Testimony of Andrew Joseph, Jr.

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

Before:

Senate Committee on Indian Affairs
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"Advancing Indian Health Care"

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Good morning Chairman Dorgan, Ranking Member Barrasso, and distinguished members of the Committee. My name is Andy Joseph I serve as a Tribal Council member for the Confederated Tribes of the Colville Reservation. I thank you for the opportunity to provide my testimony to the Senate Committee on Indian Affairs.

In my role as a Tribal leader, I also serve as the Chairperson of the Northwest Portland Area Indian Health Board (NPAIHB). 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. 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 Senator Dorgan and the Indian Affairs Committee for their work to get S. 1200, the Indian Health Care Improvement Act (IHCIA) Amendments of 2008, passed by the Senate last year. As you know there was a tremendous amount of work that went into getting this bill passed and we acknowledge your leadership and the commitment of the Committee and its staff to get this done. Thank you for holding this hearing and your continued work to support legislation to reauthorize the IHCIA.

Federal Trust Responsibility for Health Care

The United States government has a legal and moral responsibility to provide health care services to American Indian and Alaska Native (AI/AN) people. This responsibility is based upon numerous treaties signed between the United States and Indian Tribes which ceded millions of acres of land and resources in exchange for certain reserved rights and basic provisions guaranteed by the United States—including health care. The unique relationship between Tribes and the Unites States is underscored in the U.S. Constitution (Article I, Section 8), numerous Federal laws and court decisions, and Administrative policies which all affirm the unique relationship between Indian Tribes and the federal government and its obligation to provide health services to American Indians and Alaska Natives. This obligation is further compelling when the limited access to health care and significant health disparities impacting AI/AN people are considered.

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.[1]

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, and 67 percent more likely to die from pneumonia and influenza.[2] 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 was 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.[3]

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.

Reauthorization of the IHCIA

Today, I want to speak about why it's important to get the Indian Health Care Improvement Act (IHCIA) reauthorized in this session of Congress. As the Committee is aware—and with its support—Tribes have been working since 1998 on the reauthorization of the IHCIA. I want to bring your attention to a chart that we have included as an appendix to my testimony. The chart shows that immediately following passage of the IHCIA in 1976, Congress has taken action on a number of measures to address and improve health care delivery for AI/ANs by amending

[1] FY 2000-2001 Regional Differences Report, Indian Health Service, available: www.ihs.gov.
[2] Ibid.
[3] American Indian Health Care Delivery Plan 2005, American Indian Health Commission of Washington State, available at: www.aihc-wa.org.

the Act on several occasions. Unfortunately, Tribes have not seen the level of Congressional experienced in the 1980's and 1990's and our people are suffering because we have not improved our health system. In 1998, Congress extended the IHCIA by authorizing appropriations through FY 2001; however the Congress has not passed a bill since this time.

It was in 1998, that the IHCIA's National Steering Committee (NSC) began to work on legislative objectives for reauthorization. It has taken a tremendous amount of Tribal resources to work on the reauthorization effort and has been an extremely frustrating process. As a Tribal leader, I recognize that these important resources could be put toward patient care, but I also understand the importance of getting the IHCIA reauthorized. So from this standpoint it's been very frustrating to get the IHCIA reauthorized, knowing that past Congresses have passed legislation on a number of occasions to improve the health conditions for AI/AN people. Tribal leaders have been working on reauthorization of the IHCIA for eleven years, and it is critical that we get this bill passed as soon as possible in this Congress. The improvements contained in S. 1200 would allow the Indian health system to modernize the way in which it provides health care so that AI/AN people enjoy some of the same health benefits as most Americans.

Every day I see the difference that the IHCIA would make on the Colville Indian Reservation. Our reservation encompasses nearly 2,300 square miles (1.4 million acres) and is in north-central Washington State. The Colville Tribe has more than 9,300 enrolled members, making it one of the largest Indian Tribes in the Pacific Northwest. About half of our members live on or near the Colville Reservation. The long distances that our Tribal members must travel to receive health care is a tremendous burden and expense. Some the provisions in the IHCIA would allow us to develop our health programs to provide hospice care, assisted living, and home and community based services. These provisions would allow the Colville Tribe to make health services available to those that might not be able to get to health facilities.

As the Committee is aware, a significant issue for Tribes is the lack of funding to provide health care services. The IHCIA provides authority for programs to improve access for health services and addresses mechanisms to allow the Indian Health Service (IHS), Tribes, and urban Indian organizations authority to be reimbursed for services they provide. This will assist to reduce the chronic underfunding for the Indian health system. The Title IV provisions are very important to the delivery of health care services for the Colville Tribal health programs. The Medicare, Medicaid, and SCHIP reimbursements allow our health program to provide additional health services that might not be provided by IHS funding alone.

Another improvement that the IHCIA would allow is for the IHS and Tribes to be able to recruit and retain qualified Indian health professionals. Like many parts of Indian Country, it is often difficult to recruit and retain qualified health professionals to work on Indian reservations. The amendments made to the Indian health scholarship programs will permit greater flexibility for IHS and Tribes to recruit, train, and retain health professionals. This would allow the IHS and Tribes to address the high health professional vacancy rates experienced in the Indian health system.

Lastly, the Colville Indian Tribes have had a serious bout of dealing with youth suicide on our reservation. It is estimated that the national Indian suicide rate is four times greater than the national average; however, last year the Colville Indian Reservation suicide rate was twenty times higher than the national average. The Senate passed IHCIA (S. 1200) has an expanded emphasis on behavioral health for IHS and Tribal health programs. The improvements contained in S. 1200 provide for a comprehensive approach to behavioral health, providing important prevention and treatment programs for AI/AN people. The bill also emphasizes the coordination of services related to alcohol and substance abuse, child welfare, suicide prevention and social services. The addition of the youth suicide provisions will greatly assist Tribes to address suicide issues in their communities.

New Opportunities for the IHCIA

Since 1999, the IHCIA National Steering Committee (NSC) has worked to develop bill language that is representative of the health needs of Indian Country and has the consensus of over 560 federally-recognized Tribes. Over the last four years, the NSC has worked to negotiate with Congressional Committees and the Administration to arrive at the final bill language that was passed in S. 1200. As the NSC negotiated to get a bill passed by the Senate, they compromised on a number of provisions that were changed or dropped from the bill. Many of these issues were not consistent with the previous Administration's policies concerning Indian health.

In light of the new Administration and Congress, we would urge the Committee to work with the NSC to revisit some of the IHCIA provisions that were significantly altered or dropped from the bill that passed in the 110th Congress. There were important provisions that would have exempted AI/AN people from cost sharing in the Medicare program and waiving late enrollment premiums in the Medicare Part B program, that would be important to increase access and services for Tribal elders. Another key provision would have established a Qualified Indian Health Program (QIHP) as a new provider type through which Indian health programs and urban Indian health programs could more fully exercise authority to receive payments under Medicare, Medicaid and SCHIP. Tribal leaders also agreed to delete a provision that would have extended the 100% FMAP to services provided to Medicaid eligible Indians referred by IHS or tribal programs to outside providers, such as referrals made through the Contract Health Services (CHS) program. This would be a very important provision to addressing the backlog of CHS denied and deferred services. There were other Social Security Act provisions that would have been beneficial for Indian programs but were dropped from the reauthorization bills because the Department of Health and Human Services objected to negotiated rulemaking requirements.

The Administration has stated that health reform will be a priority on its agenda. The President's plan to provide affordable and accessible health care for all Americans, will build on the existing health care system. Any time the Administration and Congress have undertaken a change to the nation's health care system it has had an impact on IHS and Tribal health programs. During this era of health reform there could be some opportunities to improve the

Indian health system. There could also be threats to destroy the current system that provides culturally competent health care for AI/AN people. So it will be important for Congress to work with the NSC to understand these reform proposals and build in the protections for the Indian health system, but also allow it to be improved when and where appropriate.

It is important to note that there could be critics of the Indian health system during this time of reform. I want to stress the fact that the Indian health system is only funded at approximately 50-60 percent of its level of need. The improvements included in the IHICA, if adequately funded, would allow the IHS and tribally managed health programs to make marked improvements in overall health status of AI/AN people. It is not fair to evaluate the Indian health system under the current circumstance due to the fact that it is only funded at approximately 50-60 percent of its level of need. The Indian health system has done remarkably well with the limited funding that it receives. Health improvements made since the Agency was established and recent improvements tracked by GPRA indicators demonstrate this. Imagine the improvements that could be made if the system was funded at 100 percent of its level of need. The Indian health system should be given the same opportunity to provide comparable health care along the lines as that provided by the Veterans Administration. This can be accomplished by passing the IHCIA and providing adequate funding.

Conclusion

On behalf of the Northwest Portland Area Indian Health Board, I want to thank the Committee for allowing me to testify on Advancing Indian Health Care. I encourage the Committee to continue to work with the IHCIA National Steering Committee to identify key provisions that have been eliminated from the bill in order to improve health services provided by IHS and tribally operated health programs. And I urge Congress to make sure to protect and improve the Indian health system whenever appropriate as the Administration and Congress undertake health reform.

Chronology of the Indian Health Care Improvement Act
1955 - Present

1950	1970	1980	1990	2001	2003	2005	2008	2009
				107th Congress	108th Congress	109th Congress	110th Congress	111th Congress

1955
IHS created as new agency within Public Health Service

1975
Indian Self-Determination & Education Assistance Act (P.L. 93-638) enacted. Authorizes Tribes to assume IHS programs.

1976
Indian Health Care Improvement Act (P.L. 94-437) enacted to provide "the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy." Signed by President Gerald Ford

1980
P.L. 96-537 extended the IHCIA to FY 1984. Signed by President Jimmy Carter.

1984
S. 2166 & H.R. 4567 Bills to reauthorize IHCIA vetoed by President Ronald Reagan

1985
S. 277 & H.R. 1426 pass each chamber but bills *sine die* in 99th Congress.

1985
IHCIA programs extended by appropriations acts through 1989.

1988
P.L. 100-713 IHCIA Amendments of 1988 extend Act through FY 1992. Signed by President Ronald Reagan.

1990
P.L. 101-630 authorizes mental health and urban health services and expands facility authorities.

1992
P.L. 102-573 extends authorization for IHCIA appropriations through FY 2000. Signed by President Bush.

1993
Urban Indian Health Programs funds are cut by President Bush.

1996
P.L. 104-313 extends direct billing for Medicare, Medicaid, and other third parties authorized in 1988. Signed by President Clinton.

1998
P.L. 105-256 IHCIA technical corrections for urban programs, substance abuse, and some Tribal CHSDAs. Signed October 14, 1998 by President Clinton.

1998
P.L. 106-417 makes Medicare, Medicaid, other third party payor demonstration permanent. Signed Nov. 1, 2000 by President Clinton.

1998
P.L. 106-568 extends appropriations for IHCIA through FY 2001. Signed Dec. 27, 2000 by President Clinton.

1999
NSC convene series of four regional and one national meeting in Rapid City, Reno, Las Vegas, New Orleans, amd Washingon D.C. to reach agreement on IHCIA objectives

1998
"Speaking with One Voice" IHS Director, Dr. Michael Trujillo appoints IHCIA National Steering Committee (NSC) to develop reauthorization objectives.

2001
S. 212 Introduced by Sen. Campbell to reauthorize IHCIA in 106th Referred to Indian Affairs Committee, bill *sine die*.

2001
H.R. 1662 iIHCIA Amendments of 2001 ntroduced by Rep. Miller in 107th Congress. Referred to committees of jurisdiction, bill *sine die*.

2001
S. 2711 bill to improve "Programs Relative to Native Americans" would extend IHCIA through FY 2006. Passes Senate, referred to the House. Bill *sine die.*

2003
S. 556 introduced by Sen. Campbell to reauthorize IHCIA in the 108th Congress, passed by Indian Affairs Committee, placed on Senate calendar, bill *sine die.*

2003
H.R. 2440 introduced by Rep. Young to reauthorize IHCIA in the 108th Congress, passed by Resources Committee, referred to Ways & Means, bill *sine die.*

2005
S. 1057 introduced by Sen. McCain in 109th Congress, passed by Indian Affairs and HELP Committees, placed on Senate calendar, bill *sine die.*

2006
s. 4122 introduced by Sen. McCain manager amendments to reauthorize IHCIA in the 109th Congress bill *sine die.*

2006
H.R. 5312 introduced by Rep. Young to reauthorize IHCIA in the 109th Congress, passed by Resources Committee, referred to Ways & Means, bill *sine die.*

2006
S. 3524 introduced by Sen. Grassley to amend IHCIA provisions related to Social Security Act (Medicare, Medicaid, SCHIP), Finance passes, bill *sine die.*

2007
S. 1200 introduced by Sen. Dorgan om 110th Congress , passed by full Senate and referred to House on May 10, 2008.

2007
H.R. 1328 introduced by Rep. Pallone in 110th Congress, passes out of Resources Committee, discharged by Energy & Commerce and Ways & Means Committees. Resources bill pending as of July 4, 2008.

2009
Senate Committee on Indian Affairs conducts hearing on IHCIA February 5, 2009.

2009
IHS Director convenes national meeting of the IHCIA National Steering Committee.