

**KEEPING AMERICA'S PROMISE:  
HEALTH CARE AND CHILD WELFARE  
SERVICES FOR NATIVE AMERICANS**

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**HEARING**

BEFORE THE

**COMMITTEE ON FINANCE  
UNITED STATES SENATE**

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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MARCH 22, 2007

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Printed for the use of the Committee on Finance

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U.S. GOVERNMENT PRINTING OFFICE

44-280—PDF

WASHINGTON : 2007

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**KEEPING AMERICA'S PROMISE:  
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**THURSDAY, MARCH 22, 2007**

U.S. SENATE,  
COMMITTEE ON FINANCE,  
*Washington, DC.*

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Bingaman, Salazar, Grassley, and Thomas.

**OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR  
FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. The hearing will come to order.

A chief and Indian wise man named Shinguaconse once respectfully addressed a government official, and he said, "My father, you have made promises to me and to my children. If the promises had been made by a person of no standing, I would not be surprised to see his promises fail. But you, who are so great in riches and power, I'm astonished that I do not see your promises fulfilled."

We would be ashamed if Shinguaconse were here today. America is great in riches and power, but our health care promises to America's original inhabitants remain unfulfilled.

In 1976, Congress made promises when it passed the Indian Health Care Improvement Act, known as IHCA. IHCA provided critical funding and improvements to ensure that our Nation's first people get access to health care.

But for the last 13 years, Native Americans have been waiting for Congress to fulfill these promises. For the last 13 years, we have seen Congress fail to reauthorize the law. As a result, the current funding level for the Indian Health Service system is only 52 to 60 percent of the need. That means that, in any given year, by the month of June, the only patients who can receive treatment in Indian Health Service hospitals are those with conditions that "threaten life and limb."

Listen to the story of one 25-year-old Native American, a veteran of the Gulf War. He was diagnosed with a problem that required removal of his gall bladder. Now, gall bladder removal has become a pretty routine procedure. But this young man could not be referred for surgery in an Indian Health Service hospital. His condition did not "threaten life or limb," so he had to wait.

So his gall bladder became inflamed. His kidneys and other organs shut down. Because of this needless delay, he will be on dialysis for the rest of his life. We can trace that result back to a lack of adequate funding for his care.

Listen to some other results of inadequate health care funding in Indian country: Native Americans younger than 25 years of age die at a rate three times of that nationwide; Native Americans are three times more likely to die in accidents; Native Americans are four times more likely to die from diabetes; and Native Americans are 7.5 times more likely to die from tuberculosis.

As well in Indian country, methamphetamine abuse is at an all-time high, so today we will also examine the links between substance abuse and the tribal child welfare system. In Montana, two-thirds of child welfare cases are related to substance abuse, primarily meth.

The child welfare system is also languishing because of inadequate funding. The system also suffers from a lack of culturally appropriate approaches to help tribal children find loving, permanent homes.

I am proud to have worked last year with Senator Grassley, Senator Rockefeller, Senator Hatch, and Senator Snowe to pass the Child and Family Services Improvement Act of 2006.

This act provides \$140 million over 5 years to fund competitive grants to encourage collaboration and innovation across the country. These grants will help families to heal from addiction and these grants will help to keep children from entering the child welfare system.

There is still much work to do. More than a third of foster children in Montana are Native American. Across America, most of the Native American children in foster care are under the jurisdiction of tribal courts. But Native American tribes that administer their own child welfare systems are not eligible for title IV-E funds to run their programs.

We also need to think creatively about allowing children and loving family members the option of subsidized guardianship. Nearly 20,000 foster children who cannot return to their parents have found safe, permanent homes with relatives.

We owe the first inhabitants of this great Nation medical care consistent with the medical care found in mainstream hospitals and clinics. We also owe their children a child welfare system that works for them. We must do all we can to help provide that help.

Last year, Congress came close to reauthorizing IHCA. Three committees favorably reported bills. The Finance Committee, in a bipartisan effort, yielded the "Medicare, Medicaid and SCHIP Indian Health Care Improvement Act of 2006." So, this year let us complete the job.

Let us heed the call of Shinguaconse. Let us act like a Nation "great in riches and power," and let us fulfill our health care promises to the first Americans, and to the children.

Senator Grassley?

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,  
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Thank you very much. I thank the Chairman for calling this meeting and reflect upon the hard work that we did on similar legislation last year that got out of this committee unanimously.

We spent a long time working with the Committee on Indian Affairs to get it out, and it was all done in a bipartisan way, and I think we will continue that same way this time.

I want to also, Mr. Chairman, recognize Ms. Bear King, who is not from Iowa right now, but has had Iowa connections for a long period of time. I want to recognize her and welcome her here, as well as the other witnesses.

In 2003, the Commission on Civil Rights reported that “American Indian youths are twice as likely to commit suicide, 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 deaths compared with other groups.”

Yet, with the Indian Health Service and tribal health care delivery sites funded at less than 60 percent of the cost of providing health care to their patients, we are not doing enough to close the gap on the health disparities faced by Native Americans. The answer is for us to pass, then, the bill already referred to: the Indian Health Care Improvement Act.

Last year, the Finance Committee passed the Medicare, Medicaid and SCHIP Indian Health Care Improvement Act. The bill contained the provisions of the larger Indian Health Care Improvement Act that were in the Finance Committee’s jurisdiction.

That legislation allowed the tribes to use money from Medicare and Medicaid to maximize improvement of their health care. That legislation provided increased outreach for Indian tribes to assist Native Americans in applying for Medicaid and SCHIP.

In addition, the legislation that was reported last year provided relief for Indians for Medicaid cost sharing or premiums, if that Indian comes to Medicaid by contract or referral from the Indian Health Service.

Our legislation last session required reporting of data, the status of their health care, and efforts being made to upgrade facilities that may not be in compliance with the Social Security Act. There were valuable reporting requirements that would aid us then in the future to ensure that we are providing quality care to Native Americans.

The Indian Affairs Committee has started the process through the legislation introduced there for this Congress. I know, working with Chairman Baucus, that we are committed to moving our bill through the Finance Committee again this session. As he knows, I look forward to working with him.

I also look forward to efforts to continue the bipartisan work on improvements to the child welfare system. I recognize the importance to tribes of being able to apply directly to HHS for foster care funds. I have supported similar provisions in the past, and I am also interested in kinship care.

I am pleased that my State of Iowa has approved a waiver that supports subsidized guardianship. While I am mindful of the fiscal constraints and the needs to address the overall issue of child welfare financing, I am supportive of efforts to more broadly subsidize family guardianships.

We have an important agenda to accomplish in this committee when it comes to welfare issues generally, and specifically Indian health today. It is good that we are having this hearing to start this process again, and I think it will be an easier process this time.

The CHAIRMAN. I think so. Right. Thank you, Senator Grassley.

I would now like to introduce our witnesses. First, I am very proud to introduce the chairman of the Crow, Chairman Carl Venne. Chairman Venne is also chairman of the Montana/Wyoming Tribal Leaders Council, and president of the Council of Large Land-Based Tribes.

I do not know your name, Mr. Chairman, in native Crow, but I do know, translated to English, it means One Who Crosses the Big River and Becomes a Leader. I think that is very apt for you. You come back to Washington many times. I do not know a tribal leader who works harder for his people than you. We see you many times. I just want, personally, to tell you how much I deeply appreciate your deep commitment to your people.

We will also hear from Valerie Davidson. Ms. Davidson is senior director of Legal and Intergovernmental Affairs at the Alaska Native Tribal Health Consortium based in Anchorage, AK. Welcome, Ms. Davidson. You have traveled a long way to come here.

Next, Ms. Linda Holt. She is secretary of the Suquamish Tribal Council and legislative liaison to the State and Federal Governments. The Suquamish Tribe is located, of course, in the State of Washington and is the tribe of the great Chief Seattle.

Finally, Connie Bear King. Ms. King is an enrolled member of the Standing Rock Sioux Tribe and also the Government Affairs Associate for the National Indian Child Welfare Association. Ms. Bear King is from Sioux City, IA. Thank you very much.

Chairman Venne, you are first.

**STATEMENT OF CARL VENNE, CHAIRMAN, CROW NATION;  
CHAIRMAN, MONTANA/WYOMING TRIBAL LEADERS COUNCIL;  
AND PRESIDENT, COUNCIL OF LARGE LAND-BASED  
TRIBES, CROW AGENCY, MT**

Mr. VENNE. Thank you. Good morning, Chairman Baucus, Vice Chairman Grassley, and honorable members of the Senate Finance Committee. I am Carl Venne, chairman of the Crow tribe, chairman of the Montana/Wyoming Tribal Leaders, and president of Large Land-Based Tribes.

I am honored to be here today to provide testimony on the critical need to adopt the Indian Health Care Improvement Act. The Council of Large Land-Based Tribes is a national organization of tribes with land bases of over 100,000 acres.

The large land-based tribes continue to suffer from traditional Indian reservation issues, including poverty, high unemployment, joblessness, lack of housing, and, most critically, substandard health care.



While the discussion about the Indian Health Care Improvement Act continues, I would like to tell you real-life stories about the impact of substandard, deplorable health care on my home reservation.

One of the stories is, a little Crow girl was diagnosed with a rare cancer in one eye at age 5 months. She had to have the eye removed and have an artificial eye that must be replaced as she grows. She is now 5 years old and needs a new artificial eye.

But because it is not a life-or-limb illness, Contract Health Service will not approve of the cost for the eye. Her parents both recently became employed and make just enough to be ineligible for Medicare. Without the new artificial eye this little girl will be disfigured, but it is unlikely her parents will be able to afford it on their own. That is only one story.

You know, the mission statement of Indian Health is to ensure adequate health care, to promote healthy communities, and to protect tribal sovereignty. Without sufficient funding, this mission is meaningless.

Health care for American Indians is a treaty right. We, as tribes, have given, and given, and given to this mighty country of ours. Take my tribe, for instance. It owned all of the Powder River Basin, 38 million acres.

Today, we only own 2.5 million acres. But look at the billions of dollars that have been taken from the land because of large resources. Look at all the dams in Montana. Where were they built? On Indian reservations.

What did we receive as Indian tribes when the Federal Government has made hundreds of millions of dollars and we were only paid \$5.5 million and the land was condemned? However, we suffer from great health disparities, we suffer from higher rates of chronic disease, including diabetes, heart disease, cancer, suicide, and one of the highest infant mortality rates in the world in the Great Plains.

I think there is a misconception all over the United States about Indian tribes. There are the haves and the have-nots. We are not, especially in the Great Plains and in Montana, not gaming tribes. We do not receive gaming revenues.

You see in the papers where gaming tribes are buying and investing throughout America. We on the Great Plains and in Montana do not have that opportunity. So, we are very diverse between Indian tribes. The majority of Indian tribes live in the Great Plains and the Rocky Mountain region.

The biggest land bases are with these tribes, and the population is with these tribes. So there is a lot of misconception about Indians. While the President's budget increased in every line item, the Indian Health Service budget increase is not enough to even the deplorable status of health care.

The President's \$1.4-billion budget request falls far below the fiscal year 2006 needs-based budget, indicating at least \$19.7 billion is necessary for adequate health care.

The present budget allows Indian Health Service to meet only 60 percent of the need. In 2003, the Indian health budget allowed \$2,130 per person, while the general public expenditure for the

U.S. population was \$5,065, per capita. But in Montana, it is only \$1,688 that was expended on tribal members in the Billings area.

You know, Indians, we joke about things. I think that is how we control our depression. Come June 1, Indian Health Service is out of money to provide money for Indian tribes for health care. We joke about that and we say, don't get sick after June 1. It is not right.

The billions of dollars that this country spends in foreign aid—I look at the budget as a tribal leader. You know, the Montana area or the Billings area is \$40 million in the red, but yet we give \$40 million to BLM to take care of some wild horses, which we do not ride and we do not eat. Let us set priorities in government today where these needs are met. The human needs of this country and the morals of this country are very important to its Indians.

Looking at the proposed budget this year, take the African nations. They are asking 3 times more to fund them, when, if you go down the First Avenue in Billings, MT and you see the homeless women and children standing outside, what are we really thinking about in this country? We should be serving our people. We are your constituents. I also have constituents.

What are we really doing in America today? It is very sad to see these things, especially in Indian country, and it is deplorable. But it is time for Indian tribes to start speaking up. It is time to start doing things for all of our people.

Do I need Kevin Costner to show another "Dances With Wolves" in order to bring the Indian problems out to the general public today, or go on "Larry King Live"? No, I do not think so. It is time for all of us to work together.

You know, 70 percent of tribal members enlist in the service during war time. That is a fact. Eighteen percent of all the branches of services are Indians today. I alone have 52 young men and women in Iraq and Afghanistan today.

You know, the bullets do not say, that guy is white, that guy is red, or that guy is black. We are all in it together, and we need to work together as a people, as great Americans, great Montanans, and great Indians. We have supported everything that this great country has asked.

Give us a chance to dream like Martin Luther King dreamed for his people. We want the American dream of building our own homes, having jobs. We have unemployment rates of 47 percent. If 40 percent of Americans today were unemployed, you would see riots in the streets of Washington, DC and all the big cities.

Montana enjoys a 2.7-percent unemployment rate, but on reservations—my reservation has the lowest unemployment rate, and that is 47 percent. But look at all the reservations within Montana, it is over 50 percent.

What can we do as Americans? We need to sit down and work together. I know the reauthorization bill was stopped by the Justice Department. Why can we not sit across the table and discuss these things and get things done for all of America?

The CHAIRMAN. You make very good points, Mr. Chairman. I really appreciate that very, very much. Thank you.

[The prepared statement of Mr. Venne appears in the appendix.]

The CHAIRMAN. Ms. Davidson?

**STATEMENT OF VALERIE DAVIDSON, ESQ., SENIOR DIRECTOR,  
LEGAL AND INTERGOVERNMENTAL AFFAIRS, ALASKA NA-  
TIVE TRIBAL HEALTH CONSORTIUM, ANCHORAGE, AK**

Ms. DAVIDSON. Good morning, Chairman Baucus, Ranking Member Grassley, and honorable members of the Senate Finance Committee. "Ochwiana," or thank you for the opportunity to testify about the importance of Medicaid, Medicare and SCHIP funding for the Indian Health system.

I should introduce myself properly: Wiinga Nurraraluugua Amill amarnan-llu. Yupiugua-Mamterillermiu. Aanaka kwigillingsurmianguq ataka Portera Washington macmillloq. My Iñupiaq Eskimo names are: Nurraralaq Aanaka Millimoquinon. Feel free to call me Valerie Davidson; it is a little bit easier to pronounce.

The CHAIRMAN. What language is that?

Ms. DAVIDSON. Iñupiaq Eskimo.

The CHAIRMAN. Iñupiaq?

Ms. DAVIDSON. It is the best language in the world. [Laughter.]

The CHAIRMAN. All right. Thank you. I am not going to argue with you. [Laughter.]

Ms. DAVIDSON. I serve as the chair of the tribal technical advisory group to the Centers for Medicare and Medicaid Services, and I recently served as a non-voting member of the Medicaid Commission.

In its final report, one of the things that the Medicaid Commission did is endorse the provisions that were passed by this committee in S. 3524, the "Medicaid, Medicare, and SCHIP Indian Health Care Improvement Act of 2006."

I wanted to express my special appreciation to this committee in what has been probably the highlight of this long, long effort to be able to get the Indian Health Care Improvement Act reauthorized.

I have served on the National Steering Committee since its beginning. I cannot even remember how many years ago. I think it has been about 7, 8, or 9, but it feels like about 20.

It has been my great privilege to work for the Yukon-Kuskokwim Health Corporation in southwest Alaska, an area about the size of the State of Oregon, 75,000 square miles, with no roads connecting any communities. Health care is provided in 50 small villages, and access to care is truly a problem, where the only way you can get to the closest hospital is by anywhere between a \$300 to an \$800 round-trip plane ticket.

I currently work for the Alaska Native Tribal Health Consortium, and we provide State-wide services that were previously provided by the Indian Health Service.

Let me tell you a little bit about Alaska and Alaska natives. We represent about 19 or 20 percent of Alaska's population. Our median age is about 23.6 years, and that is because, traditionally, we get married right after high school and have children in our communities.

We get married early and our children are quite young. We have incredibly high poverty rates and unemployment, as high as 75 or 80 percent in some of our communities, and income generally will stretch to provide for the sustainability for about 15 family members.

I am not going to talk about some of the health disparities that were already mentioned by the members of this committee, as well as other folks, but I did want to talk a little bit about some of the Medicaid, Medicare, and SCHIP provisions.

If you look at those kinds of things, which I will just refer to now as third party reimbursement, there are really two critical roles that it plays in the delivery of health care to American Indians and Alaska natives.

The first role that it plays is that it supplements a source of health care that the Indian Health system cannot provide itself, and which contract health care also cannot pay for.

The second is, it also provides a critical source of revenue to be able to sustain the Indian Health system, when we know it is only funded at 60 percent of the level of need.

If it costs \$1,000 to provide care to a patient and the Indian Health system only funds \$600 of that, where does that remaining \$400 come from? It has to come from third party reimbursement, otherwise we would have to be forced to close our doors.

In the first category, Medicaid pays for services that are not currently available widely in the Indian Health system, and it pays for things like long-term care, pays for the continuum of care, and the advancement of health systems that we know that the rest of the country benefits from, like long-term care.

There are other provisions that I can maybe talk about a little bit later if I have more time, but let me turn back a little bit to sustainability. We know that the current system does not pay for, as you mentioned, substance abuse services adequately, other kinds of behavioral health services, and basic access to medical care.

One of the things that Medicaid does is, it pays for the difference in that gap. The only way that American Indians and Alaska natives currently have access to those services is when Medicaid, SCHIP, or Medicare pays for those services.

The new provisions that increase outreach and enrollment are critical to our people, and here is an example. The citizenship issues that are included in the bill are really critical, and here is one example in Indian country.

In the region that I am from, there is only one place in this 75,000-square-mile area to be able to get a State-issued ID, and that is in the big, giant city of Bethel that has about 6,000 people.

Here is the challenge: in many communities you have to buy a \$200 to an \$800 round-trip plane ticket just to be able to go there to be able to get that State-issued ID, and that DMV office, last year, was closed for 10 months out of the last year, and there were families who showed up to be able to satisfy that citizenship requirement and paid a lot of money, money that they simply did not have, to be able to protect their eligibility for Medicaid, and the door was not even open, and nobody could tell them when in the next year it could possibly be open. We know that, as resources get tighter, individual American Indians and the Indian Health system that provides their care will feel the impact more than any.

You may ask, why? Well, the reasons are pretty simple. We are disproportionately eligible for Medicaid because, as we said, we have the highest rates of unemployment and we have the lowest income levels.

We have some of the poorest health status and the greatest health disparities, and we live in rural and frontier communities where access to care is a problem, and we have a high cost of providing care and a high cost of living, which means that limited incomes get stretched even further.

What that really means is, when our people finally do get the care that they need, they have traveled further with money they simply do not have, they are sicker than the average person, and they are seen in clinics and hospitals that have fewer resources than any other facility in the country, that also, because of their rural nature, have a higher cost of providing care.

The CHAIRMAN. Thank you. Thank you very much, Ms. Davidson. [The prepared statement of Ms. Davidson appears in the appendix.]

The CHAIRMAN. Ms. Holt?

**STATEMENT OF LINDA HOLT, SECRETARY, SUQUAMISH TRIBAL COUNCIL AND CHAIR, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD, SUQUAMISH, WA**

Ms. HOLT. Hello. Good morning, Chairman Baucus, Ranking Member Grassley, and members of the committee. My name is Linda Holt. I am a Suquamish Tribal Council member from Washington State, and I bring you greetings from the Suquamish Tribe.

I also serve as chair of the Northwest Portland Area Indian Health Board and am a member of the National Indian Health Board.

The Northwest Portland Area Indian Health Board is an organization that represents 43 tribes in the States of Idaho, Oregon, and Washington. I also serve as the Portland area representative on the National Steering Committee for the Indian Health Care Improvement Act. I would like to thank you for holding this hearing today, and I am honored to be here.

I commend the Finance Committee for its work on the Indian Health Care Improvement Act in the last Congressional session. The provisions that the committee passed will allow us to address the significant health disparities that Indian people face.

I truly hope that we can get this bill passed in this session and look forward to your continued support. Medicare and Medicaid have become critically important to the health of Indian people.

Indian expenditures in Medicaid and Medicare constitute a very small share of overall costs in these programs. For example, it is estimated that Medicaid accounts for almost 20 percent of the IHS budget, but less than one-half percent of the overall Medicaid expenditures go to the Indian Health program.

I want to stress this fact, since there were challenges against some of the provisions contained in title IV in the Indian Health Care Improvement Act. The Medicare and Medicaid programs are very important to the viability of the Indian Health system. Many Indian Health programs would go bankrupt without these collections due to the chronic under-funding of the Indian Health system.

Today I want to talk to you also about health facilities and their relationship to Medicare and Medicaid reimbursements, which allow our health programs to maintain services. These reimburse-

ments are vital to our Indian Health programs and allow tribally operated programs to maximize the Contract Health Service budgets.

Unfortunately, if you happen to be a tribal member from a CHS-dependent area, you do not have the same access to health care as other Indian people within the Indian Health system. Where I come from in the Portland area, we have no hospitals or inpatient facilities.

All specialty care that is normally provided in a hospital is purchased through the CHS program. This program applies strict eligibility rules and uses a medical priority system that requires all services to be preauthorized or they will not be paid.

Because we have no hospitals, our health programs often begin the year on Priority One status. This means that only emergent and acute care services are covered in order to prevent the immediate death or impairment of health. Our programs begin the fiscal year clearing the backlog of denied or deferred services from the previous fiscal year.

You may have heard the term Chairman Venne used, do not get sick in June or you will not receive CHS health care. Well, in the Portland area this term does not hold true, as our programs often begin the fiscal year on Priority One status, so you should not get sick at all.

While those areas that have hospitals face the same issues as CHS-dependent areas, they are not as extreme. The reason for this is simple. Hospitals have medical staff that can provide a number of services that are routinely purchased through the CHS program.

Hospital-based systems internalize the costs associated with providing health care that CHS-dependent areas cannot. They are also able to provide more services, since they save unobligated CHS dollars that would have normally been used to purchase such specialty care.

It is remarkable that most Americans in this country receive health services in the most modern facilities with state-of-the-art equipment; however, Indian people do not. Our clinics in the northwest are notable exceptions, most on the average of 40 to 50 years old. A clinic on the Coleville Reservation in Washington State is over 70 years old.

In other northwest tribal communities, clinics are housed in mobile homes. Not only are the clinics old, they simply are inadequate to provide health services. They are often too small, equipment is outdated, and the staff is forced to make do as best they can.

Section 301 of the Indian Health Care Improvement Act establishes authority for the IHS to develop a facility construction priority system. This system is used to evaluate and rank health facility construction projects.

Successful projects have provided funding for construction and a recurring staffing package by Congress. The staffing packages are significant with respect to the ability of a facility to seek third party reimbursements under the Medicare and Medicaid programs. CHS-dependent areas do not enjoy the same benefits as hospital-based systems and are not as able to collect as much third party reimbursements.

This is very true for IHS areas with large hospitals and health clinics that have been built with staffing packages under the priority system. This creates health service disparities within our own Indian Health system, and it is wrong.

I want to draw your attention to some graphs and maps that are included in my written testimony. On page 7, I include a graph that shows the effect of staffing new facilities on the IHS budget increases since 1995.

The graph shows that staffing, over the past 5 years, has significantly cut into the IHS budget increase by roughly 50 percent. This means that two to three tribes that are fortunate to get a new facility get half of the IHS budget increase, while 550 other tribes must share the remaining 50 percent.

The graphs on pages 7 and 8 show the amount of funding that has been allocated within the IHS system under the current priority system. Clearly, you can see there are five to six areas that do not benefit equally in funding under the current system. Three areas have never benefitted from an inpatient hospital or outpatient clinic built under the current priority system.

Finally, I want to draw your attention to maps on pages 9 and 10. These maps clearly demonstrate that facility construction projects since 1991 have been centered around five to six IHS areas. The map on page 9 shows that there has not been one inpatient hospital built in the Bemidji, California, Nashville, and Portland areas under this system.

The map on page 10 shows that there has not been one outpatient clinic built in the California, Nashville, and Portland areas under this system, yet there are 24 tribes in the Nashville area, 43 tribes in the Portland area, 34 tribes in Bemidji, and over 75 tribes in California.

The provisions of section 301 of the Indian Health Care Improvement Act are very concerning for northwest tribes. While there is generally consensus among tribes on most provisions of the Indian Health Care Improvement Act, there is not, on section 301. It is critical that this issue be addressed before enacting this bill into law.

Section 301 includes a grandfathering that will protect all construction projects on the current priority list. The language contained in section 301 was carried over from current law and developed through tribal consultation, which responded to tribal needs and concerns in 1999.

However, given recent changes in the construction priority system, the language is now out of date. Over the last 3 years, IHS and tribes have worked to develop a new facilities priority system. If this bill language is passed, it will prevent IHS from implementing this priority system.

The reason for this is, due to the grandfathering provision, it is estimated, at the current rate of appropriations, it will take 20 to 30 years to clear the current project list.

The grandfathering provision will prevent the new system from being implemented. In our written testimony, we provide the committee with a compromise to establish an area distribution methodology for facilities construction.

We further recommend language changes in other provisions of section 301. We have provided the committee staff with these recommendations and are available to discuss our recommendations with staff.

I would, further, like to add as a note that we have been waiting 3 years for the Medicare-like rates that have been finalized, and we still have not received them in final form.

The CHAIRMAN. I am going to have to ask you to summarize your testimony as well as you can.

Ms. HOLT. All right. I just want to note that we have estimated that it would save the IHS budget about \$25 million a year just to get the Medicare-like rates and be able to have that.

I want to thank the members of the committee for allowing me to be here today. As stated, the Portland area is willing to step forward with any help that we can provide.

The CHAIRMAN. Thank you very, very much.

[The prepared statement of Ms. Holt appears in the appendix.]

The CHAIRMAN. Ms. Bear King?

**STATEMENT OF CONNIE R. BEAR KING, ENROLLED MEMBER,  
STANDING ROCK SIOUX TRIBE AND GOVERNMENT AFFAIRS  
ASSOCIATE, NATIONAL INDIAN CHILD WELFARE ASSOCIATION,  
PORTLAND, OR**

Ms. BEAR KING. Good morning. Thank you, Chairman Baucus, Ranking Member Grassley, and the other members of the committee, for giving me the opportunity to share with you my experience and insight into the methods of improving child welfare services to American Indian and Alaska Native children.

I also want to thank the committee for their support of direct funding for tribal child welfare services, as evidenced by the inclusion of tribal title IV-E provisions in the foster care and adoption assistance and welfare reform reauthorization bills in the 108th and 109th Congresses.

We also would like to thank the committee for its work to support increases in funding for eligible tribes under the Promoting Safe and Stable Families program during the last Congress.

My name is Connie Bear King, and I am a Hunkpapa Lakota. I am an enrolled member of the Standing Rock Sioux Tribe in South Dakota and North Dakota. For the last 10 years until this February, I lived and worked in Sioux City, IA.

As the executive director for the Sioux City Indian Education Committee, I came in contact with many of the community's Indian families and became aware of a lot of the major issues that families were struggling with.

While working with many of its community families, I saw that many of them had experiences with the local child welfare system either as a parent whose child had been removed, or as a prospective relative placement for a child.

The local child welfare system did not understand many of our tribal communities and, many times, opted for non-relative placement of these native children, especially when relatives did not want to adopt.

During that time period, Iowa was placing 10 percent or fewer of its children in foster care with relatives, and placement options



for relatives were very limited. Nearby tribes, of which many of the Sioux City Indian community were members, were also working actively to participate in child welfare cases by offering placement and other services.

Regina Little Beaver, the director of the Human Services for the Winnebago Tribe of Nebraska along the Iowa border, told me that her ability to assist the Iowa Department of Human Services was often predicated upon the resources that were available to her.

In many cases, she said the tribe did want to bring the children home to be with their relatives, but she was not able to do that because she did not have the resources to do it. She said this was in spite of the fact that her tribe does have a title IV-E agreement with the State of Nebraska.

The agreement does not allow the tribe to access all of the title IV-E funding that was available to the State and required that the tribal title IV-E be under State court jurisdiction.

I have also been able to learn from other tribal human service directors, such as Arlene Templer at Salish-Kootenai Tribe in Montana. In her discussions with our organization and before this committee last year, she shared some of the issues she faces, such as methamphetamine abuse.

In trying to protect and find permanency for tribal children under her care, she notes that, although her tribe has a title IV-E agreement with Montana, the State insists the tribes adhere to State policies that are not part of the Federal title IV-E program.

One of these prohibits the tribes from seeking Federal IV-E reimbursement for IV-E eligible children who are being transferred from another State and placed in foster or adoptive homes on the reservation in Montana.

Arlene has said that this severely limits her ability to assist other States in finding an appropriate placement for Salish and Kootenai children living off the reservation and does not enable her or the tribe to bring them back to be placed with relatives on the reservation.

Arlene also said that if the tribe was allowed to apply for, and operate, the program directly from the Federal Government, she could serve additional children that she is not currently able to service and provide and design programs that will more effectively meet the needs of her community.

Arlene is also working with the State of Montana to secure access for her relative caregivers to the State's subsidized guardianship waiver program. In one case, a tribal member who was providing care for her niece and nephew was asked to participate in the State's subsidized guardian waiver program.

Unfortunately, they were not selected, and they were placed in the control group, which meant that her guardianship placement would be ineligible to receive any subsidy. The aunt had very limited income, and she told the program should could not care for the children without a subsidy or support and then had to return the children back to the foster care program and system, where Arlene says they will likely stay until they age out.

I ask, what are the common findings of these experiences? First is the need to give more support to relatives as caregivers. In my upbringing, I was taught that family relationships were the most

important relationships that I would ever have in my life. We strengthen our tribal families and honor the important connections of our tribal children when we can support our extended families as caregivers.

Second, we need to ensure that people with the most extensive knowledge and skills regarding native children and their families are available to help, and that is the tribes and the community.

Tribal governments throughout the Nation are struggling to keep their families together whenever appropriate and to be able to provide permanency for their children, children who have so many factors that put them at risk for removal from their homes.

I urge you, please consider the power of supporting our dream in helping Native American children and families to continue that journey of well-being and permanency.

Thank you.

[The prepared statement of Ms. Bear King appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Bear King. That is very effective.

I have a couple, three points to make here. Number one, I think the inadequate funding is an outrage in health care. I mean, the life-and-limb restriction is unconscionable, in my judgment. We have to figure out some way to solve that and prevent that from happening at the very top.

There are just too many stories of too many people who do not get proper care because of that limitation. You, Ms. Holt, said that in your area of the country it starts earlier than it does in some other areas of the country, mid-year. It should not happen at all, regardless.

I do not know how many dollars it is going to take, but we have to find a way to get that solved just as quickly as we possibly can, in my judgment. It just bothers me to no end. Again, it is just unconscionable, totally unconscionable, in my judgment. We will get at that. I have to figure out a way to solve that one.

Next, though, the IHCA Act. You, Ms. Holt, suggested some changes in section 301. What I would like to do is, just generally, hear from all four of you the degree to which you think IHCA should be reauthorized the way it is, or the degree to which you think there are some changes, major changes, you think should be made.

I do not have a lot of time; other Senators may have similar questions. But I would just like to go down just very briefly and start with you, Chairman Venne, whether you like it the way it is, the reauthorization as it is contemplated, or would you suggest a couple, three major changes. If you could limit your remarks to about a minute, because that is about all the time I have, and going down here, please.

Mr. VENNE. I think you put it well when you started out, that you know the problems in stuff like this. But the biggest thing is probably the money situation. The priorities of money going elsewhere, I think Congress needs to sit down and make those priorities. It is very important.

The budgets that are requested are only 60 percent of the needs in Indian country, and that is very important to us. One example

is, because of the fact, without the money, doctors working in our hospital are leaving because they cannot practice good health care.

It creates a problem between the patient and the doctor because they are dedicated people to provide good health and they cannot do that. They are starting to leave the Indian Health Service also.

The CHAIRMAN. All right. Thank you.

Ms. Davidson?

Ms. DAVIDSON. Although I am happy with the way the bill reads in terms of Medicaid and Medicare provisions, I guess if I could change one thing, since you asked—

The CHAIRMAN. I asked.

Ms. DAVIDSON. I would really like to see that the increases that are available for Medicaid patients and Medicare patients, the mandatory medical inflation rates, be included when Congress funds the Indian Health Service budget.

Some may ask, well, why is that? I guess if you go back to before any of us were alive, way back to our forefathers—and because I am a woman I have to say foremothers—that there were promises that were made. Our forefathers and foremothers made promises of peace in exchange of land in order for the promise of prepaid health care, for education, for health, for housing, et cetera. And for American Indians and Alaska Natives, this really is a sacred promise and it is one that cannot be breached.

The CHAIRMAN. Just so I understand, the change would be what, again?

Ms. DAVIDSON. I guess I would encourage that there would be a provision in the bill that mandates mandatory medical inflation increases for the IHS budget.

The CHAIRMAN. Okay.

Ms. DAVIDSON. And also that we have full access to Medicaid, Medicare, and SCHIP. When a patient presents at a facility, they do not necessarily care whether the payment is coming from IHS or CMS or wherever.

The CHAIRMAN. Right. Right.

Ms. DAVIDSON. That patient just needs help and they need care. The promises that were made many, many years ago were promises made by the past presidents of these great United States, and every single employee of the United States, whether they work for the Indian Health Service, or whether they work for CMS, or whether they work for HRSA, should be able to carry out the promises of that agreement that was made many years ago.

The CHAIRMAN. All right. My time is about expired.

Ms. Holt, briefly. Very briefly, please.

Ms. HOLT. Sure. As I stated earlier, the Portland area would certainly like to see the revision, and requests the revision in section 301. We are working under a system, a health care system, that has been totally inequitable to Indian country as a whole. We should not have inequities within that system that favors tribes over other tribes.

The CHAIRMAN. Right.

Ms. HOLT. And so we would ask for the revision in section 301. We also would like, for consideration, having the language taken out as IHS being the payor of last resort. As stated by Ms. Davidson and Chairman Venne, this is a treaty obligation and a fidu-

ciary responsibility that the Federal Government has to provide health care. We should not have to put up with the payor of last resort provision.

The CHAIRMAN. Thank you very much.

Ms. Bear King?

Ms. BEAR KING. Yes. Chairman Baucus, I am here primarily to speak to child welfare issues.

The CHAIRMAN. So you would like the guardianship provision changed.

Ms. BEAR KING. Yes. Yes.

The CHAIRMAN. As well as IV-E.

Ms. BEAR KING. That is correct.

The CHAIRMAN. Right. Changed.

Ms. BEAR KING. But I would definitely defer to the experts here.

The CHAIRMAN. All right. Good. I agree with you on those two points. Thank you.

Ms. BEAR KING. Thank you.

The CHAIRMAN. Senator Bingaman?

Senator BINGAMAN. Thank you, Mr. Chairman. Let me just start by saying thanks for having the hearing. I agree with you that the funding disparities are a very major inequity that we need to try to correct.

We have a chart here that makes the point that many of these witnesses have made and that you made in your opening statement. It shows the per capita funding or health care expenditures per user through the Indian Health Service, through Medicare, through Medicaid. You can see this bottom line, which is the blue line.

Two big problems with it. Number one, it is less than half the level of expenditure that any of the other lines are. Second, it is flat. It does not go up. That is our big problem with Indian health care.

Part of the solution, of course, is getting the Indian Health Care Improvement Act reauthorized, and clearly we need to get that done, and quickly. But the other part, of course, is getting funding.

There are only two parts of the Federal budget which provide health care services that are not entitlements. One is veterans care, the other is Indian health care. Both of those have been suffering as a result of the fact that they are not entitlements and Medicare goes up, and Medicaid goes up, and these programs do not. So, it is a serious problem.

Let me ask just one question. Ms. Davidson, we had a real problem in my State with this newly enacted Medicaid citizenship documentation requirement. You somewhat alluded to that in your statement.

I think the estimate is, we lost as many as 10,000 children from the Medicaid program because of the inability to document their citizenship. I gather this is a problem that you encountered in Alaska as well.

Ms. DAVIDSON. Thank you, Senator Bingaman. It actually is a problem. It is a problem everywhere. I think it is a darn shame, if I may be so bold, that a provision that was enacted under the Medicare Modernization Act that was designed to protect and conserve those Medicaid resources from non-citizens of the United

States, it is a shame that that provision is most impacting this country's first people, people who were here first, who should be able to use tribal enrollment cards as proof of citizenship.

When we meet with folks who designed the regulations for how that is implemented and we ask the question, why is that, the answer we get is because, well, some tribes are along the borders of Mexico and Canada.

Well, it just does not make sense to engineer 99 percent of a solution to address 1 percent of the problem. So you take care of the 1 percent—or probably less than 1 percent—of the problem by creating a problem for 99.9 percent of the rest of the country. It just does not make sense.

Senator BINGAMAN. So you do not think these individuals who have tribal enrollment cards up in Alaska are illegal immigrants?

Ms. DAVIDSON. No. In fact, one of those people, my grandmother, who died 2 years ago—in fact, 2 years ago today—did not have a birth certificate. On our Tribal Technical Advisory Group, one of the technical advisors, who is young, in her 40s, is from Navajo and she herself does not have a birth certificate and was wondering about how many other people in her reservation are in that same situation. This is not just an elder problem—this is people of our younger generation's age.

We are at a point where we know that American Indians and Alaska Natives are under-enrolled, and we should be doing everything we can, extending outreach and enrollment, everything within our power to be able to reach more people, not setting up barriers to be able to have access to health care and access to enrollment. That just does not make sense.

Senator BINGAMAN. All right. Well, thank you. I will stop with that, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

Senator Thomas?

Senator THOMAS. Thank you, Mr. Chairman. Thank you for holding this hearing. As you know, I am Vice Chairman of the Indian Affairs Committee, and so this is very interesting. We have talked about it on our committee. Certainly I am encouraged by the amount of increased participation in Medicare and Medicaid, in that I think that has been a change.

By the way, the citizen thing, the law was changed last year. It has not been implemented yet entirely, but we have tried to deal with that, so that will be taken into account soon.

I do indicate that Medicare/Medicaid now is estimated, this year, to be up to \$625 million with the tribes, which is a great increase. It was only \$88 million back in 1990. So, there is a great deal of increase, and that is a good thing, because those are eligible programs that all citizens of this country are eligible for.

Chief, how many patients on your reservation are enrolled, or what percentage are enrolled in Medicare and Medicaid?

Mr. VENNE. We have 11,600 Crows. Medicaid and Medicare, probably only about 20 percent are enrolled because of the problems of signing up people, and then to have the State verify it. It takes a long time for them to verify it.

When their office, from Crow, is over 70 miles away in Forsyth, we do not know if it gets off their desk or what the holdup is, but

the State is responsible for that, for certification. So, consequently we have a lot of people who are not Medicaid—

Senator THOMAS. Isn't that something we ought to resolve, and get somebody to come to the reservation if you have to, to get them signed up? That is not a difficult thing to do, you know.

Mr. VENNE. No. But I think tribes should be given the authority to verify people on Medicaid and Medicare, because we all have the know-how to do it, and how to follow Federal guidelines. We contract with the Federal Government every day, and we should be afforded that opportunity.

Senator THOMAS. Ms. Davidson, what is the payor of last resort rule, and why is it needed for Indian health care?

Ms. DAVIDSON. The payor of last resort rule basically requires that if there is an alternate payor, whether it is Medicaid, Medicare, SCHIP, or private insurance, that those payors must pay first before the resources are taken out of the budget that is allocated to that facility.

Senator THOMAS. All right. That is not a bad thing, is it?

Ms. DAVIDSON. It depends on whether you are standing from the provider's perspective or the patient's perspective, I think. I think that is a good thing, that it allows us to be able to access additional resources, to be able to get those resources in, to be able to round out the funding for an already under-funded system.

But I think one of the things that other members of this panel indicated is that barriers to being able to access those resources can have a crippling effect on our ability to be able to get increased funds. For example, the law requires that IHS is not allowed to subtract the amount that we get from Medicaid and Medicare in their annual budget request, but we see it happen every single year.

So as we are doing our part to be able to get additional third party revenues for additional administrative costs, what we are seeing is that the IHS budget, those funds are actually coming off the top of the IHS request.

Senator THOMAS. All right.

Ms. Holt, you talked about construction and so on. It takes 20 to 30 years to clear the current projects. Are Federal dollars the only source for construction of facilities?

Ms. HOLT. On that list, yes.

Senator THOMAS. Well, I mean, for all the reservations. We have a community health center we are building in Wyoming, some community health centers, with the cooperation of the tribes and the local communities, and things of that kind.

Ms. HOLT. And a lot of tribes are having to do that. They are having to redirect dollars that could be used for education, or for detention facilities, or justice systems. They are having to redirect those monies to meet the health care needs, and that just should not happen. That is not right.

It is the Federal Government's responsibility to provide that health care and to provide the facilities, and the Federal Government should meet that obligation. At the rate of appropriations that have been happening, it is estimated that it will take 20 to 30 years to clear the current list.

Senator THOMAS. All right. My time has expired. Thank you.

The CHAIRMAN. Thank you, Senator.  
Senator Salazar?

Senator SALAZAR. Thank you very much, Chairman Baucus, for focusing on this issue. I very much agree with you and Senator Bingaman that the funding disparity is unconscionable. I am hopeful that we can work together to see how we can address that funding disparity this year.

I believe this hearing provides us a very important forum to discuss the critical issues that are facing Indian country across our country, including the health and child welfare system.

In my State of Colorado, we have about 51,000 Native Americans who reside in my State. While many belong to, and reside, on the two reservations in southwestern Colorado, we also have about 22,000 Native Americans who live in the city of Denver and the Denver metropolitan area.

The Native American communities are a vital part of Colorado's history, culture, heritage, and economy. In fact, the oldest known continuous residents of Colorado are the Utes, who were there long before my family came in and settled that area in 1851.

Currently, the Ute Mountain Ute and Southern Ute tribes are effectively led by Chairman Manuel Hart and Chairman Clement Frost. I know them both. I am proud of their work. I meet with them often to discuss issues at the reservation.

Whether it is combatting crime and the methamphetamine epidemic, we are striving to provide health care, housing, and educational services to their tribal members. Chairman Hart and Chairman Frost are hard at work, but their resources are stretched thin.

I want to ask a question of you. That is, one of the troublesome statistics in terms of health care in Indian country is the fact that Native Americans are, I understand, 6 times more likely to die from an alcohol-related disease than other people. That is an astounding statistic, in my view: 6 times more likely to die from an alcohol-related disease than other people.

What do you think we can do in terms of a push on health care to try to address that chronic problem that we have in Indian country? Whoever wants to respond to that question, please go ahead.

Ms. HOLT. Thank you, Senator Salazar. It is another epidemic in Indian country, just like methamphetamine is an epidemic in Indian country. It was a disease that was brought into Indian country 100 years or so ago.

Unfortunately—given the poverty status, as Ms. Davidson testified to, the unemployment rates, and the ruralness of most reservations—there is nothing to do. There is nothing for the kids to do, so they look to entertain themselves.

I firmly believe that Native Americans suffer from post-traumatic stress disorder because of the trauma that they have faced throughout the centuries, and continue to face, and that this also leads to the depression that alcohol suppresses in a lot of people.

Senator SALAZAR. Let me ask you whether there are programs out there somewhere within Indian country, with all the reservations, that have been proven to be effective in dealing with the issue. Do we have models out there that we could try to push to deal with the issue?

Ms. HOLT. Yes. Yes, we do.

Senator SALAZAR. Chief?

Mr. VENNE. Thank you, Senator. I developed a program for our reservation for alcohol and drug abuse that is strictly a cultural program where my people talk Indian, we go in the sweats, we have a circle, we burn sweet sage.

We also go fasting on the highest mountains within Montana. It is a spiritual thing. Plus, we are educating them in the history of the Crow, where they know who they are, and to be proud of who they are and to be proud of where they live.

Senator SALAZAR. And has that worked at your reservation? Have the alcohol abuse rates dropped in the reservation because of your program?

Mr. VENNE. Yes. I can safely say we have about a 70-percent success rate.

Senator SALAZAR. A 70-percent success rate. That is impressive.

Ms. Davidson?

Ms. DAVIDSON. There are actually examples of programs that are working throughout Indian country. What we have seen is, the most effective programs are programs that are close to home, that are culturally appropriate, and provide the full spectrum of the continuum of care.

I mean, even if we have access to a treatment program, when you send that person away, what happens when they come back? If they do not have a continuum of care, then that person is going to fall right back into the same patterns all over again.

A program that we developed in Alaska is called Behavioral Health Aid Program, and it is built on the very successful Community Health Aid Program in which we train local tribal members who speak the language to be able to do a 2-year program through the University of Alaska to be able to be cross-trained in—

Senator SALAZAR. And it has been an effective program then?

Ms. DAVIDSON. Yes, it has. To be able to provide both mental health and substance abuse services at the village level. Because the problem is, when the services are only available hundreds of miles away, you lose all those kids.

Senator SALAZAR. I agree.

Let me just thank the panel for your excellent testimony. My time is up. Thank you, Chairman Baucus.

The CHAIRMAN. Thank you, Senator.

Senator Snowe?

Senator SNOWE. Thank you, Mr. Chairman.

I want to thank all of you as well for your participation here today. I know, having recently met with Maine's Native American tribes, first and foremost, is the issue of funding for health care, and the disparities are really simply unacceptable. That is something that we really have to address as one of the foremost critical issues.

I joined Senator Clinton in offering the Kinship Caregiver Act that does provide for subsidized guardianship, because I think that is a very important avenue to pursue. It may be, obviously, very beneficial to the Native American populations.

In my State, for example, they have used State-only funds to support subsidized guardianship. I do not know if any of your



States have done anything similar in that regard. Has any other State done that? I mean, it is an option. Obviously, it should be a Federal partnership. Hopefully we can pass this legislation to give that kind of support.

What is deeply troubling as well is the health status of Native Americans. I know, for example, in the State of Maine, the issue of diabetes, which again is inconceivable that the rates could be so high, not only for Maine's population, but the Native American population.

The fact is, the prevalence of diabetes has tripled in the State of Maine, and the rate of diabetes in the Native American tribes in the State of Maine is 4 times as great as the general Maine population.

So, it is stunning that we are facing such a situation, and that is why I think that these health care programs become so instrumental, in my estimation, and we certainly have to do far more than we are obviously doing now.

One of the ways I wanted to explore with you this morning is, is there any partnership with the States, through the Medicare and the SCHIP program, to encourage enrollment among Native Americans? Have you had that experience? Do you know what your States are doing in that regard? Mr. Venne?

Mr. VENNE. It has been talked about, but the actual action of doing something is not there in enrolling people. I think to sum everything up, you know, we had the great scandal of the Walter Reed Hospital over the past 2 weeks. The Indian Health Service is a bigger scandal, if the Senators look into it. That is why we are here. I think it is very serious.

Senator SNOWE. Yes. I could not agree with you more.

Ms. Davidson?

Ms. DAVIDSON. I think there are some States that have really great relationships with tribes in which they do more active enrollment and outreach. One of the critical aspects of being able to provide that is the Medicaid Administrative Match program, which allows tribes to be able to enter into agreements with States to be able to do some of those outreach and enrollment efforts.

Unfortunately, a lot of work was done by the TTAG, the Tribal Technical Advisory Group to the CMS administrator, which worked on developing regulations and clarifying of the law and the regulation that tribes and tribal organizations are able to access that program. And no sooner had we gotten that clarity from CMS, then right after that regulations came out that basically—the end result is, it would preclude many tribal organizations and tribes from being able to participate in Medicaid administrative match because of the taxing requirement that the new proposed rule imposes. We have been assured, in our meetings with folks from CMS, that that was not the intent, that we are supposed to still be able to access that. But that is not how the current regulation is written.

Senator SNOWE. I see. When were those regulations issued?

Ms. DAVIDSON. I think the comments were due March.

Senator SNOWE. Oh. So very recent.

Ms. DAVIDSON. March 18. Yes. Very, very recent.

Senator SNOWE. All right.

Ms. DAVIDSON. And then there are other examples. It seems like sometimes we take one big step forward, and then we take two giant steps back. There is an example that was raised earlier by Chairman Holt for the Medicare-like rates.

Congress passed Medicare-like rates years ago. It would basically allow that, when a tribal member or American Indian/Alaska Native IHS beneficiary needs to use Contract Health Services for a level of service that the IHS cannot provide itself, you contract with another hospital to provide that care, and the law prevents the hospital from charging any more than what Medicare would pay.

Those regulations were supposed to be done 2 years ago and was somewhere stuck between the Office of the Secretary, the IHS, and CMS, and we have been languishing for 2 years. First it was at IHS, then they signed off, then it was at CMS, then they signed off, and then it went to the Secretary's office and they signed off, and now it is going all the way back through again.

It was supposed to be enacted 2 years ago. It was supposed to be in effect 2 years ago. We have lost at least \$75 million of buying power of Contract Health. Basically, those are Federal taxpayer dollars, \$75 million that have basically been flushed down the "cuhh" because we are sort of like the unwanted stepchild between two Federal agencies.

We are like the child of divorced parents, where one rule applies when we are at mommy IHS's house and one rule applies when we are at daddy CMS's house, and we are stuck in the middle, just trying to navigate whose rules apply when and where, and the end result is, we are not getting the services that we need.

Senator SNOWE. That is obviously something, Mr. Chairman, we ought to explore and try to address, and particularly the CMS, and obviously this issue as well, on the Medicare program. But, definitely we ought to do it because that is an avenue that should be open to you without obstruction. Thank you.

The CHAIRMAN. I want to thank the witnesses. You have been very, very good. This is compelling testimony. Frankly, it puts a lot of burden back on our shoulders now to help solve a lot of these problems that you have pointed out.

I will pretty much end where I began. The funding is just an outrage. It is up to us to find a way to solve that. Thank you very much. We will continue to work with you very aggressively. I want to do something about this.

Thank you very much. And thank you, Mr. Chairman, and thank you all.

The hearing is adjourned.

[Whereupon, at 11:20 a.m., the hearing was concluded.]

# **A P P E N D I X**

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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**TESTIMONY OF THE NATIONAL INDIAN CHILD WELFARE  
ASSOCIATION AS PRESENTED BY CONNIE BEAR KING BEFORE  
THE SENATE FINANCE COMMITTEE REGARDING**

**KEEPING AMERICA'S PROMISE: HEALTH CARE AND CHILD  
WELFARE FOR NATIVE AMERICANS**

**MARCH 22, 2007**

The National Indian Child Welfare Association submits this statement on improving child welfare services to Native American children and families. Our constituents, tribal children and families, face many health challenges and child abuse and neglect is certainly one of the most critical. Our testimony will focus on the risk factors that exist in tribal communities, the current state of tribal child welfare service delivery systems, and two important solutions that can improve outcomes for Native American children and families. At the end of our testimony is a brief description of the work of our organization.

#### **Native American Children and Families At-Risk**

Native American children and families are disproportionately represented in the child welfare system, particularly the foster care system. Nationally, Native American children represent over two percent of the state foster care population while only representing one percent of the overall population in the United States (National Data Analysis System, 2004). This data is reported from state systems. This statistic is even more significant when you factor in the exclusion of the numbers of Native American children in tribal foster care systems. Data for Native American children in tribal foster care systems is not available in a national aggregate total, but estimates have placed the rate in several larger tribal foster care systems at or above the national figures.

Other known risk factors for child abuse and neglect include poverty, unemployment, alcohol and substance abuse, family structure, and domestic violence. In Native American communities the rates of these risk factors are very high and do contribute to Native American children being placed in out-of-home care in high numbers.

Although these rates are very high great progress is being made by tribal governments to confront these issues. The strengths of tribal governments are their knowledge and skills in developing long term solutions that will reduce or eliminate these community problems. New models for research, service delivery, community involvement and prevention are developing in tribal communities every year. The process and outcomes from these models are increasingly being disseminated to other tribes and when possible they are being adapted for implementation in other tribal communities too. Even

with these great strides, Native Americans still lag behind the general population on all of these important indicators.

**Poverty and Unemployment** - Overall poverty rates in tribal communities have been very high for many years. While the overall poverty rate in the United States is 12.4 %, the poverty rate for Native American people nationally is over double that rate at 25.7 % (U.S. Department of Commerce, 2006).

Related to poverty rates is unemployment. The majority of tribal communities have little opportunity to establish viable economies that are diversified and can provide gainful employment for their citizens. Other than the few tribes that have benefited from tribal gaming or natural resource dividends, most tribal governments have little ability to raise significant amounts of tribal revenue. According to the 2000 United States Census, the unemployment rates among Native American people nationally was 15% compared to 6% for the general population (U.S. Department of Commerce, 2003). Family poverty levels are also high with almost 26% of Native American families, with children under the age of 18, from the largest 25 tribes living in poverty compared to 12% for the general population. The unemployment rate and poverty rates reported by the Bureau of Indian Affairs for Indian reservation areas are much higher than those reported by the Commerce Department. For instance, the Bureau of Indian Affairs 2003 Labor Force report shows a national average of 49% unemployment for Indian people living on or near reservations. Of those employed 32% are still living below the poverty level.

**Alcohol and Substance Abuse** - Alcohol and substance abuse is prevalent in many tribal communities. NICWA estimates that 85% of child welfare cases involving Native American families involve some form of alcohol or substance abuse. Nationally it is estimated that approximately 65% of all child welfare cases involve alcohol or substance abuse. Methamphetamine abuse is rising in many tribal areas and has jumped to the second most reported substance identified during treatment admissions among pregnant Native American women as reported by state agencies (Substance Abuse and Mental Health Services Administration, 2003).

**Family Structure** - Family structure issues that correlate to higher risk for child abuse and neglect are primarily related to the rate of single head of

household figures. Families that only have one parent present in the home experience increased stress and often have fewer resources to call upon to help address challenges. Just over 12% of all families are headed by a female householder with no male present (U.S. Department of Commerce, 2006). For Native American families from the largest 25 tribes that figure is 26%.

**Domestic Violence** - Domestic violence in Indian Country is difficult to quantify, but studies done since the 1990's and local data have suggested that the rate of domestic violence among Native American women is approximately twice that of the general population. Congress recognized this and has, in fact allocated ten percent of Violence Against Women Act grants for tribes. When domestic violence occurs, the victim is less likely to be able to address the immediate needs of her children due to the trauma of the assault. In addition, domestic violence can create a higher risk for child welfare authorities to become involved, especially if it is determined that the children are experiencing harm or are in an unsafe situation.

#### **Child Welfare Services to Native American Children and Families**

As tribal governments and communities try to address the risk factors for children being placed in out of home care they share in the consequences from this risk as families are separated and communities struggle to maintain their identity and shape their future. Reducing the number of Native American children and families in the child welfare system will require solutions that utilize the extended family more and increase the ability of tribal governments to contribute their knowledge and skills.

Until 1978, tribal children were removed from their families in shocking numbers, many times not because the removal was necessary, but because of the lack of understanding and bias private and public agencies had regarding tribal families. Prior to 1980, it was estimated that 25% of all Native American children were in some form of substitute care, most often away from their tribal communities and extended families (Select Committee on Indian Affairs, 1977). During this same period, most of the child welfare services that were provided to tribal children and families came not from tribal government programs, but from federal Bureau of Indian Affairs (BIA) programs located on tribal lands or by state child welfare agencies. Tribes had very

little say in how these programs were designed or operated, and few tribal juvenile courts were in operation.

During this same time, tribal governments also had access to very few federal funding sources to combat this critical community health issue. In most cases, tribal governments only had access to Title IV-B Child Welfare Services funding, which resulted in grants of less than \$10,000 for the vast majority of tribes or BIA Social Services funding, which was discretionary and not available to large numbers of tribes across the United States. This resulted in tribes most often not being involved in tribal child welfare matters and other agencies deciding how and when their children and families should be served. This created a negative sense of dependency upon these outside agencies and was a barrier to tribal governments and their communities to develop a sense of ownership over these problems and exercise their authority and responsibility to their children and families.

With the passage of ICWA in late 1978, Congress set out to reduce the number of Native American children and families that were removed from their homes by implementing new standards on how public and private agencies worked with this population. In addition, Congress also made it clear that tribal governments were in the best position to provide child welfare services to their members by acknowledging tribal authority to be involved in child welfare matters concerning their member children and families, and providing small grants (ICWA) to support tribal child welfare programs. Congress also acknowledged that tribal governments should be eligible to receive funding from other federal sources to support child welfare services. New funding was made available to tribes to exercise their authority and responsibility in child welfare. However, the Indian Child Welfare Act grant program was discretionary and never funded above \$13 million until 1993. This only allowed for a competitive grants process in which the majority of tribes never received any grant funds.

Today tribes receive direct federal funding from Title IV-B Child Welfare Services and Promoting Safe and Stable Families programs. The grant size has not increased significantly under Title IV-B Child Welfare Services; most tribes are still receiving grants under \$10,000 with the annual outlay to tribes at about \$5 million per year. Under the Title IV-B Promoting Safe and Stable Families program there are now approximately 120 tribal grantees

eligible for funding, up from 89 in 2005. This increase in eligible grantees comes after Congress increased the tribal set-asides to 3% under both the mandatory and discretionary programs under this law as it was reauthorized in 2006. This has the total amount of funding tribes are eligible for at approximately \$12 million annually.

The ICWA grant program is still a discretionary program, but in 1993 it became available to all tribes with the majority of grants being just under \$50,000 a year. Some tribes are eligible for BIA Social Services funding, which can support child welfare services, but the list of tribes that are eligible for this discretionary program does not include over 200 tribes nationally. The funds are also not available to support administration or training costs associated with foster care or adoption services, like those reimbursed under Title IV-E.

While the amounts and number of federal funding sources available to tribes has increased some since 1978 tribes still are considerably behind where states are in their ability to address child abuse and neglect. Parity for tribes regarding the amounts and types of federal funding sources available to states has still not been achieved. While more tribes are eligible for federal funding sources, such as Title IV-B, no tribes are eligible for the larger federal child welfare related funding sources such as Title IV-E Foster Care and Adoption Assistance and Title XX Social Services Block Grant. The small number of tribes that have been able to access some of these federal child welfare program funds have only been able to do so because the state they reside in has passed through a portion of these funds, which is not a mandatory requirement for states.

What tribes do not have access to is a stable source of non-discretionary funding to support the vulnerable children that need foster care or adoption assistance services, such as in the Title IV-E program. Without this funding, tribes are forced either place children in unsubsidized homes, which can lead to instability and failure of the placement, or turn them over to state agencies whenever possible, which burdens state governments and reduces the chance that tribal children and families will have access to services that are specifically geared to their needs. As Arlene Templer, director of human resource development for the Salish and Kootenai Tribes, describes it, without direct funding her tribe cannot be guaranteed they will be able to



provide every child that needs foster care a safe and stable home. Even with a Title IV-E agreement with the State of Montana, she notes that she is restricted from seeking IV-E reimbursement for tribal children that come home to be cared for by relatives based upon restrictions the state has included in their agreement with the tribe.

#### **Title IV-E Foster Care and Adoption Assistance Access for Tribes**

Former representative Bill Frenzel, in his role as chair of the Pew Commission on Children in Foster Care, said in his introductory remarks in releasing the 2004 Pew Commission report that "in the name of justice" we need to provide Title IV-E services to Indian children. The Pew Commission recommended, as do we, that tribes be authorized to directly administer this \$7 billion federal entitlement program which is designed to protect and provide permanent loving and safe homes for abused children.

We are appreciative of the support of the Senate Finance Committee to amend the Title IV-E statute to put this program on a government-to-government basis with regard to tribes. Over the course of the last few Congresses, Senators Daschle and Smith—both members of the Finance Committee—introduced legislation to accomplish this goal. The Finance Committee, in approving its welfare reform reauthorization bills in the 108<sup>th</sup> and 109<sup>th</sup> Congresses, included provisions to allow tribes to apply to Department of Health and Human Services to directly administer the Title IV-E program. We thank Senators Baucus and Grassley for inclusion of the tribal IV-E provisions in those bills. Unfortunately, those bills were not enacted into law.

Thank you also for the recommendation in this year's Finance Committee's "Views and Estimates" letter to the Budget Committee that the Title IV-E Foster Care and Adoption Assistance law be amended to provide direct access to this program for tribes.

Tribal governments, certainly no less than state governments, have the legal and moral responsibility to provide protection and permanency for the children under their jurisdiction who have been subjected to abuse and neglect. But the Title IV-E law extends only to state governments and to entities with which states have agreements. There are some 70 tribal-state Title IV-E agreements, many of which do not afford the full range of services

to children in tribal custody that children in state custody receive. Many such agreements provide only the maintenance payment for the foster home, but not the training, administrative and other court-related work, and data collection that states receive. And most tribes have no access to the Title IV-E program at all. States remain the grantee under tribal-state Title IV-E agreements and thus are liable for all expenditures. In some cases states will not allow Title IV-E funding to be used for foster homes that are tribally, rather than state, licensed.

Direct access to the Title IV-E program for tribes would provide those governments with much needed funding for their child welfare systems, would improve tribes' ability to recruit and retain Indian foster and adoptive homes, would provide improved and greater permanency services for tribal children, and would provide better support both in terms of training and subsidies to tribal foster care and adoptive families. We also support continued authority to continue existing tribal-state IV-E agreements and to establish such agreements in the future.

#### **Relatives as Caregivers for Native American Children**

In addition to providing direct funding to tribes under the Title IV-E program, we urge Congress to make available resources to relatives who are primary caregivers for members of their family. Some states have child welfare waivers to provide funding for subsidized guardianship. This needs to be made available to all states and tribes. Traditionally and today the extended family system is the core of a natural helping system in tribal communities that protected children and participated in their upbringing. Even though this system was under attack by intrusive federal policies and forced placement of Native American children in boarding schools into the 1900's, the extended family still plays a critical role in tribal communities everywhere in helping care for Native American children. Indian grandparents comprise the largest percentage of any racial/ethnic group with regard to being primary caregivers for their grandchildren. Of households with grandparents living with grandchildren, 56% of those grandparents were the primary caregiver for their grandchildren - this compares with a national rate of 42% (Department of Commerce, 2006). Regina Littlebeaver, director of human services for the Winnebago Tribe on the Nebraska and Iowa border, says the first place she looks for a foster care or permanent placement is with a

relative. Going outside the child's extended family systems is uncommon and risks alienating the child, their family, and other community members in the healing process. She also describes her experience in working with relative care providers who live off the reservation in Iowa.

*"It was almost unimaginable to not consider our relatives first when a child needed a foster care home. Typically, the extended family would come together with the tribe to identify someone who could care for the child. Our greatest barrier was not finding an appropriate relative, but trying to find a way for the local child welfare agency to support these relatives who were caring for these Native American children."*

While Title IV-E and other federal policies encourage the use of relatives, many times the only permanent placement option provided to relatives is adoption. This pits family members against each other and often results in further deteriorating family relationships. This has a profound affect upon the children in most cases. If family members will not adopt and there is no subsidized guardianship program available to them, the placement agency will most likely move the child to a non-relative home that will adopt. This severs the child's important family connections and leaves the family extremely distressed.

Where subsidized guardianship placements have been available tribal children have benefited greatly. Relatives that could not afford to care for additional children in their home were supported and Native American children were given the opportunity to retain and nurture those important family connections.

States, such as Iowa and Montana, that have child welfare waivers to offer subsidized guardianship placements and have included tribes have found that these placements are a very important permanent placement option for relative caregivers. However, federal requirements for the waivers and the temporary nature of the waiver have created some concerns about how these will work with Native American families. Arlene Templer, director of human resource development for the Salish and Kootenai Tribes, described a situation where a tribal member aunt was caring for a niece and nephew in her home. She wanted to provide a permanent placement for the relative children and was excited

about the possibility of the guardianship program in Montana. However, when Arlene applied for her to be a part of the program they were told that this aunt would be in the "control group" and therefore would not receive any subsidy and limited support services if they chose a guardianship placement. The aunt said she could not continue the placement without a subsidy and support services, so she had to return the children to a foster care placement where Arlene says they will likely stay until they age out of foster care. Between 2001 and 2003 the national average for the number of foster care children living with relative caregivers was 23%. In several states where federally-recognized tribes reside this rate was below the national average - Alabama (13%), Colorado (12%), Idaho (14%), Iowa (1%), Kansas (14%), Maine (17%), Massachusetts (17%), Minnesota (18%), Mississippi (19%), Nebraska (12%), New Mexico (20%), New York (17%), North Carolina (19%), North Dakota (14%), Oregon (20%), South Carolina (5%), Texas (17%), Utah (4%) and Wyoming (13%). While no figures were available specific to Native American children in relative placement these figures demonstrate the challenges that many states have to utilize relative placements.

This example illustrates the need for ongoing and reliable support for relative caregivers. Not just for the caregivers themselves, but the best interests of the children they are caring for too. Many other tribal governments are interested in this permanency option and would welcome the opportunity to offer this to their community caregivers.

#### **Conclusion**

In tribal communities, family relationships are the most important relationships people will ever have. The sense of responsibility to those family members and their children within the community is enormous. Tribal governments have waited for the day when they will be able to fulfill their responsibility to their children too, and all they need are the resources and opportunities to exercise this responsibility and ensure that all the tribal children and families under their care are provided the supports they need. By providing greater opportunities for tribes to be able to utilize their network of extended family members and providing direct funding from this nation's most prominent child welfare funding source, that promise can be kept. Please join us in bridging that divide. Thank you.

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**The National Indian Child Welfare Association**

The National Indian Child Welfare Association (NICWA) is a national, private non-profit organization dedicated to the well-being of American Indian children and families. We are the most comprehensive source of information on American Indian child welfare and work on behalf of Indian children and families. NICWA services include (1) professional training for tribal and urban Indian child welfare and mental health professionals; (2) consultation on child welfare and mental health program development; (3) facilitation of child abuse prevention efforts in tribal communities; (4) analysis and dissemination of public policy information that impacts Indian children and families; (5) development and dissemination of contemporary research specific to Native populations; and (6) assisting state, federal, and private agencies to improve the effectiveness of their services to Indian children and families.

In order to provide the best services possible to Indian children and families, NICWA has established mutually beneficial partnerships with agencies that promote effective child welfare and mental health services for children (e.g., Substance Abuse and Mental Health Services Administration; Indian Health Services; Administration for Children, Youth and Families; National Congress of American Indians; Federation of Families for Children's Mental Health; and the Child Welfare League of America).

If you have questions regarding this testimony or other public policy issues impacting Indian children and families, please contact:

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**Statement for the Record From Senator Bingaman  
Finance Committee Hearing**

**Keeping America's Promise:  
Health Care and Child Welfare Services for Native Americans**

**March 22, 2007**

Thank you, Mr. Chairman.

The Indian Health Care Improvement Act enacted in 1976 has enabled us to develop programs, facilities, and services with Tribal input. These programs and services are models of community based and culturally relevant health care delivery. This community based model, allowing programs and services to be designed to meet local needs, deserves to be studied and replicated in other parts of our nation.

Indian Health Care provides primary care; most specialty services are purchased by contract at market rates, which are customarily much higher than Medicaid and Medicare rates. A rule change allowing contracted services to be purchased at Medicare rates has been hung up between CMS and OMB for over 2 years. Current funding levels cover only 55-60% of needed services. This means that for most of the year, IHS is required to ration care. Life and limb saving measures are selected, by necessity, over non-emergent specialty needs. Heart wrenching examples of this are included in witness testimony for today's hearing.

We should also note the successes of ICHIA. For example, the infant mortality rate has decreased in Indian peoples from 22 deaths per 1000 to 8 deaths per 1000 since 1976. Yet, there is much more to do. Shocking health disparities remain for Indian people. New Mexico produces a health disparity report card to guide efforts of the state health programs. Over 10% of the population of New Mexico are American Indians. In the most recent report card distributed in August, 2006, we note the following:

Forty percent of American Indian women receive late or no prenatal care compared to national rates of 16%.

The death rate from diabetes is 71.8/100,000 for American Indians, compared to 48.2 for Hispanic and 22.9 for white New Mexicans.

Deaths from motor vehicle crashes are 47.5/100,000 compared to 23.0 for Hispanics and 16.8 for Whites in New Mexico. Death from homicide among New Mexico Indians is 13.1/100,000 compared to a national rate of 5.6/100,000 for reasons noted above.

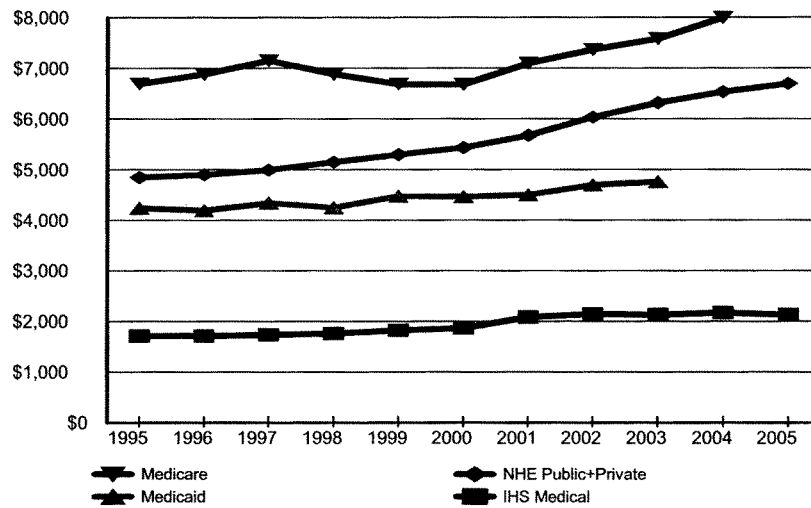
These disparities in mortality rates contribute to a shortened life expectancy for Indians compared to other Americans. National statistics show that Indians live an average of 2-3 years less than other Americans, but that discrepancy is as high as 11 years for some South Dakotan tribes.

Access to modern technology can sometimes make the difference between life and death. The average age of Indian Health Service hospitals and clinics is 33 years compared to the average age of US hospitals and clinics at 9 years. Priority lists for building improvements require years of waiting for needed facility improvements.

Indian Health Service staff suffers vacancy rates of 13% for all health professionals, and 28% for dentists. When facilities and staff are not sufficient to meet the needs, contract health services must be purchased at prevailing rates. Funds supporting contract health services run out by mid-year, leaving IHS to ration care. Life and limb saving measures are selected, by necessity, over health promotion and disease prevention.

**Per Capita Health Care Expenditures, 1995-2005: Indian Health Service, Medicare, Medicaid, and National Health Expenditures (in constant 2005 dollars)**

**NOTE:** Constant dollars based on Consumer Price Index for All Urban Consumers



(CPI-U); base year is 2005.  
**ABBREVIATIONS:**NHE = National Health Expenditures. IHS = Indian Health Service.  
**SOURCES:** *Data sources:* See “Per Capita Health Care Expenditures, 1995-2005 ... (in current dollars)”  
*CPI-U:* U.S. President, *Economic Report of the President 2007* (Washington: GPO, 2007), p. 299, Table B-60.

Aging facilities, staff shortages, and funding shortfalls are emblematic of the challenges facing the Indian Health Service.

What resources would be adequate to meet these challenges? To answer that question, I draw your attention to this graphic illustration of ten years of health care expenditures per person in Medicare (the red line), Medicaid (the yellow line), and in Indian Health Service (the blue line).

Note that Indian Health service dollars include third party collections from Medicare, Medicaid, and private insurance.

The sum of all public and private sources of health care dollars divided by the number of users nationally, or the average health care expenditure per American is depicted in the green line.



Note from this graph of 10 years of health care spending per user, provided by the Congressional Research Service, IHS has been allocated less than half the per user health care funding received under Medicaid, one third of the per capita national health care spending, and one fourth of that received under Medicare. This serious and chronic disparity in Indian health funding must be addressed.

In 2004, the US Commission on Civil Rights produced a report entitled, "Broken Promises: Evaluating the Native American Health Care System."

The report noted that

- 1) Annual per capital health expenditures for Native Americans are far less than the amount spent on other Americans under mainstream health plans.
- 2) Annual per capita expenditures fall below the level for EVERY OTHER federal medical program and standard (as illustrated on this graph).
- 3) Annual increases in IHS funding have failed to account for medical inflation rates or increases in Indian population.
- 4) Annual increases in IHS funding are less than those for other HHS components
- 5) Annual increases were so small as to represent effective reductions in appropriations, essentially punishing IHS for seeking collections for eligible members through Medicaid and Medicare.

This 2004 report concluded, and I quote, "Congress failed to provide the resources necessary to create and maintain an effective health care system for Native Americans." IHCA has not been reauthorized since.

In 1983, a President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research provided guidance to lawmakers in a report entitled "The Ethical Implications of Differences in the Availability of Health Services." The report suggests that "Priority in the use of public subsidies should be given to achieving equitable access for all before government resources are devoted to securing more care for people who already receive an adequate level."

I suggest, Mr. Chairman, that we have a substantial explanation for observed health disparities in Indian populations.

I hope that we can act quickly on the reauthorization of IHCA, and use every opportunity to increase funding for these vital programs that will reduce these glaring disparities.

**Testimony of Valerie Davidson**

Senior Director, Legal & Inter-Governmental Affairs,  
Alaska Native Tribal Health Consortium  
Chair, CMS Tribal Technical Advisory Group  
Member, Medicaid Commission

**Medicare, Medicaid and SCHIP  
and the Indian Health System**

Senate Finance Committee

March 22, 2007

Good morning, Chairman Baucus, Ranking Member Grassley and Members of the Committee. I thank you for giving me the opportunity to testify today about the importance of Medicaid, Medicare and SCHIP funding in the Indian health system. I want to express my appreciation to the chairs of the National Steering Committee for Reauthorization of the Indian Health Care Improvement Act (NSC) and the other members for their tireless work over the past several years to draft a reauthorization bill that best meets the health needs of Indian country.

I especially want to express my gratitude to this Committee for its attention to this important issue. Even though the comprehensive reauthorization bill was stalled last year, this Committee considered and passed the Medicaid, Medicare, and SCHIP Indian Health Care Improvement Act of 2006, S. 3524, a stand-alone bill that contained many of the Social Security Act amendments being considered as part of the IHCA reauthorization this year. This Committee's timely consideration and emphatic support for that legislation was a highlight in what has been a long and often disheartening reauthorization effort. It is especially encouraging to see a Committee not normally tasked with handling Indian issues reach out to Tribes in this way. I look forward to working with the Committee again this year.

I was privileged to work for many years for the Yukon-Kuskokwim Health Corporation, the Tribal health program that serves 58 Tribes in a region roughly the size of Oregon, of which Bethel is the hub. I now am honored to work for the Alaska Native Tribal Health Consortium, a statewide tribal health program that serves all 229 Tribes in Alaska, co-manages with Southcentral Foundation the Alaska Native Medical Center (ANMC), the tertiary care hospital for all American Indians and Alaska Natives (AI/ANs) in Alaska, and carries out all non-residual Area Office functions of the IHS that were not already being carried out by Tribal health programs as of 1994.

I also serve as the Chair of the Tribal Technical Advisory Group that advises CMS on policy relating to American Indians and Alaska Natives. In that capacity, I have worked closely on many of the policies that determine how Medicaid, Medicare and SCHIP funding is used by IHS and tribal clinics. I also had the opportunity to serve on the Medicaid Commission, which in its final Report endorsed the enactment of the provisions found in S. 3524.

The amendments to the Social Security Act contained in S. 3524, which we hope will be included in the IHCA Reauthorization bill this year, are essential to improving access to Medicaid, Medicare and SCHIP by AI/ANs and the viability of the Indian health system. They are essential to reducing health disparities that plague AI/ANs and to the viability of struggling IHS and tribal health programs.

Senate Report 109-278, which accompanied S. 3524, provides an excellent section by section analysis of each of the provisions considered and approved in the last Congress. There is no need to walk you through each of them today. Instead, I hope through my testimony to reinforce your resolve to pass these improvements to Medicaid, Medicare and SCHIP and the balance of the IHCIA this year.

For those of you who have not visited Indian country, I will try to paint a picture. It will be incomplete. It is impossible to understand the diversity and challenges faced by Tribes without visiting them. However, not everyone can visit. So today, I hope to help you understand why Medicaid, Medicare and SCHIP are so important to the Indian health system.

The stories I will tell you come from my experience in Alaska, but also from the experience of other tribes across the country, where tribal members experience the same difficulties accessing health care, and tribal governments and clinics experience the same pain of having to deny health care to people in need because there just isn't enough money to pay for it.

#### **I. The Indian Health Service System**

The federal government has a duty – acknowledged in treaties, statutes, court decisions and Executive Orders – to provide for the health and welfare of Indian Tribes and their members.<sup>1</sup> In order to fulfill this legal obligation to Tribes, it has long been the policy of the United States to provide health care to American Indians and Alaska Natives through a network made up of the Indian Health Service, tribal health programs and urban clinics.

The Indian Health Service (IHS), directly and through tribal health programs carrying out IHS programs under the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638, as amended (ISDEAA), provides health services to more than 1.9 million American Indians and Alaska Natives. We are members of 562 federally-recognized tribes in the United States, located in 35 different states. According to the IHS, these services are offered from the following facilities:<sup>2</sup>

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<sup>1</sup> See Federal Basis for Health Services, January 2007 ([info.ihs.gov/Files/BasisForServices-Jan2007.doc](http://info.ihs.gov/Files/BasisForServices-Jan2007.doc)).

<sup>2</sup> Indian Health Service Fact Sheet, IHS/OD/PAS January 2007 ([info.ihs.gov/Files/IHSFacts-Jan2007.doc](http://info.ihs.gov/Files/IHSFacts-Jan2007.doc)).

	IHS Directly Operated	Tribally Operated
Hospitals	33	15
Health centers	54	229
Health stations	38	116
Alaska Community Health Aide (CHA) clinics		162

There are also an additional 600,000 AI/ANs who access health care through 34 urban Indian health programs funded by IHS under Title V of the IHCA.<sup>3</sup> When health care cannot be provided through these facilities, IHS and tribal programs use funding to purchase contract health care from providers outside of the IHS system.

The number of facilities does not really tell the story though. The Indian health system is a real system of care. It is reflected in the IHCA, which addresses health provider workforce issues, a full range of health care services from prevention through services needed at the end of one's life and from services to be provided on an out-patient basis to inpatient services, nursing home services, and purchased services, facility needs, safe water and sanitation systems, behavioral health, including a continuum of mental health and substance abuse services, and the infrastructure needed by IHS and Tribes to carry out this vast array of services.

What this description covers up is how desperate the need continues to be. And, how much the system relies on Medicaid, Medicare and SCHIP to keep it viable.

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<sup>3</sup> Indian Health Service Year 2007 Profile, January 2007  
([info.ihs.gov/Files/ProfileSheet-Jan2007.doc](http://info.ihs.gov/Files/ProfileSheet-Jan2007.doc)).

## II. Under-Funding the Indian Health System

The Indian health system is consistently, persistently under-funded. Worse yet, this minimal level of funding has remained flat or actually lost ground to population growth and medical inflation, including mandatory pay cost increases (arising from the annual Pay Act passed by Congress each year); the budget for Indian health care is losing pace. Last year, the Northwest Portland Area Indian Health Board (NPAIHB), which takes a leadership role in analyzing the funding for Indian health programs, estimated that it would take an increase of “at least \$436 million to maintain current services in FY 2007.”<sup>4</sup> Instead, under the continuing resolution, there is “a mere 13.5 million increase for IHS programs.”<sup>5</sup> NPAIHB estimates that in FY 2008, the number needed to retain services has increased to \$480 million.<sup>6</sup> Adequate direct appropriations for Indian health care is consistently absent from the federal budget.

The IHS Federal Disparities Index (FDI) illustrates the severe funding shortfall in Indian health care. The FDI compares health care costs for Indians to costs of typical mainstream health insurance plans. Actuarial methods controlled for age, sex, and health status were used to price a typical health benefits plan for Indian people using costs of the Federal Employees Health Plan. The FDI does not address public health deficiencies and needs for safe water and waste disposal.

“After discounting for Medicare, Medicaid, and private insurance coverage, the FDI results show that IHS funding fell \$1.7 billion short of parity with the benchmark mainstream health plan. About 160 IHS and tribal health care delivery sites are funded at less than 60% of the benchmark cost.”<sup>7</sup> Put another way, “[t]he average cost of mainstream health insurance plans is approximately 40% greater than the IHS funding level for [AI/ANs].” *Id.* More is spent in the Federal prison system per inmate than is available for each AI/AN.

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<sup>4</sup> “NPAIHB POLICY BRIEF, President’s FY 2008 IHS Budget Request,” NPAIHB, February 9, 2007, p. 2 (found at: [www.npaihb.org/images/policy\\_docs/IHS/](http://www.npaihb.org/images/policy_docs/IHS/)).

<sup>5</sup> *Id.*

<sup>6</sup> *Id.* at 3.

<sup>7</sup> Personal Health Services Funding Disparities, IHS, January 2007 ([info.ihs.gov/Files/FundingDisparity-Jan2007.doc](http://info.ihs.gov/Files/FundingDisparity-Jan2007.doc)). Emphasis added.

Enactment of the Indian Health Care Improvement Act in 1976 was an important step to address this unmet need. Recognizing the enormous need and the limited funding appropriated for Indian Health Service, Congress authorized IHS and tribal health programs to recover reimbursements from Medicaid, Medicare and SCHIP.<sup>8</sup> While AI/ANs are entitled to free health care through the IHS system because of treaty obligations and the trust responsibility, many also qualify for low-income programs such as Medicaid. It is galling to individual AI/ANs to have to apply for Medicaid in order to assure the access to health care promised to them through countless treaties, Executive Orders, and laws; however, the compelling need to do so is inescapable.

Today, Medicaid income is an indispensable part of the federal budget for Indian programs. Since the IHCA was enacted, all appropriations have contained an estimate of Medicaid income. For example, the IHS Budget proposal for FY 2008 estimates that Indian health programs will generate \$625 million in Medicaid revenue.<sup>9</sup> While these funds are crucial to the Indian health system, they constitute less than one-half of one percent of total federal Medicaid expenditures. And, most important, they do not begin to fill the gap between the need for funding Indian health services and the direct appropriations to IHS.

### **III. The Real Effects of Under-funding – Health Disparities and Personal Tragedy**

In part because of this chronic under-funding and in part for many historical reasons that are almost too painful to recount, AI/ANs lag 20-25 years behind the general population in health status, and on the whole have the most severe health needs of any group in the United States. IHS describes the problem:

The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower health expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.<sup>10</sup>

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<sup>8</sup> Sections 401 and 402, codified at 42 U.S.C. §§ 1395qq and 1396j.

<sup>9</sup> Department of Health and Human Services FY 2008 Budget Justification, CJ-148.

<sup>10</sup> Facts on Indian Health Disparities, IHS, January 2007 ([info.ihs.gov/Files/DisparitiesFacts-Jan2007.doc](http://info.ihs.gov/Files/DisparitiesFacts-Jan2007.doc)).

Diabetes, heart disease, alcoholism, teenage suicide and infant mortality rates are higher for American Indians than for any other minority, and far higher than for the general American population. AI/AN infants “die at a rate of nearly 10 per every 1,000 live births, as compared to 7 per 1,000 for the U.S. all races population (2001-2003 rates).”<sup>11</sup> Among adults,

[AI/ANs] die at higher rates than other Americans from tuberculosis (500% higher), alcoholism (550% higher), diabetes (200% higher), unintentional injuries (150% higher), homicide (100% higher) and suicide (60% higher).<sup>12</sup>

But even these startling statistics do not fully capture the severity of the health crisis and the funding needs in Indian country.

On a reservation in Montana, a woman with a strange stomach growth was turned away from IHS clinics several times when she tried to seek treatment; she was told that she had simply gained weight. When she was finally examined, after several months, doctors removed a tumor that weighed more than 20 pounds. In telling you this story, I don’t mean it as an indictment of the doctors and other health professional practicing at the clinics where she sought treatment. Having worked on American Indian and Alaska Native health issues for as long as I have, I know that these stories are the all-too-common result of a system that is quite simply over-burdened, a system in which doctors in under-staffed clinics do not always have the luxury of examining a non-emergency patient with the care they would like to use.

In a system that is systematically under-funded, meeting the health care needs of the beneficiaries forces unacceptable choices. Due to the limited number of hospitals in the Indian health system and the under funding that makes most specialty services merely a wish, IHS and tribal health programs must rely on contract health services (CHS) funding to acquire necessary hospital and specialty care. Yet even CHS funding falls far short of what is needed. To deal with the shortage, most tribes have adopted policies that only allow CHS funding to be used for “life or limb” emergencies. Other health care needs simply go unmet.

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<sup>11</sup> *Id.*

<sup>12</sup> *Id.* Also see, United States Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (September 2004), 8 and Department of Health and Human Services FY 2008 Budget Justification, CJ-5-11.



Many throughout the system have coined a new name for this funding program: it is the “Don’t get sick after June” program. One tribe typically runs out of CHS funds in January, leaving no money for health care for the rest of the year, making even the promise of services until June look good.

As desperately inadequate as the CHS funding is, the situation would be unimaginably worse, but for Medicaid, Medicare and SCHIP, which are considered prior resources. Patients with access to these health programs rely on them to cover the cost of their care, rather than CHS, thus allowing the limited dollars in CHS to go further for those without coverage. They also pay for care that the Indian health program may not be able to provide, but which does not meet the dreadful criteria of “life and limb”.

#### **IV. Medicare, Medicaid & SCHIP’s Role in the Indian Health System**

There are two critical roles Medicare, Medicaid and SCHIP play in the Indian health system. First, they provide a source of payment for health care that the Indian health system cannot supply. Secondly, they provide a critical source of revenue to support the Indian health system.

The importance of the first role – as a source of payment for services the Indian health system cannot provide – is critical, but in many cases it provides an illusory benefit addressed better by the second role – providing revenue to support the Indian health system. Indian health programs are not merely other providers. The IHS, directly and through tribal health programs, provides culturally appropriate, integrated health services. The value of this cannot be over-estimated. AI/ANs routinely make the choice to not seek care at all, if in order to get it, they must leave their communities.

My grandmother died two years ago. Our home, Bethel, does not have a nursing home – for no other reason than lack of financial resources. My grandmother made me and my mother and aunts promise that we would never send her away to Anchorage to a nursing home. She qualified for Medicaid; she could have been in a nursing home there when she finally needed it, but she would never have accepted it, even if her decision meant she would have to forego needed health care. She chose, like other elders in our villages, to die in her own community, rather than being transported to non-Indian nursing homes where she wouldn’t understand the language, the food would be unfamiliar, and her family could only visit when they could afford a plane ticket from our region to Anchorage. Outside Alaska, the geographical distances may not be so great, but the cultural differences are just as large.

The Senate Indian Affairs Committee held a hearing on Indian health care two weeks ago, and Senator Dorgan recalled the story of a young girl who was a victim of suicide. Before she died, however, the warning signs were all there. She withdrew from school, stopped talking to people, and stayed in her room for three months; her family

had a history of alcohol and drug abuse and suicide. Despite all this, she never received mental health intervention. As Senator Dorgan pointed out, there was no clinic for several hundred miles around her home. There were no mental health professionals in the community where she lived. Even if there had been a clinic or a professional for her to see, her family had no car that could have driven her there. I tell this story to you for the same reason Senator Dorgan told it last week – the barriers American Indians and Alaska Natives face when seeking even the most basic and necessary health care can seem insurmountable. While funding alone is important, facilitating access to that funding and bringing quality care to remote communities is equally critical. The IHS and tribal health system have proven their ability to be effective interveners, but only when resources are available.

The new provisions that would be added to law if the provisions approved in S. 3524 are enacted are critical to expanding access and to making the Indian health system more viable, especially when taken in concert with other provisions of the IHCLIA Reauthorization bill.

These provisions would ensure that IHS and tribal health programs can be reimbursed for all Medicaid covered services they provide, not just those that are facility-based. That is critical to ensuring that home- and community-based services can be expanded. The new provisions also ensure that the critically needed mental health and substance abuse services that desperately need to be expanded within the Indian health service can be supported.

The new provisions would increase outreach and improve cooperation between Indian health programs and the States under Medicaid and SCHIP. The geographic, cultural, and other barriers to enrollment in Medicaid and SCHIP are huge. Services to ensure AI/ANs have meaningful access to these programs are needed to overcome the barriers. Among these barriers is the requirement for proof of citizenship – a particularly cruel requirement to be imposed on the first Americans, many of whose elders cannot produce the kinds of records currently required since their parents either did not have or were denied access to hospitals where birth certificates might have been completed. Allowing tribal records to suffice for proof of citizenship will help remove this burden on applications.

Protection against estate recovery of certain classes of property of special significance to AI/ANs was also provided in S. 3524. Many elders will not apply without the assurance that they will not be buying their own comfort with their tribal patrimony. Protection of trust land, subsistence harvesting rights, and objects of religious and cultural importance is considered by most elders to be a sacred responsibility.

Protections against premiums and other cost sharing would also be provided. I cannot overstate the importance of this for AI/ANs who use IHS and tribal health

programs. Cost sharing requirements applied in such settings merely reduce the funds available to the Indian health program since, in recognition of the Federal responsibility for Indian health care, the IHS may not charge fees for services. This means that the IHS or Tribal health program must absorb any co-payment or premium required by Medicaid, further straining the limited resources of these programs.

Barriers to payments to Indian health programs under SCHIP would be removed to ensure that the health programs most likely to be able to offer services that will be acceptable to the child and family have the resources to provide them.

Other provisions address the operation of IHS and tribal health programs, including those that deal with licensing requirements and safe harbors when they relate to each other and their patients. These are important to protecting and expanding the viability of the Indian health system.

## **V. Conclusion**

For those of you who deal with the complexities and size of the Medicare, Medicaid and SCHIP programs on a regular basis, the improvements we seek here may seem inconsequential. That could not be farther from the truth.

As American Indians and Alaska Natives, we are a people with painful legacies of forced removal – to boarding schools, to cities, to faraway hospitals – and rampaging epidemics that disrupted families for generations. Despite this, we still have very strong ties to our communities. As one of the younger members of my Tribe, with the privilege and opportunity to work in our health programs, it is my duty to try to overcome this history and to assure that no AI/AN will have to make the choice to forgo medical care entirely because culturally competent care is not available. It is my duty to be sure that we protect the health status improvements that have been made and that we accomplish more. I must leave a better system for my children and grandchildren than I inherited. It is for that reason that I am here today to testify before you.

The legislation we are discussing today will authorize many important steps toward the goal of quality health care in our home communities and in ways that respond to our needs and respect our way of life. I know that we cannot knock down all of these barriers overnight, but the provisions of S. 3524 will make a significant improvement.

In closing, I want to thank the Committee again for all the work you have done to pass this critical legislation and for your leadership in addressing such an important issue.

**Response to a Question for the Record From Valerie Davidson  
Keeping America's Promise: Health Care and  
Child Welfare Services for Native Americans  
March 22, 2007**

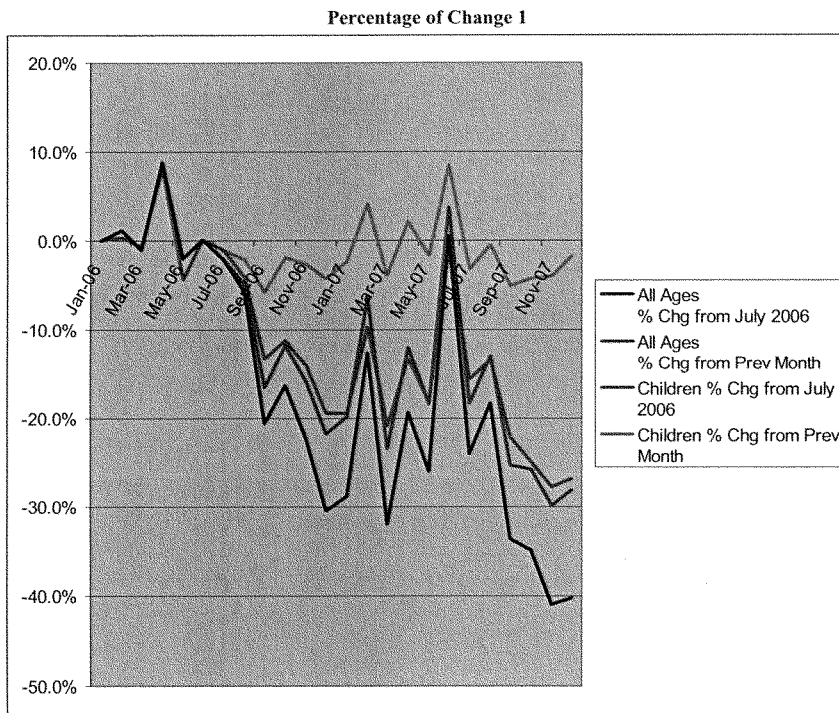
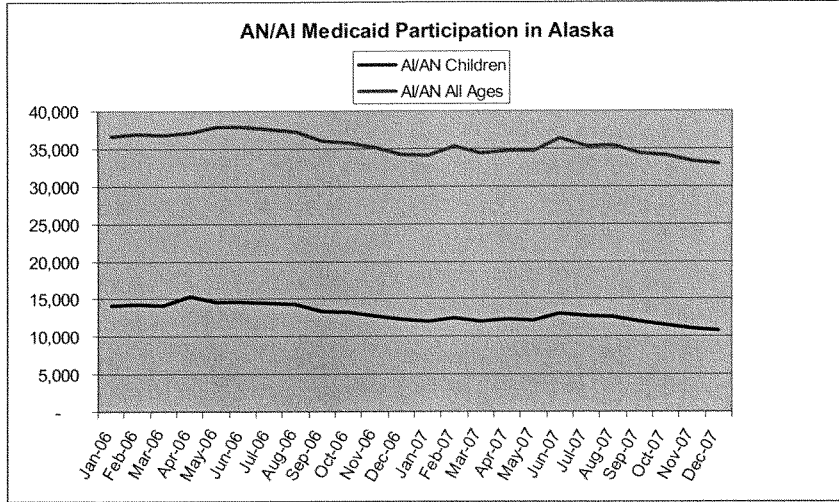
***Question From Senator Bingaman***

*Question:* In New Mexico, we have observed that requirements for original birth certificates for Medicaid were followed rapidly by a drop in enrollment of 10,000 Medicaid recipients. I would suspect that you have observed a similar drop in Alaska Medicaid enrollment because of your large American Native population. Would you supply those figures for the record?

*Answer:* Since the implementation of citizen documentation requirements in Alaska, Medicaid participation among Alaska Natives has decreased for all ages by 12 percent and decreased for children by more than 25 percent. Although the State is working to assist applicants to acquire the necessary documentation and to overcome the enormous back-log, the decrease remains a year and a half after implementation. The ability to rely on tribal documentation could have avoided and could remedy the situation.

**Alaska Native and American Indian  
Participation in the Alaska Medicaid Program  
after July 2006 Citizen Documentation Requirements**

	Children			All Ages		
	AI/AN Children	% Chg from Prev Month	% Chg from July 2006	AI/AN All Ages	% Chg from Prev Month	% Chg from July 2006
Jan-06	14,195			36,605		
Feb-06	14,256	0.4%		36,887	0.8%	
Mar-06	14,161	-0.7%		36,764	-0.3%	
Apr-06	15,314	8.1%		37,042	0.8%	
May-06	14,652	-4.3%		37,898	2.3%	
Jun-06	14,671	0.1%		37,919	0.1%	
Jul-06	14,519	-1.0%		37,517	-1.1%	
Aug-06	14,221	-2.1%	-2.1%	37,216	-0.8%	-0.8%
Sep-06	13,414	-5.7%	-7.6%	35,997	-3.3%	-4.1%
Oct-06	13,167	-1.8%	-9.3%	35,798	-0.6%	-4.6%
Nov-06	12,837	-2.5%	-11.6%	35,116	-1.9%	-6.4%
Dec-06	12,302	-4.2%	-15.3%	34,266	-2.4%	-8.7%
Jan-07	12,023	-2.3%	-17.2%	34,130	-0.4%	-9.0%
Feb-07	12,522	4.2%	-13.8%	35,214	3.2%	-6.1%
Mar-07	12,040	-3.8%	-17.1%	34,308	-2.6%	-8.6%
Apr-07	12,296	2.1%	-15.3%	34,741	1.3%	-7.4%
May-07	12,102	-1.6%	-16.6%	34,664	-0.2%	-7.6%
Jun-07	13,132	8.5%	-9.6%	36,332	4.8%	-3.2%
Jul-07	12,719	-3.1%	-12.4%	35,347	-2.7%	-5.8%
Aug-07	12,658	-0.5%	-12.8%	35,486	0.4%	-5.4%
Sep-07	12,022	-5.0%	-17.2%	34,393	-3.1%	-8.3%
Oct-07	11,511	-4.3%	-20.7%	34,086	-0.9%	-9.1%
Nov-07	11,058	-3.9%	-23.8%	33,357	-2.1%	-11.1%
Dec-07	10,865	-1.7%	-25.2%	32,951	-1.2%	-12.2%



**Testimony of Linda Holt**

**Chairperson, Northwest Portland Area Indian Health Board  
and Suquamish Tribal Council Member**

**Before:**

**Senate Finance Committee  
Dirkson Office Building, Room 215**

*"Keeping America's Promise: Health Care and  
Welfare Services for Native Americans"*

**March 22, 2007  
10:00 a.m.**

Good morning Chairman Baucus, Ranking Member Grassley, and members of the Committee. My name is Linda Holt; I am an elected Tribal Council Member of the Suquamish Tribe and serve as the Chairperson of the Northwest Portland Area Indian Health Board (NPAIHB). I also serve in a variety of capacities on national Tribal committees for agencies within the Department of Health and Human Services and serve as the Portland Area representative on the National Steering Committee (NSC) for the Reauthorization of the Indian Health Care Improvement Act. In my role serving our 43 Northwest Tribes, I am quite familiar with the health care needs of Indian Country. It is indeed honor and a pleasure to offer my remarks concerning Indian Health issues affecting American Indian and Alaska Native (AI/AN) people.

Established in 1972, NPAIHB is a P.L. 93-638 tribal organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health related matters. The Board facilitates consultation between Northwest Tribes with federal and state agencies, conducts policy and budget analysis, and operates a number of health promotion and disease prevention programs. NPAIHB is dedicated to improving the health status and quality of life of Indian people and is recognized as a national leader on Indian health issues.

I want to commend the Finance Committee for its work on the Indian Health Care Improvement Act (IHCIA) in the last Congress. Even though the bill did not pass in the 109<sup>th</sup> Congress, you all demonstrated your support to work on Indian health issues by passing the Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006 (S. 3524). The work you all completed on S. 3524 would have greatly enhanced the ability of the Indian health system to address the significant health disparities that AI/AN people face. The Finance Committee's work was a glimmer of hope for Indian Country to get this bill passed after seven years of hard work. Northwest Tribes hope that you will continue to be supportive of the IHCIA and we look forward to working with the Committee.

#### **I. Indian Health 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. Over the last thirty years the IHS and Tribes have made great strides to improve the health status of Indian people through the development of preventative, primary-care, and community-based public health services. Examples are seen in the reductions of certain health problems between 1972-74 and 2000-2002: gastrointestinal disease mortality reduced 91 percent, tuberculosis mortality reduced 80 percent, cervical cancer reduced 76 percent, and maternal mortality reduced 64 percent; with the average death rate from all causes dropping 29 percent.<sup>1</sup>

Unfortunately, while Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that other types of diseases are on the rise for Indian people. For example, national data for Indian people compared to the U.S. all races rates indicate they are 638 percent more likely to die from alcoholism, 400 percent greater to die from tuberculosis, 291 percent greater to die from diabetes complications, 91 percent greater to die from suicide,

<sup>1</sup> FY 2000-2001 Regional Differences Report, Indian Health Service, available: [www.ihs.gov](http://www.ihs.gov).



and 67 percent more likely to die from pneumonia and influenza.<sup>2</sup> In the Northwest, stagnation in the data indicates a growing gap between the AI/AN death rate and that for the general population might be widening in recent years. In 1994, average life expectancy at birth for AI/ANs born in Washington State was 74.8 years, and is 2.8 years less than the life expectancy for the general population. For 2000-2002, AI/AN life expectancy were at 74 years and the disparity gap had risen to 4 years compared to the general population. The infant mortality rate for AI/AN in the Northwest declined from 20.0 per 1,000 live births per year in 1985-1988 to 7.7 per 1,000 in 1993-1996, and then showed an increasing trend, rising to 10.5 per 1,000 in 2001.<sup>3</sup>

What is more alarming than these data is the fact that there is abundant evidence that the data might actually *underestimate* the true burden of disease and death among AI/AN because, nationally and in the Northwest, people who classify themselves as AI/AN are often misclassified as non-Indian on death certificates. A caution in using AI/AN data is that, due to small numbers, death rates are more likely to vary from year to year compared to rates for the general population. Unfortunately, it is safe to say that the improvements for the period of 1955 to 1995 have slowed; and that the disparity between AI/AN and the general population has grown. Factors such as obesity and increasing rates of diabetes contribute to the failure to reduce disparities.

## II. Indian Health Financing: Medicare and Medicaid

The major trend in the financing of Indian health over the past ten years has been the stagnation of the IHS budget. With exception of a notable increase of 9.23 percent in FY 2001, the IHS budget has not received adequate increases to maintain the costs of current services (inflation, population growth, and pay act increases). In FY 2007, it was estimated that it would take at least \$436 million to maintain current services<sup>4</sup>. Unfortunately, the FY 2007 Continuing Resolution will only provide \$138.5 million increase over the FY 2006 enacted level. This leaves over \$297 million in inflation, population growth, and pay act increases to be absorbed by IHS programs.

The IHS Federal Disparity Index (FDI) is often used to cite the level of funding for the Indian health system relative to its total need. The FDI compares actual health care costs for an IHS beneficiary to those costs of a beneficiary served in mainstream America. The FDI uses actuarial methods that control for age, sex, and health status to price health benefits for Indian people using the Federal Employee Health Benefits (FEHB) plan, which is then used to make per capita health expenditure comparisons. It is estimated by the FDI, that the IHS system is funded at less than 60 percent of its total need.<sup>5</sup>

In light of this chronic under-funding, Medicare and Medicaid collections are now a growing and critical component to providing basic health care services by the Indian health

<sup>2</sup> Ibid.

<sup>3</sup> American Indian Health Care Delivery Plan 2005, American Indian Health Commission of Washington State, available at: [www.aihc-wa.org](http://www.aihc-wa.org).

<sup>4</sup> FY 2007 IHS Budget Analysis & Recommendations, Northwest Portland Area Indian Health Board, March 18, 2006; available: [www.npaihb.org](http://www.npaihb.org).

<sup>5</sup> Level of Need Workgroup Report, Indian Health Service, available: [www.ihs.gov](http://www.ihs.gov).

system. While Medicare and Medicaid have become critically important to the health of AI/AN people, the expenditures constitute a very small share of overall costs in these programs. For example, it is estimated that Medicaid accounts for almost 20 percent of the IHS budget but less than 0.5 percent of the overall Medicaid expenditures go to Indian health. As the IHS has experienced a growing reliance on Medicaid reimbursements, another benefit has resulted from Medicaid coverage.

The IHS Contract Health Services (CHS) program purchases specialized health services for AI/AN beneficiaries that are not provided in IHS and Tribal health facilities. In order to budget the CHS resources so that as many services as possible can be provided, the agency applies stringent eligibility rules and uses a medical priority system. CHS services must be pre-authorized or no payment will be made. The agency also has adopted a payer of last resort rule which requires patients to exhaust all health care resources available to them from private insurance, state health programs, and other federal programs before IHS will pay through the CHS program. Medicare and Medicaid are the most important alternate resources to pay for care outside of the CHS budget. Furthermore, Medicaid helps protect CHS budgets from unpredictable catastrophic medical occurrences, especially for tribes with small populations and very limited CHS allocations—thereby avoiding rationing of health care.

### **III. IHCIA and Health Facilities Construction**

It is critically important to have adequate facilities and medical staff in order to be able to provide Medicare and Medicaid related services. The third-party reimbursements from these programs allow Tribal health programs to compliment their IHS budget, which in turn allow health programs to deliver a wider range of health services. If CHS budgets are in a “priority one” status and medical services are outside the scope of medical priorities than patients often go without health care.<sup>6</sup> Those IHS Areas without hospitals (CHS Dependent Areas) are at a disadvantage since most inpatient hospitals often have medical staff that can provide services that might otherwise be purchased through the CHS program. In effect, those Areas with inpatient hospitals are able to “internalize” the costs associated with purchasing specialty care that are normally borne by CHS programs; and provide more services since they continue to have the unobligated CHS amounts that would have been used to purchase such care. This creates a funding and access to health services disparity within the Indian health system.

The Medicare and Medicaid programs provide tens of billions of dollars for facilities construction annually, but there is no discussion of facilities construction before the Congress and no separate appropriation for facilities construction in connection with the Medicare or Medicaid program. Yet most American seniors receive care in the most modern clinics and hospitals in the world. Indeed it is remarkable, but true, that poor Americans who are eligible for

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<sup>6</sup> Priority One Defined - Emergent/Acutely Urgent Care Services: Diagnostic or therapeutic services that are necessary to prevent the immediate death or serious impairment of the health of the individual, and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible health care available. Priority One represents those diagnosis and treatment of injuries or medical conditions that, if left untreated, would result in uncertain but potentially grave outcomes.

Medicaid in Washington, Oregon, and Idaho now receive their care in the same facilities as other non-poor Americans, that's right, in the very same clinics and hospitals that are the envy of the world. But what about Indian people? Our clinics in the Northwest are notable exceptions; most on average are more than 40-50 years old. A clinic on the Colville Indian reservation is over 70 years old; and in other Northwest Tribal communities, clinics are housed in mobile homes. The clinics are not just old; they are also inadequate. They are often too small, the equipment is often outdated, and the staff is forced to make do as best they can. That is, the staff that is willing to stay under these less than desirable conditions. Many tribes continually battle recruitment and retention of medical doctors and nurses because of the less than desirable working conditions. Who can blame someone for not wanting to work up to his or her potential in a modern state of the art facility?

Section 301(c) of the IHCA:

I want to take an opportunity to alert the Finance Committee about an issue that is becoming a growing concern with the reauthorization of the IHCA. This concern has to do with the IHS' facility construction funding process and a new priority system for ranking construction projects. Section 301 establishes the authority for the IHS to develop a Health Facilities Construction Priority System (HFCPS). It affects the ability of CHS dependent Areas like the Portland, Bemidji, California, and Nashville to collect third party resources under the Medicare and Medicaid programs. If you do not have an adequate health facility with appropriate medical personnel how can you provide the full range of health services that other Areas within the IHS system can. This raises serious questions about access to services and funding inequities.

The Senate Committee on Indian Affairs' current bill draft includes a "grandfathering" provision in Section 301 that will protect all facility construction projects that are on the current priority list. The language contained in Section 301 was carried over from current law and developed through Tribal consultation, which responded to Tribal needs and concerns in 1999, however given recent changes in the construction priority system, the language is now out of date. It is estimated that at the current rate of appropriations for facilities construction, it would take 20-30 years to clear the current projects, thus prohibiting a new facilities construction priority system from ever being implemented and prohibiting the IHS from responding to a Congressional directive.

The reason the language at Section 301 is out of date is that over the last three years the IHS and Tribes have worked to develop a new and more equitable construction priority system. The FY 2000 Interior Appropriations Act directed the IHS to "work closely with the Tribes and the Administration to make needed revisions to the facilities construction priority system." Specifically, Congress directed the Agency to address projects "...funded primarily by tribes; anomalies such as extremely remote locations; recognition of projects that involve minimal increases in operational costs; and options for alternative funding and modular construction." The recommendations for the new system are complete and have been forwarded to the IHS Director to make a decision on the final implementation of a new HFCPS. If the Section 301 bill language was to pass today, it would seriously hamper the ability of the IHS Director to implement the new system and continue the long-standing inequities in allocating facilities construction funds.

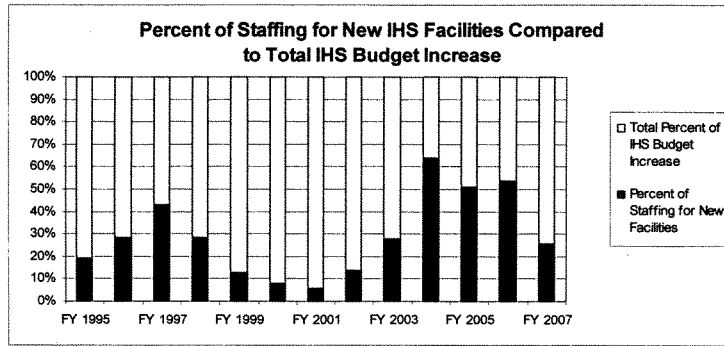
Just as the current bill language has gone through Tribal consultation, so too have the recommendations for revising the HFCPS. In fact, the HFCPS recommendations have gone through much more rigorous Tribal consultation than language in the current bill draft. A review of this Tribal Consultation process follows. In June 2004, the IHS sent out for comment a draft of a revised HFCPS. The IHS received over 1,200 comments during the comment period. Because of the complexity of the issues, the IHS Facilities Advisory Appropriation Board (FAAB) established a workgroup to review the comments and address specific issues identified by Tribes. Like the NSC, the FAAB includes Tribal representatives from each of the twelve IHS Areas and two federal representatives.

The workgroup met over six months in three meetings held in Portland, Oklahoma City, and Tucson and also conducted numerous teleconference meetings. The workgroup reported their recommendations to the full FAAB on May 11-12, 2005. Based on this report, the FAAB developed specific recommendations to make improvements in the facilities priority system and transmitted their recommendations to IHS on July 21, 2005. In October 2005, the workgroup met again in Rockville, MD to finalize their recommendations based on feedback from the IHS. The revised recommendations were transmitted to IHS on February 28, 2006. On June 26, 2006, the IHS Director sent a letter to Tribal leaders requesting additional facility data to assess the impact on projects under the new system. The full FAAB met in October 2006 in Minneapolis to review a "dry run" of facility construction project scores under the new system. There were concerns related to the project rankings, so the FAAB adjusted their recommendations that were transmitted to IHS on March 3, 2007.

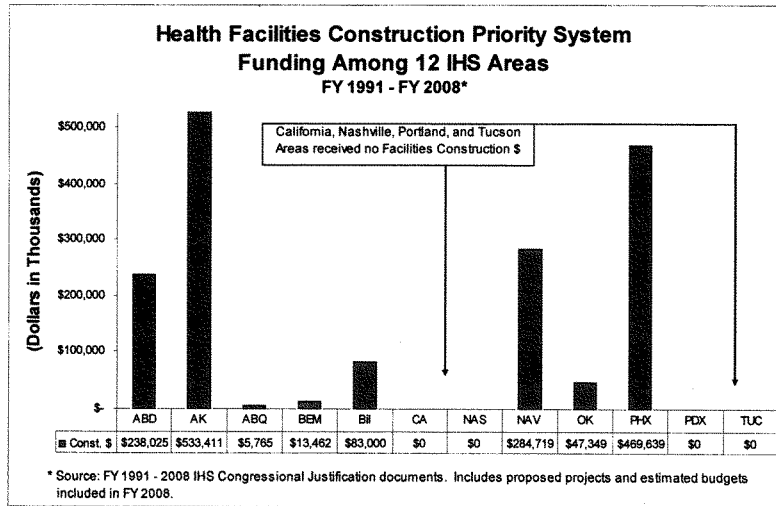
This process culminates over three years of work to revise the facilities construction priority system. If this bill language passes as proposed it will prohibit the new system from being implemented today.

#### Tribal Concerns:

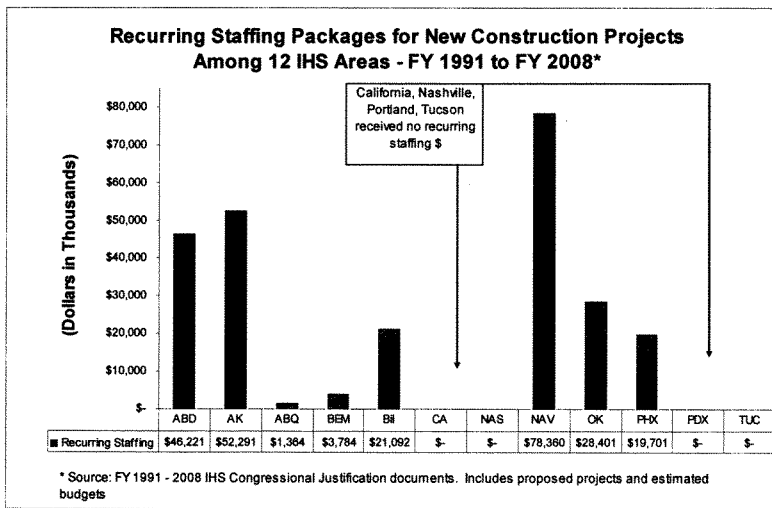
There are many Tribal concerns associated with facilities construction. Many of these concerns have been addressed in the revision of the new priority system. Generally, Tribes are opposed to the old system because it has been locked since 1991 and allocates a disproportionate share of resources to a select few Tribal communities that results in gaps in the level of health services provided to AI/AN people. The staffing requirements for newly constructed health facilities have always been a concern for Tribes that are dependent on CHS funding to provide health care. The inequities associated with health facilities construction provide a significant amount of resources to one to three Tribes that are fortunate to score well under the priority system and receive a new facility—along with a new staffing package. The significance of staffing new facilities is that it removes funds necessary to maintain current services (pay costs, inflation, and population growth) from the IHS budget increase, which then become recurring appropriations. As the graph below illustrates, staffing packages for facilities construction cuts considerably into budget increases for the IHS.



The graph above demonstrates that phasing in staff at new facilities is a growing problem within the Indian health system. The decline in FY 2007 is a result of the pause in facilities construction in part due to the fiscal effects of the federal deficit. Otherwise, the percentage for staffing new facilities would be considerably more. In FY 2004, the new staffing was over 60% of the IHS budget increase. In FY 2005 and FY 2006, new staffing costs consumed over 50% of the increase. It simply is not fair that one or two Tribes benefit by receiving 40-60 percent of the IHS budget increase, while 550-plus Tribes must divide the remaining budget to fund their mandatory cost increases.



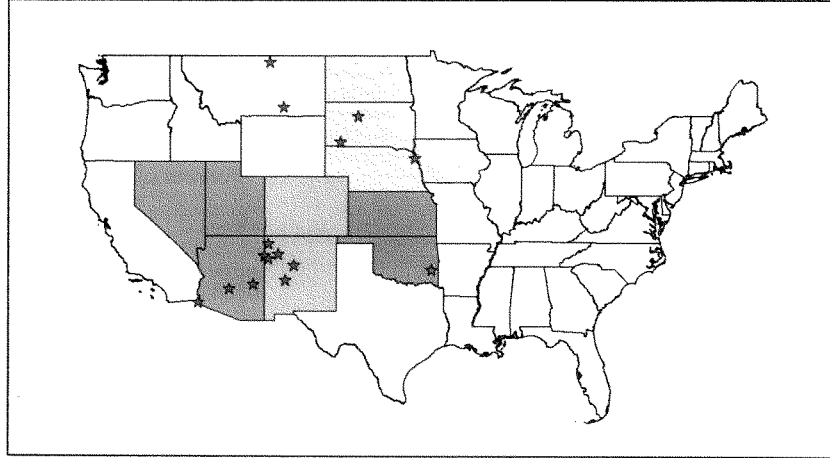
The graphs above and below demonstrate the inequities associated with allocating health facilities construction funding and recurring staffing packages among the twelve IHS Areas. While facilities construction funding is significant (approximately \$1.7 billion since 1991), the real resources are tied to recurring staffing packages estimated at approximately \$251 million (unadjusted for inflation) since 1991. These staffing packages become recurring dollars that are included in subsequent year's budgets and receive pay act, inflation, and population growth increases. The graphs above and below depict that CHS dependent Areas (California, Nashville, Bemidji, Portland) have not received an equitable amount of facilities construction funding and recurring staffing resources since the existing system has been locked since 1991.



Inpatient Facilities Construction:

The following map demonstrates the inequities in allocating facilities construction funding for inpatient hospitals. The map indicates that there has not been one inpatient hospital built in the Bemidji, California, Nashville, and Portland Areas under this system. It is important to note that there have been facilities built in these Areas under the joint-venture and small ambulatory program authorities. However, these authorities do not provide for a staffing package similar to those projects built under the HFCPS. This is critical as it provides those projects built under the HFCPS with a generous staffing package that recurs year after year. This in effect provides a disproportionate share of resources to projects built under this system. How can Congress implement a provision in the IHCA that unjustly provides funding for facilities construction? The work that the FAAB has undertaken over the last three years will address the inequities of this system and levels the playing field for Tribes to compete for facilities construction funding.

Completed and proposed Inpatient Hospitals from the 1991 Health Facilities Construction Priority System. (Source: FY 2006 IHS Vertical Status Report for Facilities Construction)







the FAAB recommendations for revising the facilities construction priority system and revise the language in subsequent provisions of Section 301(c). The first recommendation is the establishment of an Area Distribution Funding methodology. This recommendation would add a provision at Section 301(c)(1)(A) that will allow those Areas that do not benefit from the construction priority system to receive funding to address the facilities construction projects in their Areas. We further recommend language changes at Section 301(c)(2)(B) and at 301(c)(1)(D). NPAIHB has provided Finance Committee staff with a copy of our proposed language for your consideration and we are happy to discuss our recommendations in detail.

#### **IV. Conclusion**

I know that Finance Committee members understand that the Indian health system is unlike any other. It serves the poorest, sickest, and most remote populations in the United States. Despite the effective use of a public health delivery model and the advances the Indian health system has made toward addressing health disparities, the funding constraints often result in rationing health services. It has been because of the access to Medicare and Medicaid programs that have often kept many Tribal health programs from going bankrupt.

The legislation that we are discussing here today will authorize important programs for the Indian Health Service and greatly improve the lives of many American Indian and Alaska Native people. We hope you will continue to support Indian health issues and endorse similar provisions that the Committee passed in S. 3524.

In closing, I want to thank the Committee for all the work you have done and your support on Indian health issues!



**NORTHWEST  
PORTLAND  
AREA  
INDIAN  
HEALTH  
BOARD**

Burns-Paiute Tribe  
 Chehalis Tribe  
 Coeur d'Alene Tribe  
 Colville Tribe  
 Coos, Siuslaw, &  
 Lower Umpqua Tribe  
 Coquille Tribe  
 Cow Creek Tribe  
 Cowlitz Tribe  
 Grand Ronde Tribe  
 Hoh Tribe  
 Jamestown S'Klallam Tribe  
 Kalispell Tribe  
 Klamath Tribe  
 Kootenai Tribe  
 Lower Elwha Tribe  
 Lummi Tribe  
 Makah Tribe  
 Muckleshoot Tribe  
 Nez Perce Tribe  
 Nisqually Tribe  
 Nooksack Tribe  
 NW Band of Shoshoni Tribe  
 Port Gamble S'Klallam  
 Tribe  
 Puyallup Tribe  
 Quileute Tribe  
 Quinault Tribe  
 Samish Indian Nation  
 Sauk-Suiattle Tribe  
 Shoalwater Bay Tribe  
 Shoshone-Bannock Tribe  
 Siletz Tribe  
 Skokomish Tribe  
 Snoquamic Tribe  
 Spokane Tribe  
 Squaxin Island Tribe  
 Stillaguamish Tribe  
 Suquamish Tribe  
 Swinomish Tribe  
 Tualip Tribe  
 Umatilla Tribe  
 Upper Skagit Tribe  
 Warm Springs Tribe  
 Yakama Nation

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May 11, 2007

The Honorable Max Baucus  
 c/o Catherine Dratz  
 Senate Finance Committee  
 219 Dirksen Senate Office Building  
 Washington, D.C. 20510

Dear Chairman Baucus:

Thank you for the opportunity to provide comment to clarify questions that Senator Jeff Bingaman has concerning our testimony before the Finance Committee on March 22, 2007. The following provides our response to Senator Bingaman's request:

- 1) Do you know that the new priority system list will not arrive at the same priorities as the current list?

The information posed with this question is correct in that the new Health Facilities Construction Priority System (HFCPS) has not been published. At this time it is not possible to assess the impact of the new priority system on the current projects. This is because the final decision on how to incorporate the recommendations into the new priority system has not been made by the Indian Health Service (IHS). It is anticipated that the criteria weighting of the new priority system could result in a higher or lower priority for those projects that are on the current priority list. Thus, the current projects could move up or down relative to the national list of projects making application to the new priority system.

- 2) Could you describe how your methodology accounts for the volume of users served by the facility?

The statement accompanying this request is not entirely accurate. While the new Health Facility Construction Priority System (HFCPS) criteria weighting for Facility Size is lower than that of Facilities Deficiencies and Health Status, it does provide a basis for the size of facility a Tribe would qualify to build and receive funding. As well, the user population does provide for correlation to the size of an existing facility and the number of users of that facility. The Area Distribution Methodology will build upon the same components already used for HFCPS projects. Thus, a proposed Area Fund project will use the same exact criteria for scoring and evaluating projects as the new priority system.

What is different about our proposal is that it would create take a portion of the overall health facilities construction budget and allocate it among the twelve IHS Areas. An annual distribution would allow each Area to improve, expand, or replace existing health care facilities. Under the proposed HFCPS, the Agency would be able to extend funding to a significantly larger number of tribes and communities than would be possible through its current practice of funding line-item projects. The formula for Area funding allocations would be based on components of Area's overall health status, user population, and current infrastructure. The user population is a very important component that is used in both, scoring and evaluating projects, and the Area's allocation of funding.

The ADF would not displace any projects on the current priority list, unless a Tribe under its own desire would chose to build their facility under the area distribution system. In fact, those Areas that have projects on the current priority system would benefit two fold. First, projects would not be displaced on the current priority system. Secondly, the ADF would provide recurring funds to address facility expansion and renovation needs in the Area. It could also provide funds to address the backlog of Area maintenance/improvement projects. Thus, those Areas that have projects on the current priority list get the best of both worlds. They get to keep their project on the priority list and gain access to recurring funds to address other facilities needs of Tribes in their Area.

I hope this clarifies the questions you posed. If you should have additional questions, please feel free to follow up directly with Jim Roberts, Policy Analyst, at (503) 228-4185 or by email at [jroberts@npaihb.org](mailto:jroberts@npaihb.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Linda Holt". The signature is written in a cursive, flowing style.

Linda Holt, Chairperson of the Board  
Suquamish Tribal Council Member

**STATEMENT OF SENATOR GORDON H. SMITH**

U.S. Senate Finance Committee

“Keeping America’s Promise: Health Care and Child Welfare Services for Native Americans”

Thursday, March 22, 2007

Thank you, Chairman Baucus and Ranking Member Grassley for providing the Finance Committee with an opportunity to explore the important topic of providing health and child welfare services to Native Americans. I look forward to the testimony of today’s witnesses and their insight on how we can strengthen the Medicare, Medicaid and State Children’s Health Insurance Program (SCHIP) portions of the Indian Health Care Improvement Act (IHCA), as well as improve overall child welfare.

As we all know, there are many serious health issues affecting the Native American population. Native American youth are at a much higher risk of dying by suicide than the general American population. Diabetes, substance abuse and tuberculosis also remain challenging problems to this population.

A report released in September of 2004 by the U.S. Commission on Civil Rights gives us a snapshot of what health crises Native Americans face:

- Native Americans are 770 percent more likely to die from alcoholism,
- 650 percent more likely to die from tuberculosis,
- 420 percent more likely to die from diabetes,
- 52 percent more likely to die from pneumonia or influenza than the rest of the United States, and
- Suicide is the second leading cause of death among Native American youth aged 10-24. According to the CDC, American Indian and Alaskan Natives also have the highest rate of suicide in the 15 to 24 age group.

Given these circumstances, the life expectancy for Native Americans is 71 years of age, nearly five years less than the rest of the U.S. population.

I, like most of my colleagues, feel that we are past due in passing a reauthorization of the Indian Health Care Improvement Act. There are nine federally recognized tribes in my home state of Oregon. Just the other week, I met with some members of these tribes here in Washington, D.C. They emphasized the urgent need for Congress to come to an agreement and pass this bill. The services in this Act, especially those related to health care delivery, are vital to the health and well-being of their families and communities. They want us to finish our work.

Since the enactment of the Indian Health Care Improvement Act in 1976, this legislation has provided the framework for carrying out our responsibility to provide American Indians with adequate health care. As we will hear today, this Act has not been updated in more than 14 years, despite changes in needs within this population. For the past eight years we have been working to write and markup this legislation, but we have failed to get a final bill signed into law.

We cannot allow the health of this population to remain in jeopardy for another year. The legislation that we are discussing today is our first step in addressing the growing health disparities that Native Americans face. This legislation makes much needed changes to the way the Indian Health Service delivers health care to Native Americans and is the product of significant consultation and cooperation with tribes and health care providers.

In June 2006, the Finance Committee approved S. 3524, "Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006" by a unanimous voice vote. This legislation includes the Finance-related provisions, as a corollary to the Indian Health Care Improvement Act (S. 1057), which was approved by the Senate's Indian Affairs Committee.

Under the Finance-reported bill, which I supported, Native Americans enrolled in Medicaid or SCHIP would not have to pay co-payments or premiums when they receive services at the Indian Health Service, through an Indian Tribal health facility or a Tribal Organization or an Urban Indian Organization (urban clinic) (I/T/U), or if they are referred to a provider outside the IHS system by a provider at an I/T/U facility. In addition, the Finance-reported bill creates incentives for Medicaid managed care plans that enroll Native Americans to include "Indian Health" providers in their networks. The Finance-reported bill also includes new provisions directing the Secretary to encourage states to improve access to Medicaid and SCHIP for Native Americans living on or near Indian Reservations. These provisions are designed to increase enrollment among Native Americans in Medicaid and SCHIP, and to help defray the costs IHS, Tribal and Urban Indian programs are bearing for providing care.

The work we completed on S. 3524 would have greatly enhanced the ability of the Indian health system to address the significant health disparities that Native American people face. By again passing this bill we will clarify several provisions that were passed by the Indian Affairs Committee that are in the Finance Committee's jurisdiction to increase quality and coordinated care between the IHS, Medicaid, Medicare and SCHIP. I am pleased to be a member of both committees and I thank both Chairman Baucus and Ranking Member Grassley for continuing to work with the Indian Affairs Committee on this legislation.

Presently, in addition to the IHS operating hospitals for Tribes, Tribes are operating their own health programs under the Indian Self-Determination and Education Assistance Act, and 34 urban Indian health centers have been established to provide for the approximately 60 percent of the Native American population residing in cities. The IHCA was reauthorized in 1988 and again in 1992. Reauthorization is necessary so that improvements are made in the Indian health systems to raise the health status of Native American people to the highest level possible. Today, funding levels are only at 60 percent of demand for services each year, which requires IHS, tribal health facilities and organizations, and Urban Indian clinics to ration care, resulting in tragic denials of needed services. Reauthorization of the IHCA will facilitate the modernization of the systems, such as prevention and behavioral health programs for the approximately 1.8 million Native Americans who rely upon the system.

In my home state of Oregon, there is an outstanding issue related to prioritization of funds for health care facilities that I am hopeful we can also resolve quickly. As we all know, it is difficult to provide necessary and quality health care services in buildings that are outdated and ill-

equipped. The provision in the IHCIA that relates to this priority system, which ranks construction projects, was drafted over three years ago and is now out of date. Since this language was drafted, the IHS and Tribes have worked together to develop a new and more equitable construction priority system. If this outdated language is included in the bill, it would seriously hamper the ability of the IHS Director to implement the new system and would continue the long-standing inequities in allocating facilities construction funds. I understand that many tribes in Oregon are concerned that the outdated, proposed language will cause their facilities to lose priority to the extent that it could be years until facility upgrades occur there. I hope that we can work out a swift agreement on this issue so that federal funding for building improvements and construction is fairly distributed.

I also want to thank the Chairman for calling this hearing to discuss the needs of our child welfare system, particularly as it relates to the Tribal child welfare system. We know that in our nation, millions of children are reported abused or neglected each year. Of these, more than 900,000 are confirmed maltreated by child protective service organizations and our court systems. Abuse and neglect of children causes about 1,500 deaths each year.

As evident by these numbers, our entire child welfare system needs more help. However, at the top of our "to-do list", needs to be helping our child welfare system. While the overall population of our Nation's children is suffering in too high of numbers, Native American children are disproportionately affected by child abuse and neglect. We know that the rates of methamphetamine use and other substance abuse are higher here than in the general population. These are root causes that we need to counter with better funding and better oversight of Indian health programs.

I also wanted to extend my gratitude to Linda Holt, an elected Tribal Council Member of the Suquamish Tribe and Chairperson of the Northwest Portland Area Indian Health Board for testifying before the Committee today. She serves in a variety of capacities on national Tribal committees for agencies within the Department of Health and Human Services and serves as the Portland Area representative on the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act. In her role, serving the 43 Northwest Tribes, she is quite familiar with the health care needs of Indian Country.

More than 30 years ago, President Ford had the wisdom and saw the great need to sign into law the Indian Health Care Improvement Act. His signature was a promise made to American Indians that the federal government would work to improve their health status. That promise is one that we must not back away from. Reauthorizing this Act is a reaffirmation of that commitment and proves that we understand there is work yet to be done to further improve Indian health.

Again, I am thankful to Chairman Baucus and Ranking Member Grassley for their leadership and for building on the momentum from the last Congress to reauthorize this Act. I hope that we can swiftly resolve any remaining issues and get this long-overdue bill signed into law. I look forward to continuing to work with my colleagues on this legislation and to ensuring that Native Americans receive the health care they need and deserve.

**Testimony on Reauthorization of Indian Health Care Improvement Act**  
**Presented by the Honorable Carl E. Venne**  
**Chairman Crow Tribe of Indians,**  
**Chairman, Montana Wyoming Tribal Leaders Council,**  
**President, Council of Large Land Based Tribes**  
**Before the Senate Finance Committee**  
**March 22, 2007 – 10:00 AM**

Introduction

Good Morning, Chairman Baucus, Vice Chairman Grassley and honorable members of the Senate Finance Committee. I am Carl E. Venne, Chairman of the Crow Tribe of Indians in Montana and Chairman of the Montana –Wyoming Tribal Leaders Council and the Council of the Large Land Based Tribes. I am honored to appear before you today to present testimony on the Reauthorization of the Indian Health Care Improvement Act, certainly the most critical legislation for American Indians before this session of Congress. My presence here before you follows the efforts of other Tribal Leaders over several years who have also addressed Congress for the passage of this legislation.

The Tribes of Montana and Wyoming include the Blackfeet Nation, the Crow Tribe of Indians, the Confederated Salish and Kootenai Tribes of the Flathead Reservation, the Chippewa Cree of the Rocky Boy's Reservation, the Gros Ventre and Assiniboine Tribes of the Fort Belknap Reservation, the Assiniboine and Sioux Tribes of the Fort Peck Reservation, the Northern Cheyenne Tribe, the Eastern Shoshone and Northern Arapaho Tribes of the Wind River Reservation and the Little Shell Tribe. All Montana and Wyoming tribes are members of the Council of Large Land Based Tribes, a national tribal organization of tribes with land bases of 100,000 or more acres and with large on-Reservation populations. These large land based tribes continue to struggle with the longstanding Indian reservation issues of poverty, very high unemployment, joblessness, lack of adequate housing and the most serious issue, substandard health care.

As the debate and dialogue surrounding the reauthorization of the Indian Health Care Improvement Act continues, I would like to relate to you stories that illustrate the real-life impact of the deplorably substandard health care currently available to my people on the Crow Reservation.

Patient X is a five-year-old girl who was diagnosed with retinoblastoma, a rare form of cancer in the eye, at age five months. This condition required that her right eye be surgically removed. When she originally had the right eye removed in October of 2001, a prosthetic eye was made to fit, with the understanding that every few years, a new prosthesis would be required as she grew. At the end of last year, when it was clear that her prosthetic eye needed to be replaced, Indian Health Service Contract Health funding became an issue. Both of her parents, who recently gained employment, found themselves ineligible for Medicaid assistance and her case failed to meet medical priority criteria for Contract Health Services. Her family was left with the options of going without a new prosthesis, which could lead to a permanently disfigured face for B.Y., or seeking to raise the \$3000 themselves, not an easy task for a family working hard to earn a living.

Patient Y is a 35-year-old woman who was diagnosed with an unusual heart condition that led to dramatic heart failure – for an unknown reason, her heart lost its ability to pump well, and she could hardly move without becoming dramatically short of breath. She was referred to the Mayo Clinic, where she received special cardiology care and put on the list for a heart transplant. Thanks to close monitoring, the use of many medications and a permanent pacemaker, her condition stabilized, and her ability to function improved a bit. At least she can walk a short distance now without assistance. However, due to a lack of funding, her on-going visits with the cardiologist, not to mention a heart transplant, will no longer be covered.

Many similar stories exist throughout Indian Country illustrating the shameful state of health care services for American Indian people in this most powerful and wealthiest country in the world. Statistics illustrate that Indian Health Care is at the bottom of Federal Health Expenditures with medical expenditures for federal prisoners almost double the amount allocated for American Indians. This single fact flies in the face of the mission of the Federal Government's Indian Health Service, which states:



The mission, in partnership with American Indian and Alaska native people, is to raise their physical, mental, social and spiritual health to the highest level. The Goal is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indian and Alaska Native people. The Foundation is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities and culture, and to honor and protect the inherent sovereign rights of Tribes.

Without adequate funding, the mission statement of the Indian Health Service, while ambitious and noble, is meaningless. Why has providing adequate health care to America's first people become such a low priority in the development of the federal budget over the last decades? Lawmakers need to revisit the sacrifices of aboriginal lands by Indians in exchange for the federal government's commitment to provide health care. The federal government's trust responsibility has been established over and over in treaties with Tribes and Executive Orders. These treaties were entered into between two sovereign entities; thus, the federal government's obligation to provide health care is a legal commitment to another political entity, America's Indian Nations. Health care for American Indians is not a race-based privilege but a legal obligation to a political group; an obligation the United States must uphold. One should contrast the United States deplorable demonstration of trust responsibility with the Tribes' commitment to the treaties as clearly demonstrated by the record number of American Indians serving in the Afghanistan and Iran conflicts.

While the United States has been faced with the devastation of natural disaster and the ever-increasing challenges of financing overseas military operations, it cannot forget its legal obligations to the first Americans. The United States commits billions of dollars to foreign aid including aid to third world countries for health care in furtherance of humanitarian efforts. However, the United States has ignored its legal obligation to American Indians here within the borders of the United States. The time is now for Congress to recommit to its trust responsibility for health care for American Indians. The

Montana – Wyoming Tribal Leaders and the Council of the Large Land Based Tribes have expressed concerns in the following areas.

#### Health Disparities

No other segment of the United States population is more negatively impacted by health disparities than American Indians. Our Tribal members suffer from disproportionately higher rates of chronic disease and other illnesses. Native Americans have the highest rates of diabetes, heart disease, suicide, and several types of cancer of all other groups in the United States.<sup>1</sup> In the Great Plains Region, we suffer from one of the highest infant mortality rate in the nation.<sup>2</sup>

While the federal government's mission statement for American Indian health care has lofty objectives, in reality the Indian Health Services is unable to deliver health care that is even remotely comparable to the health care available to other Americans. Presently the Indian Health Service hospitals and clinics have an average age of 33 years compared to 9 years for average U.S. hospitals and clinics. The Indian Health Service is only able to provide 73.9 medical doctors per 100,000 Tribal members as compared to 220.6 MDs available to the non-Native U.S. population, constituting a 66% gap in physician availability between Natives and non-Natives. Furthermore, 229 nurses are available per 100,000 Tribal members compared to 849 nurses available for every 100,000 people in the United States, constituting a 73% gap in nurse availability between Natives and non-Natives.

#### Budget

While the President's budget recommended an increase in nearly every line item in the Indian Health Service's budget, this increase is not sufficient to maintain even the status quo of poor health care for American Indians. While we greatly appreciate the increases in funding over the last several years, the 7% funding increase cannot begin to provide adequate health care with the rising costs of health care and the population increases of American Indians. Between 1995 and 2005, IHS revenues grew by 75%,

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<sup>1</sup> See, e.g., U.S. Dept. of Health and Human Services, Indian Health Service, "Trends in Indian Health 2000-2001". [[http://www.ihs.gov/NonMedicalPrograms/IHS\\_Stats/files/Trends00-01\\_Front.pdf](http://www.ihs.gov/NonMedicalPrograms/IHS_Stats/files/Trends00-01_Front.pdf)]

<sup>2</sup> *Ibid.*

while inflation grew by 56% and number of users grew by 14%, resulting in flat buying power per individual patient.

The present \$4.1 billion budget request amount is seriously below the Indian Health Service FY06 “Needs Based Budget” indicating at least \$19.7 billion was necessary for adequate health care. The present budget request would allow the Indian Health Service to meet only 60% of established needs, falling far short of even maintaining the appalling conditions of status quo health care. The Indian Health Services has historically used the “Rules Based Budgeting” process that has not kept pace with actual cost and inflationary rates since 1954.

For example, the Indian Health Service budget in 2003 allowed for approximately \$2130.00 per individual<sup>3</sup> as opposed to general health expenditures for the United States population of \$5065.00.<sup>4</sup> Additionally, it is useful to compare 2003 IHS expenditures at \$2130.00 per capita and actually \$1688.00 per capita in the Billings Area and 2003 Veterans Administration expenditures at \$5214.00 per capita<sup>5</sup> – VA expenditures per capita are more than double the IHS per capita expenditure. Recent revelations about the intolerable state of the Veterans Administration services and facilities make this discrepancy even more disgraceful.

#### Contract Health

All Tribes have expressed a serious concern for the shortfall in Contract Health Care, health care that is unavailable within the Indian Health Service that must be purchased via contract in the private and public health services sector. During recent Indian Health Service Budget Formulation meetings, Tribal Leaders and Billings Area IHS staff determined that augmenting the Contract Health Services was the number one priority. Presently \$30 million dollars is available for the Montana – Wyoming Tribes. No tribe has over \$5 million to access surgeries and specialized health care not available within the Indian Health Service. With the costs of surgeries and specialized treatments,

<sup>3</sup> Source: Indian Health Service budget and appropriations tables for 2005. Expenditures from appropriations plus collections are divided by the 2005 HIS user population to compute actual expenditures per user.

<sup>4</sup> Centers for Medicare and Medicaid Services website, 2/6/2006.

[<http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nheprojections2004-2014.pdf>]

<sup>5</sup> Veterans' Administration website, 2/6/2006.

[[http://www.va.gov/vetdata/ProgramStatics/stat\\_apps02/Table%2011%20\(02\).xls](http://www.va.gov/vetdata/ProgramStatics/stat_apps02/Table%2011%20(02).xls)]

these dollars cover only a portion of the need. Thus, many of our Tribal members go without treatment that is accessible to the average American. Many medical procedures are “deferred” to later dates when the procedures usually are more expensive and the patient’s condition has worsened. At present, contract health is so seriously limited that a person must be at risk of losing life or limb before qualifying for contract health care dollars. While an increase in the Contract Health Service line item has been proposed, the increase is far from sufficient to meet current needs and allow coverage for medically necessary services that do not reach the current life or limb standard.

For example, in one service unit, an adolescent was in need of a heart transplant. The procedure had to be covered by contract health funds. This procedure was medically necessary to save the life of a young person. The procedure cost over \$1 million, or approximately half of the contract health budget for that service unit, which is \$2.5 million. Half of the contract health budget for this service unit, which serves over 6000 people, was used for one person. The current budgeting process does not allow for adjustments to adequately address such situations.

Additionally, Native Americans between the ages of 25-44 are 3.7 times more likely to die from accidental or unintentional injury than the general population. One recent head injury in our service unit cost \$177,000 in contract health dollars. This is an example of the cost of a traumatic injury to one single individual. The impact of this type of occurrence, which is statistically more likely to occur within our populations, on the contract health services budget cannot be overemphasized.

Over the past year, three permanent staff physicians have resigned from our hospital at Crow Agency, including one physician who had been a part of IHS for over 15 years. While each of these physicians had additional personal concerns that factored into their choice to leave the IHS, a common motivator for all three was frustration over how underfunding was steadily deteriorating the quality of care they were able to provide to their patients. Specifically, each noted that the lack of contract health service funding compromised the quality of care they were able to provide and undermined their relationships with patients. Three additional physicians who are considering an imminent departure from the hospital cited these same concerns.

#### Medicare Modernization Act

Section 506 of the Medicare Modernization Act requires the Secretary of HHS to develop regulations that that will require Medicare participating hospitals to accept the Medicare rate as payment in full for services provided to American Indians referred under the Contract Health Service program. Currently, in some areas, the Indian Health Service must pay full-billed charges to private and public sector hospitals for services provided to American Indians. Publishing these mandated regulations that were required by Section 506 for publication in December 2004 will ensure that the Indian Health Service pays rates similar to Medicare rates paid to Medicaid participating hospitals.

#### Preventative Health Care

While cancer rates in the general population have declined due to an increase in preventative services, a lack of funding has prevented the provision of cancer education and screening for early detection of cancer in Indian Country. Thus, cancer among American Indians has not declined and is the third leading cause of death for all American Indians. Further, American Indians have the poorest cancer survival rate in comparison to other racial and ethnic groups in the United States. While the President's budget includes funding for effective disease prevention, the amount is not sufficient. We need sufficient funding for cancer screenings to allow treatment before the end stages of cancer that is presently the starting point for intervention and treatment.

#### Traditional Health Care Models

Tribes have compacted and contracted health care services under the Indian Self-Determination and Education Assistance Act in an effort to provide culturally relevant treatment methods. On the Crow Reservation, we have contracted with the Indian Health Service to provide a culturally relevant substance abuse treatment program. Our facility, known as the Seven Hills, has been more successful for Crow people battling substance abuse than standard treatment methods. We have incorporated the sweat lodge ceremony, elder counseling and other cultural aspects into an effective treatment process with success rates far exceeding standard success rates. However, we read the Department of Justice's "white paper" regarding its concerns about traditional treatment

alternatives that tribes may provide through contracting or compacting with the Indian Health Service. Specifically, the concern was that Federal Torts Claims coverage may not apply and therefore, such alternative treatment methods should not be allowed via contract or compact. However, at Crow, we have never had anyone submit a claim or complaint against Seven Hills during its three-year existence to date. Further, we have been unable to verify that even a single tort claim has been attempted for any traditional treatment service provided by contract or compact by a tribe in the Billings IHS Area. Thus, the concern expressed by the Department of Justice is without basis and should not bar treatment alternatives that have proven success rates.

#### IHS Must be a Primary Provider Rather than a Payor of Last Resort

Prior to the Indian Health Care Improvement Act, health care for American Indians was paid entirely by the Indian Health Service. In the mid-1970's, the IHS was designated as the Payor of Last Resort and American Indians were required to seek other sources for payment of health services that the IHS could not provide in IHS hospitals and clinics. Thus, when a Tribal person has a catastrophic illness, he or she often must seek payment through Medicaid or Medicare prior to IHS funding. The time delay involved in seeking alternate forms of payment can exacerbate a life-threatening condition, and can, in some instances, impact a patient's ability to be treated. When a Tribal member suffers from an acute illness, the time involved to seek alternative funding (often with at least a 30 to 60 day turnaround time) will interfere with timely, effective treatment. Requiring American Indians to endure the stress and hardship of seeking alternative payment sources is contradictory to the IHS trust responsibility to provide health care to all American Indians.

#### Funding for Behavioral Health Services

Presently, the Indian Health Service has extremely limited funding to provide psychiatric, psychological and behavioral health services for adults and most significantly, for adolescents. Little to no funding is available for residential treatment services for adolescents in desperate need of behavioral intervention. Additional services to address behavioral health are critical.

For many Native American communities, there is a lack of understanding of the role of behavioral health in health promotion and disease prevention. Many chronic health conditions are linked to life-long behavior patterns, and therefore can be prevented by a change in lifestyle. Native Americans are at a higher risk for mental health disorders than other racial and ethnic groups in the United States, and are consistently overrepresented among high-need populations for mental health services, correlated to high rates of homelessness, incarceration, alcohol and drug abuse, and stress and trauma in Native American populations. Substance abuse and depression are epidemic among the Native American community, and are commonly attributed to isolation on distant reservations, pervasive poverty, hopelessness, and intergenerational trauma, including the historic attempts by the federal government to forcibly assimilate tribes. Additionally, Wyoming has been ranked number one nationwide and Montana number two, both within the Billings HIS Area, for methamphetamine abuse. However, unfortunately, due to inadequate funding, the IHS does not provide ongoing preventative psychiatric care, and has instead adopted an approach of crisis stabilization—responding to immediate mental health crises and stabilizing patients until their next episode.

We are all painfully aware of the high suicide rate among American Indians and especially in American Indian adolescents. For example, a 2003 report by the Centers for Disease Control states that Native Americans are nearly three times more likely to commit suicide than the general United States population. An additional CDC report compiling information from 1979 through 1992 shows Native Americans suffering from a 150% higher suicide rate compared with that of the general United States population. In the Billings service area, the death rate from suicide is 8.6 per 100,000, as compared with 3.0 per 100,000 for the general population. Other IHS areas serving large land based tribes have even more abysmal rates – the Aberdeen area has a rate of 19.6 per 100,000; Bemidji has a rate of 10.7 per 100,000; Tucson has a rate of 18.8 per 100,000.

The inability to treat individuals in need of behavioral health services is beyond frustrating to our local practitioners. One behavioral health practitioner recently decried the state of behavioral health services at a Montana IHS hospital: "Our service unit has no access to a child psychiatrist and no contract care funding for any individual psychiatric consults for any of our children. We currently have [an adolescent] with a long history of

severe mental illness and violence who has run out of insurance coverage for payment of [the patient's] residential mental health placement. [The patient] will shortly be released to return to the community because there is no contract care funding to support [the patient's] continued care. [The patient] will have to be charged with a serious crime in order to receive any secure placement or residential treatment. Native Americans have the highest suicide rate of any ethnic group and we have no funds to provide for any extended inpatient treatment for either adults or children."

Title VII of the Indian Health Care Improvement Act expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. However, the expansion of behavioral services should occur in a manner that allows programs to be tailored to Tribal priorities.

#### Health Care for Native American Veterans

Finally, I would like to address a concern near to my heart as an American Indian Veteran. American Indians have enlisted and historically served in the armed forces to defend this country in numbers that far exceed any other segment of the United States population. Presently, I have been provided figures that indicate approximately 17% of the armed services, including all branches, are American Indians while we comprise less than 2% of the overall population. Our commitment to defend this soil, standing side by side with our American brothers and sisters, has been unwavering since World War One. And as other Veterans, our American Indian Veterans suffer from limited health care services. I request that Congress recognize the service of our Tribal Veterans and facilitate access to health care services within the local Indian Health Service facilities. The Indian Health Service should be able to provide all required medical services including mental health counseling for Post Traumatic Stress Syndrome to Native American Veterans and receive reimbursement from the Veterans Administration. Presently, our Native American Veterans are required to travel to Veteran's hospitals that are generally long distances from the Reservations resulting in a hardship that prevents access to paid health services.



Conclusion

I urge Congress to reauthorize the Indian Health Care Improvement Act as a starting point to begin realistically fulfilling its trust responsibility to American Indian and Alaska Natives in these United States. In 2004, IHS was funded at 56.8% of the level of need, with a deficiency of approximately \$1.7 billion. Compare this to the estimated monthly cost of the war in Iraq of \$4.5 billion. This great nation is capable of doing better by Native Americans. When those Native American men and women fighting the war in Iraq come home, they deserve to have access to the same level of health care that all Americans have come to expect. This is why we send our sons and daughters to fight for this Nation – the promise of a share in the American dream and American quality of life.

The Indian Health Care Improvement Act will bring up to date Indian Health Service facilities and services. It will allow for programs to address behavioral and mental health issues that have been severely neglected under the current system. It will begin to address the horrifying and inexcusable disparities between the health levels of Native Americans and the general United States population.

While the most critical need to remedy the deplorable level of health care for Native Americans is a realistic financial commitment, the Indian Health Care Improvement Act is legislation that is necessary to increase the availability of health care, develop new approaches to health care delivery, increase the flexibility of the Indian Health Service and promote the sovereignty of American Indian Tribes.

I thank you again for the opportunity to present this testimony and look forward to a positive working relationship between Tribal Governments and Congress to address the health of American Indians.



COMMUNICATIONS

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**HEARING  
ENTITLED  
KEEPING AMERICA'S PROMISE: HEALTH CARE AND CHILD  
WELFARE SERVICES FOR NATIVE AMERICANS.**

**IN THE  
UNITED STATES  
SENATE  
COMMITTEE ON FINANCE**

**MARCH 22, 2007**

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**Introduction**

The Child Welfare League of America (CWLA), representing public and private nonprofit, child-serving member agencies across the country, is pleased to submit testimony to the Senate Finance Committee this morning. The issues of healthcare and child welfare services for Native Americans deserve enormous attention. As Congress works on the reauthorization of State Children's Health Insurance Program (SCHIP) and other vital health programs such as Medicaid, CWLA hopes that Congress ensures that tribal populations are afforded access to adequate health programs. For the purpose of this hearing today, CWLA aims to underscore the much needed expansion of vital child welfare services to tribal child welfare agencies, in particular, the Title IV-E program of the Social Security Act and subsidized guardianship for relative caregivers. Moreover, we look forward to working with the Committee on this and related issues in the near future.

**History**

National data and case studies validate the need to assess, examine, and eliminate factors that contribute to the disproportionate representation of children of color and tribal communities in the child welfare system. This disproportionate representation can be related to the disparities in the services they receive. Although there has been some congressional attention to these issues as they relate to tribal communities, there is still a lack of access to federal funding and the services they provide.

In 1978, Congress passed the Indian Child Welfare Act (ICWA, P.L. 95-608) to preserve cultural and family ties among Native American children and families and to ensure respect for tribal authority in decisions concerning the placement of Indian children in out-of-home care.

ICWA requires that states identify Indian children and notify the child's parents and tribe of their rights to intervene in a custody proceeding. ICWA also requires certain procedures regarding the use of tribal courts, child custody proceedings, tribal intervention standards, and placement preferences. The act establishes a two-part requirement for states before they remove an Indian child, which involves efforts to prevent the breakup of the Indian family, and standards for court findings.

**U.S. Government Accountability Office Recommendations**

In 2005, Congress directed the U.S. Government Accountability Office (GAO) to study the impact of ICWA. In its recommendations to the U.S. Department of Health and Human Services (HHS), GAO proposed that HHS review information made available by states through their Child and Family Service Reviews (CFSRs). This review found that 10 of 51 state reports did not mention ICWA implementation. GAO also proposed that states be required to include in their annual progress and services reports any significant ICWA issues not addressed in the Program Improvement Plans (PIPs) that resulted from the CFSRs<sup>1</sup>.

One of the key findings of the GAO study was the problem of measuring ICWA compliance and assisting improved compliance when there was no explicitly named oversight agency. In response, the Children's Bureau indicated they did not believe they were the appropriate agency to carry out additional technical assistance for states on ICWA implementation.

Although ICWA established procedures and protections for placing Indian children in out-of-home care, adequate funding to provide these services did not follow. Comments submitted to GAO during its study indicated that, at times, the lack of resources for tribes hindered placements and that states relied upon the tribes for assistance in meeting ICWA's requirements<sup>2</sup>.

#### **Access to Title IV-E Funds**

Most federal funds that could address the needs of children from tribes that come into contact with the child welfare system are not provided directly to tribal governments. Tribes receive a limited set-aside of funds (which are authorized by other committees) from Title IV-B Part 1 and 2, Child Welfare Services, and the Promoting Safe and Stable Families program respectively. Under Part 1, over half of the tribal grants are less than \$10,000, and under Part 2, most of the tribal grants are under \$40,000. Under the Child Abuse Prevention and Treatment Act (CAPTA), tribes compete for a very small portion of funding with organizations serving migrant populations. Tribes are not eligible to receive direct funding from the other grant programs and rather are forced to compete with states. In addition, tribes benefit very little from the Children's Trust Funds to prevent child abuse and neglect that are supported under the law.

Overall, tribes receive very few funds for child abuse and neglect prevention activities. Tribes receive no direct funding from the Social Services Block Grant (SSBG) and do not have the option of receiving federal Title IV-E Foster Care and Adoption Assistance funds. As a result, most Native American children placed in out-of-home and adoptive settings through tribal courts are not eligible for federal foster care maintenance or adoption assistance payments. In a few instances, tribes have been able to negotiate agreements with states that allow them to access Title IV-E funds, but these agreements are not mandatory and are available to less than 55% of federally recognized tribes.

In the last several congresses CWLA has supported the following legislative initiative: Senator Gordon Smith (R-OR) introduced legislation, the Indian and Alaska Native Foster Care and Adoption Services Amendments, which would allow tribal governments to directly apply for Title IV-E funds. In the House of Representatives, Representatives Jim McDermott (D-WA) and David Camp introduced bills that included similar provisions. It is anticipated that comparable legislation will again be introduced in the new 110<sup>th</sup> Congress.

This legislation would allow tribes to apply directly to HHS for Title IV-E funding for eligible children in foster care and adoptive homes. A Tribal government applying to draw down funds directly would have to meet most of the same requirements and standards that states do. Similar to current state requirements, a tribe would have to submit a plan indicating its area of service, which may not coincide with such geographic lines as city, county, or state borders. A tribe, however, could receive a different reimbursement rate, since the income in its service area may be lower than the particular state in which the tribal land is located.

#### **The Importance of Kinship Care and Guardianship**

Kinship care is a situation when an adult family member, such as a grandparent, aunt, uncle, or other relative, provides a home for a child who cannot live with his or her parents. For tribal communities kinship care represents an important option for keeping Native American children with their family and/or tribe. CWLA has been working to expand kinship placements for children in child welfare to keep families united during a crisis, and provide emotional and cultural benefits to children who cannot return safely to their parents, or for whom adoption is

not an option<sup>3</sup>. Given these benefits and many others documented by research, it is important that kinship care continue. It is also important to remember that, due to the financial burden, many relatives cannot provide kinship care without relying heavily on assistance.

Subsidized guardianships are relatively new. Massachusetts established the first program in 1983. By 2004, 35 states and the District of Columbia had subsidized guardianship programs. Congress enacted the Adoption and Safe Families Act (ASFA) in 1997, recognizing a child's placement with a relative or a legal guardian as a permanency option for children in foster care. Currently, the federal government does not make funds available on a continuing basis to support those placements.

States use many approaches to fund kinship arrangements and subsidized guardianship placements. A limited number of states can use Title IV-E Foster Care funds through a waiver from the U.S. Department of Health and Human Services. Other states rely on other federal sources, including Temporary Assistance for Needy Families (TANF) and the Social Services Block Grant (SSBG). Both TANF and SSBG, however, are used to fund other vital human services and are already under budget pressure.

Both the Senate and the House introduced bipartisan legislation affirming the importance of non-parental caregivers in the lives of abused and neglected children. Representative Danny Davis (D-IL) sponsored the Guardian Assistance Promotion and Kinship Support Act (H.R. 3380) in the House in the 109<sup>th</sup> Congress, and Senators Hillary Rodham Clinton (D-NY), Thad Cochran (R-MS) and Olympia Snowe (R-ME) re-introduced in Kinship Caregiver Support Act (S.661) this Congress. These bills would help the millions of children being raised by relatives and other caregivers because their parents are not able to care for them. Both bills would allow states to use federal Title IV-E foster care funds for subsidized guardianship assistance payments. These bills would also establish kinship navigator programs to help grandparents and other relatives obtain information and referral services. The legislation also requires states to notify relatives within 60 days of a child's removal from custody and entrance into foster care<sup>4</sup>. Passing kinship/guardian legislation is relevant to the purpose of ICWA—placing Native American children with their extended family and near their home and/or tribe.

#### **Policy and Budget Recommendations**

Provide greater support and implementation of ICWA. Direct HHS to address concerns raised in the Government Accountability Office study on Indian Child Welfare Act (ICWA) implementation and by tribal representatives and members of the Child and Family Services Review Work Group regarding the Children's Bureau role in improving ICWA implementation with states. Support legislative changes to ICWA that are supported by Indian Country to improve and clarify implementation of ICWA.

Extend Title IV-E funds to tribal governments. Pass legislation to provide Native American tribes with direct access to federal funding for foster care and adoption assistance through the Title IV-E program.

Expand Title IV-E funds to kinship care. Support grandparents and other relatives caring for abused and neglected children by sponsoring and passing the Kinship Caregiver Support Act in the Senate, and the Guardianship Assistance Promotion and Kinship Support Act in the House.

These bills will assist millions of children being raised by relatives and other non-relative legal guardians because their parents cannot care for them.

### **Conclusion**

CWLA appreciates the opportunity to offer testimony to the committee as a means to highlight the issue of granting Native American tribes access to Title IV-E funding, and supporting legislation to aid in keeping Native American children with their family and/or tribe. We are elated that the Finance Committee, under the leadership of Chairman Baucus and Ranking Member, Senator Grassley has held this hearing, clearly demonstrating a commitment to child welfare by the committee. This first step gives CWLA hope that this country will furnish the tribal child welfare community with the resources it needs and deserves to provide efficient and culturally competent services to Native American children and families.

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<sup>1</sup> Government Accountability Office. (2005). Indian Child Welfare Act: Existing information on implementation issues could be used to target guidance and assistance to states. (GAO-05-290). Washington DC: Author.

<sup>2</sup> Ibid.

<sup>3</sup> U.S. Children's Bureau. (2000). *Report to congress on kinship foster care*. Available online at <http://aspe.hhs.gov/hsp/kinr/2c00>. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families.

<sup>4</sup> To access a complete analysis and summary of the legislation, visit [www.cwla.org/advocacy/fostercare060201.htm](http://www.cwla.org/advocacy/fostercare060201.htm).

**MAKING UNIVERSAL HEALTH CARE WORK****Statement of**

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**for inclusion in the record of the**

**Senate Finance Committee's March 14, 2007 Hearing on "Charting a Course  
for Health Care Reform: Moving Toward Universal Coverage"**

**March 22, 2007**

After a brief overview of the U.S. health care system, this statement proposes some modest reforms that could increase coverage. Next, this statement discusses some more comprehensive approaches for expanding coverage, and finally, this statement outlines how we could make the transition to a system that provides nearly universal coverage.<sup>1</sup>

**OVERVIEW OF THE U.S. HEALTH CARE SYSTEM**

In 2004, national health expenditures totaled \$1,877.6 billion—about 16.0 percent of the gross domestic product.<sup>2</sup> The per capita health care expenditure was \$6,280. The United States currently spends about twice as much, per capita, on health care as other industrialized nations.<sup>3</sup>

The principal coverage mechanisms are employment-based health insurance, Medicare, and Medicaid. In 2005, for example, 174.8 million Americans (59.5%) were covered by employment-based private health insurance, 26.8 million (9.1%) bought their own private

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<sup>1</sup> See Jonathan Barry Forman, *Making America Work* (Washington, DC: Urban Institute Press 2006), Chapter 10; and Jonathan Barry Forman, *Making Universal Health Care Work*, 19(1) *St. Thomas Law Review* 137-149 (Fall 2006).

<sup>2</sup> National Center for Health Statistics, *Health, United States, 2006* (Washington, DC: National Center for Health Statistics, 2006), table 120.

<sup>3</sup> Organisation for Economic Co-operation and Development (OECD), *OECD Factbook: Economic, Environmental, and Social Statistics* (Paris: OECD, 2006), 209.



insurance, 80.2 million (27.3%) had government health insurance (i.e., Medicare, Medicaid, or military health care), and 46.6 million (15.9%) had no coverage.<sup>4</sup>

Far and away the biggest problem with the American health care system has to do with coverage. Clusters of individuals that tend to lack coverage include employees of small business, workers who lose their jobs, workers who decline employer coverage, low-income parents, low-income childless adults, the near elderly, young adults, children, and immigrants.

#### **MODEST CHANGES THAT COULD IMPROVE THE HEALTH CARE SYSTEM**

While universal coverage should almost certainly be our ultimate goal, we might want to start with a more incremental approach that focuses on designing and expanding health care programs for particular groups of the uninsured. For example, the government could expand the Medicaid and SCHIP programs to cover all children in families with incomes up to 300% of the poverty income guidelines.

The government might also expand Medicaid or develop other programs to ensure seamless coverage for individuals making the transition from welfare to work, and the government could extend health care coverage to more unemployed workers by expanding the recently created health care coverage tax credits.

The government could also encourage community groups and nonprofit organizations to offer health care plans and give them the same types of tax and regulatory advantages that are now available only to employment-based plans. These so-called “association health plans” could make it easier for small businesses to provide portable health insurance for their employees.

Congress might also amend the Employee Retirement Income Security Act of 1974 (ERISA) so that federal preemption no longer interferes with state efforts to expand coverage.<sup>5</sup>

#### **MORE COMPREHENSIVE SOLUTIONS**

Ultimately, however, the government will need to design a program to achieve nearly universal health care coverage. With universal coverage, we should finally be able to reduce our health care system’s burdensome administrative costs and get medical treatment costs under control.

Universal coverage would also solve much of the distortion in labor markets that results from the current structure of the health care system. In particular, universal coverage would solve the problem of job lock, as workers would no longer lose their health insurance benefits

<sup>4</sup> Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, *Income, Poverty, and Health Insurance Coverage in the United States: 2005* (Washington, DC: U.S. Government Printing Office, Current Population Report No. P60-231, 2006), table C-1.

<sup>5</sup> Jon Forman, [Uncle Sam should let the states be laboratories for health care reform](#), *Washington Examiner*, March 2, 2007, at 21.

solely because they changed jobs. Universal coverage would also solve the problems relating to the transition from welfare to work and the transition from disability to work. Today, recipients of welfare or disability benefits can lose Medicaid or Medicare coverage if they enter or reenter the work force. With universal coverage, however, they would not lose their coverage.

Over the years, there have been countless suggestions about how to achieve universal coverage. Some have argued for a single-payer national health insurance system. That could be as simple as expanding Medicare to cover everyone, or as complicated as President Bill Clinton's 1993 health care reform proposal.

Many proposals call for employer mandates—requiring employers to either provide health care coverage for their workers or pay a payroll tax so that the government can provide coverage. This is sometimes referred to as the “play or pay” approach. Alternatively, many proposals call for individual mandates—requiring individuals to secure coverage from their employers or otherwise. Many proposals would also create tax credits or other financial incentives to help employers or individuals secure coverage. Still other proposals call for the establishment of purchasing pools in every state, and some proposals call for other insurance market reforms.

#### **A UNIVERSAL COVERAGE/UNIVERSAL RESPONSIBILITY APPROACH**

One of the more promising approaches for universal health care coverage is typified by a recent proposal by the New America Foundation.<sup>6</sup> Under this approach, the government would guarantee access to adequate and affordable health insurance for everyone. In exchange, each person would be required to have health insurance and to pay for that insurance with a combination of employer and employee contributions and government assistance based on ability to pay. An adequate but basic level of health care coverage would be required, and community insurance pools would be established in each state to offer individuals a choice among alternative health care plans. Government assistance would be provided in the form of refundable tax credits calculated on a sliding scale based on need.

Similarly, Massachusetts recently enacted major legislation designed to achieve nearly universal coverage. That new law requires individuals to have health insurance and redeploys state funds to help pay for it. Everyone “plays their part:” individuals, government, health care providers, and employers.

#### **A UNIVERSAL COVERAGE/EARNINGS SUBSIDY APPROACH**

Another promising approach is to combine an *employer* mandate with targeted health-care subsidies. Under this approach, all employers would be required to either provide health care coverage for their workers or pay a payroll tax so the government can provide coverage

<sup>6</sup> Michael Calabrese and Lauri Rubiner, Universal Coverage, Universal Responsibility: A Roadmap to Make Coverage Affordable for All Americans (Washington, DC: New America Foundation Working Paper No. 1, 2004).

(“play or pay”). In addition, the government would provide targeted subsidies to help pay the health-care costs of low-income workers and their families.

To be sure, an employer mandate—without more—could decrease employment opportunities for low-skilled workers. On the other hand, a well-designed system of government subsidies could more than offset the adverse impacts of an employer mandate. Those subsidies could be provided either to employers or to workers, perhaps in the form of an earnings subsidy. For example, the federal government could provide a tax credit to the employers of low-wage workers to help offset the increased costs of providing health insurance. Alternatively, the federal government could provide health care vouchers to workers that could be used to purchase health care from authorized providers.

#### **MAKING THE TRANSITION TO UNIVERSAL COVERAGE**

We can and we should make the transition from the current system to a system of nearly universal coverage. For example, the elements of such a transition could include tax changes, an employer mandate, and an individual mandate.<sup>7</sup>


Tax Changes: The exclusion for employer-paid health insurance premiums should be capped at a fixed-dollar amount and gradually replaced with a refundable tax credit.

An Employer Mandate: Employers should be required to offer, but not necessarily pay for, at least one state-approved health insurance plan for employees. Employers should be encouraged to adopt the practice of automatically enrolling employees in the employer’s health plan unless the employees specifically choose to opt out.

An Individual Mandate: Individuals would be required to get health insurance or lose tax benefits such as personal exemptions and standard deductions.

All in all, it is both necessary and possible to redesign the health care system so it provides universal coverage, and we should be able to do it in a way that minimizes work disincentives. In short, we can make universal health care work.

Respectfully submitted,

  
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<sup>7</sup> C. Eugene Steuerle, A Workable Social Insurance Approach to Expanding Health Insurance Coverage in *Covering America: Real Remedies for the Uninsured, Volume 3* (Washington, DC: Economic & Social Research Institute, 2003): 97-112.

# ST. THOMAS

## L A W R E V I E W

VOL. 19

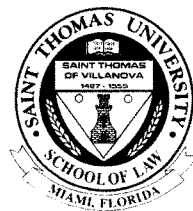
FALL 2006

ISSUE 1

### MAKING UNIVERSAL HEALTH CARE WORK

*Jonathan Barry Forman*

Reprinted from  
*St. Thomas Law Review*, Volume 19  
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2006

## MAKING UNIVERSAL HEALTH CARE WORK\*

JONATHAN BARRY FORMAN\*\*

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### I. OVERVIEW OF THE HEALTH CARE SYSTEM

In 2003, national health expenditures totaled \$1,678.9 billion, about 15.3% of the gross domestic product.<sup>1</sup> The per capita health care expenditure was \$5,671.<sup>2</sup> The United States currently spends about twice

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\*This adaptation is from Jonathan Barry Forman, *Making America Work* (Washington, DC: Urban Institute Press, 2006). Copyright 2006 by the Urban Institute Press. Portions are reprinted by permission of the Urban Institute Press, 2100 M Street N.W., Washington, D.C. 20037. An earlier version of this paper was presented at the symposium on "The Future of Employer-provided Health Benefits" at the John Marshall Law School Center for Tax Law and Employee Benefits, April 28, 2006.

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1. NAT'L CENTER FOR HEALTH STATISTICS, HEALTH, UNITED STATES, 360 (2005) [hereinafter HEALTH]. See also NAT'L CENTER FOR HEALTH STATISTICS, "FAST STATS" WEB PAGE (2006), available at <http://www.cdc.gov/nchs/fastats/hexpense.htm> (last visited Oct. 18, 2006).

2. HEALTH, *supra* note 1; see also COMMITTEE ON WAYS AND MEANS, 108TH CONG., 2004 GREEN BOOK: BACKGROUND MATERIAL AND DATA ON PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS, Appendix C-1 (Comm. Print 2004) (stating 2001 stats), available at <http://waysandmeans.house.gov/Documents.asp?section=813> (last visited Oct. 18, 2006).

as much, per capita, on health care as other industrialized nations.<sup>3</sup>

The principal coverage mechanisms are employment-based health insurance, Medicare, and Medicaid.<sup>4</sup> In 2004, for example, 174 million Americans (59.8%) were covered by employment-based private health insurance, 26.9 million (9.3%) bought their own private insurance, 79.1 million (27.2%) had government health insurance (i.e., Medicare, Medicaid, or military health care), and 45.8 million (15.7%) had no coverage.<sup>5</sup>

Most nonelderly Americans receive their health care coverage through employment-based coverage provided to workers and their families. For example, Table 1 shows that 159.1 million nonelderly Americans (62.4%) received their health care coverage through an employment-based plan in 2004.<sup>6</sup> Another 34.2 million (13.4%) were covered by Medicaid, and 6.2 million (2.5%) were covered by Medicare that year. All in all, some 210.4 million nonelderly Americans (82.2%) had health coverage in 2004, while 45.5 million (17.8%) had no coverage.

Table 1 *Health Care Coverage of the Nonelderly, 2004*<sup>7</sup>

<i>Source of Coverage</i>	<i>Millions</i>	<i>Percentage</i>
Total population	255.9	100.0
Employment-based coverage	159.1	62.4
Individually Purchased	17.0	6.6
Public	45.5	17.8
Medicare	6.2	2.5
Medicaid	34.2	13.4
Military health care	8.1	3.2
No health insurance	45.5	17.8

3. OECD FACTBOOK: ECONOMIC, ENVIRONMENTAL, AND SOCIAL STATISTICS 199 (Organisation for Econ. Co-operation and Dev. ed., 2005).

4. U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 60 (2005).

5. *Id.*

6. See John E. Buckley & Robert W. Van Glezen, *Federal Statistics on Health Care Benefits and Cost Trends: An Overview*, MONTHLY LAB. REV., Nov. 2004, at 43, 43-56; Paul Fronstin, *Uninsured Unchanged in 2004, But Employment-Based Health Care Coverage Declined*, 26 EMPL. BENEFIT RESEARCH INST. NOTES NO. 10, Oct. 2005, at 2-10.

7. Author's computations from U.S. CENSUS BUREAU, HISTORICAL HEALTH INSURANCE TABLES, at Table HI-2 (2005), available at <http://www.census.gov/hhes/www/hlthins/historic/hihist2.html> (last visited Oct. 18, 2006).

The Medicare program provides nearly universal coverage for elderly Americans. For example, Table 2 shows that 95 percent of the elderly were covered by Medicare in 2004, and only 0.8 percent of the elderly were without health care coverage that year. Also, in addition to Medicare, many elderly Americans are covered by employment-based retiree health insurance and/or individually-purchased Medigap policies.

Table 2 *Health Care Coverage of the Elderly, 2004*<sup>8</sup>

<i>Source of Coverage</i>	<i>Millions</i>	<i>Percentage</i>
Total population	35.2	100.0
Employment-based coverage	12.5	35.5
Individually Purchased	10.0	28.3
Public	33.6	95.4
Medicare	33.5	95.0
Medicaid	3.3	9.4
Military health care	2.5	7.1
No health insurance	0.3	0.8

All in all, the federal government is heavily involved in providing health care assistance through Medicare, Medicaid, the State Children's Health Insurance Program ("SCHIP"), veterans' benefits, the exclusion for employer-provided health insurance premiums, the deduction of health care costs, federal employee benefits, and other mechanisms. In 2001, for example, the federal government accounted for 32.9% (\$406.6 billion) of all personal health spending, and state and local governments picked up another 10.6% (\$130.4 billion).<sup>9</sup>

## II. MILLIONS OF AMERICANS LACK HEALTH CARE COVERAGE

Far and away the biggest problem with the American health care system has to do with coverage. In 2004, for example, while 245.3 million Americans (84.2%) had some type of health care coverage, 45.8 million (15.7%) were without coverage.<sup>10</sup> Clusters of individuals that tend to lack

8. *See supra* note 7.

9. COMMITTEE ON WAYS AND MEANS, 108TH CONG., *supra* note 4, at C-9.

10. *See supra* note 7. The estimated number of uninsured in the text is a cross-sectional estimate and so understates the number of people who experienced a spell without insurance that year. Longitudinal estimates that ask whether people had spells without insurance over a one or two-year period produce higher counts. *See generally*, PAMELA FARLEY SHORT, COUNTING AND CHARACTERIZING THE UNINSURED (2001).

coverage include employees of small business, workers who lose their jobs, workers who decline employer coverage, low-income parents, low-income childless adults, the near elderly, young adults, children, and immigrants.<sup>11</sup>

Of particular concern, many of those without insurance are workers. Indeed, of the 37.3 million uninsured Americans between 18 and 64 years old in 2004, 27.3 million worked during the year, 21.1 million of these working full-time.<sup>12</sup> Moreover, contingent and part-time workers are especially at risk. For example, in February of 2005 only 18% of contingent workers were covered by health insurance from their employer, although 59% did have insurance from some source.<sup>13</sup>

Pertinent here, a recent study by the Employee Benefit Research Institute explored the reasons why wage and salary workers ages 18 to 64 lacked coverage in 2002.<sup>14</sup> That study found that 41.9% of those workers reported they worked for an employer that did not offer health insurance, another 17% worked for an employer that offered benefits but were not eligible for those benefits, and another 27 were offered benefits but chose not to participate. Of those who were not eligible for their employer's benefits, 57% worked part time, 30 percent had not completed the required waiting period, and almost 9% were temporary or contract workers. Of those who chose not to participate, 75.4% reported that they were covered by someone else's plan, and 22% said the employer's plan was too costly.

Part and parcel of the growing coverage problem is the fact that health care costs are spiraling out of control. Spending on health care has grown from under 6 percent of gross domestic product in 1965 to 16% in 2004 and is expected to reach 19% by 2014 and 22% by 2025.<sup>15</sup> These ever-increasing costs have put pressure on employers, employees, and

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11. STAN DORN, TOWARDS INCREMENTAL PROGRESS: KEY FACTS ABOUT GROUPS OF UNINSURED (2004); *see generally* HAROLD POLLACK & KARL KRONEBUSCH, HEALTH INSURANCE AND VULNERABLE POPULATIONS, 1-52 (2004).

12. U.S. CENSUS BUREAU, *supra* note 4, at 18. *See also* U.S. General Accounting Office, *Medicaid: Transitional Coverage Can Help Families Move from Welfare to Work*, GAO-02-679T (Washington, D.C., Apr. 22, 2002).

13. BUREAU OF LABOR STATISTICS, CONTINGENT AND ALTERNATIVE EMPLOYMENT ARRANGEMENTS, FEBRUARY 2005, at Table 9, *available at* <http://www.bls.gov/news.release/conemp.nr0.htm> (last visited Oct. 18, 2006).

14. Paul Fronstin, *Employment-Based Health Benefits: Trends in Access and Coverage*, EBRI ISSUE BRIEF NO. 284, Aug. 2005, at 1, *available at* [http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content\\_id=3574](http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3574) (last visited Oct. 18, 2006). *See also* LINDA J. BLUMBERG & LEN M. NICHOLS, WHY ARE SO MANY AMERICANS UNINSURED? 35-95 (discussing how worker and employer choices combine to determine coverage levels).

15. COUNCIL OF ECONOMIC ADVISORS, ECONOMIC REPORT OF THE PRESIDENT 2006, at 85-86 (Washington, DC: U.S. Government Printing Office, 2006).



governments. For example, health insurance premiums rose by 73% from 2000 through 2005, compared to inflation growth of just 14% and wage growth of just 15%.<sup>16</sup> The average annual premiums for employment-based coverage rose to \$4,024 for single coverage in 2005 and \$10,880 for family coverage.<sup>17</sup> Moreover, both Medicare and Medicaid spending are on “unsustainable” growth paths.<sup>18</sup>

Of particular concern, the administrative costs associated with the American health care system are “enormous,” with estimates ranging anywhere from \$90 billion a year to \$294 billion a year.<sup>19</sup> Every health care plan has a different set of rules, and it seems as if every insurance company, employer, hospital, and doctor has a different set of claim forms.

Another significant problem has to do with risk segmentation in the small-group and individual insurance market.<sup>20</sup> In a free market, insurance companies will offer their best premium rates to healthy individuals and make older and sicker individuals pay much more for identical coverage. In doing so, the premiums will cover the anticipated health care costs (leaving a little extra for profits). Large employers can spread the anticipated health care costs of a few higher-risk employees over a much larger number of low-risk employees; consequently, large employers can secure relatively low group-term health insurance rates. On the other hand, insurance companies will charge individuals and small employers much higher rates for the same coverage, and those higher rates will effectively

16. THE HENRY J. KAISER FAMILY HEALTH FOUNDATION AND HEALTH RESEARCH AND EDUCATION TRUST, *EMPLOYER HEALTH BENEFITS: 2005 ANNUAL SURVEY 17* (Menlo Park, CA and Chicago, IL: Henry J. Kaiser Family Health Foundation, 2005). *See also* BUREAU OF LABOR STATISTICS, *NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN PRIVATE INDUSTRY IN THE UNITED STATES, MARCH 2005*, at 15-16 (showing employer and employee monthly premiums in 2005).

17. BUREAU OF LABOR STATISTICS, *supra* note 16.

18. COMMITTEE ON WAYS & MEANS, 109<sup>TH</sup> CONG., HEARING ON THE FUTURE OF SOCIAL SECURITY (testimony of U.S. Government Accountability Office Comptroller General David M. Walker) (March 9, 2005), *available at* <http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=388> (last visited Oct. 18, 2006). *See generally* U.S. General Accounting Office, *Highlights of a GAO Forum: The Long-Term Fiscal Challenge*, GAO-05-282SP (Washington D.C., Feb. 2005); SOCIAL SECURITY AND MEDICARE BOARDS OF TRUSTEES, *STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 2005 ANNUAL REPORTS (2005)*, *available at* <http://www.socialsecutiry.gov/OACT/TR/> (last visited Oct. 18, 2006); DANIEL SHAVIRO, *WHO SHOULD PAY FOR MEDICARE?* (Chicago and London: University of Chicago Press, 2004); CONGRESSIONAL BUDGET OFFICE, *THE LONG-TERM BUDGET OUTLOOK* (Washington, DC: Congressional Budget Office, 2005).

19. LEIF WELLINGTON HAASE, *A NEW DEAL FOR HEALTH: HOW TO COVER EVERYONE AND GET MEDICAL COSTS UNDER CONTROL 25* (2005).

20. Elliot K. Wicks, *Issues in Coverage Expansion Design: Coping with Risk Segmentation: Challenges and Policy Options*, 2 *ECO. AND SOCIAL RESEARCH INST.* 1-9 (2003), *available at* [http://www.esresearch.org/covering\\_America.php](http://www.esresearch.org/covering_America.php) (last visited Oct. 18, 2006).

price many individuals and small businesses out of the market.

### III. MODEST CHANGES THAT COULD IMPROVE THE HEALTH CARE SYSTEM

While universal coverage should almost certainly be our ultimate goal, we might want to start with a more incremental approach that focuses on designing and expanding health care programs for particular groups of the uninsured.<sup>21</sup> For example, the government might want to expand the Medicaid and SCHIP programs to cover virtually all low-income children. Of the 8.9 million children who were uninsured in 1999, some 4.6 million were actually eligible for Medicaid, and another 2.3 million were eligible for SCHIP.<sup>22</sup> The government needs to develop policies to get those uninsured children covered. In addition, the federal government could expand its Medicaid and SCHIP programs so that the systems cover all children in families with incomes up to, say, 300% of the poverty income guidelines.<sup>23</sup>

The government might also expand Medicaid or develop other programs to ensure seamless coverage for individuals making the transition from welfare to work.<sup>24</sup> For example, it could make sense to simplify transitional medical assistance by allowing former welfare recipients to continue their Medicaid coverage for months or even years after they start working, regardless of income level. Another approach would be to create a new form of earnings subsidy that would provide health care vouchers for low-income workers.<sup>25</sup> Together, these kinds of programs could help ensure that virtually all low-income working families have adequate health care coverage.

Similarly, the government could extend health care coverage to more unemployed workers by expanding the recently created health care coverage tax credits. Created by the Trade Reform Act of 2002, these

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21. See generally DORN, *supra* note 11.

22. Lisa Dubay et al, *Five Things Everyone Should Know about SCHIP*, A-55 THE URBAN INST. 1 (Oct. 2002), available at <http://www.urban.org> (last visited Oct. 18, 2006) (finding that about 27 percent of poor children were uninsured in 2002).

23. See HEATHER BOUSHEY ET AL., *HARDSHIP IN AMERICA: THE REAL STORY OF WORKING FAMILIES* 49 (Washington, DC: Economic Policy Institute, 2001); HEIDI HARTMANN ET AL., *SURVIVAL AT THE BOTTOM: THE INCOME PACKAGES OF LOW-INCOME FAMILIES WITH CHILDREN* 77 (Institute for Women's Policy Research, 2004).

24. See JOEL F. HANDLER & YEHESKEL HASENFELD, *WE THE POOR PEOPLE: WORK, POVERTY, AND WELFARE* 131-36 (1997).

25. See Robert H. Haveman, *The Clinton Alternative to "Welfare as We Know It": Is It Feasible?*, in *THE WORK ALTERNATIVE: WELFARE REFORM AND THE REALITIES OF THE JOB MARKET* 185, 200 (Demetra Smith Nightingale et al. eds., 1995).

credits pay up to 65% of the health care premiums of qualifying workers who lost their jobs because of foreign trade.<sup>26</sup> Another approach would be to extend COBRA health care continuation coverage to 36 or more months or until eligibility for Medicare at age 65.<sup>27</sup> The government might also be able to expand coverage for employees of small businesses by giving tax credits to employers that provide health insurance to their employees.<sup>28</sup>

We might also want to encourage community groups and nonprofit organizations to offer health care plans and give them the same types of tax and regulatory advantages that are now available only to employment-based plans. For example, President Bush recently called for the creation of so-called “association health plans” for small businesses that would allow insurance to be more portable and purchased more easily across state lines.<sup>29</sup>

We might also think about modifying the Employee Retirement Income Security Act (ERISA) so federal preemption no longer prevents state efforts to expand coverage. In that regard, Maryland recently flexed its muscles and enacted legislation that would require companies with at least 10,000 employees (i.e., Wal-Mart) to spend at least 8% of payroll on health care or give the difference to the state.<sup>30</sup> In July of 2006, however, a federal district court struck that legislation down, ruling that it was preempted by ERISA.<sup>31</sup> Perhaps now there will be more interest in relaxing ERISA’s overly-broad preemption rule so the states can have the ability to experiment with a broader range of approaches for expanding coverage.

Finally, we might also think about adopting rules to counter insurance industry policies that drive up premium costs in the individual and small-group market. In general, the government can reduce such insurance industry risk segmentation practices by preventing it from occurring in the first place or by allowing it but offsetting its effects.<sup>32</sup> Community rating is

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26. Trade Act of 2002, Public Law No. 107-210, 19 U.S.C. § 3801 (2002).

27. Len M. Nichols, *Policy Options for Filling Gaps in the Health Insurance Coverage of Older Workers and Retirees in ENSURING HEALTH AND INCOME SECURITY FOR AN AGING WORKFORCE* 451, 456-57 (Peter P. Budetti et al. eds., 2001).

28. See BOWEN GARRET ET AL., *WORKERS WITHOUT HEALTH INSURANCE: WHO ARE THEY AND HOW CAN POLICY REACH THEM?* 25 (Urban Institute ed., 2001); see also Jonathan Gruber, *Tax Policy for Health Insurance*, in *TAX POL’Y AND THE ECON.* 19, 39-63 (James M. Poterba, ed., 2005).

29. See COUNCIL OF ECONOMIC ADVISORS, *supra* note 15, at 100.

30. See Editorial, *Beating Up on Wal-Mart*, WASH. POST, January 12, 2006, at A20.

31. Matthew Mosk & Ylan Q. Mui, “Wal-Mart Law” in *Md. Rejected by Court*, WASH. POST, July 20, 2006, at A1.

32. Wicks, *supra* note 20, at 4.

an example of the first approach. Under a community rating system, insurance companies are required to take all comers and charge them all the same rate.<sup>33</sup> Alternatively, under the second approach, the government could allow wide variation in premiums based on risk but provide subsidies to help older and higher-risk individuals pay their higher premiums, offsetting the risk.

#### IV. MORE COMPREHENSIVE SOLUTIONS

Ultimately, however, the government will need to develop programs that provide a way to achieve nearly universal health care coverage. With universal coverage, we should finally be able to reduce our health care system's burdensome administrative costs, as well as get medical treatment costs under control.

Universal coverage would also solve much of the distortion in labor markets that results from the current structure of the health care system. In particular, universal coverage would solve the problem of job lock, as workers would no longer lose their health insurance benefits solely because they changed jobs. Universal coverage would also solve the problems relating to the transition from welfare to work and the transition from disability to work. Today, recipients of welfare or disability benefits can lose Medicaid or Medicare coverage if they enter or reenter the work force.<sup>34</sup> With universal coverage, however, they would not lose their coverage.

Over the years, there have been countless suggestions about how to achieve universal coverage. Some have argued for a single-payer national health insurance system.<sup>35</sup> That could be as simple as expanding Medicare to cover everyone,<sup>36</sup> or as complicated as President Bill Clinton's 1993 health care reform proposal.<sup>37</sup>

Many proposals call for employer mandates, requiring employers to either provide health care coverage for their workers or pay a payroll tax so the government can provide coverage.<sup>38</sup> This is sometimes referred to as

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33. *Id.*

34. *See generally* HANDLER, *supra* note 24.

35. *See* David U. Himmelstein & Steffie Woolhandler, *National Health Insurance or Incremental Reform: Aim High, or at Our Feet?*, 93 AM. J. OF PUB. HEALTH 102 (2003).

36. *See generally* James A. Morone, *Medicare for All*, in 2 COVERING AMERICA: REAL REMEDIES FOR THE UNINSURED, 63, 63-74 (Economic and Social Research Institute ed., 2003).

37. The Health Security Act of 1993, S.1757, 103rd Cong. § 1 (1993); *see generally* WHITE HOUSE DOMESTIC POLICY COUNCIL, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE (1993).

38. Michael Calabrese & Lauri Rubiner, *Universal Coverage, Universal Responsibility: A*

the “play or pay” approach.<sup>39</sup> Alternatively, there are a number of proposals that call for individual mandates, requiring individuals to secure coverage from their employers or some other source, but the burden to secure coverage is on the individual, not the employer.<sup>40</sup> Numerous proposals would also create tax credits or other financial incentives to help employers or individuals secure coverage.<sup>41</sup> Still other proposals call for the establishment of purchasing pools in every state, and others call for various insurance market reforms.<sup>42</sup>

## V. A UNIVERSAL COVERAGE/UNIVERSAL RESPONSIBILITY APPROACH

### A. THE NEW AMERICA FOUNDATION PROPOSAL

One of the more promising approaches for universal health care coverage is typified by a recent proposal by the New America Foundation.<sup>43</sup> Under this approach, the government would guarantee access to adequate and affordable health insurance for everyone.<sup>44</sup> In exchange, each person would be required to maintain health insurance and to pay for that insurance with a combination of employer and employee contributions and government assistance based on ability to pay.<sup>45</sup> An adequate but basic level of health care coverage would be required, and community insurance pools would be established in each state to offer individuals a choice among alternative health care plans.<sup>46</sup> Government assistance would be provided in the form of refundable tax credits calculated on a sliding scale based on need.<sup>47</sup>

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*Roadmap to Make Coverage Affordable for All Americans* 6 (Washington, DC: New America Foundation, Working Paper No. 1, 2004).

39. HAASE, *supra* note 19, at 8.

40. These mandates could be enforced, for example, by denying certain tax benefits unless the individual provides proof of coverage. JOINT COMMITTEE ON TAXATION, PRESENT LAW AND ANALYSIS RELATING TO THE TAX TREATMENT OF HEALTH CARE EXPENSES 21 (2006).

41. *Id.* at 19-20.

42. Calabrese, *supra* note 38, at 1, 5 (proposing the establishment of purchasing pools to offer an individual several different alternative insurance plans); *see also* HEALTH CARE ACCESS AND AFFORDABILITY CONF. COMM. REP., Apr. 3, 2006, *available at* <http://www.mass.gov/legis/summary.pdf> (proposing certain insurance market reforms to reduce premium costs).

43. *See generally* Calabrese, *supra* note 38; HAASE, *supra* note 19.

44. Calabrese, *supra* note 38, at 1, 3.

45. *Id.* at 1-2.

46. *Id.* at 1, 5.

47. *Id.* at 5.

## B. THE NEW MASSACHUSETTS HEALTH PLAN

Similarly, Massachusetts recently enacted major legislation designed to achieve nearly universal coverage.<sup>48</sup> The new law requires individuals to have health insurance and redeploys state funds to help pay for it.<sup>49</sup> Within three years, the law is expected to provide health insurance coverage to 95% of the 550,000 uninsured Massachusetts residents. Everyone “plays their part:” individuals, government, health care providers, and employers.<sup>50</sup>

The law creates a new agency—the Massachusetts Health Insurance Connector—to connect individuals and small businesses with health insurance products and to ensure that individuals continue to have insurance when they change jobs.<sup>51</sup> There are also insurance market reforms.<sup>52</sup> For example, the law will merge the individual and small-group markets in July 2007, a provision that will produce an estimated drop of 24% in non-group premium costs.<sup>53</sup>

The Massachusetts law also provides health care subsidies for low-income residents through a new Commonwealth Care Health Insurance Program.<sup>54</sup> Under this program, sliding-scale subsidies will be available to individuals with incomes below 300% of the federal poverty level (\$49,800 for a family of 3 in 2006), and there will be no premiums for people with incomes below 100% of the Poverty Level (\$9,600 for an individual in 2006).<sup>55</sup> Additionally, there are no deductibles.<sup>56</sup> Medicaid will also be expanded, for example, to cover children in families with incomes up to 300% of the poverty level.<sup>57</sup>

Under the individual mandate, individuals must have health insurance by July 1, 2007.<sup>58</sup> The penalty for not having insurance in 2007 is the loss of the personal exemption.<sup>59</sup> In subsequent years, the penalty will be a fine equal to 50% of the monthly cost of health insurance for each month

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48. See HEALTH CARE ACCESS AND AFFORDABILITY CONF. COMM. REP. *supra* note 42.

49. *Id.* at 1.

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

54. *Id.* at 2.

55. *Id.* at 2-3.

56. *Id.* at 3.

57. *Id.* at 2.

58. *Id.* at 3.

59. *Id.* at 4.

without insurance.<sup>60</sup> Those who cannot afford insurance, however, will not be penalized.<sup>61</sup>

Employers who do not make “fair and reasonable” contributions will be required to make per-worker “fair share” contributions.<sup>62</sup> These contributions will be capped at \$295 per full-time-equivalent worker, per year; however, businesses with 10 or fewer employees will not have to make these contributions.<sup>63</sup>

#### VI. A UNIVERSAL COVERAGE/EARNINGS SUBSIDY APPROACH

Another promising approach is to combine an *employer* mandate with targeted health-care subsidies.<sup>64</sup> Under this approach, all employers would be required to either provide health care coverage for their workers or pay a payroll tax so the government can provide coverage (“play or pay”).<sup>65</sup> In addition, the government would provide targeted subsidies to help pay the health-care costs of low-income workers and their families.<sup>66</sup>

To be sure, an employer mandate—without more—could decrease employment opportunities for low-skilled workers.<sup>67</sup> On the other hand, an employer mandate combined with government subsidies could be designed to increase employment opportunities.

According to standard economic theory, employee compensation is tied to productivity, and employers only care about total compensation, not about the mix between wages and health benefits. Consequently, employers would respond to an employer mandate by providing health care coverage and offsetting those costs by decreasing cash wages. But there are two problems with making that kind of dollar-for-dollar offset.

First, the minimum wage would prevent some employers from reducing cash wages by enough to cover their costs. Consider a firm that pays its workers \$7.00 per hour but does not provide any health insurance. Under an employer mandate, that firm would have to provide health care

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60. *Id.*

61. *Id.* at 3.

62. *Id.*

63. *Id.* at 3-4.

64. See CHARLES R. MORRIS, *APART AT THE SEAMS: THE COLLAPSE OF PRIVATE PENSION AND HEALTH CARE PROTECTIONS* 58 (New York: Century Foundation Press, 2006).

65. *Id.*

66. *Id.* at 57-58.

67. See generally Amy Wolaver et al., *Mandating Insurance Offers for Low-Wage Workers: An Evaluation of Labor Market Effects*, 28 J. OF HEALTH POL. POL'Y & L. 883 (2003) (suggesting that policies that increase health care coverage among low-wage workers tend to decrease full-time employment for that group).

coverage for its workers. If that health coverage costs the equivalent of \$3.00 per hour, the firm would want to cut wages to \$4.00 per hour, but the \$5.15 minimum wage would make that impossible. To the extent that the employer mandate raises the labor costs of workers above the market value of their labor, some workers would lose their jobs.<sup>68</sup>

Second, an employer mandate would also result in changes in the supply of labor, depending on the value that workers put on receiving health insurance. If workers value health insurance over its cost, they would increase their labor supply. If workers would rather have cash, however, then they would decrease their labor supply.<sup>69</sup>

The net effect of an employer mandate on employment is ambiguous, but the empirical evidence suggests that a decline in the employment levels of low-waged workers is likely.<sup>70</sup>

Still, a well-designed system of government subsidies could more than offset the adverse impacts of an employer mandate. Those subsidies could be provided either to employers or to workers, perhaps in the form of an earnings subsidy. For example, the federal government could provide a tax credit to the employers of low-wage workers to help offset the increased costs of providing health insurance.<sup>71</sup> Alternatively, the federal government could provide health care vouchers to workers that could be used to purchase health care from authorized providers.<sup>72</sup>

## VII. TRANSITION TO UNIVERSAL HEALTH CARE

We can and we should make the transition from the current system to a system of nearly universal coverage. For example, the elements of such a transition could include tax changes, an employer mandate, and an individual mandate.<sup>73</sup>

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68. Also, if some types of workers are exempt from the mandate—such as part-time and contingent workers—then employers are likely to convert full-time jobs with coverage to part-time or contingent positions without coverage. See Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums 21* (Nat'l Bureau of Econ. Research, Working Paper No. 11,160, 2005).

69. Alternatively, those workers who value the coverage the least would have an incentive to move on to jobs that do not offer coverage; see also BAICKER AND CHANDRA, *supra* note 68.

70. Wolaver et al., *supra* note 67, at 911.

71. See Haveman, *supra* note 25, at 197-98.

72. *Id.*

73. See C. Eugene Steuerle, *A Workable Social Insurance Approach to Expanding Health Insurance Coverage in 3 COVERING AMERICA: REAL REMEDIES FOR THE UNINSURED* 97, 97-112 (Washington, DC: Economic & Social Research Institute, 2003) (proposing larger private and public spending on health care through tax credits, individual choices and employer contributions).



#### A. TAX CHANGES

The exclusion for employer-paid health insurance premiums should be capped at a fixed-dollar amount and gradually replaced with a refundable tax credit.

#### B. AN EMPLOYER MANDATE

Employers should be required to offer, but not necessarily pay for, at least one state-approved health insurance plan for employees. Employers should be encouraged to adopt the practice of automatically enrolling employees in the employer's health plan unless the employees specifically choose to opt out.

#### C. AN INDIVIDUAL MANDATE

Individuals would be required to get health insurance or lose tax benefits such as personal exemptions and standard deductions.

### VIII. CONCLUSION

All in all, it is both necessary and possible to redesign the health care system so it provides universal coverage, and we should be able to do it in a way that minimizes work disincentives. In short, we can make universal health care work.



**NATIONAL INDIAN HEALTH BOARD**

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April 5, 2007

**STATEMENT FOR THE RECORD OF  
BUFORD ROLIN, CHAIRMAN, POARCH BAND CREEK OF INDIANS AND  
RACHEL A. JOSEPH, MEMBER OF THE  
LONE PINE PAUITE-SHOSHONE TRIBE OF CALIFORNIA,  
CO-CHAIRS OF THE  
NATIONAL STEERING COMMITTEE ON THE REAUTHORIZATION OF THE INDIAN  
HEALTH CARE IMPROVEMENT ACT**

**SENATE COMMITTEE ON FINANCE**

**“KEEPING AMERICA’S PROMISE: HEALTH CARE AND CHILD WELFARE SERVICES  
FOR NATIVE AMERICANS”**

**HELD MARCH 22, 2007**

Chairman Baucus and Members of the Committee:

On behalf of the National Indian Health Board (NIHB) and National Steering Committee (NSC) on the Reauthorization of the Indian Health Care Improvement Act (IHCA), we respectfully submit a statement for the record in support of reauthorization of the IHCA, and offer comment on the "payor of last resort" issue raised during your Committee's March 22 hearing. We appreciate the work of the Senate Finance Committee during the 109<sup>th</sup> Congress in introducing S. 3524, amendments to the Social Security Act to improve access to Medicare, Medicaid and SCHIP programs. The NSC and NIHB recommend those provisions be incorporated into a Senate IHCA reauthorization bill, expected to be introduced soon in this Congress.

The NSC was established in 1999 by the Indian Health Service (IHS) to provide tribal advice and consultation regarding the IHCA reauthorization. Over the last eight years, the NSC has continued to be an effective tribal advisory committee by providing advice and input to the Administration and Congressional committees regarding the IHCA reauthorization bills introduced in the 107<sup>th</sup>, 108<sup>th</sup>, and 109<sup>th</sup> Congresses. During the 110<sup>th</sup> Congress, the NSC will continue its work in securing passage of the IHCA reauthorization and we ask for the Committee's support in this endeavor.

Established in 1972, the NIHB serves all 561 Federally-recognized American Indian and Alaska Native (AI/AN) Tribal governments by advocating for the improvement of health care delivery to AI/ANs as upholding the federal government's trust responsibility to AI/AN Tribal governments.

The NSC and NIHB had an opportunity to review the written and oral testimony presented by witnesses at the March 22, 2007 hearing: *“Keeping America’s Promise: Health Care and Child Welfare Services for Native Americans.”* During the hearing, there was discussion of the payor of last resort rule provision in the IHCA reauthorization. Some witnesses objected to the payor of last resort rule. We understand that these objections stem from a concern that Indian people should not have to apply for alternate resources to obtain necessary health services: IHS should be fully funded and not dependent on third party resources to supplement its funding needs. Crow Tribal Chairman Venne, in his written testimony, explains how it is sometimes difficult for Indian people to apply for alternate resources and the time delay in applying can exacerbate a life-threatening condition. Chairman Venne writes “[r]equiring American Indians to endure the stress and hardship of seeking alternate payment sources is contradictory to the IHS trust responsibility to provide health care to all American Indians.”

We understand Chairman Venne's concern. His testimony keenly demonstrates the need to enhance outreach efforts so that Indian patients can be timely enrolled in alternate resource programs for which they qualify and to remove barriers to such enrollment. Several provisions in the Finance Committee's bill from the 109<sup>th</sup> Congress will considerably aid in those efforts.

We recognize that chronic under-funding of the IHS is the root cause of the problems described by Chairman Venne. This forces IHS and tribal health programs to seize every opportunity to access additional revenues -- such as Medicare and Medicaid -- and to maximize their limited IHS contract health services (CHS) funds. While IHS remains so under-funded, we must continue to support the payor of last resort rule as vital to IHS and tribes' ability to offer health care to more Indian patients.

The payor of last resort rule is based on the currently effective IHS payor of last resort regulations found at 42 C.F.R. 136.61. Pursuant to these regulations, the IHS is a residual payor for services provided by referral under the IHS CHS program when alternate third party resources, such as Medicare, Medicaid, and other state and local programs, exist. For instance, when an IHS Medicaid eligible beneficiary is referred under the IHS CHS program to a non-IHS provider for health services the non-IHS provider is required to bill Medicaid for payment before the IHS CHS program will pay.

The IHS CHS program currently operates under a “life or limb” medical priority system and is under-funded by approximately \$300 million annually. This estimate is based on cost of services requested by beneficiaries that are deferred until funding becomes available. Demands on CHS program funds would be even greater if IHS beneficiaries, who are otherwise eligible for alternate health programs, did not access these other sources of coverage. The payor of last resort rule is necessary to ensure Indian people have access to services provided by such programs as Medicare and Medicaid on the same basis as all other citizens, and to assure that these other sources of payment are available to the IHS system.

Over the years, the payor of last resort regulation has been challenged by state programs claiming that the provision of health care to Indian people is a Federal, not a State, responsibility, and therefore IHS should pay first. Federal court decisions have upheld the payor of last resort rule. The IHS residual payor status has been questioned by alternate health programs which have

payor of last resort rules of their own. Codification of the payor of last resort regulation in federal law, i.e, through the IHCA reauthorization legislation, will ensure that the IHS CHS program is a residual payor to other federal, state, and local programs.

We express our gratitude to the Committee for consideration of this testimony.

