



NATIONAL INDIAN HEALTH BOARD

101 Constitution Ave. N.W., Suite 8-B02 • Washington, DC 20001

Phone: (202) 742-4262 • Fax: (202) 742-4285

Website: www.nihb.org

TESTIMONY OF RACHEL A. JOSEPH

Co-Chairperson of the

*National Steering Committee for the Reauthorization of the Indian Health
Care Improvement Act*

Before a Hearing of the Health Subcommittee

Energy & Commerce Committee

U.S. House of Representatives

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Room 2322 Rayburn House Office Building

Good morning, Chairman Pallone, Ranking Member Deal, and members of the Subcommittee. My name is Rachel A. Joseph. I am a member of the Lone Pine Paiute-Shoshone Tribe of California and serve as the Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Health Care Improvement Act (IHCA). I am a former Chairperson of the Lone Pine Paiute-Shoshone Tribe and am a current board member of the Toiyabe Indian Health Project, a consortium of nine Tribes, which serves Mono and Inyo Counties in central California. I have served for several years on the Indian Health Service (IHS) National Budget Formulation team representing California and have been elected to represent the IHS East Central California Tribes to the California Area Office Advisory Committee. In these capacities, and others, I have

been fortunate to work with Tribal Leaders from across the Country in addressing health care issues. Thank you for holding this hearing and providing us the opportunity to testify in support of H.R. 1328, to amend and reauthorize the IHCIA.

This testimony is also offered on behalf of the National Indian Health Board (NIHB). The NIHB serves all 561 Federally-Recognized American Indian and Alaska Native (AI/AN) Tribal governments in advocating for the improvement of health care delivery to AI/ANs and upholding the federal government's trust responsibility to AI/AN Tribal governments. Over the last several years, the NIHB has provided tremendous administrative, technical, and policy development support to the NSC.

In June 1999, the Director of IHS established the NSC, comprised of representatives from Tribal governments and national Indian organizations, for consultation and to provide assistance regarding the reauthorization of the IHCIA, which was set to expire in 2000. The NSC drafted proposed legislation, which reflected the tribal consensus recommendations developed at area, regional meetings and a national meeting held here in Washington, DC. In October 1999, the NSC forwarded a tribal proposed IHCIA reauthorization bill to the IHS Director, to each authorizing committee in the House and Senate, and the President. An IHCIA reauthorization bill has been introduced in the 106th, 107th, 108th, and 109th Congresses; while none of the bills passed, the NSC has continued as an effective tribal committee by providing advice and "feedback" to the Administration and Congressional committees regarding the IHCIA reauthorization bills. We look forward to working with members of the Energy & Commerce Committee to guarantee passage of H.R. 1328 in this 110th Congress.

Reauthorization of the IHCA is necessary to fulfill the Federal government's obligation to provide health care to AI/ANs

Recently, Home Box Office (HBO) released the film “Bury My Heart at Wounded Knee” an adaptation of Dee Brown’s book of the same name. While the movie highlights the struggle of the Sioux Nation following the Battle of the Little Big Horn in 1876, Dee Brown’s book describes the systematic removal of several Indian Tribes from their original homelands to reservations. In fact, one chapter of the book describes the removal of the Modoc Tribe from their original homelands in California to reservations in Oregon and Oklahoma. Throughout the nineteenth century, Indian Tribes ceded over 400 million acres of land to the Federal government based on promises made by the government, including promises of health care. The U.S. Commission on Civil Rights, in its 2003 report “A Quiet Crisis” found that the federal government has not lived up to its promise to provide adequate health care. The “funding for programs associated with those promises has fallen short, and Native peoples continue to suffer the consequences of a discriminatory history Native Americans continue to rank at or near the bottom of nearly every social, health, and economic indicator.”

In 1976, Congress enacted the IHCA to address the deplorable health conditions existing in Indian Country. Over the last thirty years, progress has been made in reducing the occurrence of infectious diseases and decreasing the overall mortality rates. But, today AI/ANs still experience significant health disparities and have lower life expectancy than the general population. The enhancements in H.R. 1328 will facilitate improvements in the Indian health care delivery system. Health services will be delivered in a more efficient and pro active manner that in the long term will reduce

medical costs, will improve the quality of life of AI/ANs, and more importantly, will save the lives of thousands of AI/ANs.

Enactment of H.R. 1328 will facilitate the modernization of the systems of health care relied upon by 1.8 million AI/ANs. The bill authorizes methods of health care delivery for AI/ANs in the same manner already considered standard practice by “mainstream” America. For example, “mainstream” American health care is moving out of hospitals and into people’s homes; focus on prevention has been recognized as both a priority and a treatment; and, coordinating mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice.

Indian Country has been working for over eight years to achieve reauthorization of the IHCA ---- enactment of H.R. 1328 in this 110th Congress is critical to fulfilling the Federal government’s obligation to provide health care to Indian people.

Health Care Disparities

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

We have demonstrated that 13 percent of AI/AN deaths occur in those younger than 25 years of age, a rate three times higher than the average US population. The U.S. Commission on Civil Rights, in its report “Broken Promises: Evaluating the Native

American Health Care System, (September 2004) that “Native Americans continue to experience significant rates of diabetes, mental health disorders, cardiovascular disease, influenza and injuries . . . 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, 280 percent more likely to die from accidents, and 52 percent more likely to die from pneumonia or influenza than the rest of the United States.” Rates of cardiovascular disease among AI/ANs are twice the rate than for the general public, and continue to increase, while rates for the general public are actually decreasing. Furthermore, according to the IHS, AI/ANs have a life expectancy six years less than the rest of the US population.

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

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

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

I appreciate the opportunity to highlight some of the key provisions of H.R. 1328 that, if enacted, would further the health status of Indian people and reduce health disparities:

- *Elevation of the Indian Health Service Director*
- *Behavioral Health Programs*
- *Access to Health Services*
- *Long-Term Care and Home and Community Based Services*

Elevation of the Indian Health Service Director

The NSC and NIHB support the language in Section 601 of H.R. 1328 elevating the Director of IHS to Assistant Secretary of Indian Health. Tribal leaders have long advocated for elevation of the IHS Director to that of an Assistant Secretary of Indian Health. Elevation is consistent with the government-to-government relationship and the trust responsibility to AI/AN Tribal governments throughout all agencies of the Department of Health and Human Services (HHS). The position is comparable to the administration of the Bureau of Indian Affairs programs with an Assistant Secretary in the Department of Interior and an Assistant Secretary for Public and Indian Housing in the Department of Housing and Urban Development.

While HHS has made great strides over the past several years to address Tribal issues, the elevation of the IHS Director to that of an Assistant Secretary would facilitate the development of AI/AN health policy throughout the Department. For instance, there are some Department meetings that are restricted to the Assistant Secretary level. Sometimes the IHS Director is not in attendance at meetings where preliminary decisions

are made that could impact Indian health. By the time the IHS Director is brought into the discussion, there is little opportunity to reverse or influence policy decisions made at previous meetings. An Assistant Secretary of Indian Health is necessary to ensure that when decisions are made that will impact Indian health, there is sufficient and timely opportunity to provide an Indian health perspective before a decision is made.

Many of the Indian health issues are crossing cutting issues that involve other agencies in the Department. At the Assistant Secretary of Indian Health level, Indian health issues, involving other agencies, could be better coordinated between the agencies. An Assistant Secretary of Indian Health would be in position to work with other HHS agencies to identify additional funding and grant opportunities for Tribes.

Most recently, events have occurred that further demonstrate the importance of the elevation of the IHS Director to an Assistant Secretary of Indian Health:

- At the HHS budget consultation meeting held in March 2007, the Tribes requested a substantial increase, of \$600 – 800 million, in IHS funding. On an annual basis, HHS holds budget consultation with Tribes and each fiscal year, the tribal requests for increased funding are not successful. While Tribal leaders implored the IHS Director and other HHS officials to advocate on their behalf for increased funding, no commitments were made. By establishing an Assistant Secretary of Indian Health, there would be an office within the Department with responsibility to advocate for an increase in IHS appropriations.
- On June 4, 2007, HHS published final regulations implementing section 506 of the Medicare Modernization Act of 2003. Section 506 requires the Secretary of HHS to promulgate regulations establishing a payment methodology that

Medicare participating hospitals would accept as payment in full for services provided to IHS beneficiaries referred under the IHS contract health service program or referred by an urban Indian program. Section 506 required the Secretary to publish regulations by December 2004. For the last three years, the draft regulations have gone back and forth in clearance between IHS, Centers for Medicare & Medicaid and HHS, largely due to a lack of ownership of the regulation within HHS. If there were an Assistant Secretary of Indian Health, these regulations could have been promulgated in a more efficient manner.

- In addition, two regulations, impacting Indian health programs, were cleared through HHS without review and clearance by IHS, the primary agency within HHS for Indian health programs. One of the regulations defining “units of government” for Medicaid purposes was published on May 29, 2007. Tribes submitted comments to the regulations because the regulations, as proposed, would negatively impact the operation of tribal health programs. Yet, these regulations were not sent to IHS, as part of the HHS clearance process, before publication in the Federal Register.

Behavioral Health Programs

The NSC and NIHB strongly support the Title VII provisions of H.R. 1328, which authorize comprehensive behavioral health programs that reflect tribal values and emphasize collaboration among alcohol and substance abuse programs, social service programs and mental health programs. Title VII addresses all age groups and authorizes

specific programs for Indian youth including suicide prevention, substance abuse and family inclusion.

The Title VII provisions establishes a “systems of care” approach that means more than just coordinated or comprehensive mental health services; it involves making families and communities partners in the development of behavioral/mental health services. The provisions in Title VII are necessary to address the increased demand for behavioral health services in Indian Country:

- Indian Country is experiencing a methamphetamine epidemic: there are increased law enforcement efforts, meaning more arrests; but insufficient treatment programs to address the number of individuals needing recovery assistance. IHS is funded at less than 60% of the level needed to provide basic adequate health care services; meth treatment costs substantially more than most other addiction treatments and last substantially longer, often over a year.
- Indian Country is experiencing a youth suicide epidemic: suicide is the second leading cause of death for Indians between the ages of 15 and 24; and the third leading cause of death for children 5 to 14 years of age.

At the HHS tribal consultation meeting in March, 2007, a tribal leader from the White Mountain Apache Tribe stated, “Though we are located hundreds of miles away from the nearest metropolitan city our reservation has been swarmed with the deadly ills of society such as alcohol, illegal drugs and most recently, methamphetamine,” and “in almost all cases, our suicide incidents involved the use of alcohol.” For the White Mountain Apache youth, suicide rates among 15 to 24 year olds **are 10-12 times** higher than the U.S. average.

Access to Health Services

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

One of the more important provisions in Title II of H.R. 1328, is section 204 that ensures maximum participation and enrollment of AI/ANs in the Medicaid programs and SCHIP. The provisions exempt AI/ANs, who receive services from the Indian health programs, from Medicaid premium and cost sharing requirements, such as co-payments. In addition, the provisions exempt Indian property from being counted in making eligibility determinations and from Medicaid estate recovery rules.

Because AI/ANs ceded over 400 million acres of land to the federal government in exchange for promises of health care, the Indian health system is often called a "pre-paid" health plan. Indian people have already paid for their health care – and the most vulnerable of the Indian population, those eligible for Medicaid and SCHIP, should not spend their own money or subject their property to seizure, in order to receive Medicaid services. Often cost sharing requirements, for example co-payments, are imposed by private sector health plans to save money and to allow covered individuals to assume "personal responsibility" for their health care. However, within the Indian health system, the individual AI/AN does not expend personal resources for health care, the Indian health program would pay on behalf of the Indian beneficiary. The IHS has estimated

that it costs approximately \$20.00 to process a purchase order for a \$5.00 co-payment. The more efficient policy approach is to exempt AI/ANs, who utilize the Indian health programs, from cost sharing requirements, as provided for in section 204.

In addition, by removing barriers to enrollment through exemption of AI/ANs from Medicaid and SCHIP cost sharing requirements, the Indian health programs that provide health services to Medicaid and SCHIP eligible AI/ANs will see increased revenues. In the President's FY 2008 Budget Request, the IHS estimates that it will collect over \$600 million in Medicaid and Medicare reimbursements at its IHS operated service units – representing almost 25% of the IHS budget. The Medicaid revenues are necessary to meet Medicaid accreditation and compliance requirements, including staffing and other program needs, at Indian health direct care sites, and result in cost savings to the IHS and tribal contract health services programs.

Long-Term Care and Home and Community Based Services

While the life expectancy of AI/ANs is substantially lower than the rest of the general population, the ability to provide health care and related services for the elderly population remains one of the most pressing issues for Indian country. The need to improve and expand services for all stages of the life cycle are desperately needed; however, services utilized during the waning years of life are severely lacking in AI/AN communities. Under current authorities, in some Indian communities, AI/AN elders are placed in assisted living or nursing homes located off-reservation. Families have to travel hundreds of miles from their home to visit their elderly relatives.

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

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

H.R. 1328 contains many important and innovative provisions that are desperately needed in Indian Country to raise the health status and reduce health disparities of Indian people. We appreciate the support of this Committee in our efforts to secure passage of the IHCA this Congress. Thank you for providing me this opportunity to present testimony and I am available to answer any questions you may have.