NATIONAL INDIAN HEALTH BOARD

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TESTIMONY OF BUFORD ROLIN
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National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act

Before a Hearing of the Natural Resources Committee
U.S. House of Representatives
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Room 1324 Longworth House Office Building

Good morning Chairman Rahall and members of the Committee. I am Buford Rolin, Chairman of the Poarch Band of Creek Indians, Chairman of the Tribal Leaders Diabetes Committee (TLDC), and Vice-Chairman of the National Indian Health Board (NIHB). I serve as the Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). In these capacities, and others, I have been fortunate to work with Tribal Leaders from across the Country in addressing health care issues. Thank you for holding this hearing and providing us the opportunity to testify in support of H.R. 1328 to amend and reauthorize the IHCIA.

This testimony is also offered on behalf of the National Indian Health Board (NIHB). The NIHB serves Federally Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to AI/ANs, and upholding the federal government's trust responsibility to AI/AN Tribal governments. Over the last several years, the NIHB has provided tremendous administrative, technical, and policy development support to the NSC.

In June 1999, the Director of IHS established the NSC, comprised of representatives from Tribal governments and national Indian organizations, for consultation and to provide assistance regarding the reauthorization of the IHCIA, set to expire in 2000. The NSC drafted proposed legislation, which reflected the tribal consensus recommendations developed at area, regional meetings and a national meeting held here in Washington,

DC. In October 1999, the NSC forwarded a tribal proposed IHCIA reauthorization bill to the IHS Director, to each authorizing committee in the House and Senate, and the President. For the last eight years, the Senate and House have introduced IHCIA legislation based on the tribal bill. The NSC has continued as an effective tribal committee by providing advice and "feedback" to the Administration and Congressional committees regarding the IHCIA reauthorization bills introduced in the 107th, 108th, and 109th Congresses, none of which passed. The NSC and tribal leaders are committed to working with you to achieve passage of H.R. 1328 during the 110th Congress. Today, I respectfully request Congress and the Administration to work together with Indian Country to enact the reauthorization of the IHCIA. The NSC appreciates the support of the House Natural Resources Committee in this endeavor.

History of the IHCIA

Over thirty years ago, the IHCIA was first enacted. On October 1, 1976, the late President Gerald R. Ford, went against the veto recommendations of the then Department of Health, Education and Welfare, and the Office of Management and Budget, and signed the IHCIA into law. In his signing statement, the late President Ford wrote:

> "*I am signing S. 522, the Indian Health Care Improvement Act. This bill is not without faults, but after personal review I have decided that the well-documented needs for improvement in Indian health manpower, services, and facilities outweigh the defects in the bill. While spending for Indian Health Service activities has grown from $128 million in FY 1970 to $425 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our first Americans should not be last in opportunity."*

The late President Ford signed the IHCIA into law with a specific mission: to bring the health status of first Americans to the level of other populations.

The current framework of the IHCIA is similar to the same bill that President Ford signed into law. With the emergence of tribally operated health programs under the Indian Self-Determination Education and Assistance Act and the establishment of 34 urban Indian health centers, the Indian health care delivery system has changed considerably since 1976. Although the IHCIA was reauthorized in 1988 and again in 1992, the IHCIA has not been updated in over 14 years. Modernization of this law is necessary so that improvements are made in the Indian health systems to raise the health status of Indian people to the highest level possible.

Reauthorization Is Important

Indian Country must have access to modern systems of health care. Since the enactment of the IHCIA in 1976, the health care delivery system in America has evolved and modernized while the AI/AN system of health care has not kept up. For example, mainstream American health care is moving out of hospitals and into people's homes; focus on prevention has been recognized as both a priority and a treatment; and,

coordinating mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice.

H.R. 1328 will facilitate the modernization of the systems of health care relied upon by 1.8 million AI/ANs. H.R. 1328 authorizes methods of health care delivery for AI/AN in the same manner already considered standard practice by "mainstream" America. There is a critical need for health promotion and disease prevention activities in Indian Country and provisions of H.R. 1328 address this need. Disease prevention and health promotion activities elevate the health status at both the individual and community level. Indian Country needs flexibility to run its health care delivery systems in a manner comparable to health care systems expected by "mainstream" America.

Health Care Disparities

The IHCIA declares that this Nation's policy is to elevate the health status of the AI/AN people to a level at parity with the general U.S. population. No other segment of the American population is more negatively impacted by health disparities than the AI/AN population and our people suffer from disproportionately higher rates of chronic disease and other illnesses.

We have demonstrated that 13 percent of AI/AN deaths occur in those younger than 25 years of age, a rate three times higher than the average US population. The U.S. Commission on Civil Rights reported in 2003 that "American Indian youths are twice as likely to commit suicide…Native Americans are 630 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental death compared with other groups."

In addition, according to the IHS, AI/ANs have a life expectancy six years less than the rest of the US population. Rates of cardiovascular disease among AI/ANs are twice the amount for the general public, and continue to increase, while rates for the general public are actually decreasing.

Public health indicators, such as morbidity and mortality data, continue to reflect wide disparities in a number of major health and health-related conditions, such as Diabetes Mellitus, tuberculosis, alcoholism, homicide, suicide and accidents. These disparities are largely attributable to a serious lack of funding sufficient to advance the level and quality of adequate health services for AI/AN. Recent studies reveal that almost 20 percent fewer AI/AN women receive pre-natal care than all other races and they engage in significantly higher rates of negative personal health behavior, such as smoking and the consumption of alcohol and illegal substances during pregnancy.

A travesty in the deplorable health conditions of AI/AN is knowing that the vast majority of illnesses and deaths from disease could be prevented if additional funding and contemporary programmatic approaches to health care was available to provide a basic level of care enjoyed by most Americans. It is unfortunate that despite two centuries of

treaties and promises, American Indians endure health conditions and a level of health care funding that would be unacceptable to most other U.S. citizens.

Over the last thirty years, progress has been made in reducing the occurrence of infectious diseases and decreasing the overall mortality rates. Today, AI/ANs still experience significant health disparities and have lower life expectancy than the general population. The enhancements in H.R. 1328 will facilitate improvements in the Indian health care delivery system. Health services will be delivered in a more efficient and pro active manner that in the long term will reduce medical costs, will improve the quality of life of AI/ANs, and more importantly, will save the lives of thousands of AI/ANs.

IHCIA Reauthorization Efforts

Since 1999, the NSC and the NIHB has led reauthorization efforts which have often been long, difficult; and, at times, disappointing. Throughout these years, the NSC has accommodated Administration and Congressional concerns by working out endless compromises and by reaching consensus on key policy issues. At the same time, the NSC held to its guiding principles of no regression from current law and protection of tribal interests.

After so many years of working to secure reauthorization, you can appreciate how disappointed Indian Country was when the IHCIA failed to pass the Senate in the 109th Congress. This time, the bill was derailed largely due to an unofficial Department of Justice (DOJ) memorandum provided to key Senators during the last hours on the last day of the pre-Election Session of Congress. This memo, highly critical of many elements which are the foundation of the Indian health care system and issues that would erode sovereignty, contained several inaccurate and erroneous claims. Because the Tribes received a copy of the DOJ document late Friday afternoon (September 29, 2006), there was insufficient time for Tribes to respond before the Senate recessed. At the 11th hour for action on the reauthorization bill, Indian Country faced a nameless opponent whose assertions threatened current practices of AI/AN health care.

The NIHB responded to the DOJ document and forwarded its response to the Attorney General Alberto Gonzales and the President asking the Administration to withdraw the DOJ document. The DOJ raised two major objections that are of great concern to the NSC. The DOJ raised Constitutional questions regarding the definition of "Indian". The definition of "Indian" in the IHCIA reauthorization is the same definition in the current IHCIA, which has been in law for over thirty years, and has never been challenged on Constitutional grounds. In fact, this definition of Indian is found in other Federal laws. The NSC strongly supports the definition of Indian in section 4 (12), definition of urban Indian in section 4 (27), and eligibility of California Indians in section 806 of H.R. 1328.

The DOJ also objected to the extension of Federal Tort Claims Act (FTCA) coverage to home and community-based services provided outside of a health facility, and traditional health care practices. The DOJ was apparently concerned that these services would not be carried out following appropriate standards of care. Currently, the IHS and tribes provide home health care services following State Medicaid standards of care.

Traditional health care practices are usually provided as complementary services to Western medical practices at the request of family members. In most cases, the traditional health care practitioners are not employees of the IHS or tribes so FTCA coverage would not apply in the event that a malpractice claim was ever filed.

The NSC appreciates the work of this Committee to introduce H.R. 1328. I appreciate the opportunity to highlight some of those key provisions:

Elevation of the Indian Health Service Director

Tribal leaders have long advocated for "elevation" of the IHS Director to that of an Assistant Secretary. We believe "elevation" is consistent with the government-to-government relationship and the trust responsibility to AI/AN Tribal governments throughout all agencies of the Department of Health and Human Services (HHS). We believe that "elevation" would be comparable to the administration of the Bureau of Indian Affairs programs by an Assistant Secretary in the Department of Interior and the Assistant Secretary for Public and Indian Housing in the Department of Housing and Urban Development.

While HHS has made great strides over the past several years to address Tribal issues, the elevation of the IHS Director to that of an Assistant Secretary would facilitate the development of AI/AN health policy throughout the Department. There are many cross-cutting issues from various Department agencies, such as the Centers for Disease Control and Centers for Medicare & Medicaid Services, which impact Indian health programs. Elevating the Director's position to that of Assistant Secretary would facilitate greater collaboration with other agencies and programs of the Department concerning matters of Indian health.

The NSC supports the language in Section 601 of H.R. 1328 elevating the Director of IHS to Assistant Secretary of Health.

Bipartisan Commission

The NSC supports Section 814 of H.R. 1328 authorizing a National Bipartisan Commission on Indian Health Care. During the reauthorization process, section 814 has been modified several times and now reflects general authority for the Commission to study the provision of health services to Indians and identify needs of Indian Country by holding hearings and making funds available for feasibility studies. The Commission would make recommendations regarding the delivery of health services to Indians, including such items as eligibility, benefits, range of services, costs, and the optimal manner on how to provide such services.

Long-Term Care and Home and Community Based Services

While the life expectancy of AI/ANs is substantially lower than the rest of the general population, the ability to provide health care and related services for the elderly population remains one of the most pressing issues for Indian country. The need to improve and expand services for all stages of the life cycle are desperately needed; however, services utilized during the waning years of life are severely lacking in AI/AN

communities. Under current authorities, in some Indian communities, AI/ANs elders are placed in assisted living or nursing homes located off-reservation. Families have to travel hundreds of miles from their home to visit their elderly relatives.

The NSC supports Section 213 of H.R. 1328 authorizing IHS and Tribally-operated health systems to provide hospice care, assisted living, long-term care, and home and community based services. Section 213 enables Indian elders to receive long term care and related services in their homes, through home and community based service programs, or in tribal facilities close to their friends and family. Section 213 provides Indian communities with necessary authorities to provide long term care and related services to its Indian elders that are currently available to the general U.S. population. Section 213 is a prime example of why the IHCIA needs to be modernized.

The NSC supports the definition of "home and community-based services" as contained Section 213(c)(1) of H.R. 1328. The definition references the definition of "home and community-based services" in title XIX of the Social Security Act. The NSC further supports standards that are consistent with Medicaid standards.

Facilities

The NSC supports the provisions in Title III of the H.R. 1328. This title provides authority for the construction of health facilities including hospitals, clinics, and health stations, as well as staff quarters and sanitation facilities for Indian communities and homes. Through several years of consideration, the provisions in Title III were modified and updated through a tribal consensus decision making process and reflect the current needs of most Indian communities.

Behavioral Health Programs

The NSC strongly supports the provisions in Title VII of H.R.1328. The NSC and Indian Country strongly support the Title VII provisions authorizing comprehensive behavioral health programs which reflect tribal values and emphasize collaboration among alcohol and substance abuse programs, social service programs and mental health programs. Title VII addresses all age groups and authorizes specific programs for Indian youth including suicide prevention, substance abuse and family inclusion.

We support making the "systems of care" approach to mental health services available in Indian Country. The "systems of care" approach means more than just coordinated or comprehensive mental health services. It involves making families and communities partners in the development of behavioral/mental health services, a methodology formally recognized and encouraged by the Substance Abuse and Mental Health Services Administration (SAMHSA). In fact, an existing SAMHSA program, operated in coordination with other federal agencies, provides six-year grants to a number of Indian tribes for the express purpose of developing systems of care for mental health services in Indian communities.

Increased IHS and tribal utilization of "systems of care" methodologies for delivery of mental heath services will help tribes leverage assistance from SAMHSA, the National

Institute of Mental Health and other agencies for services to Indian children. Local evaluations of "systems of care" programs have shown less acute psychiatric hospitalizations and out-of-home placements for adolescents, better school performance and fewer crimes by children in the program.

Access to Health Services

The NSC supports the provisions in title IV as well as the provisions in Title II of H.R. 1328 amending titles XVIII (Medicare), XIX (Medicaid), and XXI (State Children's Health Insurance Program (SCHIP) of the Social Security Act. These provisions will provide the IHS, tribal and urban Indian programs with more flexibility to provide Medicare, Medicaid and SCHIP covered services and to receive appropriate reimbursement for those services.

In addition, the NSC supports language in Section 403(e)(3) to clarify that tribes or tribal organizations operating programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), have authority to file actions under the Federal Medical Care Recovery Act (FMCRA) on the same basis as the federal government. FMCRA authorizes the Federal government to recover medical costs from a responsible party, or their insurer, resulting from a tort injury, such as an automobile accident. Tribal programs operating under the ISDEAA should be afforded similar authorities to recover medical costs resulting from tort injuries to their tribal members resulting.

In the last few weeks, there has been much discussion in the media and in Congress regarding the care provided to Iraq war veterans at the Walter Reed Army Medical Center. As citizens of this great nation, American Indians have the highest per-capita participation in the armed services of any ethnic group. Indian Country supports the efforts of Congress to ensure our veterans receive the adequate health care that they deserve. Indian people accessing services from the Indian health system face problems similar to those found at Walter Reed and other Veteran Affairs' hospitals: old facilities, obsolete equipment, bureaucratic red tape, etc. How long will it be before the problems of Indian Country receive the same exposure?

The NSC stands ready to work with the Committee to ensure passage of H.R. 1328 during this Congress. In order to facilitate passage of the IHCIA in the 110th Congress, tribal leaders need to be "at the table" with Congressional and the Administration staff to discuss the IHCIA, which is consistent with a meaningful government-to-government relationship.

Thank you for providing me this opportunity to present testimony and I am available to answer any questions you may have.