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Statement of Julia Davis-Wheeler

Chairperson

National Indian Health Board

On Senate Bill 556:

The Indian Health Care Improvement Act Reauthorization of 2003

April 2, 2003 – 10:00 a.m.

Senate Russell Building, Room 485

Chairman Campbell, Vice-Chairman Inouye, and distinguished members of the Senate Indian Affairs Committee, I am Julia Davis-Wheeler, Chairperson of the National Indian Health Board (NIHB). I am an elected official of the Nez Perce Tribe, serving as Secretary, and also Chair the Northwest Portland Area Indian Health Board. On behalf of the National Indian Health Board, it is an honor and pleasure to offer my testimony this morning on Senate Bill 556 to reauthorize the Indian Health Care Improvement Act, which is the most important authorizing legislation for American Indian and Alaska Native health delivery. As you recall, I stated in my recent testimony on the FY 2004 Budget that I looked forward to coming back and testifying on the Indian Health Care Improvement Act. I am pleased that this day has come and it demonstrates your commitment to American Indian and Alaska Natives as we work towards eliminating the unique health problems facing Indian Country.

As you are well aware, the NIHB serves nearly all Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to American Indians and Alaska Natives. It is our mission to advance the level of health care in Indian Country and the adequacy of funding for health services that are operated by the Indian Health Service, programs operated directly by Tribal Governments, and other programs. Our Board Members represent each of the twelve Areas of IHS and are elected at-large by the respective Tribal Governmental Officials within their regional area.

I have been associated with the reauthorization effort since May of 1999 when I first met with other Tribal leaders and the Indian Health Service to explore how we, along with Congress and the Administration, could work together to pass this vital legislation.

In June 1999, the Director of the IHS, Dr. Michael Trujillo convened a National Steering Committee (NSC) composed of representatives from Tribal governments and national

Indian organizations to provide assistance and advice regarding the reauthorization of the IHCIA. Over the course of five months, the National Steering Committee drafted proposed legislation, which was based upon the consensus recommendations developed at four (4) regional consultation meetings held earlier in that year. The consensus recommendations formed the foundation upon which the National Steering Committee began to draft proposed legislation to reauthorize the IHCIA. In October 1999, the National Steering Committee forwarded their final proposed bill to the IHS Director and to each authorizing committee in the House and Senate and the President. Previously, the House and Senate introduced legislation based on the tribal bill, but neither passed.

Last year the Northwest Portland Area Indian Health Board and other Area Health Boards hosted a May 28-30, 2003 Indian Health Care Improvement Act meeting. The purpose of the meeting was to consider changes and provide recommendations on the proposed legislation in response to concerns raised in a September 27, 2001 letter and memorandum from Health and Human Services Secretary Tommy G. Thompson to Senator Daniel Inouye. The primary issues raised in Secretary Thompson's correspondence focused on the high costs associated with some of the bill provisions, questions about what outcomes were sought in regards to certain sections of the bill, and it also included opposition to certain elements in the bill. The participants at the Portland meeting took a hard look at the high Congressional Budget Office (CBO) score on Senate Bill 212 and the other concerns and forwarded recommendations to the House and Senate in July of 2002.

I am very pleased you have introduced Senate Bill 556 early this year and have held prompt hearings. The Bill appears to be identical to Senate Bill 212 introduced during the 107th Congress, so we look forward to bringing you up-to-date on some changes recommended by the National Steering Committee. The National Steering Committee is currently working with House members and Committee staff on a House bill that is expected to be introduced very soon that incorporates the recommendations developed at the 2002 NSC meeting in Portland, further changes discussed in subsequent meetings with House Legislative Counsel, other legislative staff meetings, and at the March 20 and 21, 2003 NSC meeting hosted by the Northwest Portland Area Indian Health Board just a couple of weeks ago.

I should tell you that in December of 2002 the NSC met in Rockville, Maryland and selected Lone Pine Paiute Shoshone Tribal Chairperson Rachel Joseph and me to co-chair this year's effort. In addition, Don Kashevaroff representing the Tribal Self-Governance Advisory Committee, former Navajo Nation Vice-President Taylor McKenzie, and Kay Culbertson of the National Council of Urban Indian Health make up this years NSC leadership group. The balance of members represent each of the 12 areas of the Indian Health Service and several national Indian organizations that I mention below. A lot of good things are possible if we pass the bill with our recommended changes. The titles have exciting new authorities.

I want to briefly review the titles contained in the Indian Health Care Improvement Act. Time only permits mentioning highlights in each title, but I am ready to answer your questions on any of the titles to the best of my ability. Although I have worked extensively on the bill over the past four years, I may have to call upon one of the technical advisers who possess a detailed knowledge of the legislation to assist with my answers to your questions.

The Preamble section of the Act has been revised, including sections on Findings, Declaration of Nation Policy and Definitions. Emphasis has been placed on the trust responsibility of the federal government to provide health services and the entitlement of Indian tribes to these services

Title I - Indian Health, Human Resources and Development, has been substantially rewritten primarily to shift priority setting and decision-making to the local Area levels, where appropriate. The importance of education is highlighted by changes proposed to the act.

Title II - Health Services represents a collection of diverse sections addressing issues related to the delivery of health services to American Indian and Alaska Native populations. Diabetes programs and epidemiology centers are just two of the many health programs authorized by this title.

Title III - Facilities, proposes that tribal consultation be required for any and all facility issues, not just facility closures. It shelters projects on the current priority list while moving toward a new method for selecting facilities projects. This title gives permanent authority to small ambulatory facilities construction.

Title IV - Access to Health Services, seeks to maximize recovery from all third-party coverage, including Medicaid, Medicare, and the State Children's Health Insurance Program (S-CHIP) and any new federally funded health care programs. It also will contain new authority for long-term care and protection against estate recovery. This was a title that resulted in the largest dollar total in the CBO score, but the NSC has agreed to some modifications to the provisions in the first tribal bill and this has resulted in billions less in costs to the federal government. The main change is that states will not receive huge increases in reimbursements.

Title V - Health Services for Urban Indians, adds facility construction authority and coverage by the Federal Tort Claims Act for the 35 urban programs. Urban representatives were very active members of the leadership group on the NSC and they feel that the changes in Title V will result in million of dollars in new funding for urban programs.

Title VI - Organizational Improvements, includes changes including the elevation of the Indian Health Service Director to Assistant Secretary in the Department of Health and Human Services. Although tribes are generally very satisfied with the relationship

Interim Director Dr. Charles Grim has with top policymakers in the Department of Health and Human Services, we want to institutionalize this access with this role change.

Title VII - Contains the newly named Behavioral Health title with major revisions, specifically to integrate Alcohol and Substance Abuse provisions with Mental Health and Social Service authorities. I know the committee is having a hearing next week on consolidation of alcohol and substance abuse programs and I think this title can be complementary to the goals of that legislation.

Title VIII - Miscellaneous was largely rewritten. It now includes a proposal to establish an entitlement commission to study and make recommendations on making Indian Health an "Entitlement," in the same manner as Medicaid and Medicare. Ten sections were moved out of Title VIII to more appropriate sections in the IHCIA. All CHS provisions were moved to Title II. A majority of the "free-standing and severability" provisions from other titles were incorporated into Title VIII.

Conclusion

On behalf of the National Indian Health Board, I would like to thank the Committee for its consideration of our testimony and for your interest in the improvement of the health of American Indian and Alaska Native people. I know that this act will not pass this year unless Congress hears from tribes that it is indeed a priority in 2003. The National Indian Health Board and tribes nationwide are renewing their efforts to make this happen. The National Steering Committee, working with the National Congress of American Indians, the Tribal Leaders Self-Governance Advisory Committee and the National Council of Urban Indian Health stand ready to work with this committee to make necessary changes and improvements to craft a bill that will assist us in our goal of raising the health status of American Indian and Alaska Natives.