Testimony of Rachel A. Joseph, Co-Chair of the National Steering Committee to reauthorize the Indian Health Care Improvement Act

Before the U.S. Senate Committee on Indian Affairs Oversight Hearing on Advancing Indian Health Care

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Introduction

Chairman Dorgan, and Vice-Chairman Barrasso, and distinguished members of the Senate Indian Affairs Committee, I am Rachel Joseph, a member of the Lone Pine Pauite-Shoshone Tribe of California and Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). I appreciate the opportunity to testify before this Committee and present views on the advancement of Indian health care.

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

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

> First and foremost, passage of the IHCIA reauthorization is a vital component of any health care reform so that the underlying authorities for the operation of the Indian health system reflect 21st century health care practices.
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> Secondly, the Indian health care delivery system needs to be fully funded, and specifically, full funding is needed for contract support costs (CSC) and contract health services (CHS).
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> And finally, the Committee should explore extending health care coverage to IHS beneficiaries through the Federal Employees Health Benefit Program or through universal health care coverage established under any health care reform legislation that might be enacted.

REFORM OF INDIAN HEALTH CARE NECESSARY TO ADDRESS HEALTH CARE DISPARITIES IN INDIAN COUNTRY:

No other segment of the American population is more negatively affected by health disparities than the American Indians and Alaska Natives (AI/ANs) population; and, our people suffer disproportionately higher rates of chronic disease and other illnesses.
13 percent of AI/AN deaths occur in those younger than 25 years of age, a rate three times higher than the average U.S. population. The U.S. Commission on Civil Rights reported in 2003 that "American Indian youths are twice as likely to commit suicide…Native Americans are 630 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 318 percent more likely to die from diabetes, and 204 percent more likely to suffer accidental death compared with other groups." These disparities are largely attributable to a serious lack of funding sufficient to advance the level and quality of health services for AI/AN.

A travesty in the deplorable health conditions of AI/AN is knowing that the vast majority of illnesses and deaths from disease could be prevented if additional funding and contemporary programmatic approaches to health care was available to provide a basic level of care enjoyed by most Americans. It is unfortunate that despite two centuries of treaties and promises, American Indians endure health conditions and a level of health care funding that would be unacceptable to most other U.S. citizens. Over the last thirty years, progress has been made in reducing the occurrence of infectious diseases and decreasing the overall mortality rates. However, AI/ANs still have lower life expectancy than the general population.

REAUTHORIZATION OF THE IHCIA IS A VITAL COMPONENT OF INDIAN HEALTH CARE REFORM:

On behalf of the NSC and Indian Country, I want to express our upmost appreciation for your leadership, in bringing S. 1200 to the Senate Floor and securing its successful passage in the 110th Congress. Although we were not successful in obtaining passage of the House companion bill, the work you did raised the awareness of Indian health care needs. And, we believe the progress made by this Committee and the Finance Committee in the 110th resulted in certain important provisions in Title II of the IHCIA being included in the Children's Health Insurance Program Reauthorization Act of 2009 and the pending American Recovery and Reinvestment Act of 2009. The amendments to the Social Security Act (SSA)[1] will result in increased access to and enrollment of American Indians and Alaska Natives (AI/AN) in the CHIP and Medicaid programs. We appreciate Senate and House leadership including Indian health specific provisions in these major pieces of legislation. We respectfully request your continuing support to ensure these provisions stay in the economic stimulus legislation.

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

Our work is never done – the NSC strongly believes reauthorization of the IHCIA is a vital component in advancing and improving the Indian health care system. The IHS, Tribal, and urban Indian programs need modern and updated authorities in order to provide the same opportunities for health care to Indian people that are standard practice for the rest of our Country. Legislation to reauthorize the IHCIA should be introduced early in this 111th Congress and should not be postponed pending further examination on how to advance Indian health care.

In 1999, the Director of IHS established the NSC, comprised of representatives from Tribal governments and national Indian organizations, for consultation and to provide assistance regarding the reauthorization of the IHCIA, set to expire in 2000. When the NSC began its work, the NSC had many options: it could have recommended reauthorization of current law, plus additional amendments to address specific health care issues, or it could have presented a concept paper and let Congressional legislative counsel draft the legislation. However, since 1992, when the IHCIA was last reauthorized, the Indian health delivery system changed considerably with the enactment of the Indian Self-Determination Education and Assistance Act Amendments of 1994, providing the Tribes with more flexibility and empowerment to operate their health programs. It was important for the NSC to incorporate the emergence of Tribally-operated programs throughout the bill. Thus, the NSC drafted proposed legislation, which reflected the tribal consensus recommendations developed at area, regional and a national meeting.

For the last ten years, the Senate and House have introduced IHCIA legislation based on the original bill drafted by the NSC. Throughout the years, 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. Although there were "compromises" to the bill we still remain committed to our position that there should be no regression from current law.

The IHCIA reauthorization is a necessary first step to any reform of Indian health care because any reform must ensure access to modern systems of health care. Since the enactment of the IHCIA in 1976, the health care delivery system in America has evolved and modernized while the AI/AN system of health care has not kept up. For example, mainstream American health care is moving out of hospitals and into people's homes; focus on prevention has been recognized as both a priority and a treatment; and, coordinating mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice.

Reauthorization of the IHCIA will facilitate the modernization of the systems of health care relied upon by 1.8 million AI/ANs. The IHCIA reauthorization bill authorizes methods of health care delivery for AI/AN in the same manner already considered standard practice by "mainstream" America. Although not an exhaustive list, the following are some of the provisions that were contained in S. 1200 that, if enacted, would bring about advancements and improvement in Indian Country:

Expanded Authorities for Mammography and Other Cancer Screening:
We need to expand authorities for the IHS and Tribal programs to provide mammographies and other cancer screenings, consistent with recommendations of the United States Preventive Services Task Force.

AI/ANs have the poorest cancer survival rates compared to other U.S. populations due to genetic risk factors, late detection and lack of timely access to diagnostic and treatment methods. The cancer mortality rates for AI/ANs are highest in Alaska and the Northern Plains. The American Cancer Society statistics indicate that detection of cancer results in higher survival rates. Providing for preventive cancer screenings, would improve, and save, the lives of AI/ANs.

New Authorities for Long Term Care:
At the Committee's Oversight Hearing on Proposals to Create Jobs and Stimulate Indian Country Economies, a question was asked regarding infrastructure needs to address long term care for the elderly. While infrastructure needs for long term care, such as nursing homes, is needed in Indian Country, it is important to clarify that long term care authorities in Indian Country do not reflect long term care practices available to the general population.

Section 213 of S. 1200 would have provided for the authorization of IHS and Tribally-operated health systems to provide hospice care, assisted living, long-term care, and home and community based services. Indian elders need to receive long term care and related services in their homes, through home and community based service programs, or in tribal facilities close to friends and family. We need necessary authorities to provide long term care and related services to our elders that are currently available to the general U.S. population.

Expansion of Indian Health Care Delivery Demonstration Projects:
We need new authorities to establish convenient care demonstration projects to provide primary health care, such as urgent services, non-emergent care services, and preventive services outside the regular hours of operation of a health care facility. This provision would enhance the health care delivery options; reducing the need for contract health services (CHS) and emergency visits.

National Bipartisan Commission:
We have consistently recommended a National Bipartisan Commission on Indian Health Care. During the reauthorization process, our recommendations have been modified several times and now reflect general authority for a Commission to study the provision of health services to Indians and to identify needs of Indian Country by holding hearings and making funds available for feasibility studies. The Commission would make recommendations regarding the delivery of health services to Indians, including such items as eligibility, benefits, range of services, costs, and the optimal manner on how to provide such services.

A Commission would provide a mechanism for this Committee to advance Indian health care by requiring a Commission to study the health care needs in Indian Country and to identify and make recommendations to improve the Indian health care delivery system.

Behavioral Health Services:

The NSC and Indian Country strongly support authorizing comprehensive behavioral health programs which reflect tribal values and emphasize collaboration among alcohol and substance abuse programs, social service programs and mental health programs. We need to address all age groups and authorize specific programs for Indian youth, including suicide prevention, substance abuse and family inclusion.

Enhancements in an IHCIA reauthorization bill needs to facilitate improvements in the Indian health care delivery system. Health services need to 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 lives of AI/ANs.

On behalf of the NSC, I respectfully request that as part of this Committee's endeavor to advance Indian Health Care, that legislation to reauthorize the IHCIA be introduced early in the 111th Congress. Indian Country does not want to lose the momentum and all of the progress we made in the 110th Congress. After almost ten years, Tribal consensus in support of the IHCIA reauthorization remains strong. At Tribal Leader meetings with President Obama's Transition Team, there was a resounding appeal for the need to reauthorize the IHCIA. The NSC is committed to working with this Committee in making recommendations and providing input to advance the IHCIA reauthorization in the 111th Congress.

FULL FUNDING OF THE INDIAN HEALTH SERVICES IS NECESSARY TO ADVANCE THE HEALTH OF INDIAN PEOPLE

I represent the IHS California Area on the I/T/U Budget Formulation Workgroup. As part of the budget formulation process, the IHS established a Level of Need Funded workgroup to measure the proportion of funding provided to the Indian health system, relative to its actual need, by comparing healthcare costs for IHS beneficiaries in relation to beneficiaries of the Federal Employee Health Benefits (FEHB) plan. This method uses actuarial methods that control for age, sex, and health status. In 2002, per capita healthcare spending totaled $2,130 for AI/ANs, compared to $3,903 in other public sector financing programs serving the non-elderly population.

It is estimated that the IHS system is funded at less than 60% of its total need. To fully fund the clinical and wrap-around service needs of the Indian healthcare system, the IHS budget would need an additional $15 billion dollars. This estimate uses standard economic and actuarial forecasting methods that take into consideration actual inflation rates to measure growth and inflation. OMB routinely uses non-medical inflation estimates to calculate budget increases for the IHS budget which vastly underestimates true healthcare inflation rates. Applying the Federal Disparities Index (FDI) to estimate

the true health care needs of Indian people corroborates the long-held view that less than 50% of true need is funded by the IHS budget.

In FY08, the IHS appropriations were $3.3 billion – which falls short of the level of funding that would permit the Indian health programs to achieve health and health system parity with the majority of other Americans.

Contract Support Costs Need to be Fully Funded:
Contract Support Cost (CSC) funding provides resources to Tribes and Tribal organizations, that operate health programs under the Indian Self-Determination and Education Assistance Act, to cover infrastructure and administrative costs associated with the delivery of health care services. Approximately 70 – 80% of CSC funding is used to pay salaries of Tribal health professionals and administrative staff. Without adequate CSC funding, Tribal health programs are forced to reduce the levels of health care in order to absorb the infrastructure and salary costs. In most instances, cutting health care services is the only alternative to financing these costs. Chronic under funding has resulted in a substantial shortfall of CSC funding in the amount of $285 million (FY 2009 -$132 million and FY 2010 - $153 million).

Contract Health Services Need to be Fully Funded:
Contract Health Services (CHS) services are provided at private or public sector facilities or providers based on referrals from the IHS or tribal CHS program. Due to the severe underfunding of the CHS program, the IHS and tribal programs must ration health care. Unless the individual's medical care is Priority Level 1 request for services that otherwise meet medical priorities are "deferred" until funding is available. Unfortunately, funding does not always become available and the services are never received. For example, in FY 2007, the IHS reported 161,750 cases of deferred services. In that same year, the IHS denied 35,155 requests for services that were not deemed to be within medical priorities. Using an average outpatient service rate of $1,107, the IHS estimates that the total amount needed to fund deferred services, denied services not within medical priorities, and Catastrophic Health Emergency Fund (CHEF) cases, is $238,032,283. This estimate also does not capture deferred or denied services from the majority of tribally operated CHS programs (nearly one-half of all tribes).

EXPLORE ALTERNATIVES FOR EXTENDING HEALTH COVERAGE TO IHS BENEFICIARIES

The chronic under funding of the Indian health programs, annual appropriations for FY 2008 and FY 2009 are at $3.3 billion and projected level of need funding is estimated at $9 to $15 billion. This suggests that alternative funding streams and additional health care coverage is needed to address health care for AI/ANs. The Federal government has not lived up to its trust responsibility to provide health care to Indians – this is evidenced by Indian people suffering from higher health care disparities than the rest of the U.S. population.

The current Indian health care delivery system that provides culturally competent health care to AI/ANs, who reside in the most remote, isolated and poorest parts of this Country must be retained and modernized. What is needed is expanded coverage of AI/ANs through existing health care coverage, such as the Federal Employees Health Benefits Program (FEHBP). An earlier draft of the IHCIA contained a provision that would explicitly authorize the Tribes and Tribal organizations to purchase health care coverage under the FEHBP. The Committee should consider re-examine this provision and require the Federal government to extend coverage to all AI/ANs under the FEHBP. The IHS, Tribal and urban Indian health care programs would be designated participating providers of the FEHBP. This would allow the Indian health programs to bill and receive reimbursements from the FEHBP to supplement annual appropriations. For services not available at an IHS or tribal facility, coverage under FEHBP could serve as an alternate resource for payment of services under the CHS program.

Reauthorization of IHCIA would put in place new services and authorities in the Indian health system. With better services and facilities, Indian Country can then participate in discussions about national health reform which will focus on the financing of available services from various health systems.

We look forward to working with this Committee to explore how to advance and improve the Indian health care system. Health care reform legislation must include Indian-specific provisions to assure that reform options can work in a self determination and self governance health delivery system. Health care reform must address the chronic underfunding of the Indian health system and must include full funding and/or mechanisms to achieve full funding. Renewal should not turn into code for continuing to be told to do more with less. The Indian health system (I/TU) have already proven themselves experts in that. It is time to give the Indian health system a chance to prove how well it could work if fully funded.

In closing, it is exciting to be apart of the federal/tribal partnership and all of us working together can make it better. Thank you for this opportunity and I will be happy to respond to any question.