National Indian Health Board

TESTIMONY OF RACHEL JOSEPH
ON BEHALF OF
THE NATIONAL TRIBAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT
AND
THE NATIONAL INDIAN HEALTH BOARD
BEFORE THE
HOUSE COMMITTEE ON NATURAL RESOURCES
REGARDING
H.R. 2708 -- INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2009

JUNE 25, 2009

Chairman Rahall, Ranking Member Hastings, and distinguished Members of the Committee:

I am Rachel Joseph, a member of the Lone Pine Paiute-Shoshone Tribe of California and Co-Chair of the National Tribal Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). I appreciate the opportunity to testify before this Committee to present views on the advancement of Indian health care and to state our strong support for the swift passage of H.R. 2708.

I have served as a Chairperson and Vice Chairperson of the Lone Pine Paiute-Shoshone Tribe and served for ten years on the Board of the Toiyabe Indian Health Project, a consortium of nine Tribes in Mono and Inyo Counties in central California. I represent the California Area on the Indian Health Service (IHS) National Budget Formulation team and am elected by the East Central California Tribes to the IHS California Area Tribal Advisory Committee.

The following recommendations are made to advance and improve the Indian health care delivery system.

> First and foremost, reauthorization of the IHCIA is vital to enable the Indian health system to utilize more efficient, effective and updated methods of health care delivery in the 21st Century. To bring stability to our system, it is critical that the IHCIA be made a permanent law of the United States, just as the Federal Government's trust responsibility to provide health care to Indian Tribes is a permanent obligation of the Federal government.

Second, the Indian health care delivery system must be fully funded in order to meet the Federal government's trust obligation. In particular, I urge Congress to properly fund the contract health services (CHS) program through which we purchase care which the Indian health system is unable to supply directly, and contract support costs (CSC) of Tribes who elect to exercise Indian self-determination rights provided by Federal law to take over direct operation of health programs at the local level.

HEALTH DISPARITIES IN INDIAN COUNTRY

No other segment of the American population experiences greater health disparities than the American Indian and Alaska Native (AI/AN) population. Our people have long suffered disproportionately higher rates of chronic diseases due to lack of timely diagnosis and treatment.

Thirteen percent of deaths in Indian Country occur among our people below the age of 25, a rate that is three times higher than the average in the U.S. population as a whole. 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.[1] These disparities are largely attributable to a serious lack of funding sufficient to advance the health care infrastructure, and the level and quality of health services for AI/AN.

The most heartbreaking aspect of these deplorable statistics is the knowledge that the majority of illnesses and deaths from disease could be prevented if additional funding and modern programmatic approaches to health care were available to provide even the most basic level of care enjoyed by most Americans**.** Despite two centuries of treaties and promises, American Indians endure adverse health conditions and a substandard level of health care that would be unacceptable to most of their fellow citizens. While over the last thirty years, progress has been made in reducing the occurrence of infectious diseases and decreasing the overall mortality rates in Indian Country, AI/ANs still have lower life expectancy and a lesser quality of life than the general population.

THE IHCIA MUST BE MADE A PERMANENT LAW OF THE UNITED STATES, COMMENSURATE WITH THE PERMANANCE OF THE FEDERAL TRUST RESPONSIBILITY FOR INDIAN HEALTH

It is time to make the IHCIA a permanent Federal law. We ask that the Committee revise H.R. 2708 to remove the "sunset" dates and permanently authorize the appropriation of funds to carry out the programs and services the Act requires, to assure Indian people that the IHCIA will continue to direct how their health care will be delivered, and to demonstrate that Congress is committed to honoring its trust responsibility for health.

The theory that "sunset" dates are needed to spur Congress to periodically review and update major laws has not worked in the IHCIA context. Such review and updating of the IHCIA

[1] U.S. Comm'm on Civil Rights, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country*, at 34-35 (2003).

should have occurred in 2000, but for ten years, despite intense work and advocacy from throughout Indian Country, Congress and the Executive Branch have not carried out their responsibility to reauthorize this law.

Our request for a permanent authorization is not a unique one. Congress has, in fact, used the permanent authorization approach for significant Federal Indian laws that implement Congress's plenary power over relations with Indian tribes – such as the Snyder Act, the Indian Self-Determination and Education Assistance Act, the BIA elementary and secondary education law, the Tribally Controlled Schools Act, the Indian Financing Act, the Indian Gaming Regulatory Act, the Johnson-O'Malley Act, the Indian Child Welfare Act, the Indian Law Enforcement Reform Act, the National Indian Forest Resources Management Act, and the Native American Graves Protection and Repatriation Act. It is now time to add the Indian health law to that list. Under separate cover, you, and other Members of Congress and the President will receive a letter signed by numerous Tribal leaders making this request.

Making the IHCIA permanent would not, of course, prevent Congress from amending and revising the IHCIA whenever it sees fit. Both the Medicare and Medicaid laws – the cornerstones of Federal support for delivery of health care to elderly and low-income Americans – are permanent laws of the United States and are routinely subject to amendment when Congress recognizes a need to so act. The law which directs Federal supervision of health care delivery to AI/ANs should have similar permanent status.

H.R. 2708 REFLECTS INDIAN TRIBES' PRIORITIES

On behalf of the NSC and Indian Country, I want to express our appreciation to you for including in IHCIA reauthorization legislation many recommendations made by tribal leaders and health advocates. We are particularly gratified that in preparing H.R. 2708, the bill's sponsors accepted so many of our recent recommendations to assure the bill is as up-to-date as possible. For this we specifically acknowledge the contributions of Rep. Frank Pallone, Chairman of the Health Subcommittee of the Energy and Commerce Committee, Rep. Nick Rahall, Chairman of the Natural Resources Committee, and Rep. Don Young, a former Chairman of this Committee and steadfast IHCIA reauthorization advocate.

H.R. 2708 is noticeably shorter than its predecessor from the 110th Congress, as a number of provisions from the prior bill were enacted into law earlier this year through the Children's Health Insurance Program Reauthorization Act and the American Recovery and Reinvestment Act. These Indian-specific amendments to the Social Security Act (SSA)[2] will result in increased access to and enrollment of AI/AN in the CHIP and Medicaid programs. We appreciate the support of Senate and House leadership and the members of this Committee for these accomplishments.

[2] The SSA amendments include: grants for outreach and enrollment of Indian children in CHIP, recognition of Tribal enrollment cards as Tier 1 documentation for Medicaid citizenship purposes, Medicaid cost-sharing exemptions for Indians, exemption of Indian trust property and resources from eligibility and estate recovery act purposes, and provisions to ensure Indian health participation in Medicaid managed care programs.

Your – and our – work is not done, however. We must now assure that reauthorization of the IHCIA is accomplished this year and validates the ten years worth of effort from tribal leaders and Members of Congress who have never waivered from the ultimate goals of bringing modern methods of health care delivery to Indian people and empowering Indian tribes to direct their own health care delivery systems, as promised by the Indian Self-Determination and Education Assistance Act..

The NSC prepared the first draft of a reauthorization bill in 1999; it set out the advancements we knew were necessary for enhancing the health status of Indian people. While the legislation has changed and matured over the past decade, the basic framework remains that prepared by tribal leaders at the request of key Congressional leaders. Indian Country has willingly and substantively participated in this process while steadfastly insisting that two principles be observed: that the legislation allow no regression from current law authorities, and that the Indian health system be modernized and strengthened. Please let us all now finally finish the job we all set out to accomplish.

I wish to mention just a few of the H.R. 2708 provisions that epitomize the advancements we seek.

Improved Standards for Mammography and Other Cancer Screening. Section 206 of the bill would adopt national standards for mammography and other cancer screening. Early detection and treatment are particularly important in Indian Country, as Indian people have the poorest cancer survival rate of any racial group in the United States, and this disease has become the leading cause of death among Alaska Native women, and the second leading cause of death among all AI/AN women. [3]

Authorization for Modern Methods of Health Care Delivery. Bill section 212 will provide express authority for IHS and tribes to operate hospice, long-term care and assisted living programs and to supply health services in homes and community-based settings. All such delivery methods are commonplace in mainstream America, but are rare in Indian Country. Not only are such approaches very effective, they are demonstrably more efficient and cost-effective ways of getting care to individual beneficiaries. We heartily support this provision.

Upgraded Authorities for Epidemiology Centers. Section 208 recognizes the need for tribal epidemiology centers to be expressly authorized to access the data they need to monitor the incidence of diseases in Indian communities in order to help tribes and urban Indian organizations design programs and services targeted to attack those diseases. Proper fulfillment of this mission necessarily requires epi centers to operate like Public Health Authorities and to access Indian Country data compiled by HHS agencies.

Expansion of Indian Health Care Delivery Demonstration Projects. Section 306 contains new authorities to establish convenient care demonstration projects to provide primary health care such as urgent services, non-emergent care services, and preventive services outside the regular hours of operation of a health care facility. This provision would enhance the health care

[3] U.S. Comm'n on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, at 17 (Sept. 2004).

delivery options and has the potential to reduce the demand for contract health services (CHS) and emergency visits.

Comprehensive Behavioral Health Programs. One of the biggest accomplishments of the NSC was re-focusing the IHCIA Title VII – which currently addresses only substance abuse programs – to reflect a comprehensive system of behavioral health programs. This new title calls for the integration of programs for mental health, social services, domestic and child abuse, youth suicide and substance abuse into the Indian health delivery system. Attacking these chronic, debilitating problems is vital to improving the quality of life in Indian Country and strengthening Indian families.

Elevation of IHS Director to Assistant Secretary for Indian Health. We are grateful that the Committee continues its steadfast support for elevating the Indian Health Service into the policy-making hierarchy of the Department of Health and Human Services. Bill Sec. 601 would accomplish this by elevating the chief officer of the Indian Health Service to the rank of Assistant Secretary. Enactment would fulfill a longstanding goal of the Indian health community.

Tax Treatment for Certain Services and Benefits. Bill section 807 addresses a serious issue that has only recently arisen in Indian Country. As decades have passed in which the funding for Indian health care has remained at barely over sixty percent of what is available to federal employees under their insurance plan, Tribes have felt compelled to step in to try to fill the gap. They have expanded direct services, augmented contract health services funding in order to purchase more care, paid premiums for Medicare Part B and D or other insurance, and developed self-insurance plans that cover their members. Unfortunately, the tax consequences of such programs is unclear. Several Internal Revenue Service auditors have cited the fact that there is no statutory exclusion from gross income for such benefits and several tribes have been selected for audit. This new section 807 will clarify that these benefits are tax exempt – as they should be. They were paid for through the exchange of tribal lands and resources. American Indian and Alaska Native people are entitled to health care at no cost to them and should not be taxed when their tribes step in to assist in obtaining that care for them.

We must point out, however, that subsection (c) must be revised to add "before, on, or" prior to the word "after" in order to assure that this new provision will not result in IRS taking the position that benefits offered prior to its enactment must have been taxable.

Retention of current law provision regarding abortions. We support Sec. 804 which would retain the current IHCIA language regarding abortions. A provision added to an IHCIA bill during Senate debate last year was highly objectionable, as it would have applied to the Indian health system – and to Indian women – a far more stringent policy than that applied to all other Federally-funded health programs. Such disparate treatment is unnecessary and unfair.

REVISIONS WE SEEK TO H.R. 2708

While the NSC is extremely supportive of H.R. 2708, there are, nonetheless, a few provisions which require revision and additional provisions we would like to see inserted into the bill. Our

proposals in this regard are outlined in the section-by-section revisions document which I attach to this testimony. I wish to highlight one important needed revision here.

Catastrophic Health Emergency Fund (CHEF). Continuing authorization for this long-standing, vital program is missing from H.R. 2708. The CHEF provision is contained in current law as Section 202 and has appeared in all IHCIA reauthorization bills since the initial one was introduced in 1999. We believe the omission was a mistake; most likely the bill's sponsors intended instead to delete Sec. 202 of bill title II – the Social Security Act amendments – as Sec. 202 in that title was enacted into law earlier this year in the CHIPRA amendments. We ask the Committee to restore the CHEF provision as it appeared in H.R. 1328 (110th Congress bill.)

CONCLUSION

Words cannot express my gratitude to the sponsors of H.R. 2708 for producing a nearly perfect bill. I am particularly gratified that this legislation reflects a true Federal/tribal partnership whose shared goal is the improvement of the health status of Indian people by strengthening the system created by the Federal government to deliver health care to them. If Congress enacts this legislation and President Obama signs it into law, I promise you that we will use the authorities this bill provides to improve the Indian health system for our people and thereby make you proud of your legislative accomplishments.

I am happy to answer any questions you may have.

NATIONAL TRIBAL STEERING COMMITTEE (NSC)
FOR IHCIA REAUTHORIZATION
AND
NATIONAL INDIAN HEALTH BOARD

SECTION-BY-SECTION DESCRIPTION OF
REQUESTED REVISIONS TO H.R. 2708

Permanent Authorization Needed for IHCIA. Please delete Secs. 128, 226, 317,417, 521(a), 603, and 717 which authorize appropriations only through 2015. Revise Sec. 818(a) to read as follows:

> **SEC. 818. AUTHORIZATION OF APPROPRIATIONS; AVAILABILITY.**
>
> "(a) AUTHORIZATION OF APPROPRIATIONS. – There are authorized to be appropriated such sums as may be necessary to carry out this ~~title~~ Act."

Sec. 2 – Findings. Insert as a new paragraph the finding from H.R. 2440 (108th Congress) which reads as follows:

> "(6) Through the cession of over 400 million acres of land to the United States in exchange for promises, often reflected in treaties, of health care Indian Tribes have secured a de facto contract that entitles Indians to health care in perpetuity, based on the moral, legal, and historic obligation of the United States."

Sec. 4 – Definitions: add "Traditional Health Care Practices". Insert definition of this term from S. 1057 (109th Congress):

> "(__) The term 'traditional health care practices' means the application by Native healing practitioners of the Native healing sciences (as opposed or in contradistinction to Western healing sciences) which embody the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which call upon these influences or forces in the promotion, restoration, preservation, and maintenance of health, well-being, and life's harmony."

IHCIA Title I – add section to make IHS scholarships and loan reimbursements non-taxable to recipients. Insert Sec. 124 from S. 212 (107th Congress):

> "SEC. ___. – **SCHOLARSHIPS.** Scholarships and loan reimbursements provided to individuals pursuant to this title shall be treated as 'qualified scholarships' for purposes of section 117 of the Internal Revenue Code of 1986."

Sec. 110 – Indian Health Service Loan Repayment Program. Two subsection cross-references are inaccurate. On bill p. 46, line 10, change "subsection (k)" to read "subsection *(l)*"; and on p. 47, line 7, change "subsection (j)" to read "subsection (k)".

IHCIA Title II – Catastrophic Health Emergency Fund. This provision, a significant and essential provision in current law, was inadvertently omitted from H.R. 2708. (We believe the sponsors intended to delete Sec. 202 of bill title II – an amendment to the Social Security Act regarding Medicaid outreach – as that provision was enacted into law in the ARRA (Pub. L. 111-05; Feb. 15, 2009). Instead, Sec. 202 of IHCIA Title II – the CHEF authorization – was deleted instead. Please re-insert the text of this provision as it appeared as Sec. 202 in H.R. 1328 (110th Congress bill).

Sec. 302(e) – Financial Assistance for Sanitation Facility Operating Costs. This bill provision [HR 2708 p. 149] limits the extent of Federal assistance that can be provided to help tribes operate and maintain sanitation facilities. Such a limitation would create particular hardship to small Indian communities. Thus, we request that the language for Sec. 302(e) as included in H.R. 1328 (as reported by the Natural Resources Committee in the 110th Congress) be used instead:

> "(e) FINANCIAL ASSISTANCE. – The Secretary is authorized to provide financial assistance to Indian Tribes, Tribal Organizations, and Indian communities for operation, management, and maintenance of their sanitation facilities."

Sec. 303(b) and (c) – Davis-Bacon Act applicability. We note that Sec. 303 contains two subsections which address Davis-Bacon applicability: (b) labeled "Pay Rates" and (c) labeled "Labor Standards". These subsections appear to be duplicative. We recommend using the text of subsection (b) which reflects current law language and is the text used by the Senate in its 110th Congress bill, S. 1200. [HR 2708 p. 156-7]

Sec. 309 – Facilities Loan Program. This bill provision calls for a study of whether to create a loan program to help tribes construct health care facilities. The NSC supports instead the restoration of the provision from 107th Congress bills which would, in fact, create such a loan program. Please insert the text that appeared as Sec. 310 in S. 212 (107th Congress).

Sec. 402(a) – Grants for Outreach. This provision contains an introductory prepositional phrase which is unnecessary and contains an inaccurate cross-reference. We recommend deletion of the following words from Sec. 402(a): "From funds appropriated to carry out this title in accordance with section 414,". [HR 2708, p. 190]

Sec. 521(b) – Authorizations for Urban Indian Organizations. This subsection identifies five programs authorized in other sections of the bill for which the IHS is authorized to establish similar programs for urban Indian organizations. Two of the referenced sections numbers are incorrect: the school health education program is Sec. 209, not Sec. 210; and the prevention of communicable diseases is Sec. 211, not Sec. 212. Plus, we

note that urban Indian organizations are included in the text of Sec. 211. [HR 2708, p. 242]

Sec. 807(c) – Treatment of Certain Services and Benefits. This provision would provide that "gross income" does not include health benefits purchased for or provided to individual Indians. This is heartily supported by Indian Country. But subsection (c) – "No Inference" – requires revision to assure that the policy of the section is actually advanced, not regressed. Please revise as follows:

> "(c) NO INFERENCE. – Nothing in this section is intended as an inference to the tax treatment of governmental benefits (including health care benefits not covered under this section) provided by Indian tribes to Indians before, on, or after the date of enactment of this section."

Unless this revision is made, the entire subsection (c) should be deleted. In its current form, negative inferences could be drawn with regard to tax reviews conducted by IRS anytime prior to enactment. Such an outcome is vigorously opposed by Indian Country.

H.R. 2708, title II, Sec. 201 – Social Security Act amendments. Sec. 201 of H.R. 2708 revises two provisions of the Social Security Act regarding the Indian health system: Sec. 1911 (Medicaid) and Sec. 1880 (Medicare). The NSC continues to support revisions to both provisions to facilitate collection of Medicare and Medicaid payments by IHS and Indian tribal programs, including updating the subsections of both 1911 and 1880 which provide a "grace period" for these programs to come into compliance with Medicare + Medicaid standards.

> MEDICAID. Please revise Sec. 201(a) of the bill to read as it did in H.R. 1328 (110th Congress). There, Sec. 1911(b) of the SSA was amended to provide a 12-month grace period for IHS/tribal programs to come into compliance with Medicaid standards. Specifically, the provision we seek appeared in H.R. 1328 as Sec. 201(a)(2) which would amend Sec. 1911(b) of the Social Security Act.
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> MEDICARE. Sec. 201(b) of H.R. 2708 does two conflicting things: It repeals Sec. 1880(b) [p. 351, lines 6-7]; and amends Sec. 1880(b) [p. 351, lines 11-25; p. 352, lines 1-3]. The NSC supports the amendment to Sec. 1880(b). The repeal of that subsection should be deleted.

H.R. 2708, title II, Sec. 202 – Increased Outreach to Indians under Medicaid and SCHIP. This provision has already been enacted into law and should, therefore, be deleted from H.R. 2708. It was added to the Social Security Act by Sec. 202 of the CHIPRA amendments, Pub.L. 111-3 (Feb. 4. 2009).