Testimony before the Senate Committee on Indian Affairs
By The Honorable Rachel A. Joseph

April 13, 2005

Good morning Mr. Chairman, Vice Chairman Dorgan and Senators of the Committee. My name is Rachel A. Joseph. I am Chairperson of the Lone Pine Paiute Shoshone Reservation, Co-Chair of the National Steering Committee for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA), a Board Member of the California Rural Indian Health Board and Chairperson for the Toiyabe Indian Health Program, a consortium of nine Tribes which serves Mono and Inyo Counties in central California. I have served for several years on the Indian Health Service (IHS) National Budget Formulation team representing California and have been elected to represent the East Central California Tribes to the Area Office Advisory Board. In these capacities, and others, I have been fortunate to work with Tribal Leaders from across the Country in addressing health care issues. Today I will provide an overview of the history of Indian health care and how that history is reflected in the present; and, I will highlight some of the issues that need to be addressed.

Each Tribe is different and the history of first contact, conflict, compromise or subjugation varies by Tribe as does the specific development of health services in each tribal area. However, we have all experienced similar patterns in U.S. Indian relations and the development and shortfalls in funding of the Indian Health Service. Originally, the provision of health services by the Federal Government to Indians was in response to the need to protect Solders from infectious diseases. Later, some tribes were successful in securing provisions concerning health care in treaties. Over time the administration of health care was passed from the War Department to the Department of Interior. In 1921 Congress formalized this responsibility with the passage of the Snyder Act which states in part …"from time to time Congress shall appropriate funds to hire doctors… and to provide for the general relief of Indians." Within a few years the quality and level of effort being given to provide for Indian health services was being questioned. In 1928 the Meriam Commission issued a report. That report identified a long list of issues that remain little changed to this day:

> "The health of the Indians as compared with that of the general population is bad. Although accurate mortality and morbidity statistics are commonly lacking, the existing evidence warrants the statement that both the general death rate and infant mortality rate are high. With comparatively few exceptions the diet of the Indians is bad… the housing conditions are conducive to bad health… The hospitals (and) sanatoria…maintained by the service, despite few exceptions, must be generally characterized as lacking in personnel, equipment management and design….***The inadequacy of appropriations has prevented the development of an adequate system of public health administration and medical relief work for the Indians…"***

The onset of the great depression in America and the general growth in federal programs had a positive affect on Indian heath. Unfortunately, this era of expanded programs was followed with a policy of termination which abrogated the rights of some tribes. A significant event of this era was the transfer of responsibility for heath services to the U.S. Public Health Service from the Bureau of Indian Affairs primarily because of poor administration of health care services by the BIA.

By the mid 1970's a change in federal Indian policy resulted in improvements to the Indian Health Service. This new policy directed by President Richard Nixon urged greater inclusion of Tribal Governments in the provision of services to their members. In 1975 Congress passed the Indian Self Determination and Education Assistance Act (ISDEA) to accomplish that goal by authorizing a system of federal contracting between Tribes and the U.S. government. In 1976, Congress passed the initial version of the Indian Health Care Improvement Act. (P.L. 94-437). That act set out a series of health status goals and authorized many significant new programs which included the IHS scholarship program, the Urban Indian Health Program and a new relationship between the IHS and federal programs Medicare and Medicaid. Over the years the Indian Health Care Improvement Act (IHCIA) has become the primary vehicle for updating and improving health services to American Indians/Alaska Natives (AI/AN).

After the initial passage of the ISDEA and the IHCIA, new resources and programs facilitated a renaissance in the provision of heath care services to Indian people. In the 1990's an era of neglect and under funding "set in". This recent era is well documented in two reports by the U.S. Civil Rights Commission. The first report "The Quiet Crisis: Funding Unmet Needs in Indian Country" focuses on all government programs of benefit to Indians. The second report "Broken Promises: Evaluating the Native American Health Care System" focuses exclusively on health. Reflecting this era of shrinking resources and strained relations is the continuing failure to reauthorize the Indian Health Care Improvement Act.

The provision of health care services to America's native people is a complex system that includes three modes of care delivery and multiple funding "streams". Forty years ago the IHS was totally dependent on its own appropriation from Congress. Today, as a result of changes brought about by ISDEA contracting and compacting and the IHCIA which authorized Urban programs, the IHS is referred to as the I/T/U System. In the I/T/U System the I stands for IHS directly operated programs; the T stands for programs operated under ISDEA Contracts and Compacts; and, the U stands for Urban Indian community grant operated programs.

IHS Tribal contracting, in some ways, began in California. California Indians were greatly devastated by the federal termination policy. The failed treaty process of the 1850's, the large number of scattered small tribes and the Congressional designation of California as a P.L. 83-280 State led to the removal of federal funded health services from the State. In the late 1960's, California Tribes organized to work for the return of IHS funded health care. We were successful in this effort and in 1973 Congress earmarked $72,000 to restart those services. This was prior to the passage of the ISDEA and those funds were distributed and administered under the Buy Indian Act. Prior to the passage of the ISDEA congressional staff and federal administrators reviewed the programs in California and saw an effective way to provide services to Indian people. At that time, the Tribal Health Program in my area was called the Tri-County Indian Health Program which operated a single clinic site with one physician. Today we provide services at a central facility on the Bishop Paiute Reservation and two satellite clinics at each end of our two county service area. Those early days were marked by battles of funding which eventually lead to a federal lawsuit which became known as the "Rincon case" named after one of the tribes that supported the litigation. That lawsuit began the changes within the Department of Health Education and Welfare (HEW) to establish mechanisms for identifying how much funding new tribes or tribes in a specific area should receive. Buy-Indian grants and later ISDEA contracts enabled the IHS to begin providing services to numerous small tribes east of the Mississippi, in California and the Northwest. To provide equity in funding to these programs the equity fund and later the Indian Health Care Improvement Fund were authorized by the IHCIA. However, funding inequities persist. One important improvement to prevent long term under funding for new tribes was the establishment, by the IHS, of a "new Tribes" funding policy in 2001. This policy states that new tribes be brought into the system with the same level of funding as the IHS national average.

The next phase of Tribal contracting and tribal compacting was the assumption of administration by Tribes of large portions of IHS programs. What started as a trend towards tribal management under ISDEA contracts of auxiliary public heath focused services grew into Tribal assumption of vertically integrated systems. This trend is reflected mostly in the Oklahoma, Phoenix and Alaska Areas. In some places, like the Cherokee Nation, it meant tribal control of a network of clinics and their attendant outreach and public heath programs while hospital services remained under IHS management. In other places, Tribes were awarded ISDEA contracts to run all direct health services; and, the size and scope of the directly operated system was diminished and often forced to restructure. The 1990's national policy to reduce the number of federal employees led to a different kind of downsizing that focused on IHS Headquarters and Area Offices and had a negative affect on IHS directly operated sites.

The expansion of ISDEA contracting and compacting saw the development of new administrative polices that greatly shaped the implementation of ISDEA contracting and ushered in an era of IHS Consultation with Tribes on policy issues. Among the first of these policies was clarifications in the ISDEA that tribes were eligible to receive contract support costs (CSC) for certain direct and indirect costs above the identified program funding provided for direct services. In providing these CSC funds, the IHS recognized tribal programs were subject to some costs that the IHS was not subject to and that certain pooled costs were considered as appropriate costs under government contracting

regulations and should be funded. Funding CSC removed a deterrent to tribal contracting. Another significant policy development that facilitated tribal contracting was clarification that all programs, services, functions and activities, regardless of the bureaucratic level at which they occurred within the agency, were subject to ISDEA contracting. This led to the development of a methodology for identifying specific portions of the IHS Headquarters and Area Offices programs known as "Tribal Shares" that were then subject to ISDEA contracting in whole or in part. Simultaneously, those programs, services, functions and activities that only a governmental agency could do were identified and designated IHS residual shares.

The ISDEA clarifications on what was contractible and the establishment of an orderly methodology to identify available funding led to an expansion in tribal contracting. The foundation in the development of these polices was the months long negotiated rule making authorized by Congress in ISDEA reauthorization. The negotiated rulemaking process led to the writing of an understandable set of regulations that resolved many former conflicts and disparities in the IHS contracting process. That same reauthorization initiated the Tribal compacting process as a further expression of Tribal self determination. These changes led to increases in tribal assumption of multiple levels of IHS programs. The epitome of tribal compacting is the All Alaska Compact which placed all IHS Area functions within a single compact under a statewide coalition of tribes and health programs. Today over 53% of IHS program funding is administered through ISDEA contracts and compacts.

URBAN PROGRAMS

Health services for urban Indians is authorized by P.L. 94-437 in Title V. These small grant programs initially provided planning to facilitate information and referral services; however, pressing needs and a lack of alternative sources of care changed the urban mission which expanded to include direct health care services. The growth of the Urban program was helped, especially in California, by the transfer of former National Institute for Alcohol and Alcohol Abuse (NIAAA) funded programs that served Indian populations. The urban programs still struggle to provide services to large populations with minimal funding. There are a few "flagship" programs in urban centers such as Seattle, Minneapolis, Oakland-San Francisco and Tulsa which provide comprehensive health care services and many urban programs that struggle. Of concern is the policy issue discussion as to whether the Title V programs overlap with the Community Health Center Program.

IHS DIRECT SERVICE PROGRAMS

The past thirty years have not been easy for the IHS direct service programs. The downward trend in IHS appropriations has directly affected the growth and quality of these programs. Additionally, forced restructuring when Tribes contract or compact away resources adds to the "squeeze" on limited resources. In some areas the IHS direct care system is kept in place partially due to the strong belief that this care is a Federal responsibility. There is also a shrewd analysis by some large land based tribes that the problems of recruitment and retention of professional health staff for small isolated systems could lead to deterioration in service levels and quality. Still, the IHS direct care system has proven resilient partly due to its public health oriented model and the vertical integration of its delivery system. Recent threats to this delivery system have come in the form of administrative initiatives to centralize services such as personnel services across all Health and Human Services (HHS) Departmental operating divisions. These threats and a commitment to improve health care has led to the development of a coalition of direct service tribes that meets annually.

The I/T/U system is more complex than the old IHS system partly because of its reliance on multiple funding streams. Initially, IHS funds were directly appropriated by the Interior Committees in Congress. In 1976 Title IV of the IHCIA gave the IHS statutory authority to bill the federal programs of Medicaid and Medicare for services provided in IHS facilities. The original authority implied that these funds would be used to maintain JCAHO accreditation at IHS operated hospitals and clinics. By this time, Tribally operated IHS grant programs in California had already begun to bill California's Medicaid program. In the late 1990's, the need to improve the capacity of the IHS direct service program to assist eligible Indians to apply for Medicaid and Medicare led to the "Business Office Initiative" which provided staff and training across the IHS system. The struggle to identify the appropriate use of these Medicaid and Medicare funds has resulted in various changes to the IHCIA. For example, sections of the Act identify how Area Offices must distribute collections back to the site of billing and directs Congress not to "off set" the IHS appropriation because of these collected funds. For the ease of administration, the Health Care Financing Administration (HCFA) allowed the IHS to establish an annually negotiated provider encounter rate for the purpose of billing Medicaid for ambulatory services. Initially, Tribally operated programs were only able to bill state Medicaid programs as fee for service providers. In 1996 an IHS/HCFA Memorandum of Agreement extended the IHS all inclusive or global encounter rate to Tribal Contractors like those in California.

The 1977 Balanced Budget Act created the State-Children's Health Insurance Program to provide health coverage for children up to the age of 19 who do not meet the poverty requirements for Medicaid. This expansion of coverage was particularly important to the Indian community which is younger than the nation as a whole. Combined collections from these three sources are not easy to quantify due to gaps in the data collection systems at both IHS and CMS. The IHS methodology for identifying funding shortfalls by operating unit asserts that 25% of all operating funds come from non IHS collections. It is clear that the bulk of these funds represent collections from the Medicaid program. For FY 2006 the Administration request is to authorize an IHS operating budget of $3,846,174,000 that includes $648,208,000 in projected third party collections
In response to the growing importance to Indian country of programs administered by the Center for Medicare and Medicaid Services (CMS) which includes the S-CHIP program, the National Steering Committee (NSC) for the reauthorization of the IHCIA and Tribes

recommended the establishment of a formal consultation body for CMS to assist in the development of CMS Indian policy and regulation. In response to these requests CMS established a Tribal-Technical Assistance Group (T-TAG).

The T-TAG has been active in reviewing the impacts of the recently passed Medicare Modernization Act (MMA). The first round of MMA implementation focused on the Transitional Assistance program which was touted as a "new benefit" for seniors, especially low income seniors. Unfortunately, the roll out was too slow and the program too confusing to have much affect in Indian country. Out of a nation-wide projected benefit of $12,000,000 only a little over $1,000,000 was actually collected by IHS and Tribal programs. The implementation of the permanent program (Medicare Advantage and Part D Pharmacy Benefits) is occurring under statute with less Indian specific language than the Transitional Assistance section. Of particular concern going forward is the affect of the MMA on dual eligibles who currently receive their pharmacy coverage through the Medicaid program. Low income elders make up a large portion of the Indian elder population. Like other elders they are confronting confusion of enrolling in a plan and face new co-payments for services. They will also experience the gap in coverage when their costs exceed the $1500 initial coverage limit. These clients will expect their IHS and Tribal Clinics to pay for their pharmaceuticals after they fully utilize their Part D coverage. Sadly, IHS expenditures will not be counted toward the threshold to qualify for catastrophic coverage under Part D. **IHS will have to absorb all pharmacy costs for Indian elders over the $1,500 annual threshold.**

Of equal concern is the issue of charging Indian clients premiums and co-pays. **We recommended that premiums and co-payments should be waived as was done in the State Children's Health Insurance program.** Some provisions of the MMA will be helpful to Indian country such as the "capping" of Contract Health Service payments at Medicare rates and reimbursement for hospital emergency treatments provided to undocumented aliens. These issues and the establishment of the CMS/T-TAG is reflective of recognition by both CMS and Tribes of the increasing importance of CMS programs to improving the health of the Indian communities.

HEALTH DISPARITIES

Today, Native Americans continue to experience significant rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries. Specifically,

Native Americans are 517 percent more likely to die from alcoholism, 533 percent more likely to die from tuberculosis, 208 percent more likely to die from diabetes, 150 percent more likely to accidents, and 52 percent more likely to die from pneumonia or influenza than the rest of the United States, including white and minority populations. As a result of these increased mortality rates, the life expectancy for Native Americans is 71 years of age, nearly five years less than the rest of the U.S. population.

In their recent REACH 2010 Risk Factor Survey the Center for Disease Control (CDC) reported that American Indians and Alaska Natives had the highest prevalence of obesity, current smoking, cardiovascular disease, and diabetes among both men and women in minority groups; reported that among all minority men, AI/AN men had the highest prevalence of self-reported hypertension and high blood cholesterol levels; and reported that among all minority women, AI/AN women had the second highest prevalence of self-reported hypertension and high blood cholesterol levels.

As the CDC survey demonstrated in the REACH 2010 Risk Factor Survey, the prevalence of chronic diseases such as cardiovascular disease in Indian Country are increasing and require immediate attention. Due to a lack of adequate preventative care and education for American Indians and Alaska Natives, heart disease has become the leading cause of death among American Indians and Alaska Natives according to the CDC's 1997 report on cardiovascular disease risk factors. The prevalence of risk factors such as hypertension, current cigarette smoking, high cholesterol, obesity, and diabetes among American Indians and Alaska Natives need to be addressed. As such, the Indian Health Service and Tribal health centers must receive additional resources to aggressively treat the risk factors and improve the overall health and well being of American Indian and Alaska Native communities.

Native Americans/Alaska Natives continue to also experience significant rates of mental health disorders; and, there is approximately one (1) psychologist per 8,333 American Indians and Alaska Natives compared to one (1) per 2,213 for the general population. The suicide rate per 100,000 for AI/AN in (2001) was 10.6 per 100,000; and, the "Healthy People 2010" goal is to be at 5 per 100,000.

LONG TERM AFFECTS OF PERSISTENT UNDER FUNDING

The Indian Health Service Budget Formulation Process and the Federal Disparities Index (FDI) Workgroup have both established that the approximate level of funding needed to meet the health care needs of Indian people is $9-10

billion. This corroborates the long held view that less than 50% of true need is funded by the Indian Health Service budget. If funded at $9 billion, an additional phased-in facilities cost of $9-10 billion would be needed to house the expanded health care services and for new construction, rehabilitation and renovation. This is sometimes stated as a $20 billion need-based budget, but in reality, the annualized need after facilities is approximately $10 billion per year in 2005 dollars. A 10-year phase-in of the $20 billion budget can be achieved if the Congress and the Administration commit to several years of sizeable increases.[1]

Throughout the years, this Northwest Portland Area Indian Health Board (NPAIHB) analysis has sought to maintain the integrity of its estimates by not inflating amounts in the manner of conventional negotiations. The NPAIHB asserts there is nothing to be gained by overestimating the funding required to meet the health care needs of Indian people and invites discussion over every estimate presented in the following analysis.

The following graph illustrates the diminished purchasing power of the IHS budget over the past fourteen years. The graph demonstrates the compounding effect of multi-year funding shortfalls that have considerably eroded the IHS base budget. In 1993, the IHS health services accounts received $1.52 billion; and, had the accounts received adequate increases for inflation and population growth, that amount would be $5.2 billion today. The NPAIHB estimates that the IHS budget has lost over $2.46 billion over the last fourteen years.

[1] For more discussion on the "IHS Needs Based Budget," see: The True Health Care Needs of American Indians

The issue of funding equity has been of special interest to Tribes in California ever since the Rincon case was concluded. The court findings in that case ended what was base budget funding and established criteria for IHS budget distributions that they meet the threshold tests of being reasonable, rational and defensible. Unfortunately, in spite of improved data collection and new actuarial based methodologies for identifying funding needs the vast majority of the IHS appropriation is distributed on the basis of previous year distributions. The result is that little corrections to the identified local under funding has been done and unless a larger infusion of new funds are identified for this purpose it never will. This situation condemns some tribes to extreme under service while other tribes receive more acceptable levels of care. This problem is often compounded for small ambulatory care programs because the current systems of resource distribution does not link access to Contract Health Service funds to the lack of access to IHS operated or Tribally operated hospitals, diagnostic services or pharmacies. This lack of resource coordination affects not only the Indian clients but also local health providers who must absorb higher and higher levels of unfunded care. This is especially true for rural hospitals located near reservation lands.

The medical inflationary rate has grown over 200% since 1984. Unfortunately, the basis for calculating inflation used by government agencies is not consistent with that used by the private sector. The OMB uses an increase ranging from 1.9% to 4% per year to compensate for inflation, when the medical inflationary rate is between 6.2% and 18.0%. This discrepancy has seriously diminished the purchasing power of Tribal health programs because medical salaries, pharmaceuticals, medical equipment, and facilities maintenance cost Tribes the same as they do the private sector.

Health care spending for American Indians and Alaska Natives lags far behind spending for other segments of society. **For example, per capita expenditures for American Indian/Alaska Native beneficiaries receiving services in the IHS are approximately one-half of the per capita expenditures for Medicaid beneficiaries and one-third of the per capita expenditures for Veterans Administration beneficiaries. In fact, the federal government spends almost twice as much money for a federal prisoner's health care (FBP) than it does for an American Indian or Alaska Native (IHS).**

According to information provided by the National Center for Health Statistics, birth-death records indicate that the American Indian and Alaska Native population is increasing at 1.7% per year. The 1.7% population increase translates to approximately 70,000 new patients into the Indian Health care system annually; and we have not received population growth funding in over a decade. However, the President's FY '06 budget request includes $33,495,000 for population growth and we heartily support that request.

The travesty in the deplorable health conditions of American Indians and Alaska Natives is knowing that the poor health indicators could be improved if funding was available to provide even a basic level of care. It is unfortunate that despite two centuries of treaties and promises, American Indians are forced to endure health conditions and a level of health care funding that would be unacceptable to most other U.S. citizens.

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and Alaska Natives, Northwest Portland Area Indian Health Board, June 2003: available at www.npaihb.org.

A fairly new source of significant funding to the I/T/U System is the Special Diabetes Program for Indians (SDPI). This initiative is funded through the Health Committees as a "set aside" from a National Diabetes Initiative and is now $150,000,000 per year. This increased appropriation is critical for a number of reasons. Foremost is that the Indian communities suffers the consequences of this disease at a rate that 208% higher than the rest of the U.S. general population. Also, this disease has significant consequences and is the major contributor to the increasing rate of cardiovascular disease in the Indian population and has resulted in a disproportionably high rate of amputations. The distribution of these funds through a formula distribution and competitive grants has fostered growth in local programs and the national interventions are having a positive affect on outcome measures for this disease. There is a distortion effect to funds when treatment for one disease becomes easily accessible and other health problems go unaddressed due to funding constraints. Ultimately it is better to fund a system of care not individual diseases.

OUTCOME MEASURES

Over the past five years one of the most important improvements in the operation of the ITU system is the development of standardized outcome measures pursuant to the Government Performance and Results Act (GPRA). GPRA indicators provide a benchmark against which levels of program competence can be measured. The California Area has demonstrated leadership in both GPRA system participation and movement towards national goals. National GPRA measurements are now available on seventeen indicators by IHS Area. They show IHS to be above the 2010 Healthy People Goals in the level of some screenings such as diabetic related screenings but below 2010 goals for important indicators of diabetic health status such as percentage of screened diabetics who have achieved good blood sugar control or blood pressure control.

Expanded reliance on information technology and telecommunications is a growing phenomenon. The IHS and Tribal programs are uniformly attached to the world wide web and most practice sites operate a local area computer networks. Some training is being done over the internet and less frequently via video conferencing. Conference calls are routinely used for program management and planning purposes. Nationally, and in California, the installation and use of new Electronic Practice Management systems and Electron Health Record systems will magnify our reliance on information technology and telecommunications. These latter applications require ever increasing band width to operate efficiently and increased technical expertise. Both of those come with cost. Under funded line charges in California alone have been calculated at $775,000 for the current year.

The provision of culturally competent and comprehensive health care services requires a large investment in staff to be successful. The pool of available health providers, management staff and support staff needs to be expanded by expanding educational opportunities for Indian people. Increased opportunities for staff training would help stem the outflow of existing staff and improve program quality. Currently in California, only three of the twenty four largest Tribal Health Programs are lead by American Indian Executive Directors. There is also a need for succession planning as much of the existing leadership will soon mature out of the work force.

The IHS facilities program recently received an above average score on the OMB Program Assessment Rating Tool (PART) review. A new formula for prioritizing which facilities get built has been years in the making. A significant unresolved issue is how to handle the proposals that are now on the Congressional to-be-funded list. Should they be forced to re-compete or go first? The current system has never constructed and staffed a single facility in the state of California in over thirty five years. The needs of small tribes and programs never seem to surface. The current system with its built in "final year of construction" increases for new manpower and equipment impinges on the rest of the system's new funds needed to address population growth and cost inflation. The current proposed moratorium on new facility construction may be a good thing. It will provide time for all areas of the IHS to complete new health services and facilities master plans. It also might allow for a realistic level of consultation on the new construction priority system formula.

CONSULTATION ON REAUTHORIZATION OF THE IHCIA

Beginning in 1999, for almost ten months, tribes engaged in a tribally-driven consultation process with the Indian Health Service (IHS) and urban Indian health providers regarding reauthorization of the Indian Health Care Improvement Act. This process began with the first Area consultation meeting in San Diego, December 1998, with over 100 participants who gathered to develop California Area recommendations for reauthorization. Subsequent to the San Diego meeting, each Area of the IHS convened meetings of Tribal leaders and urban providers to discuss the reauthorization of this important legislation. Discussions were held during several meetings with the expectation that Area concerns and recommendations would be forwarded to the next step in the consultation process. It was agreed, that the goal of the process was to build a consensus on issues and that draft legislation would be submitted to Congress and would reflect a consensus of the Indian Health Services/Tribes/Urban Programs (I/T/U), to ensure that when we speak of the reauthorization we would be "Speaking with One Voice".

Regional Consultation

From January to April 1999, four regional meetings were held across the United States. These regional meeting were intended to provide a forum for I/T/Us to provide input, to share the recommendations from each Area, and to build consensus among the participants for a unified position from each region and throughout Indian Country.

National Steering Committee (NSC)

Upon completion of the four regional meetings, the IHS Director convened a National Steering committee to develop a report on national policy issue recommendations and IHCIA reauthorization. The National Steering committee is composed of one elected tribal representative and one alternate from each of the twelve IHS Areas, a representative from the National Indian Health Board, National Council on Urban Indian Health and the Tribal Self-Governance Advisory Committee.

A 135 page matrix, comparing the recommendations from each of the four regions for every section of the IHCIA, was reviewed by the National Steering committee to develop a final consensus document. The work was divided into five teams as follows:

1. Health Services Workgroup for Titles I, II, V, and VII, Chaired by Dr. Taylor McKenzie;
2. Health Facilities Workgroup for Title III, Chaired by Julia Davis Wheeler and Robert Nakai;
3. Health Financing Workgroup for Title IV, Chaired by Buford Rolin;
4. Miscellaneous Workgroup for Titles VI and VIII, Chaired by Tony Largo; and,
5. Preamble Workgroup, Chaired by Henry Cagey.

Each group was responsible for final presentation of recommendations setting forth a framework for reauthorization legislation.

It was agreed by the NSC that, specific "draft bill language" would be developed and proposed by the National Steering committee to minimize any misinterpretations of our position. The NSC maintained an aggressive schedule of meetings as follows:

Rockville, MD	June 3, 4, 1999
Gaithersburg, MD	June 17, 18, 1999
Rockville, MD	July 7, 8, 9, 1999
Reno, NV	July 13, 14, 1999
Washington, DC	July 27, 28, 29, 1999 (National Meeting)
Salt Lake City, UT	August, 10, September, 1, 2, 1999
Rockville, MD	September 28, 29, 1999
Palm Springs, CA	October 5, 1999

National Forum

At the conclusion of all four regional meetings and after the NSC had met four times and developed draft consensus bill language, a national meeting, co-sponsored by the Senate Indian Affairs Committee was held here in Washington D.C. This meeting was to provide an opportunity for Tribal leaders, urban health representatives, national organizations, federal agencies, and friends of Indian Health, to provide "feedback" on the legislative proposal. Before this meeting, on July 16, 1999, the draft bill language was mailed to over 1200 tribal leaders, tribal health directors, I.H.S. officials, and urban health programs and other health organizations.

The Steering Committee addressed all of the approximately 1000 comments received and incorporated many comments and recommendations into the proposed bill to reauthorize the Indian Health Care Improvement Act. A copy of the draft bill was delivered on October 8, 1999 to both the Senate Indian Affairs Committee and the House Committee on Resources and other appropriate committees with jurisdiction. A copy of our proposed bill was mailed to every tribe and Indian organization.

The NSC sought to update the Act to make it more responsive to current "real world" Tribal Health Program needs; to enhance opportunities for attracting greater revenue into

the Indian Health system; and, to facilitate greater exercise of Indian self-determination in health care program decision-making and regulations.

Our recommendations were primarily reflected in S. 556 which was reported out unanimously by this Committee last November.

CONCLUSION

I have provided an overview of Indian Health today; thus, in closing, I must report that in California we are currently dismantling programs that we have spent the past thirty years developing. Consistent under funding is having the following affects: California, like the rest of the nation, is experiencing increasing levels of deferred care. California Tribally operated programs are placing more and more restrictions on what constitutes a life threatening emergency to which the program will provide coverage. We are seeing employee benefit "take backs" and reductions, reduced hours of operation and reductions in staffing levels. We are also seeing more staff "burn out" and increasing problems with staff retention.

There are no easy answers to the problems that confront the I/T/U system of health care. Funding is surely an issue but we need Congressional support in other ways too.

I respectfully urge you to do whatever you can to ensure passage of the reauthorization of the IHCIA this year; and, thank you for this opportunity to provide testimony.