Natives to the highest possible level;

(5) to ensure that the federal government delivers health care services to American Indians and Alaska Natives in such a way that is consonant with and effectuates this Nation's recognized Indian self-determination policy."

Mr. FALEOMAVAEGA. Thank you, Mr. Stearns.

I wonder if Mr. Lincoln is still here.

Mr. STEARNS. He left a long time ago.

Mr. FALEOMAVAEGA. I appreciate your comments and certainly your suggestions. I know that over the years this one area has always been a very difficult situation for the Indian Health Service and, for that matter, for the whole Bureau of Indian Affairs always the problem of adequate annual funding levels. The spirit and intent of H.R. 3600, as I read it, is to give the tribes a choice to participate in the health alliance proposal as President Clinton has it in his bill, or to maintain the present structure of the Indian Health Service.

Your suggestion that we provide some guaranteed level of funding. I wish it was possible to guarantee funding on a yearly basis. Since we have tried to balance the budget for the last 15 years, we have ended up with what, $4 trillion debt now? I think the intent of the legislation is, as the Chairman has indicated earlier, not so much that we are looking at the dollar situation, but the organizational and the structural situation that perhaps the services can be provided on a much better basis.

Now, as you well know, the proposal that President Clinton has provided, this alliance, the regional alliances is a brand-new imaginative creation by Mr. Ira Magaziner other members of the Clinton team, including Hillary Rodham Clinton's idea that these regional alliances be established to provide for this kind of health service system. I think legislatively what we are trying to do here is to give the tribes those options, you either want to try the alliance system or you want to maintain the same situation that we are under now, with the limited funds, so far as the resources are concerned. So, I think this is something that your tribes will have to really examine a little closer and see if the present situation might be better than what you might be getting if you decide to opt for the alliance concept that President Clinton currently has in his proposed health care security system.

I am sorry, I wasn't here earlier to hear Ms. Davis' testimony concerning the Nez Perce Tribe in Idaho. But I think one of the complications that we have here as well, just as it is among the Indian tribes, is that there is no sense of oneness as far as problems, as far as the numbers, as far as the situation. I sense that your situation up in Alaska is quite different from how some of our tribes here in the Continental U.S. provide for their health care system.

And maybe Mr. Stearns, you can elaborate a little further on how Alaska provides for this as far as the Alaska Native corporations provide for health care? Can you elaborate a little further?

Do you seem satisfied with the current situation, given the fact that we recognize the limited resources and funding has always been the problem?

Mr. STEARNS. With respect to Alaska, I can only speak to Bristol Bay which was the first tribal organization to take over the operation of an IHS hospital back in 1973. The answer is probably yes and no, I mean, I think the IHS does actually do a pretty good job in terms of delivering, in terms of delivering health care services.

Earlier Mike Lincoln had said it cost about $1,250 or $1,300 per capita, which is actually pretty good.

What usually happens in lower-income areas or providers that serve low-income people, they are much more efficient. And that is one of the things that I think we can do a lot with the money that comes in. In terms of actually, you know, trying to guarantee funding, I know that obviously you are not an Appropriations Committee.

You are an authorization committee, but one of the things that I think we would like to look at is to the extent to which we can incorporate an entitlement to the comprehensive benefit package funding. I know that this probably isn't the best atmosphere to be seeking additional entitlements but it might be something that is possible given the extreme cuts that are being proposed in terms of medicaid. Maybe that could be one offsetting factor.

Also, I think that we are different. Certainly, we are different. And we have different needs in Alaska. But there are probably a lot of areas where there is consensus within all Indian country. And I think we share the same concerns that many tribes across the country do have. I hope that answers your question.

Mr. FALEOMAVAEGA. Well, I think there is no question about what you have just stated.

Ms. Davis.

Ms. DAVIS. Yes, I would like to comment. I would like to make one correction. I am the Vice Chair of the Nez Perce Tribe, but I testify here today for the National Indian Health Board and the Northwest Portland Indian Health Board. But regarding your question, Indian Health Service does do a good job but it could be better. And I think that the regional health alliance question that you asked, if tribes would—I think how I feel—this is just my opinion as a tribal council member—is that we have a special trust responsibility with the Federal Government. And the Indian Health Service provides those services to our Indian people. And I think not all tribes would be amenable to endorse the regional health alliance because that would mean that they would have to work with the States, which some tribes do not have a good relationship with the States.

And I think that as you stated earlier, that the tribes really need to look at this. And I am going to say again, as I stated earlier, the funding for these things needs to be put in place so that tribes can look at this accurately and really get a good picture of what this is going to do.

Also, the money that the health alliances have, they have that to already implement, and here the tribes are still in the back seat again. We don't have any funding to even start looking at that concept.

Thank you.

Mr. FALEOMAVAEGA. Ms. Montiel?

Ms. MONTIEL. The tribes in Arizona have endorsed, and we have submitted letters and position papers as well, to President Clinton, that we do support the continuation of the Indian Health Service and the expansion of the Indian Health Service to provide the comprehensive benefits package. My project also covers the health project, as coordinator, Inter Tribal Council of Arizona, and we

have an liaison project that includes all the tribes in the Phoenix area. And for the most part, except in the urban areas such as in Phoenix, the tribal members are not going to have access to health alliance services, for the most part.

IHS is the sole provider in those States. The tribes, particularly in Nevada, they are largely using contract health dollars. And they have their health centers and they rely on contract health dollars to provide the additional range of services. So we are looking forward to incorporating and elaborating the services that Indian Health Service is providing now.

For example, on the reservations in the three-State area, we have limited emergency medical services. As you know, no long-term care and home and community-based services are limited. We lack skilled nursing facilities, adult inpatient alcohol treatment centers, we lack partial and residential mental health treatment and hospice care facilities. And all of these are identified in the comprehensive benefits package. So we do endorse maintaining Indian Health Service.

Mr. FALEOMAVAEGA. I think one of the problems, is that the Indian health care system has not been seen as a priority in terms of providing for the health care needs of Native Americans throughout the country. It is always the bottom of the barrel as far as the services are concerned. I suppose the question that is raised here is whether or not there is going to be an improvement of the delivery of these health care services to Indian country under this new Health Security Act, given these options.

Mr. STEARNS. I guess this is pretty tough, but the answer is in theory, sure. In theory, we are going to get long-term care. We are going to get hospice care. We are going to get home health care. You know, in theory, every Indian will have—is guaranteed all the services, plus all the things in the comprehensive benefit package, many of which are not available to Indian tribes, especially on the contract care basis. But the question is, is there enough in the act to actually make the plan work? Can it be implemented?

And I don't want to just harp on funding but without proper funding, you can't make the thing work. What I am worried about is having something that is appealing in theory and appalling in practice.

Mr. FALEOMAVAEGA. My point is, and I make this as an observation. Over the years, the delivery of Indian health care services has been the bottom of the barrel as compared to all the health care systems that our country currently provides. And my question is, is this legislation going to be in some ways an improvement, or is it just going to be maintaining the status quo of providing the proper health care services to Indian country?

Over the years, even to the present times, it has been totally inadequate. That is my observation that I make on this. We can be talking about this in theory the same way that President Clinton is saying that he wants to guarantee that every American be given the best possible health care under the circumstances, whether you are rich or poor, or middle-class, or whatever.

But I make this observation of all the people in this country, Indians or Native Americans have been the worst off. The challenge is going to be here in the Congress as well as in the administra-

tion. How can we increase the level of delivery in providing the proper health care services to Indian country under the circumstances?

I am not saying it as a matter of theory, but I am saying it as a matter of fact, that that is what we are faced with. And perhaps in some way—I don't know, sometimes the administration plays numbers saying that they would kill 300 programs and it makes them feel better to say that we are cutting waste and fraud, and so forth, and that some of these programs are so small and it doesn't even so much as buy a $5 billion aircraft carrier, but to the poor people that need to improve their teacher education, and so forth, they are very, very valuable programs. So we are trying to see what can be done.

We know that there are complications and that every tribe has different needs. The situation in Alaska is very, very different from the situation here in the Continental U.S. This is the very reason, if there are ways of assuring you, Mr. Stearns, and the others on the panels, we don't have all the answers to these questions, especially here in this Committee. We are very grateful that you were able to travel and to provide this kind of testimony and input in the process.

Hopefully, we can find some way, in whatever possible amendments that can be made to the bill, that will improve the whole delivery system as far as health care is concerned for Indian country.

And I know that this is going to continue. We are going to have more hearings. I essentially would like to encourage your colleagues and your networking of all the tribes around the country. Please let them know that we are very interested in your input and we want to proceed to get a sense of where we are going to end up, as far as getting the final draft for purposes of our debate and, hopefully, approval of this whole health care package by the end of this Congress.

So please don't feel that the door is closed at any time. We are still open to your suggestions. I hope it is not just in whispers, but I hope that Indian country out there is really raving and making sure that we know, that the staff knows, and that Chairman Richardson knows, what some of the unique situations that should get our attention and make sure that we follow up so that we can provide the best possible services to Indian country out there as far as health care is concerned.

Did you have any further comments?

We are leaving the record open for the next two weeks. Talk it over in Indian country. We need your input and we really appreciate your presence.

Thank you very much. The committee hearing is adjourned.

[Whereupon, at 12:24 p.m., the subcommittee was adjourned.]

APPENDIX

FEBRUARY 28, 1994

ADDITIONAL MATERIAL SUBMITTED FOR THE HEARING RECORD

TIM JOHNSON
SOUTH DAKOTA

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STATEMENT OF REP. TIM JOHNSON
NATIVE AMERICAN AFFAIRS SUBCOMMITTEE
FEBRUARY 28, 1994

Mr. Chairman, I ask unanimous consent so that my remarks can be included in today's hearing record. I regret that I am unable to be present at today's hearing. I commend you, Representative Richardson, for holding today's critically important hearing on the Indian provisions in the Health Security Act.

I applaud the Clinton Administration's efforts to reform the health care delivery system in our country. Even though our country has the best health care in the world, there are still gaps in delivering that care to certain segments of society. Residents in rural America, for example, frequently are not afforded the same access to quality care as those of us who live and work in urban areas where most of the major medical centers are located. Within rural America, American Indians receive special treatment based upon political, legal and historic government-to-government obligations. Despite the special relationship between federal and tribal governments, those Native Americans receiving their care from the Indian Health Service, are no less immune to the shortages in delivery of quality care in rural America.

With the advent of the President's Health Security Act, there will be additional requirements placed upon the IHS and tribes in order to meet the goals of universal coverage. Under the FY 1995 budget, I am concerned that IHS and tribal programs will be unable to continue to provide adequate care and will be unable to undertake new responsibilities. In the HHS budget requests for FY 1995, there are proposals which if unchanged, will be detrimental to the IHS.

Specifically, these proposals include the FY 1994 and 1995 administrative reductions of approximately $9 million and $10 million, FTE reductions pursuant to Executive Order, potential FTE reductions as called for in HR 3400 (REGO), and overly optimistic budget offsets from third-party collections to fund IHS services. Savings from the HHS reductions are intended to finance new "initiatives" to benefit the whole country. These include increases for Head Start, child immunization programs, and substance abuse programs. I am troubled that IHS funding levels are being reduced in order to help fund these admirable initiatives. The issue is how will the Health Security Act compensate for these reductions to vital IHS and tribal programs.

Mr. Chairman, I have the following questions for the IHS:

The FY 1995 budget relies heavily on proposed 3rd party collections of $281 billion. How will the IHS deal with insufficient funding levels when and if there are insufficient collections?

What would it cost to bring the IHS to parity with the goals in the Indian Health Care Improvement Act? What would it cost to provide for transition costs associated with health care reform?

No construction funds have been authorized for hospitals, clinics, and sanitation facilities. Without adequate staff, funds, and facilities, will not tribes be forced to contract with costly private providers? Will there be adequate contract dollars available to the tribes? Will the IHS be able reassume responsibilities surrendered by the tribes who run out of contract support dollars?

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February 22, 1994

The Honorable Bill Richardson
Chairman, Subcommittee on Native American Affairs
House Committee on Natural Resources
1522 Longworth House Office Building
Washington, D. C. 20515

Dear Congressman Richardson:

The American Academy of Physician Assistants (AAPA) has recently learned that a number of PA students who have applied for admission to the Commissioned Officers Student Training Employment Program (COSTEP) of the Public Health Service will not have their applications processed and will not be hired by the Indian Health Service (IHS) during the summer academic break period, as was expected, due to a freeze in hiring by the Public Health Service.

It is our understanding that a hiring freeze was imposed on all positions in the Public Health Service, including IHS Scholarship Program externs, in December, 1993. The Indian Health Care Improvement Act (P.L. 94-437), as amended, would appear to exempt COSTEP students from this type of personnel action and, in fact, specifically entitles them to employment during the period of the year that they are not in school (Title I, Sec. 105).

The training experiences offered to students by this summer employment program are extremely important. It is the first opportunity for many students to be involved in the hands-on delivery of primary care services, and it is frequently their first exposure to delivering medical care in underserved areas of the country. It is, of course, the intention of the program to encourage these students to choose to practice in these areas after graduation. This temporary employment opportunity is not only an important part of the education of these students, but for many, it defines their future practices as physician assistants.

We understand that you are holding hearings on Monday, February 28 on the role of the Indian Health Service in the Administrion's proposed health-care revisions. Applying the hiring freeze to an exempt program of the Indian Health Service would appear to be contrary to the Administration's emphasis on preparing more primary care providers to serve in underserved areas of the country. We would appreciate your encouraging the Public Health Service to rescind the hiring freeze on the extern program of the Indian Health Service so that applications can be processed and students can be hired for the coming summer.

Sincerely yours,

Leah W. Schroeder

Leah Webb Schroeder
Director of Federal Affairs

Attachments (2)

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