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INDIAN HEALTH CARE IMPROVEMENT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

ON

INDIAN HEALTH CARE IMPROVEMENT ACT

MARCH 8, 2007
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INDIAN HEALTH CARE IMPROVEMENTS ACT

THURSDAY, MARCH 8, 2007

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:32 a.m. in room 485, Russell Senate Office Building, Hon. Byron L. Dorgan (chairman of the committee) presiding.

Present: Senators Dorgan, Coburn, Inouye, Murkowski, Tester, and Thomas.

STATEMENT OF HON. BYRON L. DORGAN, U.S. SENATOR FROM NORTH DAKOTA, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. We will call the hearing to order.

This is a hearing of the Senate Committee on Indian Affairs dealing with the Indian Health Care Improvement Act. I would like to make just a couple of brief opening comments.

First, the U.S. Senate has now approved, after 2 long years, a new assistant secretary for Indian Affairs in the Department of the Interior. I have said previously that it is shameful that position was open for 2 full years. This is the position that has responsibility for the management of the Indian programs. It has been a position that has been around since I believe 1806, and for 2 full years it was unfilled. It is unbelievable to me.

We finally now have approved the President's nominee, someone I supported last year, someone I supported this year. I pushed very hard to force a vote in the U.S. Senate. What we have discovered from the vote is that one U.S. Senator had held that up, one. Senators have certain rights, but it seems to me to have been exercised at the expense of American Indians and Indian programs. I regret that, but nonetheless, that is done.

Second, this issue of Indian health care is a very important issue. We had people at that table just recently describe to us the health care issues, the difficulties, a doctor describing a patient coming to him that had been to the Indian Health Service with a knee that had a very serious torn ligament, and was told to wrap it in cabbage leaves for 4 days and come back. The stories are unbelievable.

Look, we have a serious problem in Indian health care. We have tried very hard to reauthorize the Indian Health Care Improvement Act, and I can't tell you how frustrated I am and how frustrated Senator McCain was in the last Congress when every single time we would try to move this, we would have an objection from somewhere, sometimes in HHS, sometimes in Justice. No matter

what we did, there was always another objection, and this never moved.

This time it is going to move. People can object if they want. They can vote against it if they want, but we are not going to spend 24 months trying to figure out where HHS is, where the Justice Department is, where their next urge or hits might come from. I want consultation. I want to hear your thoughts. I am very pleased you are here today, I say to Justice and HHS, but I want to work with members of this committee and my vice chairman and pass a reauthorization of the Indian Health Care Improvement Act at long, long last, an Improvement Act that we can improve even further in this session of the Congress.

I just want to start by saying I sound a little crabby about this. I am crabby about this. I am upset after 2 full years. Every single time we would make a proposal, there was another objection. And it never moved. This time it is going to move, one way or the other. We are going to be voting on the proposal on the floor of the Senate.

I say to the Justice Department, Health and Human Services, the Administration, all of my colleagues, let's all cooperate, provide input. We want to hear from everybody, to provide the best product we can, develop the best product we can, and then I am going to push it because I think it is long, long overdue. We have a bona fide crisis in Indian health care. I won't recite the statistics or I won't recite the anecdotes today, but I can if necessary.

I really appreciate my colleague, Vice Chairman Thomas, here; my colleague Dr. Coburn. My understanding is Dr. Coburn has a couple of other committee markups and assignments that are meeting this morning, so I will call on the vice chairman, unless he wishes to relinquish.

Let me then call on Dr. Coburn for an opening statement so that he can then depart.

STATEMENT OF HON. TOM COBURN, M.D., U.S. SENATOR FROM OKLAHOMA

Senator COBURN. Thank you.

I would like unanimous consent that a full opening statement by me be added to the record.

I just want to make some comments. I was one of the ones holding the Indian Health Care bill. To modify in a very small way, without significant improvements, Indian health care is a violation of our duty. What we have today is not tolerable, but to not fix it right is absolutely intolerable. When we tell people more of the status quo, where people will not get the care they need, and not to have a major, and I am talking major reorganization of the way we deliver health care to the tribal citizens in this Country, that gives flexibility, opportunity and choice, that puts them on a par with everybody else in this Country, rather than to give them second and third tier care, I will continue to hope.

So I look forward to working with the Chairman, but the tribal citizens of this country deserve at least as equal a health care as everybody else in this Country. I intend to offer amendments to give them the option, if they don't have available care, to use their rights as tribal citizens to get care at any Medicare-approved facil-

ity in this Country. If in fact we have an obligation, then we have an obligation to make sure they have the exact same level of care as they can get anywhere else.

I would put forward, we have the Chickasaw Nation in Oklahoma. They are trying to develop health care. They have been stymied in every way as they develop this new hospital and health care center, to tell them what they can't do, when they are trying to do and give and offer better care for their tribal citizens, because they have some resources. And then we take away resources that the Government offers saying you can't do it that way.

We have to build in flexibility in any reauthorization, and we have to make sure that our goal is at least equal health care for what everybody else in this Country is getting. Anything less than that is a violation of our good faith trust to the tribal citizens of this Country. I pledge to you, Mr. Chairman and Mr. Vice Chairman, that I will do everything in my power to do that.

I am introducing a Global Health Care bill next week to reform health care all the way across this Country, that gives access to everyone in this Country, everyone, so that no one is denied care, but that care has to be quality care, and we can't call it "care" if it is not quality care. We do great injustice not only to this institution, but under our duties of the treaties that we are faced with, if we give less than great quality care to tribal members.

I thank you for the time.

[Prepared statement of Senator Coburn appears in appendix.]

The CHAIRMAN. Let me be clear, you have not been the one holding up the assistant secretary for Indian Affairs. You were not. One Senator did that, regrettably. In my judgment, you didn't hold up anything in the last session on Indian health care because what happened in the last session on the Indian Health Care Improvement Act, month after month after month, we would get new objections and new objections from HHS and from Justice. You just couldn't solve the issues.

So I will commit this to you. We are going to write this bill, introduce it. You are going to have a significant role in providing input. You are a doctor. You have a great deal of experience in these areas. We can provide a bill that doesn't advance the status quo. I have very little interest in advancing the status quo of a system that is not working as well as it should.

These folks represent the Administration. They have asked for a certain amount of money. You might say the issue isn't money. It is not completely money, but you have to have the funds to provide for health care. When a woman is brought in on a gurney with a piece of paper taped to her leg, and she is having a heart attack, and the piece of paper says:

> By the way, hospital, if you admit this person, understand that Contract Health Care is gone. This is not life and limb and you may not be paid for this.

I am just saying, I think that sort of thing is shameful. We need to provide whatever funding is necessary.

I am anxious to have your input because you know a lot about this. We are going to work on a bill, get a good bill, one that we can be proud of, and then we are going to push like the dickens to get it done finally at long, long last.

Senator COBURN. You have my commitment to work with you.

The CHAIRMAN. Senator Thomas.

STATEMENT OF HON. CRAIG THOMAS, U.S. SENATOR FROM WYOMING, VICE CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

Senator THOMAS. Thank you very much, Mr. Chairman, and thank you for being here.

I am delighted that we are having this hearing. I think we do need to take a look and make sure we advance this legislation, incorporating the best practices that we can. I think we have to work with other committees. There is divided jurisdiction over this thing.

I do need to say, however, at least from our experience, Indian health care has not been all that bad. In our communities, we are looking at a community health center, for example, between the local community and the tribes. The tribal people have gone to the other community to sek ways for improvements.

So we need to make sure we do the best that we can, but I hope we are not overly critical of what we have had. At least in our community, it has been pretty good health care. We need to make sure it continues to stay that way. So I get a little taken away with being terribly negative about it.

At any rate, I look forward to the witnesses and their testimony. We ought to get this bill out of here and get it in good shape.

Thank you.

The CHAIRMAN. Senator Thomas, thank you very much.

The first panel is Dr. John Agwunobi, who is the assistant secretary for Health at the Department of Health and Human Services. He is accompanied by Dr. Charles Grim, the director of the Indian Health Service at HHS. We also have Frederick Beckner, III, deputy assistant attorney general, Department of Justice.

Let's start with you, Dr. Agwunobi. Thank you for helping me pronounce your name before this hearing started.

STATEMENT OF JOHN O. AGWUNOBI, ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY CHARLES W. GRIM, DIRECTOR, INDIAN HEALTH SERVICE

Mr. AGWUNOBI. Thank you, sir. I think I was 12 years old before I could pronounce it as well as you just did. [Laughter.]

Thank you.

Good morning, Chairman Dorgan and distinguished members. My name is John Agwunobi and I am the assistant secretary for Health for the Department of Health and Human Services. As the assistant secretary, I serve as the Secretary's primary adviser on matters involving the Nation's public health. I oversee the Public Health Service, of which Indian Health is one of those agencies.

I am joined by Dr. Chuck Grim. He is a personal friend and a great leader. He is also the director of the Indian Health Service.

I am honored to testify before you today on the important issue of the reauthorization of the Indian Health Care Improvement Act. The Department's mission is to uphold the Federal Government's responsibility to promote healthy American Indian and Alaska Native people, communities and cultures, and to honor and protect the inherent sovereign rights of the tribes that we work with.

We are committed to working in partnership with tribes to improve the health of Indian people and to eliminate health disparities through health promotion, disease prevention, behavioral health, and chronic disease management.

The Indian Health Service is the principal Federal health care provider to the American Indian and Alaska Native peoples. As part of the Federal Government's special relationship with tribal governments, IHS provides health care to 1.8 million members of the more than 560 federally recognized tribes. The Indian Health Care Improvement Act forms the backbone of the system through which Federal health programs serve and encourage participation of eligible American Indians and Alaska Natives.

Since the enactment of the law in 1976, statutory authority has substantially expanded programs and activities to keep pace with changes in health care services and administration. Federal funding has contributed billions of dollars to these efforts over the years.

We are happy to see that this has led to significant achievements in improving Indian health. From 1973–2002, infant mortality among American Indian and Alaska Natives decreased 60 percent. Tuberculosis deaths over the same period of time dropped 80 percent. And many other categories of mortality such as pneumonia, influenza, cervical cancer, and cardiovascular illness have all decreased.

However, I don't want to imply that we don't still face significant challenges, because we do. In this position, the position of assistant secretary for health, I have had the honor of traveling with Chuck and others on his team to tribal country, and quite frankly, it was a humbling experience for me. I met with tribal leaders and others in those communities. I now have first-hand understanding of the problems they face, we face.

Major disparities in health status and health outcomes continue. Death from diabetes, alcoholism, and injuries occur in far greater numbers than in other populations. We have an obligation to address these very serious health challenges. That is why the President's budget demonstrates a commitment to address the priorities identified by tribes through our annual budget consultation process with increases in funding. That is why the Department strongly supports reauthorization of the Indian Health Care Improvement Act at the soonest possible opportunity.

We have worked closely with this committee in the past, and we have made progress in moving toward legislation that the Department can support. We appreciate that Congress has responded to many of the Department's concerns, especially those related to secretarial management authority.

Last year's bill continued to contain certain provisions which may have negatively impacted our ability to provide needed access to services. Such provisions established program mandates and burdensome requirements that might have diverted resources from important services.

However, we are confident that we can work with this Congress to continue to address these concerns, and agree on legislation that will live up to our mission to raise the health of American Indians and Alaska Natives to the highest level.

Once again, sir, I appreciate this opportunity to appear before you to discuss reauthorization of the Indian Health Care Improvement Act, which we support. I will answer any question that you may have at this time.

I thank you, sir.

[Prepared statement of Dr. Agwunobi appears in appendix.]

The CHAIRMAN. Dr. Agwunobi, thank you very much.

Dr. Grim, do you have testimony?

Mr. GRIM. No, sir.

The CHAIRMAN. Okay, you will be available to answer questions as well.

Mr. Beckner, thank you very much for being here. I think it is the first time we have had someone from the Department of Justice testifying on this matter. We have asked you to be here specifically because we have had rather repeated and routine objections. Maybe I shouldn't characterize them as routine. We have had repeated objections as we have moved along trying to write this legislation from the Justice Department, and we wanted to have testimony from the Justice Department this morning. We appreciate very much your being here. You are the deputy assistant attorney general.

STATEMENT OF C. FREDERICK BECKNER, III, DEPUTY ASSISTANT ATTORNEY GENERAL, DEPARTMENT OF JUSTICE

Mr. BECKNER. Thank you, Mr. Chairman, and good morning.

As you mentioned, I am the assistant deputy assistant attorney general for the civil division of the Department of Justice. Thank you very much for the opportunity to share the views of the Department of Justice on the reauthorization of the Indian Health Care Improvement Act.

As of today, the Department of Justice has not had the opportunity to fully review the current version of the proposed legislation. We are not therefore in a position to provide specific comments on this legislation.

That said, the Department strongly supports the laudable objectives of improving Indian health care for American Indians and Alaska Natives. The Department looks forward to continuing to work with the committee to achieve these goals. The Department worked extensively with the committee and met with representatives of the American Indian community on a prior version of this legislation. We expect that this cooperative relationship will continue as the Department reviews the current legislation.

In commenting on the prior legislation, the Department identified targeted concerns that could be, and for the most part were in fact, addressed with relatively modest changes to the legislation, but did not detract from the overall goal of improving health care for American Indians and Alaska Natives.

For example, in an earlier version of the proposed legislation, the Department of Health and Human Services and Indian tribes could enter into self-determination contracts that covered tribal traditional health care practices. Such practices are unique to American Indian tribes and cannot be evaluated by established standards of medical care recognized by State law.

The Department was concerned that if a party sued the United States under the Federal Tort Claims Act for an injury allegedly caused by a traditional health care practice, the Department might not be able to meaningfully defend the case, and particularly the Department was concerned that the courts might incorrectly, in the Department's view, conclude a viable cause of action exists under the FTCA because traditional tribal practitioners are providing medical services and that these services do not comply with standards of the relevant State's medical community.

Consequently, we met with representatives of the American Indian community and worked extensively with the committee late last year to add language that would have clarified that the United States and ultimately the taxpayers would not be liable for malpractice claims under the FTCA arising out of the provision of traditional health care practices. This language would not have impacted other tort suits that could be brought against the United States for other services provided under self-determination contracts.

The Department also expressed its concern regarding a provision that would have extended FTCA coverage to persons who are providing home-based or community-based services. These services are sometimes provided by relatives and in many instances there are no established standards for such lay person care or for the environment in which they are provided. To address these concerns, the Department worked with committee staff on language that would have clarified that home-based or community-based services that can be provided under self-determination contracts are those for which the Secretary of the Department of Health and Human Services had developed meaningful standards of care.

Similarly, the Department expressed concerns in previous versions of the bill regarding the possibility of unlicensed individuals providing mental health treatment to American Indians and Alaska Natives. In a previous version of the bill, the Department worked with the committee to add language that would have ensured a licensing requirement for providing mental health services, and we believe the change was in the interests of both the United States and the Indian community.

Finally, the Department noted its concern that previously proposed legislation may raise a constitutional issue. We had previously attempted to work with the committee to address this concern, but unfortunately resolution was not attained. Most of the programs authorized by the current law or that would have been authorized by the previously proposed legislation tie the provision of benefits to membership in a federally recognized Indian tribe, and courts therefore likely would uphold them as constitutional. The Supreme Court has held that classifications based on membership in a federally recognized tribe are political, rather than racial, and therefore would be upheld as long as there is a rational basis for them.

Congress may also have limited authority to provide benefits that extend beyond members of federally recognized tribes, to individuals such as spouses and dependent children of tribal members, who are recognized by the tribal entity as having a clear and close relationship with the tribal entity.

To the extent, however, that programs benefiting urban Indians under current law or in the prior version of the bill could be viewed as authorizing the award of grants for other governmental benefits on the basis of racial or ethnic criteria, rather than tribal affiliation, these programs would be subject to strict scrutiny under the Supreme Court's equal protection jurisprudence.

For example, the statute in the previous reauthorization bill broadly defined "urban Indian" to include individuals who are not necessarily affiliated with a federally recognized Indian tribe, including descendants in the first or second degree of a tribal member, members of a State recognized tribe, and any individual who is an Eskimo, Aleut, or other Alaska Native. There is a likelihood that legislation providing special benefits to such individuals might be regarded by the courts as a racial classification subject to strict scrutiny, rather than a political classification subject to rational basis review.

This distinction is important because if the legislation awards Government benefits on grounds that trigger strict scrutiny, courts may uphold the legislation as constitutional only upon a showing that its use of race-based criteria to award the subject benefits is narrowly tailored to serve a compelling governmental interest.

In closing, the Department believes that any proposed legislation regarding Indian health care is important and significant. We are grateful for the opportunity to share our views with the Committee. As we have in the past, we look forward to working with the Committee on this important piece of legislation.

[Prepared statement of Mr. Beckner appears in appendix.]

The CHAIRMAN. Mr. Beckner, thank you very much.

We have been joined by Senator Inouye, who has for many years previously been chairman and ranking member of this committee. Senator Inouye, welcome.

STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII

Senator INOUYE. Thank you very much. I am sorry I am late. The usual thing happened, a motorcycle collided with a bus.

The programs and services covered by the measure before us are based upon a government-to-government relationship that Presidents Nixon, Bush, Carter, Reagan, Clinton, and the present Bush have all consistently reaffirmed as a Federal Indian policy of our Country.

Furthermore, the U.S. Constitution recognizes tribal governments as sovereign governments. In article I, section 8, clause 3, the Congress is vested with the authority to conduct relations with the several States, foreign nations, and Indian tribes.

Therefore, this bill should not be viewed as race-based, but rather legislation by which Congress is exercising its authority to address deficient health care conditions in Indian country. Therefore, I commend my colleagues, and particularly the chairman, Chairman Dorgan, for holding this hearing on this bill that provides crucial health care programs and services to Indian country.

Mr. Chairman, may I ask that my full statement be made part of the record.

The CHAIRMAN. Without objection, Senator Inouye.

[Prepared statement of Senator Inouye appears in appendix.]

The CHAIRMAN. Thanks for your comments and your long experience on this committee.

Senator Tester, welcome.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Yes; thank you, Mr. Chairman. I also want to thank you for having this hearing. I would just ask unanimous consent that my remarks be added to the record. I have them here, but we might as well proceed.

Sorry for being late, but I have to leave early, too, to sorry about it on both counts. Thank you.

The CHAIRMAN. Thank you very much.

[Prepared statement of Senator Tester appears in appendix.]

The CHAIRMAN. Let me ask a couple of questions of Mr. Agwunobi and Dr. Grim. It relates in some measure to what my colleague, Senator Thomas, was observing.

Look, there are areas, I think, of unbelievable care, for which I am deeply indebted. I have great admiration when I go to clinics in various places and see folks in the Indian Health Service and the Public Health Service working, often for less money than they could make elsewhere, very dedicated to their service.

Yet, my observation is that we are woefully short of that which is necessary. Let me give you an example, and see if you agree, Dr. Agwunobi. I will give you an example of one tribe. It applies to every tribe I visited. A young girl hangs herself, aged 14. She lies in bed in a fetal position for 90 days before she hangs herself and commits suicide. She misses school, the whole thing. Her sister had committed suicide 2 years before. Her father had taken his life 6 years before. Her mother was drug-dependent. So this young girl just falls out of the view of people and lies in bed for 90 days, misses school, and finally takes her own life.

I went to the reservation. Her name was Avis Little Wind. I say her name with the consent of the remaining family. I went to the reservation and talked to the tribal leaders, talked to the school officials, talked to her extended family. What I found is exactly what I found elsewhere. There wasn't a ghost of a chance of this young girl getting the psychological help she needed. There wasn't even a car to drive her to a clinic had there been a clinic that provided the professional resources. They would have to beg and borrow a car to get Avis to a clinic. It wouldn't matter to get her to a clinic, they didn't have the capability.

And that is true. You know, you talk about improvements, Indian kids have 10 times the rate of suicide of the national average in the northern Great Plains; a 600 percent higher tuberculosis rate; 500 percent higher alcoholism rate; and so on.

So my point is, maybe we have made improvement in some areas. Some of the discussion about diabetes, I am heartened by some of the research and some of the treatment. But I just think we have a huge hill to climb here to address these unbelievable problems. And the victims, kids like Avis Little Wind, who felt hopeless and helpless and took her life, their memories cry out for

us to do something. Senator Coburn said it, let's just not do something and say it is good enough. Let's do something that works.

You talked about improvements, and I don't want to denigrate improvements at all, and don't want to denigrate the people that work for the IHS and public health, but boy, I tell you, I get so depressed sometimes when I see the lack of services. Tell me your impression of that.

Mr. Agwunobi. Sir, I have been on the job now for about 1½ years. Very early on in that tenure, Admiral Grim reached out to me and he said, John, let me show you something. You are a public health worker. You have worked at the State level for years, but I want to show you something you have not seen.

He sent me out to I believe it was the Crow Nation, just south of Billings, MT. The tragedy of the story that you describe, sir, and it is a tragedy as an individual case, but the real tragedy is that it is not uncommon. The stories that I heard when I visited the tribal nation there and the stories that I have heard from tribal leaders since then would say it is actually fairly common.

So I concur completely. The Administration concurs completely. I have been sent today not only to support Chuck, but to be a symbol of our commitment, our recognition of the fact that we have to do this now. My job, as the public health service coordinator, is to make sure that within our Department, across the different agencies, that we get it done and we get it done quickly.

I am going to be working between the scenes, working in the background to support Admiral Grim, to support you, sir, and this Committee in trying to get this bill reauthorized.

The CHAIRMAN. Could I ask, my understanding is that for every 100,000 American Indians, there are about 90 doctors. For every 100,000 Americans, there are about 239 doctors. It is about 2 to 1. Is that a close approximation, Dr. Grim?

Mr. AGWUNOBI. Admiral Grim whispered to me that it is correct, but I will let him say it louder so everyone can hear.

Mr. GRIM. Yes, sir; those statistics are correct.

The CHAIRMAN. Does that statistic have any relevance at all with respect to a potential level of care, the potential to receive the kind of treatment one needs?

Mr. GRIM. One would assume that it does. One of the things that we are trying to do new, though, that I would like to mention to you, is that we are working with an internationally renowned institute called the Institute for Health Care Improvement to try to develop a new model of care around the management of chronic diseases. That includes behavioral health sorts of diseases, integrating behavioral health, the kind of care that Avis could have used, into our primary care delivery system. We have 14 pilot sites under test right now. We are manipulating an evidence-based tested model so that it will work in our system. So we are trying to work smarter and more efficiently, too, within the limited resources that we do have.

The CHAIRMAN. And we have been working, as you know, on the telemental health side as well to address it.

Let me ask you one other quick question, and then I am going to ask Mr. Beckner a question, then turn it over to the vice chairman.

You know I am interested in the issue of a new medical model of convenient care on Indian reservations. I know of one reservation, they have a fine clinic. It is old and it obviously is not up to date, but the people there are great. They are trying as hard as they can. But I think it is 9 o'clock to 5 o'clock. It closes at 5 o'clock on Friday. This is a remote reservation. If at 6 o'clock on Friday night you have a problem, you are in trouble. You are going to have to go about 90 miles.

My hope is that we can develop a new model of convenient care, using physician assistants and nurse practitioners, you know, convenient hours, long hours, 7 days a week in some of these walk-in clinics on reservations, because they are so remote.

Are you interested in working with me and the committee to see if we can find a way to do that?

Mr. GRIM. Very much. I think a lot of the ideas you have are important and very valid. Some of our locations where the staffing allows, we do have extended hours and the patients have proven to like that very much. So the Administration wants to work closely with you on it. We have a lot of new models of health care we are testing. We are excited about your additions of telehealth for psychiatry and things like that. You are going to hear a little bit about in the next panel about the use of telemedicine with our Community Health Aid Program up in Alaska.

We are very interested in showing you innovative models that we are already using internally, plus talk about models that we aren't right now that the committee would like to discuss.

The CHAIRMAN. Thank you, Dr. Grim.

Mr. Agwunobi, what you have said today gives me some heart because you say you want to work through the crevices and the cracks, and try to form some joints here between all of the agencies to find a way for us to improve things and get things done. So you can be sure that we, the minority and the majority on this committee, want to work with you and work with you very closely, along with Dr. Grim, and see if we can make some significant progress.

Mr. Beckner, very quickly, as you know, there are legal discussions about this issue of the constitutional issues that you raised today. I don't dismiss them and don't suggest they are not without some interest to us and concern to us, but we need to find a way to address them. I have been frustrated in the way the Justice Department has connected to the committee.

I hope that we can work with you the same way that Dr. Agwunobi has committed to work with us. Let's find a way to address these and solve them, and perhaps we will even in the end disagree, but at least we will have had a good exchange and then we can put a bill together and proceed, even knowing what the disagreement might be.

Would you be willing to work with us on that basis? I don't want to wait until October or November or December of this year. I want to put this together and begin moving the legislation.

Mr. BECKNER. I can answer that question in one word: Yes, we would be happy and delighted to work with the committee. In fact, we worked extensively with the committee last year and addressed all our liability concerns, and did not oppose passage of S. 4122. Our liability concerns were addressed in S. 4122 and we did not

oppose passage of that legislation. We look forward to working just as cooperatively with this committee on the next version of the bill.

The CHAIRMAN. All right. I am going to send you some written questions, with your permission, and would ask both to be available.

Senator Thomas.

Senator THOMAS. Thank you, Mr. Chairman.

Doctor, you in your comments talked a little bit about rulemaking as time consuming. However, isn't it true that negotiated rulemaking can result in probably better results than having to go to court and so on?

mr. AGWUNOBI. Sir, there are obvious advantages to negotiated rulemaking in many settings. Our concern relates to any language that would constrain the Secretary from his ability to reach out to tribes in direct conversation and direct consultation, and to meet needs as they arise over time.

Senator THOMAS. All right. You talk about the flexibility for the Secretary to do that. The tribes also should be afforded flexibility, don't you agree with that?

Mr. AGWUNOBI. Yes; I would concur.

Senator THOMAS. What is the involvement with tribal members or Indians on Medicare and Medicaid?

Mr. GRIM. The Department has established in the last couple of years a group called the Tribal Technical Advisory Group. CMS established that in consultation with tribal leadership. There are representatives from each region, each Indian Health Service region of the Country, and then also from several of the major tribal groups that comprise tribal leaders. CMS holds regular meetings with them to discuss policy issues.

Senator THOMAS. I am talking about what percentage of the tribal members actually are signed up to involve themselves in part D of Medicare?

Mr. GRIM. I don't have those numbers off the top of my head, Senator, but we do have numbers of how many tribal members we have signed up under the new Medicare part D legislation, and we can provide that to you for the record.

Senator THOMAS. Do you encourage that? Why wouldn't you?

Mr. GRIM. Yes, sir.

Senator THOMAS. I understand, where you have tribes that are a long ways away, but the tribes I represent, for instance, are right outside the town, and they can participate fully, can't they, in these other programs?

Mr. GRIM. Yes, sir; we are encouraging that. All of our patients' benefits coordinators have been trained on how to educate and get people enrolled in Medicare part D. We played a large part in the Department in both supporting that and trying to get our members enrolled in that. We are very supportive of it.

Senator THOMAS. I am obviously very much for an Indian Health Program because it has unique aspects, but on the other hand I think we ought to recognize that these folks are eligible to participate in the same program that you and I are.

Mr. GRIM. Yes, sir; we sign them up for Medicare and Medicaid, if they have private insurance. And that is one of the things that we pointed out to Senator Dorgan and some of his questioning in

the past is that we try to use all those alternate resources before we use our contract health services budget to pay for things.

Senator THOMAS. I guess that is particularly true about the detailed kinds of unique treatments.

Mr. GRIM. Yes, sir; especially for a lot of specialty care that we can't provide in our setting.

Senator THOMAS. Specialty care and so on you are not going to provide. I think we need to recognize that and get this combination of things going as well.

Mr. Beckner, I guess I am a little surprised you say you have not had a chance to look at the bill. You have people to do that, don't you?

Mr. BECKNER. Yes; we do have people to look at the bill, but I don't believe they have been provided the current version fo the bill.

Senator THOMAS. But it is generally not too much different than it has been and so on.

Mr. BECKNER. Then we look forward to working with you. If it is not too much different, we would expect our concerns to be pretty narrow or possibly already resolved.

Senator THOMAS. That is really how it kept from happening last time, wasn't it, the concerns that the Department had and so on?

Mr. BECKNER. Kept what from happening, Senator?

Senator THOMAS. Kept us from passing the bill.

Mr. BECKNER. I don't believe so, Senator. Our concerns were resolved with S. 4122, and we did not oppose passage of S. 4122. We did not object to it. Our liability concerns were resolved and we did not object to its passage.

Senator THOMAS. Okay, good.

If State law doesn't impose medical malpractice liability, how would the United States be liable?

Mr. BECKNER. Are you referring to traditional tribal healing practices?

Senator THOMAS. Yes.

Mr. BECKNER. If there is no cause of action for malpractice for tribal healing practices, then the United States could not be held liable for those practices.

Senator THOMAS. Okay.

Mr. BECKNER. We believe that is the better reading of the law today, and we were seeking just clarification in the passed Act that that was the case.

Senator THOMAS. You referred in your written testimony to medical community standards. What is that?

Mr. BECKNER. Well, ordinarily in an ordinary medical malpractice case, the way that they are resolved is by looking at how medicine is practiced in the prevailing medical community. Under State law, that is ordinary State medical practitioners. So if you had an open heart surgery and something went wrong, they would look to how the ordinary standard of care that was provided by the medical licensed open heart practitioners, and judge whether the care you received was deficient relative to that standard.

Senator THOMAS. I see. Well, the Department dropped their objections at the very last minute, so we are going to have a little different arrangement this time, do you think?

Mr. BECKNER. Dropped our objection to what?

Senator THOMAS. To the bill last year. That is the reason why it didn't pass.

Mr. BECKNER. We are prepared to work very cooperatively and I would hope that we would be able to resolve any issues we have with the current version of the bill readily and as quickly as possible.

Senator THOMAS. Good. Have there been any medical malpractice lawsuits arising from traditional health care practices?

Mr. BECKNER. Have there been any?

Senator THOMAS. Yes.

Mr. BECKNER. Not that I am aware of, sir.

Senator THOMAS. Okay.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

As I have been fairly active getting around the State of Montana the last couple of years, there are all sorts of stories out there dealing with health care from the non-Indian population. And then you walk onto Indian Country and those horrors are compounded tenfold. I appreciate the fact that you visited the Crow Reservation. I think it is fair to say most of the tribes in the northern Great Plains are in that same situation.

It is the biggest concern I hear about when I go in Indian country. I was on the Salish Kootenai Tribe last weekend. A good portion of that meeting was eaten up by health care concerns. It is a very, very critical issue, both from access and availability. I don't have to tell you that if you happen to get sick at the wrong time of the year when the budget runs out, you can't get services.

It is not an easy problem to solve. It is a problem that quite frankly is a bit overwhelming to me, but it is a problem that has to be solved.

My question to you is, do you have any ideas on how we can deliver health care better in Indian country, and quite frankly, in the urban centers, too, off the reservations? Are there any ideas? Does it solely revolve around money resources? Or are there other things we can do? I know it is a pretty broad question, but you can answer any way you would like.

Mr. AGWUNOBI. Thank you, sir. I think one of the most important things that we can do in the near term is to reauthorize the Indian Health Care Improvement Act. I am very clear in my mind on that. My colleague, Admiral Grim, and I have had long conversations about the fact that getting it done, not only does it relate to what is in the bill, but it is a symbol of our commitment as a Nation.

Senator TESTER. Let's just assume that it is passed and it is done. What is the next step?

Mr. AGWUNOBI. I think there is an ongoing need for us to address access issues. One of the things that we are working with with the Indian Health Service is trying to make sure that they are fully staffed, their need for nurses and for doctors, that we find ways either through the U.S. Public Health Service Commission Corps or other ways to make sure they have access to the staff, the kinds of staff that they need, such as mental health providers, nurses, physicians, dentists.

I do think we also have to keep our mind and our focus on the fact that there are emerging threats that threaten to compound this circumstance even more, methamphetamine abuse for example, and the epidemic of use that is tearing into many of these communities.

I think when all is said and done, it is going to require that we consult with the tribes themselves, that they help give us the ideas of how we might be able to help. These are sovereign nations, proud people, and they need to be a part of the solution in terms of its design.

I will turn to my colleague to see if there is anything else you want to add.

Mr. GRIM. I would just say I agree 100 percent with what Admiral Agwunobi says. There are a lot of innovative things going on within Indian Health Service. The thing that we haven't done is that we haven't spread some of those innovative things all over the country. We are looking at methods to do that now. I think that is an advantage of our system, that we can rapidly spread best practices or new things that we are learning in one place rapidly across our system, whether they are the Federal system or the tribal system.

We are working on really that methodology right now. We have done it in diabetes. We have become world renowned, I think, in that in the way we have dealt with diabetes. We are starting to do that in chronic care now and in behavioral health.

So that is part of working smarter within the system that we have or bringing in new innovations that this committee might want to discuss. That is some of the things we are looking at for the future.

Senator TESTER. I appreciate your respect for the sovereignty issue. I also appreciate your comment about working together to find solutions, and listening, because I think that is critical.

I also appreciate the fact that you are using best practices in other areas and trying to spread them around the Country.

I also appreciate your haircut, by the way. [Laughter.]

Mr. GRIM. I like yours, too. [Laughter.]

Senator TESTER. The next question I had was, is has there been, are you actively seeking communication from individual sovereign nations? I would like to ask in Montana, specifically, but it is important all over the Country. Has that dialogue started? Is it continuing? Is it regular? Because quite frankly, sometimes I wish I was still on the farm so I didn't have to deal with these kinds of issues, because I am telling you, it is serious, serious business. If we don't address these problems, they are only going to get far, far worse. So has that dialog been going on and is it going to continue, and with what kind of regularity?

Mr. AGWUNOBI. I will start, and then turn it over to my colleague. It has absolutely started. The notion of consultation is something we believe is an obligation on our end, to uphold and facilitate. My trip to Billings and then on down into Crow country was a beginning of a larger commitment. I have spoken with tribal leaders and committed to coming to them, not just having them seek us out, but coming to them. And I came to that community to listen to what are the needs, how can we help.

The answer, sir, is yes, yes, yes, and yes. We have started talking. We are going to continue talking. And we are going to increase our communication. "Talking" is perhaps the wrong word. We are going to increase our listening, not just hearing, but listening.

Senator TESTER. I appreciate that.

Thank you.

The CHAIRMAN. Thank you very much, Senator Tester.

Before I turn to Senator Murkowski, Mr. Beckner, Vice Chairman Thomas was asking you some questions. I felt like you were shifting in some ways from a direct answer, and I want to describe the concern. We worked for two years on the Indian Health Care Improvement Act, worked very hard on it, Senator McCain, myself and others on the committee, to try to put something together. We worked for 2 years.

On September 26 last year, at the end of the 2-year period, this showed up. It is a Department of Justice white paper. It is not signed. It was given to the steering committee of one political caucus in the Senate, not both, just one political caucus. It wasn't offered to the Committee on Indian Affairs, neither to the majority nor the minority; raises all kinds of questions in six single spaced pages. It takes the position similar to the position you have taken today on things. The classification of Alaska Native is based on race, and therefore will be a problem.

So this is what I don't understand. One of the reasons I asked you to be here is that Senator Thomas was asking you about cooperation. How does it work that at the end of a 2-year period, we have a white paper show up at the steering committee of one political caucus in the Senate, not shared with this committee? It did result, by the way, in several holds being put on the bill. The result is 2 years of work on a bill that we had watered down substantially because of objections from HHS, objections from Justice. It resulted in us not being able to pass a bill.

So how does this white paper show up, and especially how does it show up not to us, but to a steering committee of a political caucus in the Senate?

Mr. BECKNER. Thank you, Mr. Chairman, and thank you for giving me the opportunity to clear up the confusion about the white paper.

It is my understanding that the Department's staff met with committee staff for, as you said, 2 to 3 years on this bill. The views that were set forth in that white paper reflected the issues that had been previously raised in those meetings. In those prior meetings, the staff was somewhat frustrated that all the discussions were verbal, and they asked the Department to put into writing some suggestions for language.

The white paper was intended to serve as a constructive roadmap for resolving those concerns. It was the Department's intention to provide the white paper to the Committee staff after the Senate had gone into recess in the fall, in order to further our discussions and use the white paper in continued meetings with the staff.

Unfortunately, a version of the white paper was released prior to that time and not to the committee staff.

The CHAIRMAN. Who released it?

Mr. BECKNER. I don't know, your honor.

The CHAIRMAN. Who prepared it?

Mr. BECKNER. It was prepared by lawyers in the Department of Justice, lawyers at the Torts Division, Office of Legal Counsel and others.

The CHAIRMAN. Have you asked the question of who released it?

Mr. BECKNER. I have asked whether the Department of Justice released it and I was told that no one in the Department of Justice released it. And I understand that after we found out it was released prematurely, that it was provided to committee staff and that we then also met with representatives of the American Indian community to discuss it as well.

I do apologize for the timing. It was not our intent to have it come out while the Senate was still in session. It was our intent to use it to address staff concerns for written specific targeted dialog that could result in actual language. I would say that that actually happened, that based on the white paper, we had very fruitful discussions with committee staff. We ended up resolving our liability concerns with three or four targeted suggestions, and our liability concerns were resolved by S. 4122. We did not object to that bill.

The CHAIRMAN. It was not clear in September that we were going to be back for a lame duck session, but it appears to me this was designed at the end of the process to kill the bill. I can simply say to you neither Senator McCain's staff nor my staff, he was chairman and I was vice chairman, were privy to this, and I don't believe either of those staffs asked you to prepare this. I don't believe for 1 moment that no one released it. It shows up in one caucus here in the Senate accidentally? I don't think so.

That is why I started out this hearing with some concern and some frustration. It is the case that there have been efforts at every step along the way to undermine the efforts to pass this bill. We have a piece of legislation that we need to reauthorize. It deals with people's lives, health care. You are suggesting to us we can't deal with Alaska Natives because it is racial, for God's sake? The Department of the Interior recognizes Alaska Natives.

So anyway, I have gotten rid of my frustrations with you today only to say that this can't happen again. If you are going to cooperate with us down at Justice, you have to do that with all of us. We want to work with you in a forthright way to get something done here. That is the reason Senator Thomas was asking the questions. I am just telling you the evidence at the end of last year is that Justice put out a white paper to kill this legislation. And they did.

God bless you, but the fact is this legislation needs to be passed and soon, and we will work with you, but at some point you can put all of the white papers you want. If you don't agree with us, don't come by in the midnight hour trying to kill the product with white papers going to one political caucus in the Senate. That is not going to work.

Mr. BECKNER. I hear your concerns and I understand your frustration. I can just reiterate that it was not our intent to have it released.

The CHAIRMAN. Yes; but let me tell you something. You read your response. When I asked you the question, you read what you

had prepared, and I think you have carefully considered how you would respond to this uncomfortable question. I would much prefer that you would not have had to read that, and instead you would not have killed that bill last year. So let's start over and work and see if we can get it done this year.

Senator Thomas, I don't know whether you have a comment on that.

Senator THOMAS. No.

The CHAIRMAN. Senator Murkowski.

STATEMENT OF HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman. I am glad that you jumped in front of me because I was certainly prepared to ask many of the same questions. I think we all find it troubling that you spend the amount of time and, Mr. Chairman, I know that you and Senator McCain spent an inordinate amount of time working this through in the past couple of years, along with the rest of us on the committee.

We recognize the importance of this legislation. To have it, someone suggested, stalled out, but I think you have appropriately said it, it was killed, and I think in a most unfortunate way.

Mr. Beckner, you have just indicated in response to Senator Thomas that you are going to look to resolve any issues that you have with this bill and indicate that you are going to cooperate with this, but I think it is fair to say that it needs to be done openly, honestly, throughout the process. This is too important an issue to the people in my State and the people in States that are represented around this table, to have legislation like this that relates to the basic health care needs of our American Indians, Alaska Natives, and Native Hawaiians, to not have it be reauthorized.

I appreciate you, Mr. Chairman, bringing this forward today, the opportunity to ask some of the tough questions. I apologize that I was not able to hear the testimony this morning. I will have to go back and read the transcript and make sure that I am fully up on what you all have said.

Mr. Chairman, I want to thank you. You had encouraged me to work with you on how we might be able to move forward some models for perhaps community health aide programs. In the next panel, we will have Steven Gate from Sitka here today to talk about the Alaskan model. With that in mind, Dr. Grim, I would like to ask you your assessment of the success of the Community Health Aide Program in Alaska. You have been around for a long time watching what we are doing up there. Can you just speak to this program and how it might be a model for the rest of the country?

Mr. GRIM. I think it has been an outstanding success, Senator. In fact, it has been used as a model in other parts of the world. We have been asked to have dignitaries from other parts of the world come visit Alaska to see how they use it. They have innovatively trained community members. I have visited with some of those people. I don't know how they do it, living in some of the remote communities that they do. They are basically on call 24/7 be-

cause the community knows where they live. It is a stressful job for them, but they do an outstanding job.

You have also linked telemedicine very recently in innovative ways so that those community health aide practitioners have links to our major medical centers there in Alaska. So when they have problems or need to send pictures or get consults, they now have consults with some of the best specialists and sub-specialists in the State.

It is an outstanding model and they do a great job. I would like to publicly applaud them.

Senator MURKOWSKI. Thank you. I know that they appreciate your support.

As you know, we have many in the community who are not State licensed to deliver the care. Over the 40 year history of the program, to your knowledge, do we have any problems in terms of liability?

Mr. GRIM. To the best of my knowledge, I could ask our people that deal with that and give you a more perfect response for the record, but no, we have not had, and we have had a Federal oversight board, as you know, that certifies those individuals.

Senator MURKOWSKI. That is my understanding. We are doing very well and have not had problems with the liability issue. It is something that I know that Justice had expressed some concerns about. I am not quite sure why, so it is nice to have it on the record. If you have anything that would supplement that, I would certainly appreciate that, but I think we can use this as one of those models applicable throughout the rest of the country as we attempt to deliver health care in rural and isolated places.

Mr. Chairman, I just want to note for the record that among the Alaska Natives, my constituents up north, there is no one more important piece of legislation that this Congress could pass than the reauthorization of this. So we look forward to working with you on this and hopefully have the genuine commitment from all involved.

I also have an opening statement that I would like to have included as part of the record.

The CHAIRMAN. Without objection, Senator Murkowski.

[Prepared statement of Senator Murkowski appears in appendix.]

The CHAIRMAN. We talked a little about a new medical model of convenient care centers and so on that we have been talking about and working on.

Senator Tester had another question.

Senator TESTER. Yes, Mr. Chairman; thank you very much. I want to take a step back because I may have made an assumption I should not have made, that the passage of this bill is automatic, because it is obviously not. What is the date on that white paper?

The CHAIRMAN. The date is September 26, I believe.

Senator TESTER. Of last year?

The CHAIRMAN. Yes.

Senator TESTER. Was the bill amended after that date?

The CHAIRMAN. We worked on the bill leading up to and through the lame duck session. We made some modifications following that date as well.

Senator TESTER. Okay. The question I had was for Mr. Beckner. You had said, when Vice Chairman Thomas was asking you ques-

tions, that you had not had a chance to take a look at the bill, but if it was similar or identical to the bill in the 109th Congress, that you were not going to have any problems with it.

Mr. BECKNER. If it was identical to S. 4122, we had no objections to S. 4122.

Senator TESTER. And so those few changes that were made after September 26, 2006 took care of all your concerns in that 6-page single spaced white paper?

Mr. BECKNER. I am sorry I interrupted you, Senator.

Senator TESTER. That is all right.

Mr. BECKNER. They resolved all our liability concerns, and we agreed to disagree on the constitutional issues. We did not object to the legislation.

Senator TESTER. Okay. Thank you very much.

Senator THOMAS. The Senate might be interested to know that the bill was introduced 2 hours before the end of the session last year, so it had gone through a lot of things.

The CHAIRMAN. Let me also make the point, to finalize the point, the bill that was introduced at the end of the last session was not something that I had signed up to or agreed to. What happened was your September white paper actually forced a circumstance where objections were raised on the floor so that the floor couldn't be brought forward. It forced more discussions to happen in the last hours of the session. Changes were made to the bill that I did not agree with and did not support.

The bill didn't pass, in any event. My point, Mr. Beckner, is I think it is pretty clear to me, and I have been around here a long while, the way it works, this tubed the bill. I have invited you to testify today, and I appreciate your being here. You have said you want to cooperate with us. I want to cooperate with Justice and I want to turn the page. But I don't like what happened last year. I don't want it to happen again. If we disagree, that is fine.

You are in the executive branch, and you can disagree with us. We are in the legislative branch. We are going to legislate. We will work with you to solicit your input, solicit the input of HHS, do the best we can to put together the best legislation we can do, and try to move legislation. I don't want to wait until the end of next year to find out that we would fail again. I want to succeed and I want to do it sooner, rather than later.

So I appreciate your pledge of cooperation. We will look forward to working closely with you.

Mr. Agwunobi, we are going to work closely with you and Dr. Grim as well, because we want to work on some changes in the medical models and convenience care and other things that will write a new bill, one that I think is more exciting, more interesting, and as Dr. Coburn said earlier, that really does change the delivery system of better health care to people who desperately need it.

I want to thank the three of you for appearing today and for being with us at the hearing. Thank you very much.

Mr. AGWUNOBI. Thank you.

Mr. BECKNER. Thank you, Mr. Chairman.

The CHAIRMAN. I would like to now call the final four witnesses. Richard Brannan is chairman of the Northern Arapaho Business Council at Fort Washakie, WY.

Might I ask the Indian Health Service to stay, and Justice? If you have the time, I would love to have you stay just for a bit to hear some of the testimony.

Okay, thank you.

Rachel Joseph is cochair of the National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act. Edward Lazarus is a partner at Akin Gump. Steve Gage is director, Community Health Aide Program, Southeast Alaska Regional Health Consortium in Sitka, AK

We thank you for being here. We appreciate your patience. We will have Richard Brannan begin.

Would you wish to say a word?

Senator THOMAS. Yes; I would. I want to welcome the chairman, Richard Brannan, from the Northern Arapaho Tribe at Fort Washakie, WY, to testify. Chairman Brannan participates in the National Indian Health Budget Formulation Team, the National Tribal Leaders Diabetes Committee for the special diabetes program for Indians. I appreciate his leadership and am delighted to have you here, sir.

I am sorry you had problems getting here. I understand you came to Denver to Los Angeles to Washington.

Mr. BRANNAN. Yes, I did. [Laughter.]

Senator THOMAS. That is the long way around.

The CHAIRMAN. Mr. Brannan, you may proceed. Your entire statement, in fact the statements of the panel will be made part of the record.

Mr. BRANNAN. Thank you.

STATEMENT OF RICHARD BRANNAN, CHAIRMAN, NORTHERN ARAPAHO BUSINESS COUNCIL

Mr. BRANNAN. Good morning, Chairman Dorgan, Vice Chairman Thomas, members of the committee. My name is Richard Brannan. I am the chairman of the Northern Arapaho Tribe of the Wind River Reservation in Ethete, WY. I am serving my fourth term as chairman of my tribe. I am a member of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act, the Tribal Leaders Diabetes Committee, and the Indian Health Service Budget Formulation Team, representing the Montana and Wyoming tribes.

I worked several years for the Wind River Service Unit, the IHS facility on my reservation, as the Administrative Officer. Health care has been a personal priority not only during my interim in the IHS, but as a tribal leader. I appreciate this opportunity to address the health issues of tribes, and would like to thank the committee for the opportunity to testify in support of the Senate bill to reauthorize the Indian Health Care Improvement Act.

Today, I would like to divert from the usual delivery of testimony. I have faith in my colleagues and their knowledge and experience that they will impart to the committee today the priority issues relating to and the importance of reauthorizing the Indian Health Care Improvement Act.

Instead, today I would like to put a face to these priority issues so that as we deliberate on reauthorization that we keep the faces of American Indian and Alaska Native people in our minds and hearts. As I begin this address, there are fundamental principles that need to be reaffirmed regarding tribes and our sovereign status.

The overarching principle of tribal sovereignty is tribes are and have always been sovereign nations. Tribes pre-existed the Federal union and draw our rights from our original status as sovereigns before Europeans arrived. The fundamental principles of tribal sovereignty are as a sovereign nation. Tribes, as evidenced through the treaty-making Indian commerce clause of the Constitution, engage in a government-to-government relationship with the United States.

The sovereign power of tribes include the power to determine our form of government, determine tribal membership, regulate domestic relations among our members, prescribe rules of inheritance, levy taxes on members and persons doing business with members on tribal lands, control entry onto tribal lands, regulate the use and distribution of tribal property, and administer justice among members of our tribe.

Today, I would like to take you back approximately 143 years to one of the most horrendous acts perpetrated on the Arapaho people, the Sand Creek Massacre. To this day, we do not really know the level of historical trauma sustained by our tribe because of this event, but we do know that it is there and we continue to suffer because of it.

Colonel John Chivington, a Methodist minister, and his 800 troops marched in order to attack the campsite of Black Kettle. On the morning of November 29, 1864, the Army attacked the village and massacred most of its inhabitants. Chivington proclaimed before the attack, "Kill and scalp all big and little. Nits make lice." Only 9 or 10 soldiers were killed, and 3 dozen of them were wounded. Between 150 and 184 Arapahos and Cheyennes were reported dead or killed, murdered. And some were reportedly mutilated, and most were women, children, and elderly men.

Chivington and his men later displayed scalps and other body parts, including unborn babies that were cut from their mother's wombs and the private parts of women.

The Joint Committee on the Conduct of the War declared as to Colonel Chivington, your committee can hardly find fitting terms to describe his conduct. Wearing the uniform of the United States, what should be the emblem of justice and humanity, holding the important position of commander of a military district.

Therefore having the honor of the Government to that extent in his keeping, he deliberately planned and executed a foul and dastardly massacre, which would have disgraced the vilest savage among those who were the victims of his cruelty. Having full knowledge of their friendly character, having himself been instrumental to some extent in placing them in their position of fancied security, he took advantage of their inapprehension and defenseless condition to gratify the worst passions that ever cursed the heart of a man.

I am an Arapaho, and when I speak about the Sand Creek Massacre, I am amazed that we as Arapaho people have persevered. During the Sand Creek Massacre, Arapaho women and children were brutally murdered. The soldiers especially targeted children that day, with the idea to exterminate them and destroy the entire tribe.

The Sand Creek Massacre occurred in 1864 and today it is 2007. We as tribal people continue to fend off the attack on our children. This time, the attacker is not as visible as Colonel Chivington's troops, but more deadly. In 2007, we are defending our children from succumbing to the effects of the decreasing Indian Health Care budget, devastating health disparities, and dangerous emerging diseases, the impacts of methamphetamine abuse.

Nationwide, the disparity in health status and access to health care for American Indians and Alaska Natives is staggering. Tribal leadership and the Indian Health Service continues to educate Congress and the Administration and all of America on the devastating disparity suffered by American Indians, Alaska Natives in health status, mortality rates, and access to health care. Diseases that continue to challenge the health of American Indians and Alaska Natives are diabetes, alcohol substance abuse, heart disease, and cancer.

Today, what I did is, I brought pictures of three little Arapaho angels. I call them angels because they are in heaven now. They couldn't be here in person. I apologize. What I did is I had to show them. This is what I face every day, is the death of children, and the suffering.

This beautiful little baby whose name is Dylan Whitcomb. Dylan is Arapaho. He was diagnosed in late 2004 and died in early 2005 of neuroblastoma. He had just turned 5 years old. He was a brave little boy and often amazed his grandmother in his unwavering certainty that he would get better. In fact, he often comforted his family. Dylan needed treatment that was more than could be provided by the Wind River Service Unit.

By the time resources were made available through private sector partnerships and charitable givings, Dylan had advanced stages of the disease. He entered a children's cancer treatment center where one of his friends was a little girl that was diagnosed with the same disease about the same time as Dylan. She was able to access care earlier than Dylan and was healthy at the time of the reporting. Cancer is devastating.

What I did is I brought a picture. Her name is Marcella Hope, a little 22 month old baby that was killed. She died hanging in a closet on a hanger, years of abuse because her parents were methamphetamine addicts. I have to live with this as the chairman. I have to live with my conscience. I have to see what can I do. I come here. I am not trying to grandstand. I am trying to get a point across here. People are dying. Children are dying. We need to do something. People are suffering. I live this every day.

This little boy here is also a 22-month old little Arapaho angel. We only buried him in November. At 22 months, he was beaten to death. I went to his funeral. It is not natural to see a little 22 month old baby in a casket. They had to have a hat on him because his head had swelled so large. I went the night before to his grand-

father's residence. I went in there and I asked him, I said, can you please forgive me for failing you and your little grandson. And what he responded back to me, he said, he was special. People feel guilty. They may feel guilty, but he was special, and God called him early.

His other grandfather is being buried today. He died from sorrow of losing his grandbaby.

I did have written testimony, but I need to get that across to everybody in this room, that we are dealing with little children. We are dealing with human beings that have feelings. I always try to do that. I am not much in terms of statistics, because that doesn't really show the true story.

In closing, my grandmother, she lived to be 99 years old. Her name was Cleland Thunder. And what she told me is her elders taught her to pray for the President, the Vice President, Congress, all of the people that work here in Washington, that they would be blessed; that they would have a good life; and hopes that life would be so good for them that they would look back on the Arapaho people with some pity.

We continue to practice that today. That is a continuous practice. What I come here today for is asking for the Federal Government just for some pity, some compassion. I thank you for giving me this opportunity to testify. The Sand Creek Massacre is my legacy. That is my life. I live that every day. I live that trauma. So that is why I am talking about it, and I am trying to make the connection of the Sand Creek Massacre of what is happening to our children today.

Thank you, Mr. Chairman. Thank you, Committee members for allowing me to testify. You have given me the honor to be here.

[Prepared statement of Mr. Brannan appear in appendix.]

The CHAIRMAN. Chairman Brannan, thank you very much for being here. Thank you for your passion. We understand that it was difficult for you to even get here, just with the arrangements and so on. And thank you for invoking the memory of some wonderful young members of your tribe and telling us about their lives. We appreciate that very much.

Ms. Rachel Joseph is the cochair of the National Steering Committee on the Reauthorization of the Indian Health Care Improvement Act. Ms. Joseph, thank you for your abiding work on this issue over a long period of time. We appreciate very much your being here.

STATEMENT OF RACHEL A. JOSEPH, COCHAIR, NATIONAL STEERING COMMITTEE ON THE REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

Ms. JOSEPH. Thank you. Good morning, Chairman Dorgan, Vice Chairman Thomas, and members of the committee.

I am Rachel Joseph, Co-Chair of the National Steering Committee for the Reauthorization of the Indian Health Care Improvement Act.

In 1999, the director of the Indian Health Service comprised the National Steering Committee of Tribal Representatives, a national organization. After extensive consultation with the tribes, we forwarded a consensus bill which reflected the best thinking of tribal

leaders across the Country. We continue to provide advice and feedback to the Administration and Congress regarding reauthorization.

In 1976, when the Indian Health Care Improvement Act was enacted and signed by President Ford, with the mission to bring the health status of the first Americans to the level of the general U.S. population. The Indian Health Care Improvement Act was reauthorized in 1988, and again in 1992, but has not been updated in over 14 years. Modernization is necessary for improvements to the health care systems.

The health disparities as already articulated by the assistant secretary of Health and the chairman of the committee demonstrates the need to provide enhancements so that we can update our health care delivery systems, improve the quality of life, and save the lives of Indian people.

Since 1999, we have accommodated Administration and congressional concerns by working out many compromises and by reaching consensus on key policy issues. At the same time, the steering committee has held to the guiding principles of no regression from current law and protection of tribal interests.

After working to secure reauthorization, you can imagine how disappointed Indian country was when the Indian Health Care Improvement Act failed to pass the Senate in the 109th Congress. The bill, we believe, was largely derailed by the DOJ memorandum already discussed today.

The memo addressed issues that would erode sovereignty and contained several inaccurate claims. DOJ raised constitutional issues regarding the definition of Indian. The definition of Indian in the reauthorization is the same definition that has been in the law for over 30 years, and has never been challenged on constitutional grounds. This definition is consistent with definitions of Indian found in other Federal laws, such as the No Child Left Behind Act.

To ensure no regression from current law, the steering committee strongly recommends that the definition of Indian, definition of urban Indian and definition of California Indian be retained.

DOJ also objected to FTCA coverage for home and community-based services and traditional health care practices because of standard of care issues. Currently, the IHS and tribes provide home health care services following State Medicaid standards of care. Traditional health care practice can be complementary to Western medical medicine. In most cases, traditional health care practitioners are not employees of the IHS or tribes so FTCA coverage would not apply. Also, it is our understanding, as already testified to by the Department of Justice, that no FTCA claim has ever been made for this kind of health care.

Over the past few months, the steering committee has worked with congressional staff in recommending legislative changes to any reauthorization. My written testimony highlights these issues in great detail.

As asserted by Mr. Chairman and Senator Coburn, the status quo is not acceptable. Thus, we support strongly the elevation of the IHS director to the assistant secretary of Health and Human Services. We believe that elevation is consistent with the govern-

ment-to-government relation and the trust responsibility to tribal governments.

We support strongly the establishment of a bipartisan commission to study the optimal way to provide health care to Indian people. We believe that the last version of the legislation did modify language relate-d to the study and we would recommend that we stay with the language that was in S. 1057.

We believe strongly that tribes should provide the kind of long-term care and human community-based services that are made available to other populations in our Country, enabling elders to receive long-term care and related services in their homes or tribal facilities closer to family and friends.

We strongly support comprehensive behavioral programs for at-risk Indians, and the authorization would allow behavioral health programs to reflect tribal values and emphasizes collaboration among alcohol substance abuse and social service programs, and mental health for all age groups, with specific programs for Indian youth.

Chairman Dorgan, in your Senate floor statement of January 22, you discussed the need for improving emergency access to reservation health care through expanding clinic hours and other innovations. You asserted the need for an Indian health care delivery model to replace existing emergency rooms at hospitals with low cost and after walk-in clinics, a model currently available in the private sector. We appreciate your leadership in proposing delivery systems in Indian country that are more accessible.

In spite of our consistent underfunding, our tribal programs continue to establish innovations that make care more accessible. For instance, some tribes have established after-hour programs for health promotion and disease prevention. My local health board is proposing a preventive dental health program on Saturday mornings for families who are not able to access these services during the week.

Some programs provide after-hours services by establishing toll-free numbers for patients to call in. I have a copy of our magnets that list all the toll free numbers of our health project, to ensure access for our service population, particularly since 10 percent of the people that we serve are over 65 years of age, and 32 percent of our children under five are at poverty level or below.

It lists the toll-free number for medical, dental, pharmacy and on. I have called this number after hours, and with the answering service asked to speak to a doctor who was able to get back to me, and we worked through my need for care at that particular time.

While the NSC supports legislative language clarifying existing authorities or expanding existing authorities to demonstration projects, additional funding is needed to facilitate any new programs that are authorized.

In closing, I would like to emphasize that we believe that the passage of this legislation would be facilitated if tribal leaders are at the table with congressional staff and the Administration, which is consistent with meaningful government-to-government relations and collaboration.

Thank you to the committee for the leadership you provide in support for the reauthorization, and the other critical issues that

affect Indian country. I appreciate the opportunity to testify today, and with my steering committee colleague, Chairman Brannan.

If I may make just a brief notation, and comment on the testimony the Administration made about objections to behavioral health programs in section 712 addressing fetal alcohol disorder services, tribal leaders spoke strongly that we should be able to educate expectant mothers about the harm that is done if they should continue to use alcohol, meth or other substances. So we feel strongly about ensuring that we have a comprehensive approach and the ability to do our jobs.

Thank you.

[Prepared statement of Ms. Joseph appears in appendix.]

The CHAIRMAN. Ms. Joseph, thank you very much. As I said, thanks for your continuing work on these issues.

Next, we will hear from Edward Lazarus, who is a partner at Akin, Gump, Strauss, Hauer, and Feld in Los Angeles, CA. Mr. Lazarus, thank you for joining us.

STATEMENT OF EDWARD P. LAZARUS, PARTNER, AKIN, GUMP, STRAUSS, HAUER, AND FELD, LLP

Mr. LAZARUS. Thank you, Chairman Dorgan and Vice Chairman Thomas, distinguished members of the committee.

It is a particular pleasure for me to come and appear this morning. I vividly remember as a boy coming to watch my father testify before this committee, and it was a significant reason that I ended up going to law school, and now I am here appearing as a constitutional authority. So there is a special poignancy in that for me.

Listening to Chairman Brannan this morning has actually caused me to revise the summary that I was going to give because in light of that, there seemed something terribly theoretical and abstract about arguing about which standard of review ought to apply, whether it is the *Morton* v. *Mancari* standard of rational relations, or the stricter test that applies to racial classifications.

I think one thing that is important to bear in mind is that the Department of Justice has never suggested that the Act, regardless of the standard of review, is unconstitutional. I think it is very much worth bearing in mind that even if the stricter test were to apply, that this committee and the Congress can do a great deal to try and ensure that it would pass even the stricter test that would be applied to a racial preference.

In my statement, I was presumptuous enough to suggest that the act might be amended to add some additional findings to meet the test of strict scrutiny, which talks about the need for the benefit, the failure of race-neutral alternatives, and the impact on rights of third parties, and the fit of the classification.

I think just listening to Chairman Brannan today and the comments that had already been made by the other witnesses, and by the distinguished members of the committee, it seems to me that a very, very compelling case can be made that given the conditions of Indian health, both in the cities and on the reservations, that this is legislation that meets all of those criteria.

That said, the question does remain, which standard of review should apply. The main question really boils down to this one of whether the definitions of Indians and urban Indians in the act is

so broad by including members of State-recognized tribes and non-members who are one or two degrees descended from members is so broad that it tips this over from the political classification recognized in *Morton* v. *Mancari* into being a race-based classification. While the question is not completely without doubt, I think the better answer is that this remains a bill that creates a political classification.

The starting point for the analysis has to be the extraordinary power and responsibility that the Congress has in the area of Indian affairs. The extraordinary power comes from the Indian Commerce Clause, a specific grant of power in the Constitution, and the 175 years of court decisions interpreting that clause to give Congress broad plenary authority in the area of Indian affairs.

The responsibility comes from the more than 200 year history of relations between the United States and the tribes, much of which is very tragic and was touched upon, of course, by Chairman Brannan, which has created a remarkable and strong duty of protection on the part of the Congress. Congress has legislated many, many times pursuant to that duty of protection to create special benefits for tribes. Health care has been a very, very important component of that going back, again way back into the early part of the 19th century.

The basic rule has been that when Congress legislates for the benefit of tribes, that treatment need only be rationally tied, and this is the language of the court, to Congress's unique obligation toward Indians. That is the language of *Morton* v. *Mancari.*

So the question is whether somehow by broadening out the coverage of this act to members of State-recognized tribes and not merely federally recognized tribes, and by bringing within the ambit of its benefits those Indians who are defined as urban Indians, who are non-members descended in the first or second degree from members, or Eskimo, Aleuts, and Native Alaskans, that this somehow has become a racial classification.

I think the answer with respect to State-recognized tribes is pretty straightforward. State-recognized tribes are, of course, political entities as well. There is a long history of recognizing Congress's very substantial power to define tribal relations and to recognize tribes for all purposes or just for some purposes. When you put those powers together, it does seem that there is no reason to consider providing benefits to State-recognized tribes as a racial classification, as opposed to a political one.

With respect to the urban Indian definition, the truth is the case law just doesn't provide a definitive answer. In *Morton* v. *Mancari,* the court spoke very generally about the unique obligation to Indians, not federally recognized tribal members only. But at the same time, that case did arise in the context of a preference that was limited to federally recognized tribal members.

Several cases after *Morton* v. *Mancari,* the most prominent *Delaware Tribal Business Commission* v. *Weeks,* made no distinction between Indians and tribal members only. The *Rice* v. *Cayetano* case, which the case on which the Department of Justice relies, does note that *Morton* v. *Mancari* is limited to a preference in favor of members of recognized tribes, but the decision does not turn on

that fact. The court was making no effort to delineate exactly where the line is between political and racial classifications.

So in the absence of any defining case law, to me I think this question boils down to a matter of history and logic. When you look at the history, and we know——

Chairman DORGAN. Mr. Lazarus.

Mr. LAZARUS. I am sorry.

Chairman DORGAN. Perhaps even as your father experienced many years ago, we require discussions of the Constitution to be limited to 5 minutes. [Laughter.]

Mr. LAZARUS. And so they should be. I will simply close by saying that Congress has the power, it seems to me, to view these urban Indians as defined in the act as derivative of the political relationship with the tribes, and therefore bring it within the ambit of their power.

Thank you, Mr. Chairman.

[Prepared statement of Mr. Lazarus appears in appendix.]

The CHAIRMAN. Thank you for coming all this way and testifying. I regret that we do have limits on testimony by witnesses. I allowed Chairman Brannan to proceed longer because of the nature of his testimony. Your testimony is very helpful to us and we hope to engage with you as we construct this legislation.

Senator Murkowski, would you like to introduce the next witness?

Senator MURKOWSKI. Thank you, Mr. Chairman.

I would like to welcome to the committee this morning Steven Gage. Steve is the director for Southeast Alaska Regional Health Consortium, SEARHC, and he is also the chair of the Alaska Association of the Community Health Aide Program, a program that has been described earlier as being around about 40 years now. He has done a very fine job in this, and I think we will have an opportunity to again hear a little bit more about how this particular program in Alaska can be a model for throughout the Country.

Welcome, Mr. Gage.

The CHAIRMAN. You may proceed. Your entire statement is made a part of the record.

STATEMENT OF STEVE GAGE, DIRECTOR, COMMUNITY HEALTH AIDE PROGRAM, SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

Mr. GAGE. Thank you. Good morning, Chairman Dorgan and Vice Chairman Thomas and committee members. As you heard, my name is Steve Gage and I am a physician assistant. I work for the Southeast Alaska Regional Health Consortium. I am based in Sitka, Alaska. I am the director of the Community Health Aide Program that SEARHC operates.

SEARHC is as consortium of 18 tribes and predominantly serves the Tlingit, Haida, and Tsimshian Indian peoples of Southeast Alaska. I have been associated with the Community Health Aide Program for about 17 years. If you can picture yourself in a small town of a few hundred people, not unlike many rural areas throughout the United States in the early 1900's, access to medical care in that setting is hours and days away, and travel may involve land, water and air, and is entirely based on weather.

In this setting, if you become ill or injured, who are you going to call? In the scenario that I just described, if you were in Alaska, you would most likely be calling a community health aide. Presently, there are about 500 community health aides working in 180 communities throughout Alaska. They are employed by 27 638 tribal organizations. There were about 300,000 patient encounters in 2006.

As you heard, the Community Health Aide Program is about 40-years old and it was developed in Alaska to deal with the tuberculosis epidemic in Alaskan villages. It has evolved into the backbone of health care delivery in nearly all rural areas of Alaska.

Community health aides are generally recruited from the communities they serve, and approximately 80 percent of them are Alaska Natives. Being a resident of the community enables health aides to understand the language, the customs, and the traditions of the community, and they are less likely to leave after 1 or 2 years.

Training consists of emergency skills to at least the emergency trauma technician level, and that is combined with four 1 month sessions covering most aspects of basic primary medical care. Training is based on a statewide curriculum and is done at one of four training centers: Sitka, Nome, Bethel, and Anchorage.

The first two sessions of training are usually complete within 6 months of hire, and the entire process is usually complete within 2 years. The University of Alaska College of Rural Health recognizes this training and extends credit toward an AA degree for health aides.

Following the four sessions, health aides have a clinical preceptorship and testing process which, when passed, qualifies them as a community health practitioner. Continuing medical education must be maintained and a 1 week-long clinical evaluation is repeated every 6 years. In some cases, health aides have received additional training in health care such as early prevention screening and testing for childhood diseases.

Health aides work using a revised manual that directs their history, physical exam, and guides them to an assessment. Regardless of their years of experience and training, the manual must be used in all patient encounters. I have brought a copy of our new manual, and there are copies that are available if you wish to have one. Each community where health aides serve has medical oversight by tribal or IHS referral physicians. The manual guides the health aide to a general diagnosis. Treatment options are then discussed with the referral physician.

This physician may delegate some supervision of health aides to mid-level practitioners like physician assistants or family nurse practitioners. The physician may also approve a limited number of medical standing orders which enable the health aide to treat those conditions based on previous consultations.

Apart from standing orders, all patient encounters require consultation with a higher level medical provider. In Alaska, the Federal Telehealth Program provides the mechanism for this and has supplemented telephone counsels. Health aides usually work regular hours on a weekday schedule, and provide after-hours emergency care on a call rotation. Health aides work in all areas of

medicine. Preventive health care services is an area that is getting increased attention by health aides, and one we hope will reduce the need for acute and chronic medical care.

As an example, in part due to health aide services, Alaska's maternal and infant health have improved recently. In 1998, a Community Health Aide Program certification board was established to oversee the program statewide. The program is cost-effective and well received in Alaska. The State of Alaska contributes funds for program operations, and while tribal groups operating health aide programs are struggling with funding, they are committed to maintain the program as one of the most important that they offer their people.

I understand you are considering using the program as a model to provide health care. I will tell you that it works well in Alaska. Part of Alaska Native culture is to share what you have with others, and we would be very happy to share our program and our expertise with you.

Thank you.

[Prepared statement of Mr. Gage appears in appendix.]

The CHAIRMAN. Mr. Gage, thank you very much. You have come a long way to provide us information, which is very, very helpful. Alaska is, of course, unique and its challenges in delivering health care are very unique. I am very interested. You said you were a physician's assistant?

Mr. GAGE. I am.

The CHAIRMAN. The opportunity to use physician assistants and nurse practitioners to be involved in more convenient care for routine diagnosis in remote locations is something I am very interested in. I have talked with Senator Murkowski about that, as a national model. We talked to Dr. Grim as well. So I appreciate very much your testimony as well.

I will ask a couple of questions, but I will ask them at the end. I will call on Vice Chairman Thomas first for any questions.

Senator THOMAS. Is that your statement in the green package there, Mr. Gage? [Laughter.]

Mr. GAGE. It is not quite that long. [Laughter.]

Senator THOMAS. Okay.

Mr. GAGE. But it is quick reading, actually. Once you get started, you can't put it down. [Laughter.]

Senator THOMAS. Mr. Brannan, you have talked a lot about one of the reasons for all the medical care and prevention programs are important at reducing alcoholism. What kind of training and communication programs do you think would benefit your tribe?

Mr. BRANNAN. Senator Thomas, I look at alcohol as being a gateway drug, for lack of a better term, for methamphetamine addiction. In terms of the Indian Health Service, the budget is so strained there really isn't any funding available to do any preventive health education, any training whatsoever.

As we talked on our reservation, it is about 2.2 million or 2.3 million acres. In some instances, we have six police officers, sometimes maybe one police officer patrolling the whole reservation. They have approached the council a number of times very frustrated because all they do is arrest people. They said if they had enough resources, they could go into the schools, talk with the

young children, similar to what the DARE Program was before. That was very beneficial.

But the critical thing here is in terms of our children, at least 50 percent of the Arapaho Tribe is 21 years or younger. What we are attempting to do is build self esteem, trying to let them learn their identity as Arapaho children.

Senator THOMAS. Some of the health care programs would be supported by doing things outside of the health care expense.

Mr. BRANNAN. Yes.

Senator THOMAS. Okay.

Ms. Joseph, there have been concerns expressed about expanding the joint venture programs, how successful have these programs been, and how do they work under the existing program.

Ms. JOSEPH. Senator, what I understand from the tribes that have been involved in joint venture programs that they have been very successful. Unfortunately joint venture in the small ambulatory care program have not received appropriations consistently over the years. But the couple of years in the last few years, there has been money. It allows tribes to move forward and construct a facility. The Indian Health Service provides the staffing for that facility.

Senator THOMAS. DOJ has been concerned that the standards don't apply, that the tribal facilities are not subject to the standards. Is that a concern of yours?

Ms. JOSEPH. Not that I am aware of. When we construct facilities, and we are going to receive Indian Health Service funding for staffing, we have to meet State standards, or they have to meet some standard.

Senator THOMAS. Do you use lay persons or relatives to provide public health care?

Ms. JOSEPH. Not in our project.

Senator THOMAS. Okay. [Laughter.]

All right, very good.

Mr. Lazarus, you cited the *Morton* case, the unique obligation toward Indians. Can you explain what that means, unique obligation toward Indians, very briefly?

Mr. LAZARUS. Yes, Senator; I think the unique obligation toward Indians is something that has developed through the *Cogma* case called the course of dealings. You have the Indian Commerce Clause, which gives Congress the authority to deal with the Indian tribes and the course of dealings have created this duty of protection.

Senator THOMAS. What is the problem?

Mr. LAZARUS. Well, in many circumstances, the Indian nations have become dependent upon the United States for their health and welfare, and Congress has the authority to do something about that.

Senator THOMAS. I don't think that answers the question.

Mr. LAZARUS. I am sorry if I misunderstood you, Senator.

The CHAIRMAN. Is there a trust responsibility here?

Mr. LAZARUS. Of course. The duty of protection is——

Senator THOMAS. Without regard to tribal membership, though. Isn't that the issue?

Mr. LAZARUS. The question is whether it is limited to tribal members, and I think in my view, the best reading of *Morton* v. *Mancari* is that while that case involved a preference for tribal members, the general rule stated in Mancari is not limited to that. If you look at the Delaware Business Committee case that I referenced, that is a case in which Congress distributed claims money to both members and non-members, and so it is not limited just to members.

Senator THOMAS. Got you.

Mr. Gage, you mentioned your August, 2006 attrition survey, and 20 percent of your medical attrition rate among medical providers. What could be done, in your opinion, to encourage reducing that attrition rate?

Mr. GAGE. Could you say the question again?

Senator THOMAS. You indicated a current attrition rate of 20 percent in your medical and nursing professionals in Alaska.

Mr. GAGE. About 80 percent of our community health aides are Native Alaskans. We have some turnover in that, and I think one of the factors that might impact the attrition rate would be if we could pay better salaries, if we could staff the clinics with an additional person. In some cases, it is the constant drain of being on call, and the workload that burns people out.

So funding would be a key component in that.

Senator THOMAS. Okay. Thank you.

The CHAIRMAN. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Let me just followup with that, Mr. Gage, because I did want to ask about the funding aspect of it. We recognize that in these small communities in the villages, as remote as they are, yes, you may be working a regular work week, but if you are on call and you know everybody in town, even if you are not on call you are going to be working. It is very intense in that way.

Senator Stevens and I have been working to increase the IHS funding to help with the CHAP's program. What is the funding gap that we have right now, would you say?

Mr. GAGE. The program overall costs about $55 million, as best as I can understand it. Presently, the tribes are contributing a gap between what we get in IHS funding and Medicaid. There are State contributions to this program of about $17 million that they basically take from other sources and supplement this program just because they feel it is so important. That is money that is taken away from other services, but it is probably money that is well spent.

We are asking for an additional recurring funding to do things like maintain this manual. This re-edit in 2006 was largely done with volunteers and just kind of pieced together. We were very fortunate that a lot of people took such an interest in this that they made it part of their job, and the corporations released people from other activities to work on this.

We are not going to be able to do that again and expect that kind of support. So we need funding for that.

Senator MURKOWSKI. Let me ask you, you said you have been with SEARHC for 17 years. If we didn't have the Community Health Aide Program in the State, where would we be in terms of

our ability to provide for the health care need for Alaska Natives, in your opinion?

Mr. GAGE. Boy, Senator, I wouldn't even want to picture that. We just wouldn't have health care in a lot of communities. There might be somebody with some EMT training, or able to provide some basic first aid, but it would require everyone traveling, if they could afford it and if the weather permitted, or simply enduring consequences of disease. We have diabetes. We have chronic diseases. We have children. All of those things would be impacted. Our health care would go way down. I couldn't imagine it without the community health aides.

Senator MURKOWSKI. We don't want to go backward.

I asked the question of Dr. Grim about any liability issues that he was aware of as a consequence of the fact that you don't have some that are State licensed. Are you aware of any liability issues, at least within your experience down in SEARHC?

Mr. GAGE. No; I am not. I have worked in this capacity for about 17 years, and I am not aware of any that have come from our preparation.

Senator MURKOWSKI. Mr. Chairman, I just might want to add for the record, we had an opportunity last week up in the State to hold a field hearing for the HELP Committee on the shortage of medical providers in the State of Alaska, just overall, not necessarily within IHS. But our reality is we have the lowest population to physician ratio in the Nation. It is getting worse. We don't have providers, period. So if we didn't have this Community Health Aide Program in our villages, as Mr. Gage has mentioned, we just wouldn't have the ability to provide for health care.

So again, I thank you for the opportunity to have Mr. Gage here today, and I look forward to working with you on some innovative ideas that we can use across the Country.

Thank you.

The CHAIRMAN. Senator Murkowski, thank you very much.

I have been doing some listening sessions around the Country with Indian tribes and members of tribes, just to listen and talk. My impression is that methamphetamine, substance abuse, mental health services, so many areas are in desperate need of resources and restructuring in order to properly deliver health care services to those for whom we have a trust responsibility.

We have had people come who say, tribal chairs who say we understand in our tribe, do not get sick after June 1, because there is no contract health care money available. That is what happened to the woman that was hauled into a hospital having a heart attack, with a piece of paper taped to her thigh that says, "If you admit her, you are on your own because there is no contract health services available."

Because they didn't consider it life or limb, whoever it was that put her in the ambulance.

It is pretty unbelievable. I had a tribal Chairman testify that in their tribe they ran out of contract health care money in January. Think of that, in January, 3 months after the year begins. And that means that the only way you get help is if your life is at stake or you at stake of losing a limb. Otherwise, I am sorry.

We had people sit at this table who I talked earlier about a woman with a very serious torn ligament in her knee, is told, wrap it in cabbage leaves for four days. A rancher, an Indian rancher has a torn ligament in his shoulder, something that most Americans would go to a doctor for and get fixed, and 4 years, 4 years before he was finally referred to get help, because of the lack of contract health care funds. The only way he got help was a doctor finally said, "What can a one-armed rancher do?" And they finally put him on a priority list to get help for something most Americans would expect to get resolved in a few months. So we just have real challenges here.

Chairman Brannan, you know, your discussion today with the photographs is heartbreaking. It reminded me of one of the things that got me really passionately involved in this issue. It was a little girl I have spoken of previously named Tamara. She was put in a foster home by a social worker who was handling 150 cases. Well, it turns out the foster home for this 3-year old girl was not safe. A drunken party on a Saturday night, and little Tamara had her hair pulled out by its roots, her arm broken, her nose broken. She will live with those scars forever.

I met with her and her grandfather some months later. It was just heartbreaking to know what happened to this young girl, because one social worker had to handle 150 cases. She didn't go check out where she was going to put the 3-year old kid.

We have so many unbelievable problems that really need resources. It is not all about money. It is about restructuring, commitment to do the right thing. This is not about somebody asking us. This is about our trust responsibilities. We have trust responsibilities, and our requirement is to meet them.

I am determined in this committee, working with my colleagues, to pass a reauthorization of the Indian Health Care Improvement Act that updates, revitalizes this piece of legislation, and gives us a chance to do something different. We will build on the successes, Mr. Gage. I understand the testimony about what works, but I also understand the testimony about what is left and what is not being done.

So I think I will defer questions and just say, Chairman Brannan, I understand your passion. I really appreciate your getting here. I didn't realize that you left Denver and had to fly to Los Angeles to get to Washington, DC, but that happens with airlines, as you know.

Ms. Joseph, you have worked a long while on this. We appreciate it.

Mr. Lazarus, the committee would like to call on you and work with you. I don't understand why the Department of Justice seems to go out of its way to interpret problems here, but they seem to. I want to cooperate with the Department of Justice, and I want them to cooperate with us.

I do want to make a comment. At the end of the day in the last Congress, I said it was fine to go ahead and put the skeleton of the bill that was left, and I said that was fine. I put a statement in the record that explained the problems with it and why I felt it fell far short. But I don't like what happened at the end of the last ses-

sion because it didn't meet our needs and what we were trying to do.

Mr. Gage, you have traveled perhaps more miles than anyone to be here and to tell us the stories. Senator Murkowski continues to tell us that story. Unless you live in Alaska, you probably can't understand what problems distance causes for virtually the delivery of all services, but we appreciate your being here as well.

So thank you very much for testifying.

This committee is adjourned.

[Whereupon, at 11:29 a.m. the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF JOHN AGWUNOBI, ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairmen and members of the committee: My name is John Agwunobi and I am the assistant secretary for Health for the Department of Health and Human Services [HHS]. As the assistant secretary, I serve as the Secretary's primary adviser on matters involving the Nation's public health. I also oversee the U.S. Public Health Service and its Commissioned Corps for the Secretary.

This landmark legislation forms the backbone of the system through which Federal health programs serve American Indians/Alaska Natives and encourages participation of eligible American Indians/Alaska Natives in these and other programs.

The IHS has the responsibility for the delivery of health services to more than 1.8 million federally recognized American Indians/Alaska Natives through a system of IHS, tribal, and urban [FT/U] health programs governed by judicial decisions and statutes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indian/Alaska Natives to the highest level, in partnership with the population we serve. The agency goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our duty is to uphold the Federal Government's responsibility to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribes.

Two major statutes are at the core of the Federal Government's responsibility for meeting the health needs of American Indians/Alaska Natives: The Snyder Act of 1921, Public Law 67–85, and the Indian Health Care Improvement Act [IHCIA], Public Law 94–437, as amended. The Snyder Act authorized regular appropriations for "the relief of distress and conservation of health" of American Indians/Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the Federal Government programs that deliver health services to Indian people, but it also provides additional guidance in several areas. The IHC1A contains specific language addressing the recruitment and retention of health professionals serving Indian communities; the provision of health services; the construction, replacement, and repair of health care facilities; access to health services; and, the provision of health services for urban Indian people.

Since enactment of the IHCIA in 1976, Congress has substantially expanded the statutory authority for programs and activities in order to keep pace with changes in health care services and administration. Federal funding for the IHCIA has contributed billions of dollars to improve the health status of American Indians/Alaska Natives. And, much progress has been made particularly in the areas of infant and maternal mortality.

The Department under this Administration's leadership reactivated the Intra-departmental Council on Native American Affairs [ICNAA] to provide for a consistent

HHS policy when working with the more than 560 federally recognized tribes. This Council's vice chairperson is the IHS Director, giving him a highly visible role within the Department on Indian policy.

In January 2005 the Department completed work ushering through a revised HHS tribal consultation policy and involving tribal leaders in the process. This policy further emphasizes the unique government-to-government relationship between Indian tribes and the Federal Government and assists in improving services to the Indian community through better communications. Consultation may take place at many different levels. To ensure the active participation of tribes in the development of the Department's budget request, an HHS-wide budget consultation session is held annually. This meeting provides tribes with an opportunity to meet directly with leadership from all Department agencies and identify their priorities for upcoming program requests. For fiscal year 2008, tribes identified population growth and increases in the cost of providing health care as their top budget priorities and IHS's fiscal year 2008 budget request included an increase of $88 million for these items.

Through the Centers for Medicare & Medicaid Services [CMS], a Technical Tribal Advisory Group was established which provides tribes with a vehicle for communicating concerns and comments to CMS on Medicare, Medicaid and SCHIP policies impacting their members. And, the IHS has been vigilant about improving outcomes for Indian children and families with diabetes by increasing education and physical activity programs aimed at preventing and addressing the needs of those susceptible to, or struggling with, this potentially disabling disease. In addition, a tribal leaders diabetes committee continues to meet several times a year at the direction of the IHS Director to review information on the progress of the Special Diabetes Program for Indians activities and to provide general recommendations to IHS.

It is clear the Department has not been a passive observer of the health needs of eligible American Indians/Alaska Natives. Yet, we recognize that health disparities among this population do exist and are among some of the highest in the Nation for certain diseases [for example; alcoholism, cardiovascular disease, diabetes, and injuries], and that improvements in access to IHS and other Federal and private sector programs will result in improved health status for Indian people.

The IHCIA was enacted to provide primary and preventive services in recognition of the Federal Government's unique relationship with members of federally recognized tribes. Members of federally recognized tribes and their descendants are also eligible for other Federal health programs [such as Medicare, Medicaid, and SCHIP] on the same basis as other Americans, and many also receive health care through employer-sponsored or other health care coverage.

It is within the context of current law and programs that we turn our attention to reauthorization of the "Indian Health Care Improvement Act."

We are here today to discuss reauthorization of the IHCIA, and its impact on programs and services provided for in current law. In December 2006, the Department submitted to this committee comments on proposed legislation that the 109th Congress was considering. These comments are the basis for our testimony today, and any changes introduced by the bill under review in the 110th Congress will be considered once we have had an opportunity to review newly introduced legislation. Improving access to health care for all eligible American Indians and Alaska Natives is a priority for all those involved in the administration of the IHS program. We have worked closely with this committee in the past and we have made progress in moving toward a program supportive of existing authority while maintaining the Secretary's flexibility to effectively manage the HIS program. However, in the last bill, S. 1057, there continued to be provisions which could negatively impact our ability to provide needed access to services. Such provisions established program mandates and burdensome requirements that could, or would, divert resources from important services. To the extent that those provisions are included in the new legislation, we hope to work with you to continue to address these concerns.

The Department is supportive of reauthorization of the IHCIA and supports provisions that maintain or increase the Secretary's flexibility to work with tribes, and to increase the availability of health care. Committee leadership previously responded to some concerns raised about certain provisions and some of the changes went a long way toward improving the Secretary's ability to effectively manage the program within current budgetary resources.

I would like to note for you today our particular interest in provisions previously reported out of this committee.

We have a number of general objections to previous language, including, expanded requirements for negotiated rulemaking and consultation; new requirements using "shall" instead of "may"; use of the term "funding" in place of "grant"; expansion of authorities for Urban Indian Organizations; new permissive authorities; provi-

sions governing traditional health care practices; new reporting requirements; establishment of the Bipartisan Commission on Indian Health Care; and new provisions that contemplate the Secretary exercising authority through the service, tribes and tribal organizations which is not tied to agreements entered into under the Indian Self-Determination and Education Assistance Act [ISDEAA]. In addition, we noted concerns in previous language about modifying current law with respect to Medicaid and the State Children's Health Insurance Program [SCHIP] and, in some cases, we believe maintaining the current structure of Medicaid and the State Children's Health Insurance Program [SCHIP] preserves access, delivery, efficiency, and quality of services to American Indians.

We also have some more specific comments on proposals we have previously reviewed for comment.

In the area of behavioral health, proposed title VII provisions provided for the needs of Indian women and youth and expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. The Department supports this effort, but opposes language in sections 704, 706, 711 (b) and 712 that requires the establishment or expansion of specific additional services. The Department should be given the flexibility to provide for all Behavioral Health Programs in a manner that supports the local control and priorities of tribes, and to address their specific needs within IHS overall budgetary levels.

The last version of S. 1057 that we reviewed contained various new requirements for reporting to Congress, including requirements for specific information to be included within the President's Budget and a new annual report to Congress by the Centers for Medicare & Medicaid Services and the IHS on Indians served by Social Security Act health benefit programs. The IHS, CMS, and HHS will work with Congress to provide the most complete and relevant information on IHS programs, activities, and performance and other Indian health matters. However, we recommend striking language that requires additional specificity about what should be included in the President's budget request and new requirements for annual reports.

Sanitation facilities construction is conducted in 38 States with federally recognized tribes who take ownership of the facilities to operate and maintain them once completed. IHS and tribes operate 49 hospitals, 247 health centers, 5 school health centers, over 2000 units of staff housing, and 309 health stations, satellite clinics, and Alaska village clinics supporting the delivery of health care to Indian people.

One provision in last year's bill, section 301(d) (1), required Government Accountability Office [GAO] to complete a report, after consultation with tribes, on the needs for health care facilities construction, including renovation and expansion needs. However, efforts are currently underway to develop a complete description of need similar to what would have been required by the bill. The IHS plan is to base our future facilities construction priority system methodology application on a more complete listing of tribal and Federal facilities needs for delivery of health care services funded through the IHS. We will continue to explore with the tribes less resource intensive means for acquiring and updating the information that would be required in these reports.

We recommend the deletion of the reference to the Government Accountability Office undertaking the report because it would be redundant of and a setback for IHS's current efforts to develop an improved facilities construction methodology.

Retroactive funding of Joint Venture Construction Projects In last year's bill, section 311 (a)(1) would permit a tribe that has "begun or substantially completed" the process of acquisition of a facility to participate in the Joint Venture Program, regardless of government involvement or lack thereof in the facility acquisition. A Joint Venture Program agreement implies that all parties have participated in the development of a plan and have arrived at some kind of consensus regarding the actions to be taken. By permitting a tribe that has "begun or substantially completed" the process of acquisition or construction, the proposed provisions could force IHS to commit the government to support already completed actions that have not included the government in the review and approval process. We are concerned that this language could put the government in the position of accepting space that is inefficient or ineffective to operate. We, therefore, would oppose such a provision.

Another section 302(h) (4) would provide ambiguous definitions of the sanitation deficiencies used to identify and prioritize water and sewer projects in Indian country. As previously proposed "deficiency level III" could be interpreted to mean all methods of service delivery [including methods where water and sewer service is provided by hauling rather than through piping systems directly into the home] are adequate to meet the level III requirements and only the operating condition, such as frequent service interruptions, makes that facility deficient. This description assumes that water haul delivery systems and piped systems provide a similar level of service. We believe it is important to distinguish between the two.

In addition, the definition for deficiency level V and deficiency level IV, though phrased differently, have essentially the same meaning. Level IV should refer to an individual home or community lacking either water or wastewater facilities, whereas, level V should refer to an individual home or community lacking both water and wastewater facilities.

We recommend retaining current law to distinguish the various levels of deficiencies which determine the allocation of existing resources.

Yet another section 305(b) (1) would amend current law to set two minimum thresholds for the Small Ambulatory Program—one for number of patient visits and another for the number of eligible Indians. In order to be eligible for the Small Ambulatory Program under the previously proposed criteria, a facility must provide at least 150 patient visits annually in a service area with no fewer than 1,500 eligible Indians. Aside from the fact that these are both minimum thresholds and so somewhat contradictory, the proposed provisions would make implementation difficult. First, the IHS cannot validate patient visits unless the applicant participates in the Resource Patient Management System [RPMS]. Since some tribes do not participate in the RPMS, it is difficult to ensure a fair evaluation of all applicants. Second, the term "eligible Indians" refers to the census population figures, which cannot be verified, since they are based on the individual's statement regarding ethnicity.

In addition, we are concerned about the requirements for negotiated rulemaking and increased requirements for consultation in the bill because of the high cost and staff time associated with this approach. We are committed to our on-going consultation with tribes under current executive orders, as well as using the authority of chapter V of title 5, U.S.C. [commonly known as the Administrative Procedures Act] to promulgate regulations where necessary to carryout IHCIA.

The comments expressed today in this testimony do not represent a comprehensive list of our current concerns. And, we will be reviewing legislation introduced in this Congress for any provisions that might be addressed in the future.

I reiterate our commitment to working with you to reauthorize the Indian Health Care Improvement Act, and the strengthening of Indian health care programs. And we will continue to work with the committee, other committees of Congress, and representatives of Indian country to develop a bill that all stakeholders in these important programs can support. Again, I appreciate the opportunity to appear before you today to discuss reauthorization of the "Indian Health Care Improvement Act" and I will answer any questions that you may have at this time. Thank you.

PREPARED STATEMENT OF C. FREDERICK BECKNER III, DEPUTY ASSISTANT ATTORNEY GENERAL, CIVIL DIVISION DEPARTMENT OF JUSTICE

Mr. Chairman, members of the committee, my name is C. Frederick Beckner III. I am a deputy assistant attorney general for the Civil Division of the Department of Justice. Thank you very much for the opportunity to share the views of the Department of Justice on the reauthorization of the Indian Health Care Improvement Act. As of today, the Department of Justice has not had the opportunity to fully review the most current version of the proposed legislation, and we are not, therefore, in a position to provide specific comments on this legislation.

That said, the Department of Justice strongly supports the laudable objectives of improving health care for American Indians and Alaska Natives, and the Department looks forward to working with the committee to achieve these goals. The Department worked extensively with this committee and met with representatives of the American Indian community on a prior version of this legislation. We expect that this cooperative relationship will continue as the Department reviews the current legislation.

In commenting on the prior legislation, the Department identified targeted concerns that could be—and for the most part were—addressed with relatively modest changes to the legislation that did not detract from the overall goal of improving health care for American Indians and Alaska Natives. Indeed, in the Department's view, the changes benefited both the American Indian community specifically and taxpayers generally.

For example, in an earlier version of proposed legislation, the Department of Health and Human Services and Indian tribes could enter into self-determination contracts that cover tribal "traditional health care practices." Such practices are unique to American Indian tribes and cannot be evaluated by established standards of medical care recognized by the state. However, to the extent that these traditional health care practices were being provided by an Indian tribe under a self-determination contract, a party injured by such a practice could potentially sue the United States under the Federal Tort Claims Act [known as the "FTCA"] and expose

taxpayers to unwarranted liability. It is a basic tenet of the FTCA that the United States is liable in tort only "under circumstances where the United States, if a private person, would be liable to claimant in accordance with the law of the place where the act or omission occurred." Case law has defined "the law of the place" to mean State law, not Federal law, not tribal law.

The Department was thus concerned that the bill would require the Department to litigate tort claims with no meaningful way to defend the cases. In particular, the Department was concerned that it would not be able to defend such suits because the courts might conclude that tribal health practitioners were providing "medical" services that, by definition, do not comply with the standards of the relevant State's medical community. Consequently, we met with the American Indian community and worked extensively with the committee late last year to add language that would have clarified that the United States, and ultimately the taxpayers, would not be liable for malpractice claims under the FTCA arising out of the provision of traditional health care practices. This language would not have impacted tort suits against the United States for any other service provided under self-determination contracts.

The Department also expressed its concern regarding a provision that would have extended FTCA coverage to persons who are providing home-based or community-based services. Again, the Department stresses that it has no objection to the act's goal of increasing the availability of these services. However, these services are sometimes provided by relatives and, in many instances, there are no established standards for such layperson care or for the environment in which they are provided. Thus, the United States should not have to defend against, nor should the taxpayers be required to pay for, negligent or wrongful conduct by such individuals performing home-based or community-based services that are not subject to any standards of care. To address these concerns, the Department worked with committee staff on language that would have clarified that the home-based or community-based services that can be provided under self-determination contracts are those for which the Secretary of the Department of Health and Human Services had developed meaningful standards of care.

The Department expressed concerns in previous versions of the bill regarding the possibility of unlicensed individuals providing mental health treatment to Indians and Alaska Natives. In the previous version of the bill, the Department worked with the committee to add language that would have ensured the licensing requirement for providing mental health services, and we believe the change was in the interest of both the United States and the Indian community.

Finally, the Department noted its concern that the previously proposed legislation may raise a significant constitutional issue. We had previously attempted to work with the committee to address this concern, but unfortunately, resolution was not attained. Most of the programs authorized by current law or that would have been authorized by the previously proposed legislation tied the provision of benefits to membership in a federally recognized Indian tribe, and courts would therefore likely uphold them as constitutional. The Supreme Court has held that classifications based on membership in a federally recognized tribe are "political rather than racial," and therefore will be upheld as long as there is a rational basis for them. *Morton* v. *Mancari,* 417 U.S. 535, 555 [1974]. Congress may have limited authority in Indian affairs to provide benefits that extend beyond members of federally recognized tribes to individuals such as spouses and dependent children of tribal members [particularly in circumstances where such children are not yet eligible for tribal membership], who are recognized by the tribal entity as having a clear and close relationship with the tribal entity. To regulate beyond such confines, however, presents a risk that the statute may be subject to strict scrutiny. To the extent that programs benefiting "Urban Indians" under current law or in the prior version of the bill could be viewed as authorizing the award of grants and other government benefits on the basis of racial or ethnic criteria, rather than tribal affiliation, these programs would be subject to strict scrutiny under the requirement of equal protection of the laws, as set out in *Adarand Constructors, Inc.* v. *Pena,* 515 U.S. 200, 235 [1995] and other cases. For example, the statute and the previous reauthorization bill broadly define "Urban Indian" to include individuals who are not necessarily affiliated with a federally recognized Indian tribe, such as descendants in the first or second degree of a tribal member, members of state recognized tribes, and any individual who is "an Eskimo, Aleut, or other Alaskan Native." Under the Supreme Court's decisions, there is a substantial likelihood that legislation providing special benefits to individuals of Indian or Alaska Native descent based on something other than membership or equivalent affiliation with a federally recognized tribe would be regarded by the courts as a racial classification subject to strict constitutional scrutiny, rather than as a political classification subject to rational basis

review. This distinction is important, because if the legislation awards government benefits on grounds that trigger strict scrutiny, courts may uphold the legislation as constitutional only upon a showing that its use of race-based criteria to award the subject benefits is "narrowly tailored" to serve a "compelling" governmental interest.

In closing, the Department believes that any proposed legislation regarding Indian health care is important and significant, and we are grateful for the opportunity to share our views with the Committee. As we have in the past, we look forward to working with the Committee on this important piece of legislation.

PREPARED STATEMENT HON. TOM A. COBURN, M.D., U.S. SENATOR FROM OKLAHOMA

Chairman Dorgan, Vice Chairman Thomas, I thank you for conducting this hearing today.

There is no more important issue before this committee than that of health care for tribal citizens. Reauthorization of the Indian Health Care Improvement Act is long overdue, and it is incumbent upon this Congress to finish this critical work.

As many of you know, I opposed the most recent version of this legislation introduced in the 109th Congress. I did so reluctantly, but with a firm conviction that business as usual is no longer acceptable. As Members of Congress, as tribal leaders, and citizens of this country—everyone in this room today—we can longer tell tribal citizens that the current system of health care delivery in Indian country is tolerable. A system that turns away those most in need, and that rewards bureaucracies and punishes innovation, cannot be allowed to persist. I will oppose any plan that advances more of the same.

To those who say that a failure to reauthorize the Indian Health Care Improvement Act is a violation of our trust obligations, I agree. I would argue, however, that simply reauthorizing the same old system with minor modification is an ever greater violation of that commitment.

I have met with dozens of tribal leaders over the past 2 years, and not one has expressed enthusiasm for the current structure. Instead, I hear a constant and consistent theme of frustration, anger, and resolve that we must do better, that we must unlock the potential of tribes to design their own health care systems that recognize the unique needs of the community. I desire a system that maintains the flexibility of tribes to seek outside investment, and that rewards innovative health practices, instead of punishing those whose try to make the lives of their citizens better.

The myriad of problems facing health care in Indian country, are many of the same issues confronting health care delivery throughout rural America. They are compounded, however, by a system that refuses to recognize its own role in holding back health care delivery for tribal citizens.

In designing health care reform, we know that markets work when we allow them to: They lower the price of all goods and services and they attract much needed outside investment. Many tribes in my state are at the forefront of new and innovative health care delivery systems, and they are poised to become a model for delivery throughout the system. We must ensure, however, that their efforts aren't discouraged or stopped altogether by the current system. Furthermore, there is no good reason that forward thinking tribal governments should be prevented from developing market driven health care centers of excellence that will attract researchers, physicians and patients for cutting edge, life-saving treatments.

I also believe that individual patients tend to receive better, more effective care when they are empowered to make their own health care decisions. In future legislation, we must explore ways to accomplish this objective, and give tribal citizens a reason to invest in their own health. Long lines, bureaucratic headaches and rationed, substandard care completely disallow this sort of investment.

I am also hopeful the committee will consider a demonstration project that will allow tribal citizens to receive health care at any Medicare approved facility. While this will not provide the panacea we are all hoping for, in more developed regions, it will inject competition into a sector that desperately needs it.

While we may encounter differences on the specific steps, there can no be no doubt that we all agree on the urgent need to deliver higher quality health care in Indian country. To that end, I look forward to working with my colleagues in bringing about a system that upholds our commitments and best serves all tribal citizens.

Chairman Dorgan, Vice Chairman Thomas, thank you again for holding this important hearing.

PREPARED STATEMENT OF TERRY L. HUNTER, CHIEF EXECUTIVE OFFICER OKLAHOMA CITY INDIAN CLINIC

The Reauthorization of the Indian Health Care Improvement Act March 22, 2007
The reauthorization of the Indian Health Care Improvement Act [IHCIA] is vital to the health care of all American Indians. The law first enacted in 1976 and reauthorized in 1988, and 1992 must be reauthorized to meet today's health care standards enjoyed by most Americans. The original bill established 34 urban Indian clinics and with the passage of the Indian Self-Determination Education and Assistance Act tribes began to operate their own health care delivery systems. Due to the emergence of these two critical health care delivery systems the Indian Health Care Improvement Act must be reauthorized to address today's health care delivery issues. As one of the original 34 urban Indian clinics funded by the Indian Health care Improvement Act, the Oklahoma City Indian Clinic offers its testimony as an example of how the Clinic is not duplicating service, and how the Oklahoma City Indian Clinic patients could not be absorbed by the county, city or community clinics system.

Prior to the 1950's, most American Indians resided on reservations, in nearby rural towns, or in tribal jurisdictional areas. In the era of the 1950's and 1960's, the Federal Government passed legislation to terminate its legal obligations to Indian tribes, resulting in policies and programs to assimilate Indian people into the mainstream of American society. This philosophy produced the Bureau of Indian Affairs [BIA] Relocation/Employment Assistance Programs which enticed Indian families living on impoverished Indian Reservations to "relocate" to various urbanized areas across the country. BIA relocation offered job training and placement, and was presented as a way to escape rampant poverty on the reservation.

In 1976, the American Indian Policy Review Commission, established by the Congress estimated that as many as 160,000 American Indians and Alaska Natives were relocated to urban centers. While many Indian families did well in the cities, thousands found themselves without basic services, especially health care. As identified by the 2000 census, 66 percent of all American Indians identified reside off-reservation.

We believe that for a true understanding of the health care status of American Indians living in urban areas, it is essential to realize that the Synder Act of 1921, which mandated federally funded Indian health care programs, did not require tribal members to live on reservation lands in order to access health care services. Nor did it stipulate a responsibility to provide health care off-reservation. Thus, any American Indian that did not live on tribal land were compelled to return to their rural communities to access health care guaranteed to them by their status as members of federally recognized tribes. A return that often was made difficult due to economic deprivation-based barriers to transportation options.

In order to address the expanding problem of lack of access to basic health care, a number of urban communities established volunteer Indian centers and free health clinics. hi the late 1960's, urban Indian community leaders advocated at the local, State and Federal levels for culturally appropriate health programs that addressed the unique social, cultural and health needs of American Indians residing in urban settings. These community-based grassroots efforts resulted in programs that targeted health and outreach services to the Indian community. Programs that were developed at that time were in many cases staffed by volunteers, offering limited primary care and maintaining programs in storefront settings with comparatively minuscule budgets. These remained small local efforts, and until 1976 urban Indians continued to be largely neglected by the Federal health system.

In response to the efforts of the urban Indian community leaders in the 1960's, Congress appropriated funds in 1966, through IHS for a pilot urban Indian clinic in Rapid City. In 1973, Congress appropriated funds to study unmet urban Indian health needs in Minneapolis. The findings of this study documented cultural, economic, and access barriers to health care and led to congressional appropriations under the Snyder Act to support emerging Urban Indian clinics in several BIA relocation cities.

The 1976 Indian Health Care Improvement Act [IHCIA] provided authority for urban health programs through provisions under title V. This authorized IHS to provide funding to health programs serving urban Indian populations. The enactment of title V was a pivotal turning point for urban Indian health programs across the Nation. Title V targeted specific funding for the development of programs for American Indians who lived in urban areas. Since passage of this landmark legislation, amendments to title V have strengthened urban programs to expand medical services, HIV services, health promotion and disease prevention services, as well as mental health services, and alcohol and substance abuse services.

It is from this richly complex environment that the Oklahoma City Indian Clinic [OKCIC] was established in 1974 as an Indian-controlled, nonprofit corporation with the sole purpose of serving the health care needs of American Indians in central Oklahoma. In the beginning, like other programs mentioned above, the clinic's volunteer staff operated in cramped, antiquated facilities, and was dependent upon donated medical supplies and equipment. But after the 1976 Indian Health Care Improvement Act was enacted, the Clinic enjoyed recognition and support of the Federal Government and the resources that followed.

The Native American population of Oklahoma is second only to that of the most populated State, California. The 2000 Census indicated that 391,949 Oklahomans identified their race as Indian when given the opportunity to indicate either full or partial heritage. It is estimated that over 50,000 American Indians live in central Oklahoma. There are 39 federally recognized tribal governments in Oklahoma alone, with all tribal governments being located on tribal lands in rural areas, where they generally have access to health care services through IHS and tribally operated health care systems.

In 1995 the Oklahoma City Indian Clinic began serving patients from its new 27,000 square foot Corinne Y. Halfmoon Medical Facility, delivering a wide range of services, including medical, prenatal, dental, pharmacy, optometry, as well as family, behavioral health and substance abuse counseling and treatment. OKCIC provides x-ray, ultrasound, lab and mammography services. Clinic patients make use of diabetes and cardiovascular treatment and services, in addition to health and nutrition education and preventative care services. OKCIC serves over 16,000 patients from more than 225 federally recognized tribes, employs diverse staff of approximately 90 people, and adheres to IHS's Indian preference hiring policy.

The service population and overall utilization of services has increased dramatically over the past 15 years. Total outpatient visits for the Oklahoma City Indian Clinic has increased from less than 20,000 in 1992, to more than 60,000 visits in 2006. During this timeframe the Oklahoma City Indian Clinic achieved national accreditation with the Accreditation Association for Ambulatory Health Care [AAAHC].

The current Oklahoma City metropolitan health care system does not have the capacity to absorb the Oklahoma City Indian Clinic patient load without overwhelming the hospital emergency rooms. It is imperative that the urban Indian health programs authorized under title V be allowed to continue as a vital part of the Indian Health Service health care delivery system.

The mission of the Oklahoma City Indian Clinic is driven by our patient's needs and our ability to meet those needs. The Oklahoma City Indian Clinic plays a vital role in IHS health care delivery system. H.R. 4818, the Consolidated Appropriations Act, 2005, stipulates under the "Administrative Provisions, Indian Health Services" section that"

> Notwithstanding any other provision of law, the Tulsa and Oklahoma City Clinic demonstration projects shall be permanent programs under the direct care program of the Indian Health Service; shall be treated as service units and operating units in the allocation of resources and coordination of care; shall continue to meet the requirements applicable to an urban Indian organization under this title; and shall not be subject to the Indian Self-Determination and Education Assistance Act [25 U.S.C. 450 et seq.].

With the adoption of this language and after 30 years of providing health care to Indians residing in Oklahoma City, OKCIC will continue to provide quality health care to its eligible population. The Reauthorization is critical in meeting the health needs of all Indians. With 66 percent of the American Indians now residing in urban areas an increase in the Urban Title V of the IHCIA would assist in meeting the great disparity in urban health funding.

As the committee deliberates the reauthorization of the IHCIA, we ask Congress to maintain the existing language concerning the Oklahoma City Indian Clinic so that our patients will continue to receive high quality health care. The Oklahoma City Indian Clinic's provision of concern is with the deletion of section 124 (b), which exempts National Health Service Corps [NHSC] scholars qualifying for the U.S. Public Health Service Commissioned Corps to be exempt from the NHSC and IHS full time equivalent [FTE] limitations when serving at a Tribal or urban Indian program. The placement of Commissioned Corps officers at these sites without FTE limitations is a vital health professional recruitment tool, and thus the NSC recommends that Section 124(b) be reinserted.

In addition, the Oklahoma City Indian Clinic supports the testimony of Rachel Joseph, cochairperson of the National Steering Committee for the Reauthorization of

the Indian Health Care Improvement Act. Before a hearing of the Senate Committee on Indian Affairs presented March 8, 2007.

PREPARED STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII

Thank you, Mr. Chairman. I commend the committee for holding this hearing today.

Indian tribes purchased the first pre-paid health plan in this Nation when they ceded 550 million acres of tribal lands to the United States in exchange for the United States'commitment to provide health care in perpetuity.

This contract was largely accomplished through treaties between the United States and Sovereign Tribal Governments. However, it is important to note there are other sources of authority for the Government's responsibility to provide health care services to Indian Nations and their citizens.

In 1976 the Indian Health Care Improvement Act was enacted into law for the specific purpose of raising the health status of America's Native peoples. While the condition of Indian health care has improved, we can do better.

American Indians and Alaska Natives born today have a life expectancy that is 2.4 years less than others in the United States. They die from tuberculosis, alcoholism, motor vehicle accidents, diabetes, homicide, and suicide at higher rates than other Americans.

In each Congress we have introduced legislation to address these conditions by improving programs and services with the goal of assuring that all Native peoples have full and timely access to quality health care.

However, I am concerned about assertions that some of the programs and services under the Indian Health Care Improvement Act are based on race—assertions that are not accurate.

These programs and services are based upon the government to government relationship that Presidents Nixon, Bush, Carter, Reagan, Clinton and Bush have all consistently reaffirmed as the United States' Fundamental Federal-Indian Policy.

Furthermore, the U.S. Constitution recognizes tribal governments as sovereign governments. In Article 1, Section 8, Clause 3. The Congress is vested with the authority to conduct relations with the several States, Foreign Nations and Indian Tribes.

Therefore, this bill should not be viewed as race-based, but rather as legislation by which Congress is exercising its authority to address deficient health care conditions in Indian country.

I commend my colleagues, in particular Senator Dorgan, for holding this hearing on a bill that provides crucial health care programs and services to Indian country. I look forward to furthering this important initiative.

PREPARED STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Thank you Mr. Chairman, first, let me thank you for introducing this legislation and holding this hearing. I continually hear from my friends in Montana that Indians are struggling to access health care. I am saddened with every new story.

All of us on the committee have heard from our constituents that tell us about the perils of getting sick or injured if you're Indian in this country. For example, most Indians know, "Don't get sick after July" because the local clinic is out of money by then.

Or, how about the situation where budgets only allow service for life or limb-threatening injuries?

Mr. Chairman, this just doesn't make sense!

As parents, we preach to our children the importance of preventative medicine. We tell our children how important it is to pay attention to their bodies and address health issues as soon as they are aware of potential problems.

In other areas, we urge our citizens not to wait until they notice health problems. We encourage them to test their bodies for cancer and other threatening illnesses, even before they notice problems.

Why should it be so drastically different for my friends living on the Rocky Boy Reservation? Why are we telling Indians that their health is not as important as the health of everybody else in this country?

Mr. Chairman, our grandfathers and great grandfathers signed treaties with Indian people promising to provide, among other things, health care in perpetuity. We have an obligation to Indian people and we have an obligation to American taxpayers.

As you well know, an investment in health care is an investment in our future. By investing money in health care, and encouraging good health, we save money in the long-run. Waiting until a relatively routine injury becomes life or limb-threatening—is absurd!

If doctors can solve a minor problem before it becomes a major problem, we should provide them with resources to accomplish that goal. If my friend in Browning gets sick in August, he should see a doctor!

For those reasons, I will support passage of this bill. I look forward to working with you to make that happen. Thank you, Mr. Chairman.

Testimony of

The Honorable Richard Brannan

Chairman of the Northern Arapaho Tribe

For the Reauthorization of

The Indian Health Care Improvement Act

Before

The Senate Committee on Indian Affairs

March 8, 2007 – 9:30 AM

Room 485, Senate Russell Building

Good morning, Chairman Dorgan, Vice Chairman Thomas and members of the committee. My name is Richard Brannan. I am the Chairman of the Northern Arapaho Tribe of the Wind River Reservation in Ethete, Wyoming. I am serving my fourth term as Chairman of my Tribe. I am a member of the National Steering Committee for the reauthorization of the Indian Health Care Improvement Act, the Tribal Leaders Diabetes Committee and the Indian Health Service (IHS) Budget Formulation team representing the Montana and Wyoming Tribes. I worked for several years for the Wind River Service Unit, the IHS facility on my reservation, as the administrative officer. Health care has been a personal priority not only during my interim in the IHS but as a Tribal leader. I appreciate this opportunity to address the health issues of Tribes and would like to thank the committee for the opportunity to testify in support of a senate bill to reauthorize the Indian Health Care Improvement Act.

Today I would like to divert from the usual delivery of testimony. I have faith in my colleagues with their knowledge and experience that they will impart to the committee today the priority issues relating to and the importance of reauthorizing the Indian Health Care Improvement Act. Instead today, I would like to put a face to those priority issues, so that as we deliberate on reauthorization, that we keep the faces of American Indian/Alaska Native people in our minds and hearts.

As I begin this address, there are fundamental principles that need to be reaffirmed regarding Tribes and our sovereign status.

Principles of Tribal Sovereignty

The overarching principle of Tribal sovereignty is that Tribes are and have always been sovereign nations, Tribes pre-existed the federal Union and draw our right

from our original status as sovereigns before European arrival. The fundamental principles of Tribal sovereignty are:

• As a sovereign nation, Tribes, as evidenced through Treaty-making and Indian Commerce Clauses of the Constitution, engage in a government-to-government relationship with the United States, and

• The sovereign powers of Tribes include: (1) the power to determine our own form of government, (2) determine Tribal membership, (3) regulate domestic relations among our members, (4) prescribe rules of inheritance, (5) levy taxes on members and persons doing business with members or on Tribal lands, (6) control entry onto Tribal lands, (7) regulate the use and distribution of Tribal property, and (8) administer justice among members of the Tribe.

We are sovereign nations, with distinct treaty rights, which have been negotiated with the full faith and honor of the United States. The United States has a trust responsibility toward Tribes based on these treaty rights.

The Sand Creek Massacre

I want to take you back 143 years, to one of the most horrendous acts perpetrated upon the Arapaho people, the Sand Creek Massacre. To this day we do not really know the level of historical trauma sustained by our Tribe because of this event...but we do know that it is there and we continue to suffer because of it.

Colonel Chivington and his 800 troops marched in order to attack the campsite of Black Kettle. On the morning of November 29, 1864, the army attacked the village and massacred most of its inhabitants. Chivington proclaimed before the attack "*Kill and scalp all, big and little; nits make lice.*" Only 9 or 10 soldiers were killed and three dozen wounded. Between 150 and 184 Arapahos and Cheyennes were reported dead, and some were reportedly mutilated, and most were women, children, and elderly men. Chivington and his men later displayed scalps and other body parts, including unborn babies and the private parts of women.

The Joint Committee on the Conduct of the War declared:

"*As to Colonel Chivington, your committee can hardly find fitting terms to describe his conduct. Wearing the uniform of the United States, which should be the emblem of justice and humanity; holding the important position of commander of a military district, and therefore having the honor of the government to that extent in his keeping, he deliberately planned and executed a foul and dastardly massacre which would have disgraced the verist [sic] savage among those who were the victims of his cruelty. Having full knowledge of their friendly character, having himself been instrumental to some extent in placing them in their position of fancied security, he took advantage of their in-apprehension and defenceless [sic]*

condition to gratify the worst passions that ever cursed the heart of man.

"Whatever influence this may have had upon Colonel Chivington, the truth is that he surprised and murdered, in cold blood, the unsuspecting men, women, and children on Sand Creek, who had every reason to believe they were under the protection of the United States authorities, and then returned to Denver and boasted of the brave deed he and the men under his command had performed.

"In conclusion, your committee are of the opinion that for the purpose of vindicating the cause of justice and upholding the honor of the nation, prompt and energetic measures should be at once taken to remove from office those who have thus disgraced the government by whom they are employed, and to punish, as their crimes deserve, those who have been guilty of these brutal and cowardly acts."

I am Arapaho and when I speak about the Sand Creek massacre, I am amazed that we as Arapaho people have persevered. During the Sand Creek Massacre Arapaho women and children were brutally murdered. The soldiers especially targeted children that day with the idea to "exterminate" them would destroy the entire Tribe. The Sand Creek Massacre occurred in 1864 and today in 2007, we as Tribal people continue to fend off the attack on our children. This time the attacker is not as visible as Colonel Chivingtons troops but more deadly. In 2007 we are defending our children from succumbing to the effects of a decreasing Indian Healthcare budget, devastating health disparities, and dangerous emerging diseases i.e. the impacts of methamphetamine abuse.

American Indian/Alaska Native Health Disparities

Nationwide, the disparity in health status and access to healthcare for AI/AN is staggering. Tribal Leadership and the Indian Health Service continues to educate Congress, the administration and all of America, on the devastating disparities suffered by AI/AN in health status, mortality rates and access to healthcare. Diseases that continue to challenge the health of AI/AN are diabetes, alcohol & substance abuse, heart disease and cancer.

Cancer - Dylan Whiteplume

This is Dylan Whiteplume. Dylan is Arapaho. He was diagnosed in late 2004 and died in early 2005 of neuroblastoma. He had just turned 5 years old. He was a brave little boy and often amazed his grandmother in his unwavering certainty that he would get better. In fact, he often comforted his family. Dylan needed extensive treatment that the Wind River Service Unit could not provide him. By the time resources were made available through private sector partnerships and charitable giving, Dylan was in advanced stages of the disease. He entered a children's cancer

treatment facility where one of his friends was a little girl that was diagnosed with the same disease about the same time as Dylan. She was able to access treatment earlier than Dylan and was healthy at the time of our reporting.

In 2005, the Wind River Service Unit was unable to provide chemotherapy as part of the treatment plan for cancer patients. There simply was not enough money. There were 6 cancer patients in FY 2005. Two of those patients did not make it through the year – Dylan Whiteplume was one of them.

Cancer is devastating to Tribal communities. The cancer patient is not the only one that suffers. The family, friends and community suffers as well and continues to long after the cancer patient who could not be cured is gone. Cancer treatment can drain the limited income of most AI/AN families, to further strain the energy needed to address their family member's illness. Treatment resources are limited, and prevention is a challenge in a decreasing Indian Healthcare budget.

Emerging Diseases: Methamphetamine Abuse – Marcella Hope Yellow Bear

This is Marcella Hope Yellow Bear; she was 22 months old when her parents were charged with her death. When Marcella was brought to the emergency room unresponsive, the medical staff examined her and saw evidence of several broken bones that had mended without attention, new and old cuts and bruises all over her body, burns on the soles of her feet. She died of suffocation. She had been found hanging in a closet by the suspenders of her clothing. It was obvious to the medical staff that examined Marcella that she had been sustaining a brutal level of physical abuse for some time in her short life. Marcella's parents were long time meth abusers.

The Indian Healthcare budget is strained and funding to address emerging diseases is limited to non-existent. Meth is the scourge of my reservation. Marcella's death is one that my community will never forget. We all share a responsibility in her death. Knowing that, I share her story with you today, so that we are more vigilant in addressing the impacts of meth abuse, and we are more aggressive in demanding funding to address mental health issues, alcohol & substance abuse issues and emerging diseases in the Indian healthcare budget. We need to be more persistent in securing the legislation that will ensure our health, our children's health…children like Marcella are counting on us.

The reauthorization of the Indian Healthcare Improvement Act will ensure that AI/ANs will have the healthcare that is needed in order to ensure that our children have a future. I thank you for this opportunity to present testimony.

UNITED STATES SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON THE INDIAN HEALTH CARE IMPROVEMENT ACT

March 8, 2007

Written Testimony
Dr. Sven-Erik Bursell, Joslin Diabetes Center

Introduction
Mr. Chairman and Members of the Committee, we would like to thank you for the opportunity to submit written testimony on behalf of Joslin Diabetes Center and the Joslin Vision Network TeleHealth Program in the Indian Health Service.

Diabetes is at least 2 to 5 times more prevalent among American Indians and Alaska Natives (AI/AN) as compared to the general US population. Diabetic retinopathy (DR) occurs in almost all individuals with diabetes and is the most common cause of new blindness among adults. Blindness from diabetic retinopathy can be prevented with timely diagnosis and treatment, but historically, only 50% of AI/AN's obtain the recommended annual retinal evaluation needed for this. This is costly both in terms of human suffering as well as medical economics. It is much more costly to care for the blinding complication of this disease rather than properly assess for and treat DR.

The Interior Subcommittee recommended that the Indian Health Service develop in FY 2000 a $1,000,000 cooperative relationship with the Joslin Diabetes Center / Joslin Vision Network (JVN) to address diabetes issues within the Indian Health Service and among the Native American patient population by integrating the JVN and Joslin Diabetes Eye Health Care Model into the care of the Native American population. This IHS/JVN teleophthalmology program has completed its 6th clinical year in FY06. This year was characterized by continued rapid expansion of the clinical program and accomplishment of key development milestones.

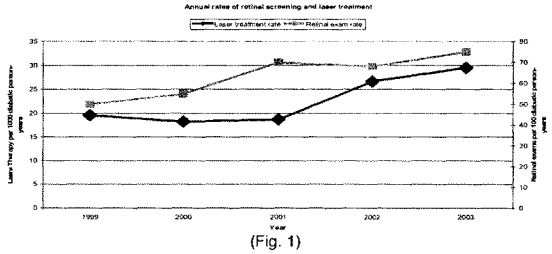
The Joslin Diabetes Center JVN TeleHealth program is a telemedicine initiative designed to facilitate appropriate clinical diabetes management and promote better blood glucose control to reduce the risks of complications such as blindness amongst people with diabetes. The program will and to access all diabetic patients into cost-effective, quality diabetes care and eye care programs regardless of geographic or cultural boundaries.

Joslin has developed the JVN TeleHealth Program through a Cooperative agreement with the Department of Defense and in collaboration with the Department of Veterans Affairs and the Indian Health Service. This telemedicine application was developed specifically to provide the flexibility to integrate with all Federal Agency Electronic Health Record Systems.

Summary of Progress
Nineteen new IHS/JVN sites were deployed in FY06. By the end of the year 50 deployments were completed in 15 states. These deployments have provided an increased opportunity for compliance with the standard of care for surveillance of diabetic retinopathy. By the end of the year, the program completed more than 15,000 studies since its inception. This has been done with a consistent decrease in the incremental costs of deployment and support each year since inception

This clinical activity with the IHS/JVN has had a measurable impact on the visual public health of these patients. A focused evaluation of the four year experience of one of these deployments

showed a 50% increase in compliance in the DR surveillance standard of care, with an associated 51% increase in retinal lasers treatments done on the same population. (Fig. 1) Each of those additional laser treatments performed as a result of the IHS/JVN surveillance represent a patient saved from blindness due to DR.



(Fig. 1)

In addition to the clinical success the program sustained in FY06, there were also some notable technical developments. A proof of concept portable JVN system was developed and tested in Selawik, AK in February 06. This site north of the arctic circle in mid winter provided particularly harsh testing conditions that included ---20° F temperatures, equipment transport by small aircraft and dog sled, and data connectivity via satellite. Despite the rigors of these conditions, the test was highly successful. Based upon this testing we have continued with the development of the portable system and are currently awaiting software interface development to enable the deployment of this new technology in smaller and more remotely located communities. The same interface will also enable new web based architecture for bidirectional data transport between the IHS/JVN as well as improved secure transmission of images and reports.

Ongoing evaluations and validation studies have broadened the evidence basis for the JVN. The JVN system is currently validated through reports in the peer reviewed literature as being equivalent or superior to the clinical gold standards of dilated eye photography and dilated eye examinations performed by retinal specialists for the purpose of diagnosing the level of diabetic retinopathy and presence or absence of clinically significant diabetic macular edema a major cause for moderate vision loss in patients with diabetes. Additionally, since individuals with diabetes are at increased risk for eye diseases other than diabetic retinopathy, a validation study was performed to determine the ability of this telemedicine modality to detect non-diabetes related retinal disease. This study showed excellent agreement with dilated ophthalmic examination by retinal specialists in the detection of ocular disease other than diabetic retinopathy.

In another four year study conducted at an IHS facility results demonstrated a 50% increase in DR surveillance and a 51% increase in DR laser treatments as compared to the pre-deployment baseline year. Further review of the data showed that 100% of the increase in both measures were due to the JVN imaging activity.

Finally, a study was performed to evaluate the business model for the IHS/JVN Program that takes into account local cost effectiveness considerations using IHS specific epidemiology and costs of operations in the analysis. This study showed the IHS/JVN to be less costly and more effective than a live eye examination for detecting diabetic retinopathy and preventing vision loss.

The following goals have been set for the program in FY07

- Deployment of ~20 IHS/JVN Teleophthalmology sites
- Completion and deployment of the portable JVN

- Technical upgrade of the National Reading Center reading workstations
- Development of a vehicle mounted JVN system for mobile operations using improved roads.
- Deployment of the Web based JVN Server with bidirectional communication with the IHS hospital information system and electronic health record

The portable JVN platforms and bidirectional data flow between JVN and the IHS electronic health record data base are pivotal developments from the perspective of patient safety, efficient and cost effective workflow, and compliance with the Presidents Executive Order for movement to an electronic health record.

We will also develop a Continuing Medical Education (CME) program to augment the JVN protocol to meet three critical goals. *First*, CME will maintain high performance standards among the approximately 50 Imaging Specialists who conduct teleretinal imaging. *Second*, CME will ensure maximum retention of trained Imaging Specialists by sustaining meaningful contact between them and the IHS. *Third*, CME will maintain high performance standards among the three Reading Specialists who evaluate the images for level of retinopathy at the Phoenix Indian Medical Center. The data arising from this effort will also provide an evidence basis for Imager and Reader Specialist recertification and re-privileging. It will also ensure ongoing clinical fidelity with the original validation studies across time and geography.

In addition to the JVN Eye care programs described above we will also implement the web-based comprehensive diabetes management program of which the JVN eye care system is a module. This interactive care platform also includes a patient portal to facilitate a more continuous communication between patient and care team and provides the basis for a Personal Health Record that will allow a patient to interact with their own medical record information as well as to automatically download data from different home monitoring devices such as a blood glucose meter, blood pressure and weight scales. Recent data from a study using this system to manage high risk Hispanic diabetic patients has shown that these patients significantly improve their blood glucose levels and experience less stress with their diabetes over a period of 6 months compared to patients receiving standard care.

Summary

In FY06 the IHS/JVN Teleophthalmology Program produced the largest annual increase in deployments and clinical studies since inception in FY2000. The program continues to increase compliance with the standards of care for diabetic retinopathy at deployed sites in Indian county, resulting in decreased vision loss due to diabetes at these locations. Development has produced new opportunities for this technology in the less populated and more remote locations. Planned development will improve data integration in the IHS electronic medical record, further enhancing safe and effective patient care.

Mr. Chairman, we are pleased to be a part of this Diabetes project with the Indian Health Service and we are grateful for the support from the Indian Health Service and look forward to continuing implementation of this very successful program for Native Americans and Alaskan Indians.

Community Health Aide Program

Overview 2007

Alaska Association of Community Health Aide Program Directors

Steve Gage, PA-C
CHAP Director, SouthEast Alaska Tribal Health Consortium
Chair, Alaska Association of CHAP Directors

March 7, 2007

Community Health Aide Program 2007 Overview
Executive Summary

Community Health Aide Program (CHAP) services are a sustainable, effective, and culturally acceptable method for delivering health care. This unique program has demonstrated adaptability to advances in medicine and the evolving health needs of the population, and it does so at comparatively low cost. The total combined program expenses of $55M provide 270,000 emergency and primary health visits annually to approximately 50,000 Alaska Natives at a cost of approximately $1,100 annually per patient ($55M/50,000).

Today over 550 Community Health Aides/Community Health Practitioners (CHA/Ps) are employed by 27 tribal health organizations in 178 rural communities. CHA/Ps are the patients' first contact within the network of health professionals in the Alaska Tribal Health System.

The Community Health Aide Program was developed to meet the health care needs of Alaska Natives in remote villages. It is the only health care delivery system of its kind in the United States. The program emerged, in part, as a result of the tuberculosis epidemic and the use of village workers to distribute antibiotics in the 1950s. It became a formal, federally funded program in 1968 under the authority of the Act of November 2, 1921 (25 U.S.C. § 13, popularly known as the Snyder Act) pursuant to 25 U.S.C. § 1616*l* (Section 121 of Public law 94-437, the Indian Health Care Improvement Act, as amended) and directives and circulars of the United States Department of Health and Human Services, Public Health Service, Indian Health Service, and the Alaska Area Native Health Service (1).

CHA/Ps complete training and education requirements as outlined in the *Community Health Aide Program Certification Board Standards and Procedures.* They work within the guidelines of the *Alaska Community Health Aide/Practitioner Manual, 2006 Revised Edition,* which outlines assessment and treatment protocols. There is an established four tiered referral relationship, which includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians, and dentists make visits to villages to see clients in collaboration with the CHA/Ps.

The success of the Community Health Aide Program model has been used as a template to develop a dental care component; which now has 33 certified providers addressing dental needs specifically. A behavioral health component is in progress to address unmet needs in mental health and substance abuse.

CHAP has proven to be a cost effective, efficient and essential component in improving the health of the Alaska Native people by decreasing morbidity and mortality. Improvement in infant mortality and immunization rates are a direct result of the work of the Community Health Aides and their long term relationships with their communities. The Community Health Aide Program is a model for the delivery of primary health care services which could be used throughout the rural United States.

Introduction

The concept of "Village Health Services" with parallel programs for both dental and behavioral health workers using the model and infrastructure of the CHA Program addresses these needs and builds on the CHA Program as the foundation of village health care. The dental component of this process is well established with dental health aide training, education, and competencies incorporated into the *Community Health Aide Program Certification Board Standards and Procedures*. Efforts are underway to include behavioral health services (mental health and substance abuse) which focus on prevention, early intervention, and case management to help reduce outpatient, emergency, and inpatient medical workload and cost. This process facilitates an integrated approach to health care services in Alaska villages.

Alaska

Alaska has a total landmass of 586,585 square miles and constitutes one-fifth of the area of the United States (see Figure 1). Within this vast area, approximately 50,000 Alaska Natives live in over 178 villages located as far as 1300 miles from the nearest regional center (2). Ninety percent of the villages in rural Alaska are isolated from each other, separated by tremendous distances, vast mountain ranges, stretches of tundra, glaciers, and impassable river systems. Most of the communities are not connected to a road system. Air transportation is the primary means of travel on a statewide basis. Provision of goods and services and the delivery of health care to these remote sites is always a challenge.

Village of Stebbins in Norton Sound
6 CHA/Ps Serve a Population of 547

Same Scale Comparison - Alaska Area to Lower 48 States

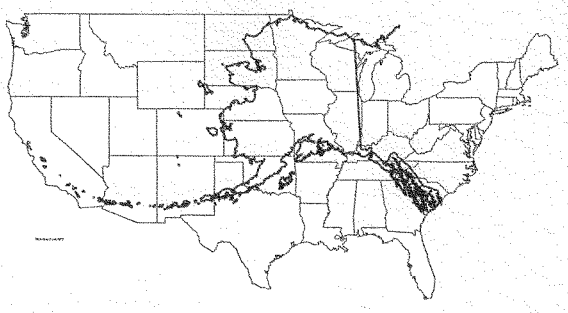


Figure 1

Population and Health Status – Alaska Natives

The Alaska Native population has increased by 20% since 1990. Alaska Natives now represent 19% of the state's population. The Alaska Native population is youthful compared to the U.S. All Races population. The youth (age birth to 14 years) comprise 34% of the Native population compared to 21% for the entire U.S. population. The percentage of infants (birth to 1 year) is twice that of the general population. Fifty one percent are less than 25 years old. While only 5% are older than 65 years (U.S. All Races is 13% 65 or older), this group is growing rapidly. The median age for Alaska Natives is 23.6 years compared to 35.3 years for the U.S. All Races (3).

The Alaska Native age-adjusted unintentional injury mortality rates are 3.3 times the rate for U.S. All Races. Cancer is now the leading cause of death in Alaska Natives followed by heart disease, unintentional injuries, stroke, and suicide (3).

The health status of rural Alaska Natives is also related to low socio-economic status, subsistence lifestyle, rapid social change, the harsh climate and terrain, and the isolation of the communities in which they live. Twenty-four percent (24.3%) of Alaska Natives live below the poverty level compared to 12.4% for U.S. All Races (4). Until recently, emphasis of care was on infectious disease and accidents.

Prenatal, Newborn, and Well-Child Care

Community Health Aide Program History

In the 1940s and 1950s, the tuberculosis epidemic necessitated sending many people away from their homes and communities for care in sanitariums. With the advent of effective antibiotic therapy, the possibility of home treatment was realized. In coordination with the Territorial Department of Health (now State of Alaska, Department of Health and Social Services) and later the United States Public Health Service, local villagers volunteered to assist in medical management of patients by administering medication and observing its consumption. As these volunteers (known then as "chemotherapy aides") worked alongside the doctors and nurses they learned additional skills. Health care workers and volunteers both realized the benefits of providing direct services in the village. A natural progression of training and supervision developed and the Community Health Aide Program evolved. With Congressional funding in 1968, CHAs were paid a salary and formal training programs were established (5).

"When I first started I told my husband, 'This is only temporary until you get a job.' But I got used to it and I learned a lot. I liked the thought of being there for the people, helping them. After I went to training I didn't want to quit. I learned so much and wanted to use it to help out."

A Community Health Practitioner

Community Health Aide Program Today

Disease patterns, and concurrently CHA/P duties, have changed over the last 50 years. When the program began, infectious diseases were the major emphasis with tuberculosis and meningitis causing great morbidity and mortality in the villages. Since then, infectious diseases are not as prominent but lifestyle diseases have become a dominant concern. Diabetes, heart disease and cancer were nearly unknown in the population during the 1950s but are common today. Behavioral health diagnoses are common. AIDS is also a concern for both patients and health care providers.

Today there are approximately 550 CHA/Ps employed by 27 tribal health organizations working in 178 clinics. These providers have approximately 270,000 patient encounters per year (6). In addition to staffing and managing their individual clinics during regular office hours 5 days a week, CHA/Ps respond to medical emergencies 24 hours a day, seven days a week, 365 days a year.

Training Center Capacity

The role of the CHA/P has evolved and expanded, as has the training of these health care workers. The curriculum is standardized and is always in a dynamic state of change to accommodate advances in medical practice, medication regimes, and technology.

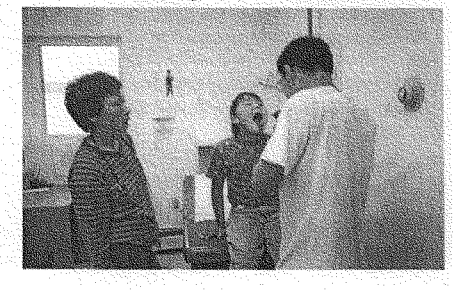
Students are taught a comprehensive approach to each patient including how to obtain a history, how to perform a physical examination, how to make an assessment and how to develop a treatment plan. The short intensive nature of CHA medical training requires a faculty to student ratio of 1 to 1 or 1 to 2 depending on the competency of the students' clinical skills.

There are currently four Community Health Aide Training Centers. Each is managed by a tribal health organization with a combined operating budget of $ 4.5 million per year (7). Faculty attrition and hiring cycles create a backlog for training. There is a total system capacity of approximately 240 training slots per year which does not include training related to dental and behavioral health initiatives. Training for a new-hire Community Health Aide through to Community Health Practitioner takes approximately 2 years. After successful completion of a training session, the individual may work and be certified at that level.

Since we know that CHA/Ps are typically the first responders in a village emergency, they are required to pass an Emergency Trauma Technician or Emergency Medical Technician course. Emergency care skills are reviewed and additional skills are taught in each of the four training sessions.

Great strides in technology and connectivity over the past few years have made it possible to offer a Session I training presented by Distance Delivery which began in February 2007 for eight students in remote villages.

CHA Assessing Patient with a CHP Mentor



CHA/P Workload

Many of Alaska's rural villages are small, employing only two or three CHA/Ps. A multiuse concept is logical with respect to utilization of resources. The typical village clinic performs multiple functions such as:

- primary care health clinic
- public health clinic
- dental office
- pharmacy
- laboratory
- counseling center
- patient travel center

CHA/Ps must be supported by their village tribal councils, community and family members in order to be an effective health care provider. Frustration due to lack of support, unreasonable demands such as non-urgent after-hours call-outs and criticism may contribute to stress, burnout, and resignation.

Field Supervision

Supervision is an essential component of this program. Supervisors help assure the quality of health care provided at the village level, monitor job performance, and support and guide the worker. This is critical due to the nature of the CHA Program. Frequent contact and face to face visits are strong factors in the success of a Community Health Aide.

> *"Since I started working, which is 9/17/90, we have had these emergencies: fatal knife stab to the heart, several heart failures, strokes, deliveries, broken bones, drownings, accidents: snowmachine, all terrain vehicle, boating, sports, and work related; infants choking, chronic patient emergencies, sudden infant death syndrome, allergic reactions: to bugs, food, home products; child abuse, domestic violence, alcohol related accidents, severe frostbite, gunshot wounds, suicides and least of all dealing with a sniper shooting at anybody just recently. Our closest hospital is 95 air miles away..."*
>
> *A Community Health Practitioner*

Quality Assurance

Since this program is unique in the United States, educators and supervisors must create or modify all of the essential documents used to guide the health care practice of the CHA/Ps. The instructors, supervisors, and clinical medical staff and who work directly with the CHA/Ps, appropriately do this work.

The *Community Health Aide Program Certification Board Standards and Procedures* and the *Alaska Community Health Aide/Practitioner Manual* provide training and standard of care

guidelines. The CHAM is indexed by symptoms and provides the CHA/P with a "how to" guide to collect a patient's history, perform appropriate examination and lab tests, formulate an assessment and develop a treatment plan.

Attrition and Burnout

As it happens with other medical and nursing disciplines, Alaska is losing some of its most experienced CHA/Ps from the "graying" of the profession. At times the losses are coming from younger and less experienced CHA/Ps who become frustrated by the immense responsibility and the lack of sufficient clinic staff and supervisory and technical support.

CHA/P attrition rates have been documented at several points since 1987 with a range between 33% in 1987 to 12% in 1993. An August 2006 Attrition Survey of CHAP Directors indicates the current attrition rate of 20.2 % (8).

Village Built Clinic Lease Program

Sand Point, Alaska
Integrated Health Service Facility

In 1969 the Indian Health Service (IHS) obtained authorization and funding to initiate a Village Built Clinic (VBC) leasing program to meet the need for health facilities in isolated Alaska villages. The VBC leasing program is available only to village clinics in which a Community Health Aide is responsible for providing primary health care. Lease monies support operation and maintenance expenses of the facility such as janitorial, electricity, water, sewage disposal, fuel, loan amortization, insurance and repairs (9).

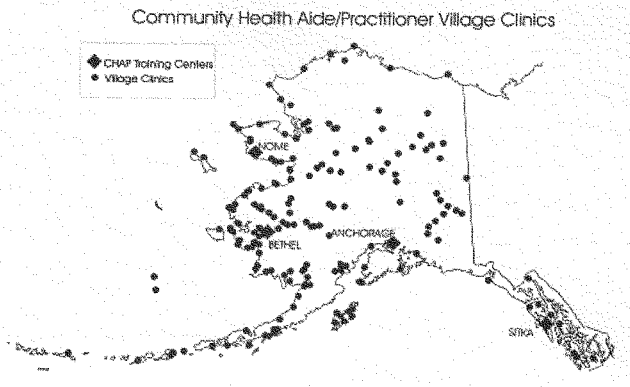


Figure 2

Funding Issues

The CHA Program has achieved success despite the lack of sufficient dedicated funding streams. The annual estimated funding of $55 million is pieced together from a variety of tribal, federal, private and state funding sources and is not sufficient to meet program needs over time.

The CHA Program has been historically funded through Indian Health Service funds. The IHS annual funding level of $33.3 million is not keeping up with basic medical inflation, nor with the high cost of providing care in rural and remote locations.

Modest enhancements have been made possible through Medicaid reimbursements that total approximately $2.7 million annually (10). Various state grants contribute another $ 2 million to the program.

Thus, the Alaska Tribal Health Programs have been forced to supplement the CHA Program with approximately $17 million annually. These funds typically come from reprogrammed health resources, effectively taking other dedicated health resources to ensure basic coverage for patients in rural Alaska.

Unfortunately, as these health care resources get more limited, it is unclear how much more the Alaska Tribal Health System can continue to absorb, while maintaining our commitment to provide quality, safe care for our patients. Additional resources are necessary to address inflation, pay cost increases and provide for increased patient needs.

Conclusion

For almost forty years, local Native CHA/Ps have been delivering primary health care to the people in their remote villages. CHA/P services are a sustainable, effective, and culturally acceptable method for delivering health care. This unique program has demonstrated adaptability to advances in medicine and the evolving health needs of the population, and it does so at comparatively low cost. The total program operating budget is approximately $55M and provides emergency and primary health care to approximately 50,000 Alaska Natives at a cost of approximately $1,100 annually per patient ($55M/50,000). Stated another way, the cost is approximately $200 per visit ($55M/270,000 patient visits).

A more detailed description of the Community Health Aide Program funding need can be found in the document, "Community Health Aide Program Update 2001: Alaska's Rural Health Care at Risk" (11).

For further information please contact:

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List of References

1) Alaska Area Native Health Service. Community Health Aide Program Certification Board Standards and Procedures, as amended October 3, 2006.

2) Alaska Area Native Health Service, Alaska Native Tribal Health Consortium. Alaska Native Population 1999 Estimates, February 1999.

3) Alaska Native Tribal Health Consortium, Division of Information Technology. ALASKA NATIVES: Key Facts, August 2002.

4) U.S. Census Bureau. Number in Poverty and Poverty Rates by Race and Hispanic Origin Using 2- and 3-Year Averages: 2002-2004, 2004.

5) Nice, Philip. The Alaska Health Aide Program, 1998.

6) Alaska Native Tribal Health Consortium. Alaska CHAP Workload, FY 2004, December 2005.

7) Mather and Associates. CHAP Basic Training Review, January 2005.

8) Association of Alaska Community Health Aide Program Directors. CHAP Salary Survey, September 2006.

9) Alaska Area Native Health Service. Indian Health Service Village Built Clinic Lease Program. Report from Paula M. Poncho, Area Realty Officer, May 4, 2001.

10) State of Alaska, Medicaid Program. Tribal Medicaid Activity Report-CHA/P Claims Comparison, FFY 2006 and FFY 2005, February 2007.

11) CHAP Directors' Association for the Alaska Native Health Board and Association of Tribal Health Directors. Community Health Aide Program Update 2001: Alaska's Rural Health Care at Risk, May 8, 2001.

SENATE COMMITTEE ON INDIAN AFFAIRS

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

STATEMENT BY
FORREST J. GERARD (RETIRED)

March 12, 2007

Chairman Dorgan and Members of the Committee,

I appreciate the opportunity to submit a statement for the record in support of enactment of legislation to reauthorize the Indian Health Care Improvement Act. The authorization for the Act expired in 2000, and congressional efforts to reauthorize near the end of the second session, 109th Congress failed due to questionable tactics by the Department of Justice that effectively killed the legislation.

For introductory purposes, I worked virtually my entire professional career, encompassing 35 years in Washington, DC, serving in various capacities on behalf of Indian people. During this span of time, I gained experience in governmental operations and public administration at various levels in federal agencies; served as a Federal Fellow in the congress under auspices of the American Political Science Association; served on staff of then Senate Committee on Interior and Insular Affairs that held legislative and oversight functions for Indians; nominated by President Carter and confirmed by the Senate to serve as first Assistant Secretary of Indian Affairs; and served as owner-operator of a private corporation that represented tribal clientele on legislative and executive branch issues.

With this background, I gained valuable insight on policy formulation in our tripartite system of government and the manner in which policy decisions are reached at the highest levels of government, including the role of the Executive and Legislative Branches. Although not professionally trained in the law, I further understand the role of the Judiciary Branch in handing down decisions that often have a profound influence on major Indian issues. In short, I literally became a student of government operations and public policy, not in an academic sense, but in a practical sense by participating in these processes and by their hands-on application in government.

Therefore, I feel quite comfortable in my strong recommendation that the Committee favorably report this vital Indian health measure to the Senate for consideration and passage. The Committee has developed a unambiguous record over the years on the adverse health status of Indian people, including Natives of Alaska; and there is urgent need to reauthorize the Act to bring the preventive and curative measures embodied therein to bear on the illnesses and diseases contributing to these adverse conditions among Indians.

I am certain that numerous tribal witnesses and other proponents have testified for enactment of reauthorization of this legislation, and they have undoubtedly submitted relevant and compelling Indian health statistics to bolster their position. I shall justify my support for reauthorization legislation in a different manner that falls within the context of

public policy formulation in Indian affairs. In doing so, I shall identify certain historical events, involving governmental actions to provide health services to Indians; identify a self-imposed federal responsibility for delivery of health services to Indians; refer to several public laws on Indian health services; address the Justice Department's White Paper and tactics in the legislative process near the end of the 109th Congress that effectively killed enactment of reauthorization legislation; and discuss congress' broad plenary powers over Indian affairs.

HISTORICAL EVENTS

History informs us that as early as 1802, military doctors invoked emergency health services to contain contagious diseases among tribal groups located near military forts; additionally, federal health services for Indians were established in the War Department in 1824; and Congress authorized massive smallpox inoculation of Indians in 1832, presumably, more for the protection of military personnel than the Indians. The military administered Indian affairs throughout this period of time.

Another significant historical event occurred when the administration of Indian affairs, including the Bureau of Indian Affairs (BIA), was transferred from military control to civilian control, upon establishment of the Department of the Interior in 1849.

With respect to delivery of federal health services to Indians, the BIA established a hospital and clinic system of small facilities on many Indian reservations where Indians were ultimately located. The BIA faced monumental challenges in efforts to maintain an acceptable level of Indian health, since tribal groups had been adversely affected by upheaval from native grounds and physically moved to often dismal and unproductive reservations. Moreover, communicable diseases inflicted suffering and death on thousands of Indian people, and by the end of the 19th century, the Indian population once estimated at one-million when the Pilgrims landed at Plymouth Rock had been reduced to an estimated 250,000.

The Western Movement and the unquenchable thirst of settlers for more and more Indian lands inflicted illness, unwarranted death, poverty, untold suffering and hardship on Indians.

SELF-IMPOSED FEDERAL RESPONSIBILITY

It is significant, I submit, to make an assertion at this point, that the federal government has, indeed, assumed a self-imposed responsibility for delivery of health services to Indian people. This assertion is based on the government's historical delivery of such services to Indians since the early 1800's and beyond. Moreover, this responsibility has been buttressed by congressional enactment of discrete laws related to Federal Indian health services.

Therefore, Indians today are justified in advancing the proposition that the federal government's fulfillment of this self-imposed responsibility for over two centuries has risen to the level where it is now national Indian policy—not some vague health activity supported by so-called "gratuitous appropriations" as argued by many federal officials.

DISCRETE PUBLIC LAWS RELATED TO INDIAN HEALTH SERVICES

I now wish to identify several discrete public laws that feed into the notion that the Federal Government's self-imposed responsibility for delivery of health services to Indians has risen to the level of national Indian policy.

1921 Snyder Act, A broad authorization for federal agencies, Bureau of Indian Affairs and Indian Health Service, to seek congressional appropriations to fund various Indian services. The Act is open-ended with respect to tenure and it is not subject to periodic reauthorization.

1954, PL 83-568 ("The Transfer Act") Transferred responsibility for Indian health services from the Department of the Interior to the Department of Health, Education and Welfare.

1959. PL 86-121, The Indian Sanitation Facilities Construction Act.

1975, PL 93-638, The Indian Self-Determination and Education Assistance Act.

1976, PL 94-437, The Indian Health Care Improvement Act.

These several discrete public laws taken together, I contend, reflect the federal government's determination to strengthen curative and preventive health services for Indians and to grant tribes the right to exercise self-determination in the administration and delivery of these services. Moreover, these public laws reinforce and ratify that federal delivery of health services to Indians is now national Indian public policy.

DEPARTMENT OF JUSTICE'S WHITE PAPER

Today, March 11, 2007, I obtained a copy of the White Paper from the Internet. My initial reading is that the Department of Justice raised strong legal and constitutional arguments against enactment of reauthorization in the 109th Congress. It is my understanding that a lawyer, versed in constitutional law, testified last week before this Committee and offered a strong rebuttal to Justice's position. I have not had an opportunity read the lawyer's testimony.

I propose to direct my position on the highly questionable manner in which the White Paper found its way from Justice to the Senate in the waning days of the 109th Congress and ended up in the hands of only the members of the Republican Caucus, and that several Republican Senators were motivated to place a hold on the pending reauthorization legislation, effectively killing it.

Mr. Chairman and members of the Committee, in order for the Legislative Branch of Government to fulfill its constitutional function in our Democracy, I contend that the legislative process must be conducted in a manner that sheds transparency on the purpose of pending legislation, a guarantee that all parties—general public, federal departments and agencies, public interest groups, state governments where appropriate, etc.—are afforded an opportunity to express their views and stand on specific legislative proposals. But this

guarantee carries a concomitant responsibility that the interested parties must submit their views and recommendations in an open and timely manner that affords all parties and members of congress the opportunity to study such positions and to support, modify or oppose.

But the deceitful manner in which the Justice Department's White Paper was framed, appeared in Republican hands only and served its purpose to kill the pending reauthorization legislation was exposed at the Committee's hearing last week on reauthorization legislation. It was disclosed that neither Majority nor Minority members of the Committed requested preparation of the White Paper by Justice.

Whatever merits were inherent in Justice's White Paper against enactment of reauthorization legislation, I submit they have been seriously eroded and Justice's reputation for honesty and fair play in the legislative process has been called into question. As a former Senate committee staff person, I submit further that Justice officials and committee staff may have been able to work through reasonable compromises for consideration by Committee members, and the pending reauthorization could have been enacted into law in the 109th Congress.

There are lessons to be learned from the Justice Department's unacceptable behavior in the 109th Congress. Let us look forward to their participation in the legislative process in a fair and above board manner in the future.

But we are now operating in the 110th Congress, and Majority control has shifted to the Democratic members in both the Senate and House of Representatives, and the Republicans members are now in the Minority. Indians across the country are hopeful that we shall see enactment of the sorely needed reauthorization of the Indian Health Care Improvement Act soon.

PLENARY POWER OF CONGRESS OVER INDIAN AFFAIRS

I accept the premise that the Plenary Power of Congress Over Indian Affairs is absolute, and the source of that power goes directly to the Constitution of the United States.

Indians have witnessed the Congress' exercise of such power by enactment of numerous public laws throughout the long history of Indian affairs; some constructive and some destructive, from the Indians' perspective.

Therefore, I submit that Congress possesses all of the authority and power necessary to enact legislation for Reauthorization of The Indian Health Care Improvement Act, including provisions to enable urban Indians to enter into contractual arrangement with the Indian Health Service to address health needs of urban Indians, notwithstanding opposition from the Justice Department. These provisions do not replicate a "mini Indian Health Service" in urban settings, but they provide the urban Indian leaders with tools to formulate health programs and services that are responsive their respective constituencies.

I strongly urge retention of the urban health provisions in reauthorization legislation.

Mr. Chairman, I have endeavored to weave together a series of actions to bolster my strong recommendation that the reauthorization legislation pending before the Committee be enacted into law.

While serving as a staff member on the former Senate Committee on Interior and Insular Affairs, I was privileged to have worked with Majority and Minority staff in helping to frame the original legislation on The Indian Health Care Improvement Act.

The late Senators, Henry M Jackson and Paul Fannin, Chairman and Ranking Minority of the Committee, respectively, were principal sponsors of this far-reaching Indian health legislative proposal. Their direction to staff on this matter was straightforward, draft Indian health legislation that will help to improve the health status of Indian people, that will draw Indians' support, that will gain bipartisan support in the Congress and that will gain the signature of the President upon passage of the legislation by Congress. I believe that Committee staff, essentially, fulfilled the Chairman's and Ranking Minority's direction on this matter.

I also played a staff role in framing legislation to give meaning and substance to President Nixon's Historic Message to Congress on Indian Policy. The Message called for "Self-Determination for Indians, Without Termination." Here again, Chairman Jackson's legislative proposal on the newly proposed policy was enacted into law on a bipartisan basis as The Self-Determination And Education Assistance Act of 1975.

Throughout my professional career in Indian affairs, I understood that Indians maintain a unique relationship with the federal government unlike that of any other group of citizens, and that the relationship is supported by actions and decisions of the Executive, Legislative and Judicial Branches of Government. Moreover, I understood further that the federal government has assumed a self-imposed trust responsibility, calling for the protection of Indian lands and associated natural resources and the Indians' governmental rights. Finally, this relationship provides for delivery of selected community services to Indians, *solely on the basis of their status as Indians.* This unique relationship has served as a guide in my service to Indian people.

Thank you for providing me with an opportunity to express my views on this vital Indian legislation.

Forrest J. Gerard is an enrolled member of the Blackfeet Tribe of Montana and a veteran of World War II. He served as a crew member on a B24 bomber with the 15th Air Force and flew 35 combat missions over Nazi-occupied Europe.

NATIONAL INDIAN HEALTH BOARD

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Testimony by 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 Senate Committees on Indian Affairs

March 8, 2007 – 9:30 AM
Room 485, Senate Russell Building

Good morning Chairman Dorgan, Vice Chairman Thomas, and members of the Committee. My name is Rachel A. Joseph. I am a member of the Lone Pine Pauite-Shoshone Tribe of California and serve as the Co-Chair of the National Steering Committee (NSC) for the Reauthorization of the Indian Heath Care Improvement Act (IHCIA). I am a former Chairperson of the Lone Pine Pauite-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 legislation to amend and reauthorize the IHCIA.

This testimony is also offered on behalf of the National Indian Health Board (NIHB). The NIHB serves 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, 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. For the last eight years, the Senate and House have introduced IHCIA legislation based on the tribal bill. 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 introduced in the 107th, 108th, and 109th Congresses, none of which passed. The NSC and tribal leaders are committed to working with you to achieve passage of an IHCIA reauthorization bill during the 110th Congress. Today, I respectfully request Congress and the Administration to work together with Indian Country to enact the reauthorization of the IHCIA. The NSC appreciates the support of the Senate Indian Affairs Committee Chairman Dorgan and Committee Vice Chairman Thomas in this endeavor.

History of the IHCIA

Over thirty years ago, the IHCIA was first enacted. On October 1, 1976, the late President Gerald R. Ford, went against the veto recommendations of the then Department of Health and Human Services and the Office of Management and Budget, and signed the IHCIA into law. In his signing statement, the late President Ford wrote:

> *"I am signing S. 522, the Indian Health Care Improvement Act. This bill is not without faults, but after personal review I have decided that the well-documented needs for improvement in Indian health manpower, services, and facilities*

outweigh the defects in the bill. While spending for Indian Health Service activities has grown from $128 million in FY 1970 to $425 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our first Americans should not be last in opportunity."

The late President Ford signed the IHCIA into law with a specific mission: to bring the health status of first Americans to the level of other populations.

The current framework of the IHCIA is similar to the same bill that President Ford signed into law. With the emergence of tribally operated health programs under the Indian Self-Determination Education and Assistance Act and the establishment of 34 urban Indian health centers, the Indian health care delivery system has changed considerably since 1976. Although the IHCIA was reauthorized in 1988 and again in 1992, the IHCIA has not been updated in over 14 years. Modernization of this law is necessary so that improvements are made in the Indian health systems to raise the health status of Indian people to the highest level possible.

Reauthorization Is Important

Indian Country must have 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. There is a critical need for health promotion

and disease prevention activities in Indian Country and provisions of the reauthorization legislation address this need. Disease prevention and health promotion activities elevate the health status at both the individual and community level. Indian Country needs flexibility to run its health care delivery systems in a manner comparable to health care systems expected by "mainstream" America.

Health Care 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. 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 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."

In addition, according to the IHS, AI/ANs have a life expectancy six years less than the rest of the US population. Rates of cardiovascular disease among AI/ANs are twice the amount for the general public, and continue to increase, while rates for the general public are actually decreasing.

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/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. Today, AI/ANs still experience significant health disparities and have lower life expectancy than the general population. The enhancements in the IHCIA reauthorization bill 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.

IHCIA Reauthorization Efforts

Since 1999, the NSC and the NIHB has led reauthorization efforts which have often been long, difficult; and, at times, disappointing. Throughout these years, the NSC has accommodated Administration and Congressional concerns by working out endless compromises and by reaching consensus on key policy issues. At the same time, the NSC held to its guiding principles of no regression from current law and protection of tribal interests.

After so many years of working to secure reauthorization, you can appreciate how disappointed Indian Country was when the IHCIA failed to pass the Senate in the 109th Congress. This time, the bill was derailed largely due to an unofficial Department of

Justice (DOJ) memorandum provided to key Senators during the last hours on the last day of the pre-Election Session of Congress. This memo, highly critical of many elements which are the foundation of the Indian health care system and issues that would erode sovereignty, contained several inaccurate and erroneous claims. Because the Tribes received a copy of the DOJ document late Friday afternoon (September 29, 2006), there was insufficient time for Tribes to respond before the Senate recessed. At the 11th hour for action on the reauthorization bill, Indian Country faced a nameless opponent whose assertions threatened current practices of AI/AN health care.

The NIHB responded to the DOJ document and forwarded its response to the Attorney General Alberto Gonzales and the President asking the Administration to withdraw the DOJ document. The DOJ raised two major objections that are of great concern to the NSC. The DOJ raised Constitutional questions regarding the definition of "Indian". The definition of "Indian" in the IHCIA reauthorization is the same definition in the current IHCIA, which has been in law for over thirty years, and has never been challenged on Constitutional grounds. In fact, this definition of Indian is found in other Federal laws. The NSC strongly recommends that the definition of Indian in section 4 (12), definition of urban Indian in section 4 (27), and eligibility of California Indians in section 806 of the IHCIA reauthorization be retained so there is **no regression from current law**.

The DOJ also objected to the extension of Federal Tort Claims Act (FTCA) coverage to home and community-based services provided outside of a health facility, and traditional health care practices. The DOJ was apparently concerned that these services would not be carried out following appropriate standards of care. Currently, the IHS and tribes provide home health care services following State Medicaid standards of care. Traditional health care practices are usually provided as complementary services to Western medical practices at the request of family members. In most cases, the traditional health care practitioners are not employees of the IHS or tribes so FTCA coverage would not apply in the event that a malpractice claim was ever filed.

The NSC appreciates the work of this Committee during the 109th Congress to secure passage of the IHCIA, S. 1057. It is the NSC's understanding that S. 4122, introduced on the last day of the Session, reflects last minute changes to the IHCIA that were made to address the Department of Justice and Republican Steering Committee concerns. Over the last few months, the NSC has had an opportunity to review the IHCIA bills, S. 1057, and S. 4122, and has worked with Congressional committee staff in recommending legislative changes to any draft reauthorization bill to be introduced. I appreciate the opportunity to highlight some of those key provisions:

Elevation of the Indian Health Service Director

Tribal leaders have long advocated for "elevation" of the IHS Director to that of an Assistant Secretary. We believe "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). We believe that "elevation" would be comparable to the administration of the Bureau of Indian Affairs programs by an Assistant Secretary in the Department of Interior and the 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. There are many cross-cutting issues from various Department agencies, such as the Centers for Disease Control and Centers for Medicare & Medicaid Services, which impact Indian health programs. Elevating the Director's position to that of Assistant Secretary would facilitate greater collaboration with other agencies and programs of the Department concerning matters of Indian health.

The NSC recommends that the language elevating the Director of IHS to Assistant Secretary of Health be included in any reauthorization bill introduced, including any conforming amendments to the definition and other sections, as appropriate.

Bipartisan Commission

Section 814 of the IHCIA reauthorization bill, S. 1057, authorizes a National Bipartisan Commission on Indian Health Care. During the reauthorization process, section 814 has been modified several times and now reflects general authority for the Commission to study the provision of health services to Indians and 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. The NSC supports section 814 of S. 1057.

The NSC was concerned to read that S. 4122 modified section 814 to require the commission to study utilization rates and included language that could be interpreted to call into question the foundation for the Federal government's responsibility to provide health care to AI/ANs. Indian tribes ceded 400 million acres of land to the United States in exchange for promises of health care and other services, a fact that is reflected in treaties. We believe these documents and actions secured a de-facto contract, which entitles Native peoples to health care in perpetuity and are based on moral, legal and historic obligations of the United States. The NSC would object to any language in the bill that would undermine the government's obligation to Indian people.

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/ANs 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.

Section 213 provides 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. Section 213 would enable 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. Section 213 is a prime example of why the IHCIA needs to be modernized.

The NSC was dismayed to read that S. 4122 modified the definition of "home and community based services" by deleting certain services such as "personal care services" and "training for family services." The NSC recommends that the definition of "home and community based services" should include the same services that title XIX of the Social Security Act includes in its definition of "home and community based services." The NSC further recommends that any standards should be consistent with Medicaid standards.

Behavioral Health Programs

S. 4122 did not modify Title VII of the IHCIA reauthorization. The NSC and Indian Country strongly support the Title VII provisions 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. Title VII addresses all age groups and authorizes specific programs for Indian youth including suicide prevention, substance abuse and family inclusion.

We support making the "systems of care" approach to mental health services available in Indian Country. The "systems of care" approach 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, a methodology formally recognized and encouraged by the Substance Abuse and Mental Health Services Administration (SAMHSA). In fact, an existing SAMHSA program, operated in

coordination with other federal agencies, provides six-year grants to a number of Indian tribes for the express purpose of developing systems of care for mental health services in Indian communities.

Increased IHS and tribal utilization of "systems of care" methodologies for delivery of mental heath services will help tribes leverage assistance from SAMHSA, the National Institute of Mental Health and other agencies for services to Indian children. Local evaluations of "systems of care" programs have shown less acute psychiatric hospitalizations and out-of-home placements for adolescents, better school performance and fewer crimes by children in the program.

Innovative Health Care Delivery Systems

Senator Dorgan, in your Senate Floor statement of January 22, you discussed the need for improving emergency access to reservation-based health care through expanding clinic hours and other innovations. Specifically, you discussed the need to establish a new Indian health care delivery model to replace existing emergency rooms at Indian health hospitals with low-cost, "after hour", walk-in clinics – a model currently available in the private sector. We appreciate your leadership in proposing to develop new health care delivery systems in Indian Country that are accessible to the general public.

Some tribal programs have extended ambulatory health care center hours using current authorities. For instance, many tribal programs have established "after-hour" programs, such as on Saturday mornings, specifically geared to particular health promotion and disease prevention (HP/DP) activities. A tribal program in California operates a dental preventative program on Saturday mornings for families who are not able to access these services during the week due to school and work commitments. Thus, the tribal program has health professionals on staff to provide dental preventative services. At the same time, the health professionals are available to treat walk-in patients seeking other medical treatment or to provide necessary emergency medical treatment or referrals. Some tribal programs provide "after hour" services by establishing a toll-free number for patients to call physicians or nurses who are "on call" to handle routine care and/or emergencies.

While the NSC would support legislative language clarifying existing authorities, or expanding existing authorities through demonstration projects, sufficient additional funding is needed to ensure the viability of these new programs.

In reviewing S. 4122 for any changes made to S. 1057 (Managers' Amendment), the NSC reviewed all provisions in the bill including Section 301 – Consultation, Construction and Renovation of Facilities; Reports. The NSC reviewed Section 301 in particular because during the 109th Congress changes were made to Section 301(c) - Health Care Facility Priority System, as reflected in S. 1057 (Managers' Amendment). These provisions were not modified further by S. 4122, and at a February 15 -16th meeting of the NSC, the NSC reached consensus to support language in Section 301(c), including the priority of certain projects protected language in Section 301(c) (1) (D), as contained in S. 1057 and S. 4122.

As a result of tribal concerns about proposed closures of health care facilities, including emergency departments and urban Indian clinics, the NSC would ask the Committee to revisit Section 301 (b) Closures. During a meeting with Senator Dorgan and NIHB Executive Board members, Lester Secatero, NIHB Member at Large, expressed concerns that the IHS might be planning to close emergency departments in existing IHS operated hospitals in the Albuquerque Area. If these emergency departments are closed, tribal members will be required to travel over 60 miles to Albuquerque to receive emergency services. Closure of existing emergency departments of hospitals, without sufficient notice to Congress, will only exacerbate the concerns regarding the availability of "after hour" services available to Indian people.

Section 301 (b) as currently contained in the IHCIA reauthorization would prohibit the agency from closing a facility unless the agency has submitted a report to Congress at least 1 year prior to the date of the proposed closure. Under current law, the agency is prohibited from closing "a Service hospital or other outpatient health care facility of the Service, or any portion of such a hospital or facility" unless the agency has submitted a report to Congress at least 1 year prior to the proposed closure date such hospital or facility (or portion thereof). The NSC recommends that Section 301 (b) be modified to

require the IHS to submit a report to Congress even when contemplating closure of a portion of a hospital, such as an emergency room. Congress could require, before closure of any emergency department of a hospital, that the IHS include as part of its report to Congress an analysis of the feasibility of converting the emergency department to an "after hour" walk-in clinic.

Other Miscellaneous Provisions:
The NSC reviewed S. 4122 for modifications to other provisions of the IHCIA reauthorization and was concerned that some of these modifications were either a regression of current law or not consistent with tribal interests. The following is a summary of some of those provisions and NSC's recommendations:

Section 124 (b): This provision exempts National Health Service Corps (NHSC) scholars qualifying for the U.S. Public Health Service Commissioned Corps to be exempt from the NHSC and IHS full time equivalent (FTE) limitations when serving at a Tribal or urban Indian program. This provision was deleted in S. 4122 and the NSC recommends that Section 124(b) be reinserted into the IHCIA reauthorization bill. Placement of Commissioned Corps officers at tribal or urban sites is an important health professional recruitment tool and should not count towards FTE limitations.

Section 302 (c)(5): S. 4122 deleted this provision that allows tribes to use appropriated dollars to pay back loans acquired through other federal loan programs. There are other Federal loan programs where money is available for tribes to construct sanitation facilities, but tribes cannot access these funds because they do not have the resources to pay back these loans. The NSC recommends reinserting this provision into the bill. Also, S. 4122 revised section 302 by adding a new provision at 302 (c)(9) to clarify that goods and services from other sources can be used for all related costs associated with sanitation facility construction. The NSC has no objection to this new provision.

Section 314 (a): S. 4122 revised Section 314 (a) to require that rental rates for quarters be established according to OMB Circular A-45. The reference to OMB Circular A-45 defeats the purpose of the section which was intended to provide tribes with flexibility to

set rental rates based on **reasonable** rental rates available in their local communities. The NSC would recommend deleting the reference to OMB Circular A-45 in Section 314(a).

Section 403: S. 1057 and S. 4122 currently provide that the IHS and tribes have a right of recovery from third parties for "reasonable expenses incurred." During the 109th Congress, the tribes requested to change this language to "reasonable charges billed" because some tribes have encountered problems with insurance companies not reimbursing the tribes because of the "expenses incurred" language. The NSC recommends that the "reasonable expenses incurred and billed" language in section 403(a) be changed to "reasonable charges billed."

The NSC recommends that section 403 be further amended to clarify that tribes or tribal organizations operating programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), have authority to file actions under the Federal Medical Care Recovery Act (FMCRA) on the same basis as the federal government. FMCRA authorizes the Federal government to recover medical costs from a responsible party, or their insurer, resulting from a tort injury, such as an automobile accident. Tribal programs operating under the ISDEAA should be afforded similar authorities to recover medical costs resulting from tort injuries to their tribal members resulting.

Section 805: S. 4122 revised Section 805, by adding a new subsection (b) that would allow the Secretary to promote traditional health care practices, but would exclude FTCA coverage of traditional health care services. The NSC would recommend deleting subsection (b) because excluding particular services from FTCA coverage is a **regression from current law**.

While we can build on previous legislative activities, we look to this new Congress and the introduction of a new reauthorization bill. However, in order to facilitate passage of the IHCIA in the 110th Congress, tribal leaders need to be "at the table" with Congressional and the Administration staff to discuss the IHCIA, which is consistent with a meaningful government-to-government relationship. The NSC stands ready to work with Congress, and the Administration to ensure passage of the IHCIA during this Congress.

Thank you for providing me this opportunity to present testimony and I am available to answer any questions you may have.

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To the U.S. Senate Committee on Indian Affairs

Hearing on the Indian Health Care Improvement Act

March 8, 2007

INTRODUCTION

Good morning, Chairman Dorgan, Vice Chairman Thomas, and distinguished members of the Committee. Thank you for inviting me to testify about the constitutionality of the proposed amendments to the Indian Health Care Improvement Act (the IHCIA; as amended, "the Act").[1] In particular, I have been asked to address: (1) whether Congress has the constitutional authority to amend the Act to provide benefits and services to "Indians"[2] and "Urban Indians"[3]

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[1] Unless otherwise specified, section citations in this testimony refer to the amendments proposed in S. 1057, 109th Congress (2005).

[2] Section 4(12) of the Act defines "Indians" as:

> The term 'Indian', unless otherwise designated, means any person who is a member of an Indian Tribe or is eligible for health services under section 806, except that, for the purpose of sections 102 and 103, the term also means any individual who—
>
> (A)(i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside; or
>
> (ii) is a descendant, in the first or second degree, of any such member;
>
> (B) is an Eskimo or Aleut or other Alaska Native;
>
> (C) is considered by the Secretary of the Interior to be an Indian for any purpose; or
>
> (D) is determined to be an Indian under regulations promulgated by the Secretary.

[3] Section 4(28) of the Act defines "Urban Indians" as:

as those terms are expected to be defined, and (2) whether the Act's support for traditional health care practices offends the First Amendment's ban on establishments of religion.

Last year, the Department of Justice (the "Department") issued a "White Paper" suggesting that the Act's definitions of Indian and Urban Indian would transform the legislation into a constitutionally disfavored racial preference and thus trigger potentially fatal "strict" judicial scrutiny. With respect, I have concluded that the Department's concerns, though not entirely without foundation, do not reflect the best reading of the Constitution given the wide latitude Congress has always enjoyed when legislating on behalf of Indian peoples. Moreover, even if the Department is right that courts may subject the Act to strict scrutiny, Congress need not hesitate to pass the proposed legislation because it is narrowly tailored to the compelling governmental interest – recognized by Congress since the early days of the Republic – to provide for the health of the indigenous peoples that this nation dispossessed as it expanded across the continent. I have further concluded that the Department's Establishment Clause concerns, which the White Paper does not explain, are largely unfounded.

I. THE ACT DOES NOT CREATE AN UNCONSTITUTIONAL RACIAL PREFERENCE

A. The Proposed Legislation Creates A Political, Not A Racial, Classification

The starting point for analyzing the constitutionality of the proposed amendments must be the Indian Commerce Clause, which explicitly authorizes Congress "to regulate Commerce with . . . the Indian Tribes."[4] As recognized in an unbroken wall of Supreme Court precedent

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The term 'Urban Indian' means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:

(A) Irrespective of whether the individual lives on or near a reservation, the individual is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member.

(B) The individual is an Eskimo, Aleut, or other Alaska Native.

(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.

(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

[4] U.S. Const. Art. I, § 8, cl. 3.

stretching back more than 175 years, through this textual commitment, the Constitution's Framers vested in Congress "broad," "plenary and exclusive" power to legislate in this field.[5]

With this great power has come great responsibility. By dint of history, much of it sorry and tragic, Indian tribes became dependent upon the United States. As a result, the nation – and Congress in particular – assumed a "duty of protection" and an obligation to look after the health and welfare of its indigenous communities.[6] Pursuant to this responsibility, Congress has passed a host of statutes "that single[] out Indians for particular and special treatment."[7] And the law books are replete with cases upholding these preferential statutes against constitutional challenge in essence because the Constitution expressly singles out Indians for unique legislative treatment.[8] As the Supreme Court summarized the point in *Morton v. Mancari*: "As long as the special treatment can be tied rationally to the fulfillment of Congress' unique obligation towards the Indians, such legislative judgments will not be disturbed."[9]

Without question, legislation providing health programs and benefits is a classic example of Congress attending to its responsibility to Indians pursuant to its authority under the Indian Commerce Clause. Since the 1830s at the latest, treaties between the United States and Indian tribes contained promises of hospitals, medical supplies, and other health services.[10] Over time, as the health of Indian populations declined, the provision of health services became a necessary and fundamental part of the relationship between Indians and the United States. As long ago as the passage of the Snyder Act in 1921, Congress stated its commitment to fund health conservation programs for "Indians throughout the United States."[11] More recently, in passing the IHCIA, Congress mandated "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and urban Indians and to provide all resources necessary to effect that policy."[12]

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[5] *See, e.g., United States v. Wheeler*, 435 U.S. 313, 319 (1978); *Lone Wolf v. Hitchcock*, 187 U.S. 553, 564-565 (1903); *United States v. Kagama*, 118 U.S. 375, 383-384 (1887).

[6] *United States v. Kagama*, 118 U.S. 375, 384-85 (1886); *see also United States v. Sandoval*, 231 U.S. 28, 45-46 (1913).

[7] *Morton v. Mancari*, 417 U.S. 535, 554-55 (1974).

[8] *United States v. Antelope*, 430 U.S. 631, 645 (1977).

[9] *Mancari*, 417 U.S. at 555.

[10] Cohen's Handbook of Federal Indian Law 1376 (Neil J. Newton, et al. eds., 2005).

[11] 25 U.S.C. § 13.

[12] 25 U.S.C. § 1602(a).

In light of this history, it is virtually self-evident that the proposed amendments to the IHCIA and its existing provisions meet the standard test applied to legislation benefiting Indians – that the legislation be rationally tied to the fulfillment of Congress's obligations. From a constitutional perspective, then, the only issue is whether something about the Act is so extraordinary that it exempts the legislation from the usual rules of judicial review.

In its White Paper, the Department purports to have discovered just such an extraordinary circumstance in the fact that the Act does not limit the benefits it confers to members of a federally-recognized tribal entity or to persons having what the Department deems to be a clear and close relationship with such a tribal entity. As the Department observes, the Act would award grants and other benefits to members of state-recognized tribes, descendents in the first or second degree of members of federally- and state-recognized tribes, and Eskimos, Aleuts, or other Alaska Natives even if not affiliated with a recognized Village. In the Department's view, because of the scope of the Act's intended beneficiaries, courts would likely view the legislation as creating a "racial" classification subject to strict judicial scrutiny under *Adarand Constructors, Inc. v. Pena*[13] rather than a "political" classification based on tribal affiliation subject to the deferential rule enunciated in *Morton v. Mancari*.

In my view, and as explained further below, the line the Department seeks to draw between "political" and "racial" classifications is misplaced. Congress's plenary authority under the Indian Commerce Clause is not limited to federally-recognized tribes and their members. Nor does a congressional act benefiting Indians who are members of no recognized tribe (federal or state) necessarily involve a "racial" classification, especially when federal Indian policy was itself the main cause for attenuating the connection between these Indians and their tribes.

With respect to the Act's extension of benefits to members of state-recognized tribes, it must be observed that the Indian Commerce Clause – which simply speaks of "Indian Tribes" – makes no such distinction.[14] After all, the concept of "federal recognition" is a modern creation.

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[13] 515 U.S. 200 (1995).

[14] One of Congress's earliest acts in the field of Indian affairs, the 1790 Indian Trade and Intercourse Act, illustrates the absence of any distinction as well as Congress's authority to legislate with respect to all Indians. There, Congress mandated "that no sale of land made by *any Indians, or any nation or tribe of Indians within the United States*, shall be valid . . . unless the same shall be made and duly executed at some public treaty, held under the authority of the United States." Although this first enactment was a temporary measure, Congress subsequently amended the 1790 Act and made its protections permanent. This congressional protection applies to lands held by "Indian tribes" that exist as distinct political entities, even though a particular tribe may not be federally recognized. *See Passamaquoddy v. Morton*, 528 F.2d 370 (1st Cir. 1975).

And I am aware of no case law disempowering Congress from acting on behalf of state-recognized tribes.

To the contrary, Congress has repeatedly passed legislation encompassing both state- and federally-recognized tribes. For example, in addition to providing health care services for members of state-recognized tribes,[15] Congress has authorized state-recognized tribes to participate in Indian housing and education programs,[16] has included state-recognized tribes within the protections of the Indian Arts and Crafts Act,[17] and has authorized the Department of Agriculture to make tribes with state reservations eligible for various programs.[18]

The legal underpinning for such congressional action is strong. The Supreme Court has repeatedly affirmed the power of Congress to recognize tribes and legislate on their behalf and also to recognize tribes for some purposes but not for others.[19] Indeed, the Court has gone so far as to say that Congress's constitutional authority over tribes is "a continuing power of which Congress could not divest itself. It could be exerted at any time and in various forms during the continuance of the tribal relation . . . ."[20] In view of this broad authority, Congress can confer benefits on state-recognized tribes and their members. Surely, Congress's ultimate authority to recognize Indian tribes in the first instance contains the lesser authority of providing services or programs for non-federally-recognized tribes – as Congress has seen fit to do on many occasions.

As particularly relevant here, there is no reasonable basis for concluding that, when Congress chooses to confer benefits on both federally-recognized and state-recognized tribes and their members, it crosses a line between legislation creating a political classification and legislation creating a racial classification. State-recognized tribes are political entities no less than federally-recognized tribes. State-recognized tribes are Indian tribes acknowledged by State governments as maintaining political authority over their members and their territory. Like

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[15] 25 U.S.C. §§ 1601 *et seq.*

[16] 25 U.S.C. § 4103 (defining "Indian tribe" as "a tribe that is a federally recognized tribe or a State recognized tribe"); 20 U.S.C. § 7491. Congress has also included state-recognized tribes under various Native American programs administered by the Secretary of Health and Human Services. *See* 42 U.S.C. § 2992c.

[17] 18 U.S.C. § 1159(c)(3)(B).

[18] 7 U.S.C. §§ 1926, 1932, 2009cc, 2661.

[19] *United States v. Sandoval*, 231 U.S. 28, 46 (1913); *Menominee Tribe v. United States*, 391 U.S. 404 (1968).

[20] *United States v. Nice*, 241 U.S. 591, 600 (1916). *See also* Cohen's Handbook of Federal Indian Law 815 (1982 ed.) ("Indian tribes can be recognized by the United States for some purposes and not for others."); and Cohen's Handbook of Federal Indian Law 272 (1942 ed.) ("It remains true, however, that an Indian tribe may 'exist' for certain purposes, and not for others.").

federally-recognized tribes, many state-recognized tribes entered into treaties with independent states prior to the formation of the Union; state governments recognized other tribes through executive or legislative actions.[21] Today, many states provide an administrative process for recognition of tribal governments.[22] Moreover, just like members of federally-recognized Indian tribes, members of state-recognized tribes may renounce their affiliation. In sum, the relationship between Congress and state-recognized tribes – a status that is often a precursor to federal recognition[23] – is a political one. And, accordingly, Congressional enactments benefiting their members are best seen as based on a political classification.

As the Department notes, the proposed legislation also benefits urban Indians who are not themselves members of any tribe, but who are descended in the first or second degree from a tribal member. Contrary to the implication of the Department's White Paper, however, current case law provides no definitive answer as to whether extending benefits in this way transforms the classification from political to racial.

In *Morton v. Mancari*, the Supreme Court rejected a claim that the law providing Indians with a hiring preference for positions at the BIA constituted invidious racial discrimination. The Court construed the preference to be "political" rather than racial in nature in part because it was limited to members of federally-recognized tribes who would be overseeing programs aimed at exactly that constituency.[24] But the Court never suggested that a preference benefiting a group of Indians broader than simply members of federally-recognized tribes would necessarily be considered racial in nature and, moreover, stated unequivocally that special legislation for Indians would be upheld if reasonably linked to Congress's "unique obligation toward the Indians" without reference to membership status.[25]

In *Rice v. Cayetano*,[26] the case on which the Department principally relies, the Court held that the Fifteenth Amendment prohibited Hawaii from limiting voters for positions on a state

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[21] *See* Treaty of 1677 between Virginia and the Indians, May 29, 1677 (discussed in Virginia Op. Att'y Gen, February 7, 1977, 1977 WL 27313); N.Y. Indian Law § 120; Conn. Gen. Stat. § 47-59a; Mass. E.O. No. 126 (1976); La. Con. Res. No. 60 (1974).

[22] *See* Ala. Code § 41-9-708; Va. Code § 2.2-2629; N.C. Gen. Stat. § 143B-406; Md. Code Ann., Art. 83B, § 5-406.

[23] Importantly, there are many tribes currently seeking federal recognition, which can be an agonizingly slow process. It would be quite arbitrary to say that Congress cannot provide special health benefits to members of such tribes without transforming its program into a racial classification.

[24] *Mancari*, 417 U.S. at 554.

[25] *Id.* at 554-555.

[26] 528 U.S. 495 (2000).

agency solely to Hawaiians and Native Hawaiians as defined by statute. As part of that decision, the Court rejected attempts to analogize the challenged law to the hiring preference in *Mancari* because nothing in *Mancari* suggests that Congress may empower a state to override the Fifteenth Amendment and disenfranchise non-Indian citizens from an election involving the selection of state officials.[27] While the Court described *Mancari* as involving a preference limited to tribal members, here, too, the Court was not called upon and did not seek to define precisely the line between political and racial classifications.

At least one lower federal court has held, with respect to certain housing benefits, that Congress's plenary powers extend to a broad class of urban Indians without reference to tribal affiliation.[28] According to this court, Congress's power pursuant to its trust relationship with the Indians necessarily must be flexible enough to account for the changing needs of Indian communities, including urbanization. Applying that principle, the court concluded that "in light of the broad scope of the trust doctrine, it is not surprising that it can extend to Indians individually, as well as collectively, and off the reservation as well as on it."[29]

But determining whether Congress creates a racial classification when it provides benefits to urban Indians descended one or two degrees from a tribal member is more a matter of logic than of precedent. There is no secret about how this group of unaffiliated urban Indians came into being. They are the product of Congress's previous *political* interactions with the tribes. From the Dawes Act through termination and relocation, the federal government imposed upon the tribes policies that aggressively encouraged or forced the migration of Indians into urban areas and sought to sever ties between those Indians and their tribes. The failure of economic development on many reservations – also a manifestation of political decisions – further swelled the urban migration.

The question, then, is whether Congress has authority to treat these Indians – who are no more than two degrees removed from actual tribal membership – as still having a political relationship with the United States, given that Congress's political dealings with their tribes largely created their state of alienation. In my view, the answer to this question should be yes. Given Congress's broad authority in the field of Indian affairs, Congress ought not to be prohibited from considering itself as having a derivative political relationship with a community of Indians its political decisions created, where the individual Indians have significant blood ties

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[27] *Id.* at 520.

[28] *St. Paul Intertribal Housing Bd. v. Reynolds*, 564 F. Supp. 1408 (D. Minn. 1983).

[29] *Id.* at 1413.

back to a recognized tribal community. Put simply, when Congress, in exercising its Indian Commerce Clause power, legislates to protect the health and welfare of Indian tribes by dispersing their members, Congress's subsequent programs designed to take responsibility for and ameliorate the failures of that political judgment remain political (and not racial) in character.

Congress itself followed exactly this logic when it first created the current definitions of "Indian" and "Urban Indian" in the IHCIA of 1976.[30] And Congress discussed the underlying rationale when it enacted the IHCIA amendments of 1987. As the Senate Report declared:

> The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation.* Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and *the responsibility for the provision of health care services follows them there.*[31]

I see no reason grounded in the Constitution to second-guess this considered and long-standing congressional judgment in an area in which congressional judgment has always been paramount.

At the same time, there are some significant reasons not to second-guess this judgment by deeming the Act to have created a racial classification – as the Department would have it. As a practical matter, such second-guessing risks hamstringing Congress in its efforts to deal with an urban Indian population with uniquely Indian problems by creating rather arbitrary and entirely ahistorical distinctions between those Indians who can readily benefit from Congressional programs and those who cannot. Moreover, the Department's approach would obliterate the deep ancestral distinctions between Indians with different tribal backgrounds by lumping all Indians without a tribal affiliation into an undifferentiated "race" of Indians. I see no constitutional mandate forcing such a perverse result.[32]

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[30] Indeed, these definitions date back as far as the Transfer Act of 1954.

[31] S. Rep. 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, at 25 (emphasis added).

[32] Essentially the same analysis applies to Eskimos, Aleuts, and other Native Alaskans unaffiliated with native villages. As Congress recognized when it created a separate Native Corporation for these persons in the Alaska

B. Even If Deemed To Be A Racial Classification, The Proposed Legislation Is Constitutional

As discussed above, the proposed Act should be reviewed under the rational basis standard of review. Even assuming, however, that the Department is correct in suggesting that strict scrutiny applies, a persuasive argument can nonetheless be made that the Act should pass constitutional muster.

1. The Strict Scrutiny Standard

The Due Process Clause of the Fifth Amendment includes a guarantee of equal protection[33] that is coterminous with the Equal Protection Clause of the Fourteenth Amendment.[34] Given our nation's history, we take a cautious approach to classifying persons according to their race, a practice that, as the Supreme Court has noted, "is more likely to reflect racial prejudice than legitimate public concerns."[35]

Accordingly, the Supreme Court has held that government classifications that expressly distinguish among citizens because of their race must be narrowly tailored to further a compelling governmental interest,[36] even when they are part of measures designed to redress racial discrimination.[37]

The Court has recently confirmed, however, that strict scrutiny is not fatal: "Although all governmental uses of race are subject to strict scrutiny, not all are invalidated by it . . . When race-based action is necessary to further a compelling governmental interest, such action does not violate the constitutional guarantee of equal protection so long as the narrow-tailoring requirement is also satisfied."[38]

Native Claims Settlement Act, Congress bears a responsibility for their diaspora – and it has shouldered that responsibility in enacting programs such as those contemplated here.

[33] *See Bolling v. Sharpe*, 347 U.S. 497, 499 (1954).

[34] *Johnson v. Robison*, 415 U.S. 361, 364 (1974).

[35] *Id.* at 432 (citing *Personnel Admin. of Mass. v. Feeney*, 442 U.S. 256, 272 (1979)).

[36] *Shaw v. Reno*, 509 U.S. 630, 643 (1993) (citation omitted).

[37] *Adarand Constructors v. Pena*, 515 U.S. 200, 227 (1995).

[38] *Grutter v. Bollinger*, 539 U.S. 306, 326-37 (2003); *see id.* at 327 ("Not every decision influenced by race is equally objectionable[;] ... strict scrutiny is designed to provide a framework for carefully examining the importance

2. The Government Has a Compelling Interest in Promoting Indian Health

As a preliminary matter, it is clear that the Act serves a compelling government interest. As discussed above, the federal government has a unique relationship with and responsibility to the American Indian people. This relationship and corresponding duty are set forth in the Act, which states in its Findings that:

> (1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.
>
> (2) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.
>
> (3) Federal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.
>
> (4) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.[39]

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and the sincerity of the reasons advanced by the governmental decisionmaker for the use of race in that particular context.").

[39] *See* § 2 of the proposed Act; *See also* § 3 of the proposed Act, entitled "Declaration of National Indian Health Policy," which states that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to Indians:

> (1) to assure the highest possible health status for Indians and to provide all resources necessary to effect that policy;
>
> (2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010 or successor objectives;
>
> (3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

Given the history of our relationship with the Indians, which, to say the least, has not always been a proud one, the federal government has properly recognized its duty to address the health needs of Indians, whose plight is directly linked to that history. While race-based classifications are often deemed suspect because of the tenuous nature of the link between the problems the government seeks to redress and the persons who actually stand to benefit from the proposed measure,[40] that concern is allayed here. The Act is aimed at meeting the needs of the very persons whose difficulties arise from the government policies responsible for the health crisis the Act seeks to redress. The following are just a few well-known examples of policies and events that are largely and directly responsible for the flight of Indians to urban areas and the current health plight of urban Indians.

- The General Allotment Act of 1887 resulted in the transfer of the majority of Indian land to non-Indians, disrupting tribal culture and resulting in massive relocation of Indians to urban areas.

- More recent efforts by the federal government to break down tribal governments and force Indians to assimilate have resulted in a loss of community and a diaspora characterized by poverty, alcoholism, and disease.

- On the reservations, the failure of federal initiatives to stimulate economic development created an environment plagued by poverty. This too has led many Indians to leave the reservation in the hopes of finding a better way of life in metropolitan areas.

As the Supreme Court noted in *Grutter v. Bollinger*, it is important to consider context "when reviewing race-based governmental action under the Equal Protection Clause."[41] Viewed

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(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;

(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to implement this Act and the national policy of Indian self-determination; and

(6) to provide funding for programs and facilities operated by Indian Tribes and Tribal Organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

[40] *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 493 (1989) (To be narrowly tailored, "there must be a sufficient nexus between the compelling governmental interest" and the challenged measure.).

[41] *Grutter*, 539 U.S. at 327.

in historical context, there can be no question but that the proposed Act serves a compelling government interest. Assuming it can be shown that the Act "use[s] the least restrictive reasonable means to achieve its goals," it should pass muster even under the strict scrutiny test.[42]

3. The Proposed Act Is Narrowly Tailored to Meet the Government's Compelling Interest

The Supreme Court considers various factors in the narrow tailoring analysis, including, as relevant here: (1) the necessity of relief; (2) the efficacy of alternative, race-neutral remedies; (3) the impact of relief on the rights of third parties; and (4) the over-inclusiveness or under-inclusiveness of the racial classification.[43]

While the Findings in the Act do not address all of the relevant factors explicitly, the path they chart demonstrates that the Act is narrowly tailored to meet its stated goal, namely, "to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Indian Health Programs and Urban Indian Organizations involved in the provision of health services to Indians."[44]

The first factor used to assess whether a measure is narrowly tailored – necessity of relief – is present here. As noted in the Findings of the Act, disease is rampant among Indians, notwithstanding federal efforts to provide health care.[45] The findings could easily be amplified to include such specifics as the following:

- Indians have a shorter life expectancy – nearly six years less – and higher rates of disease than the general population.[46]
- American Indian and Alaska Native infants die at a rate of 8.5 per every 1,000 live births, as compared to 6.8 per 1,000 for the general population.[47]

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[42] *Dunn v. Blumstein*, 405 U.S. 330, 343 (1972).

[43] *United States v. Paradise*, 480 U.S. 149, 171 (1987); *Croson*, 488 U.S. at 506 (including over- and under-inclusiveness in the narrow tailoring factors); *Adarand*, 515 U.S. at 237-38 (noting that the lower court on remand should consider whether the legislative body had tried race-neutral alternatives and whether the program was limited in duration).

[44] *See* § 101 of the proposed Act.

[45] § 2 of the proposed Act.

[46] *See* U.S. Commission on Civil Rights (USCCR), *Broken Promises: Evaluating the Native American Health Care System* (2004), at http://www.usccr.gov/pubs/nahealth/nabroken.pdf)

- Indians suffer significantly higher rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries.[48]

- Cardiovascular disease is now the leading cause of mortality among Indians, with a rising rate that is significantly higher than that of the U.S. general population.[49]

- The prevalence of type 2 diabetes amongst Indians and Alaska Natives has been documented as being one of the highest in the world.[50]

- Rates of substance dependence and abuse among persons age 12 and older is highest among Indians and Alaska Natives.[51]

- Access to health care and to competent providers remains a critical problem for Indians.[52]

The second factor, race-neutral remedies, cannot be viewed as a reliable alternative in view of the fact, noted in the Findings of the Act, that even programs specifically designed to address the peculiar health care needs of Indians have failed to date.[53]

The third factor, the impact of relief on the rights of third parties, is negligible. The Act does not discriminate among individuals vying for the same program. Rather, it is designed to address problems specific to Indians.

Fourth and finally, the classification of urban Indians is neither over- nor under-inclusive. As a result of historic federal policies touched on above, the Indian tribal culture has been widely dispersed, giving rise to diverse urban Indian communities. The Government retains its responsibility to these non-reservation Indians – who comprise over half of the Indian population

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[47] *See* U.S. Department of Health and Human Services, Indian Health Service, *Facts on Indian Health Disparities* (Jan. 2006) at http://info.ihs.gov/Files/DisparitiesFacts-Jan2006.pdf.

[48] *See* USCCR, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country* (2003).

[49] *See* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Heart Disease Facts and Statistics* (Feb. 2007) at http://www.cdc.gov/HeartDisease/facts.htm; *see also* http://www.medicalnewstoday.com/medicalnews.php?newsid=24326 dated May 13, 2005.

[50] *See* http://www.ahsc.arizona.edu/nartc/articles/young98.htm.

[51] *See* U.S. Department of Health and Human Services, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health – The NSDUH Report* (Jan. 2007) at http://www.drugabusestatistics.samhsa.gov/2k7/AmIndians/AmIndians.htm.

[52] *See* GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans* (2005).

[53] § 2 of the proposed Act.

according to the 2000 census – just as it does to Indians who retain their tribal affiliation and remain on the reservation. The health problems associated with the Indian population as a whole cannot be addressed unless health services are provided to the urban Indian population, as well as to the reservation population.

It cannot be gainsaid that our history is marred by racism and hostility against Indians, nor that the effects of those past wrongs are still being felt by Indians wherever they reside. Indians, both on the reservation and off, remain deeply affected by incidents of state-sponsored racism and discrimination. Accordingly, the classification of Indians and Urban Indians in the Act is relevant and necessary to fulfilling the federal government's unique obligation to Indians.[54] In *Grutter v. Bollinger*, the Supreme Court noted that racial preferences to support diversity in higher education may be unnecessary in 25 years. The sun will not set any sooner on Congress's trust obligation to the American Indian people.

In sum, the Findings included in the Act may suffice to establish that it is narrowly tailored to fulfill its goal of redressing the health crisis facing Indians today. To the extent the Findings fall short, they could easily be augmented to meet the demands of strict scrutiny.

II. THE ACT DOES NOT VIOLATE THE ESTABLISHMENT CLAUSE

The Department's White Paper contends that portions of the proposed Act may violate the First Amendment's Establishment Clause due to the Act's support of "traditional health care practices" and practitioners. The Justice Department offers no support for this position. It simply asserts that there is an Establishment Clause problem, without referencing the bill's provisions it believes raise concerns or analyzing the provisions under Establishment Clause precedent. The Justice Department's position is overstated. I will first explain how the Act supports traditional health care practices. I will then explain why this support is unlikely to violate the Establishment Clause.

A. The Act Invokes "Traditional Health Care Practices" in Several Ways

The Act defines "traditional health care practices" (THCP) in non-religious terms:

> The term "Traditional Health Care Practices" means the application by Native healing practitioners of the Native healing sciences (as opposed or in

[54] *Croson*, 488 U.S. at 510 ("Proper findings [to support the need for remedial action] are necessary to define both the scope of the injury and the extent of the remedy necessary to cure its effects.")

> contradistinction to Western healing sciences) which embody the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which call upon these influences or forces in the promotion, restoration, preservation, and maintenance of health, well-being, and life's harmony.[55]

The Establishment Clause proscribes certain forms of government support for religion. But nothing in this definition ties the definition of THCPs to religious beliefs or practices, and so, at least on its face, the Act would not appear to raise Establishment Clause concerns.

The provisions in the Act that refer to THCPs can be divided into three general groups. The first group of provisions merely requires the Secretary to consider THCPs in formulating health care policies under the statute.[56] The second group of provisions permits the Secretary to support or implement THCPs directly. For example, § 704(d) requires the Secretary to ensure that the Indian Health Service's mental health technician program "involves the use and promotion of the Traditional Health Care Practices of the Indian Tribes to be served."[57] The third group of provisions permits the Secretary to "incorporate" THCP practitioners in government grant programs.[58]

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[55] § 4(23) of the proposed Act.

[56] § 109(b)(6) (requiring Community Health Representative Program to "promote Traditional Health Care Practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention"); § 126(c)(2) ("Position specific training criteria . . . shall ensure that appropriate information regarding Traditional Health Care Practices is provided."). The former provision, § 109(b)(6), is already codified in the U.S. Code. *See* 25 U.S.C. § 1616(b)(6). It was enacted as part of the Indian Health Care Amendments of 1988, Pub. L. No. 100-713, 102 Stat. 4784, and does not seem to have been subject to any litigation since.

[57] *See also* § 201(a)(5)(K) (permitting Secretary to expend funds to "augment[] the ability of the Service to meet the following health service responsibilities . . . Traditional Health Care Practices"); § 701(c)(1)(I) (requiring Secretary to provide "[a] comprehensive continuum of behavioral health care," including "Traditional Health Care Practices"); § 703(a)(1) ("The Secretary . . . shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, including Traditional Health Care Practices . . . ."); § 711(b)(5) ("The project may deliver services in a manner consistent with Traditional Health Care Practices."); § 713(b)(3) ("Funding provided pursuant to this section shall be used . . . [t]o develop prevention and intervention models which incorporate Traditional Health Care Practices . . . .").

[58] § 211(b)(1)(A) ("Funds made available under this section may be used to . . . develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate . . . traditional health care practitioners . . . ."); § 712(a)(2)(E) ("Funding provided pursuant to this section shall be used . . . [t]o develop prevention and intervention models which incorporate practitioners of Traditional Health Care Practices. . . ."); § 715(3) ("An aftercare plan may use such resources as . . . traditional health care practitioners . . . .").

B. The Act's Use of "Traditional Health Care Practices" Complies with the Establishment Clause

The Supreme Court's test for evaluating whether government action amounts to impermissible support for religion in violation of the Establishment Clause has been described in a number of ways. *Lemon v. Kurtzman*[59] articulated the original test for determining whether a statute effects an unconstitutional establishment of religion. To pass muster under the *Lemon* test, a statute must meet three factors: "First, the statute must have a secular legislative purpose; second, its principal or primary effect must be one that neither advances nor inhibits religion; finally, the statute must not foster an excessive government entanglement with religion."[60] The Court later provided several modifications of the *Lemon* test. In *Agostini v. Felton*,[61] the Court held that the last two prongs of the *Lemon* test are identical, and in *County of Allegheny v. ACLU*,[62] the Court held that the last two prongs essentially inquire into whether a statute "has the purpose or effect of 'endorsing' religion"[63] – *i.e.*, if the statute promotes religion or "convey[s] a message that religion or a particular religious belief is favored or preferred."[64]

There can be little doubt that the Act has a primarily secular legislative purpose: to provide for "the highest possible health status for Indians" without intruding on Indian self-determination.[65] Thus, the only question remaining is whether the Act impermissibly advances or endorses religion.

The answer to this question depends in large part on whether the phrase "traditional health care practices" is construed as being inherently religious. The best reading of the Act is that THCPs are *not* inherently religious. The Act's definition of a THCP does not expressly tie such practices to religious beliefs or practices; rather, the definition sweeps broadly to include practices that are influenced by any aspect of Indian culture regarding "the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness."[66] Thus, THCPs could reflect such non-religious influences as superstition,

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[59] 403 U.S. 602 (1971).

[60] *Id.* at 612-13 (internal quotation marks and citations omitted).

[61] 521 U.S. 203, 233 (1997).

[62] 492 U.S. 573, 597 (1989).

[63] *Id.* at 592.

[64] *Wallace v. Jaffree*, 472 U.S. 38, 70 (1985) (O'Connor, J., concurring in judgment).

[65] § 3 of the proposed Act.

[66] § 4(23) of the proposed Act.

historical customs, and culturally appropriate gender roles.[67] Moreover, even THCPs motivated by religious beliefs or originating from religious traditions are not necessarily religious in character.[68] For example, herbal medicines may be administered in a non-religious manner even if they are or have been connected in some way to religious beliefs. Of course, some THCPs – such as healing prayers and rituals – may be inseparable from religious beliefs and practices, but such inherently religious THCPs are only a subset of the practices covered by the Act.

Given this understanding of THCPs, the first group of provisions listed above – requiring the Secretary to consider THCPs – is almost certainly constitutional. These provisions do not require the Secretary to subordinate non-traditional programs and practices in favor of THCPs. At most, they permit the Secretary to take THCPs into account in implementing the statute. Requiring such an awareness of potential cultural differences does not violate the Establishment Clause.[69] Rather, it merely reflects the statute's goal of providing health care services to Indian tribes in a way that respects their cultures and traditions.

Because THCPs are not inherently religious, the second group of provisions – relating to direct government funding or implementation of THCPs – will also likely be constitutional, if the federal government itself only funds or implements non-religious THCPs. The Establishment Clause does not restrict the federal government's power to provide non-religious services and programs itself. The government's implementation of the non-religious cultural health practices of Indian tribes will neither advance nor endorse religion, for the simple reason that religion will not be involved in the government's programs.

The Secretary could also directly fund THCP practitioners – including religious THCP practitioners – so long as (1) the money was not used for religious activities,[70] and (2) the practitioners were not so "pervasively sectarian" that "'a substantial portion of [their] functions are subsumed in the religious mission.'"[71] For example, the Supreme Court has allowed

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[67] *Cf. Cholla Ready Mix, Inc. v. Civish*, 382 F.3d 969, 977 (9th Cir. 2004) ("Native American tribes are not solely religious in character or purpose. Rather, they are ethnic and cultural in character as well.").

[68] *See Bowen v. Kendrick*, 487 U.S. 589, 604-05 (1988) (noting that counseling and education services provided by religious organizations "are not religious in character"); *McGowan v. Maryland*, 366 U.S. 420 (1961) (upholding Sunday closing laws because they served secular purposes despite originally being religiously motivated).

[69] Indeed, this conclusion would be true even if THCPs were inherently religious. *See Bowen*, 487 U.S. at 607 (upholding statute that required recipients of federal funds to "to describe how they [would] involve religious organizations in the provision of services").

[70] *See Hunt v. McNair*, 413 U.S. 734, 743 (1973) ("Aid normally may be thought to have a primary effect of advancing religion . . . when it funds a specifically religious activity.").

[71] *Bowen*, 487 U.S. at 610 (quoting *Hunt*, 413 U.S. at 743).

religious schools to receive federal grants for building construction when the statute made clear that "the federally subsidized facilities would be devoted to the secular and not the religious function of the recipient institutions."[72] Similarly, the Court has allowed religious groups – but not pervasively sectarian ones – to be the recipients of federal funds when "[t]he services to be provided" under the statute by the groups were "not religious in character."[73] Thus, in funding THCPs, the Secretary will have to ensure that direct government funding flows only to the non-religious activities of non-pervasively sectarian THCP practitioners.

The third group of provisions – relating to the incorporation of THCP practitioners into the activities of government grantees – should also pose no problems under the Establishment Clause. Two of these provisions authorize the Secretary to provide grants to non-governmental organizations which, in turn, are permitted to incorporate THCP practitioners,[74] and the third provision allows "behavioral health aftercare plans" to "use such resources as" THCP practitioners.[75] Under these provisions, THCP practitioners – including religious ones – may ultimately benefit from government aid, but they do so only if the immediate or direct recipients of federal funds choose to incorporate THCP practitioners.

That the third group of provisions does not directly fund inherently religious THCPs places these provisions within the Establishment Clause boundaries of *Bowen v. Kendrick*,[76] which considered the constitutionality of similar provisions in the Adolescent Family Life Act (AFLA). AFLA provided grants to non-governmental organizations for services and research in the area of premarital adolescent sexual relations and pregnancy. Along with expressly acknowledging the benefits of involving "religious organizations" to further its mission, the statute required grant applicants to show "how they [would] involve religious organizations, among other groups, in the provision of services under the Act."[77] The Supreme Court upheld these provisions of the statute, noting that there was no Establishment Clause violation because the statute simply "recognize[d] that 'religious organizations have a role to play' in addressing the problems associated with teenage sexuality."[78] A similar argument would seem to apply here. Just as the AFLA permitted non-governmental organizations to use federal funds to

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[72] *Tilton v. Richardson*, 403 U.S. 672, 679-80 (1971).

[73] *Bowen v. Kendrick*, 487 U.S. 589, 604-05 (1988).

[74] § 211(b)(1)(A) of the proposed Act; § 712(a)(2)(E) of the proposed Act.

[75] § 715(3) of the proposed Act.

[76] 487 U.S. 589 (1988).

[77] *Id.* at 606.

[78] *Id.* at 605-06.

incorporate religious groups in programs regarding teenage sexuality, so this Act permits non-governmental organizations to use federal funds to incorporate potentially religious THCP practitioners in health programs. The upholding of AFLA in *Bowen* against an Establishment Clause challenge suggests that analogous provisions of this Act will pass constitutional scrutiny as well.

These provisions would also likely be constitutional even if the non-governmental grantees passed federal funds to THCP practitioners who then engaged in religious practices. So long as the immediate recipients of government aid are not chosen due to their religion, there is no Establishment Clause violation if those recipients in turn "direct government aid to religious [institutions] wholly as a result of their own genuine and independent private choice," even when those institutions use the funds for religious activities.[79] To the extent that religion is advanced or endorsed due to the religious institutions' indirect receipt of government funds, that advancement or endorsement "is reasonably attributable to the individual recipient, not to the government, whose role ends with the disbursement of benefits."[80] This reasoning applies to the provisions of the Act involving THCP practitioners. None of these provisions conditions receipt of federal funds on the religious nature of the recipient. Moreover, none of these provisions requires recipients to apply federal funds to religious THCP practitioners, nor are recipients who do so rewarded.[81] Instead, each of these provisions lists a large number of other institutions and practices that may be incorporated, and of course recipients are always free to involve non-religious THCP practitioners. Given the freedom of choice and range of options provided by the Act, any diversion of federal funds to religious THCP practitioners and activities would be the result of a "genuine and independent private choice." The Establishment Clause does not forbid such a scheme of federal funding.

Finally, I would like to draw your attention to one possible objection that opponents of the Act may raise. The Establishment Clause flatly forbids government action that advances or endorses "one religious denomination . . . over another."[82] The Act may appear to violate this rule by expressly involving THCP practitioners -- but no other potentially religious groups – in the Act's implementation. However, the mere fact that the Act mentions THCP practitioners

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[79] *Zelman v. Simmons-Harris*, 536 U.S. 639, 653 (2002) (upholding such indirect government aid to parochial schools).

[80] *Id.*

[81] *Witters v. Wash. Dept. of Servs. for the Blind*, 474 U.S. 481, 488 (1986) ("[The statute] does not tend to provide greater or broader benefits for recipients who apply their aid to religious education, nor are the full benefits of the program limited, in large part or in whole, to students at sectarian institutions.").

[82] *Larson v. Valente*, 456 U.S. 228, 244 (1982).

does not necessarily imply that it excludes non-THCP practitioners who are religious. Nothing in the Act prevents the Secretary or grant recipients from incorporating religious organizations who do not engage in THCPs – subject, of course, to the same restrictions that apply to religious THCP practitioners. Indeed, § 715(3) of the Act expressly recommends the use of "community-based therapeutic group[s]" and "other community-based groups," without restricting those terms to non-religious or THCP-specific organizations. Thus, the Establishment Clause's prohibition on sectarian preferences should not apply to the Act.

CONCLUSION

In conclusion, I would like to thank you, Chairman Dorgan, Vice Chairman Thomas, and the members of the Committee for taking so seriously your responsibility to independently evaluate the constitutionality of these amendments to the Indian Health Care Improvement Act. Your concern will ensure that the Act can continue to perform its important role of maintaining and improving the health of American Indians.

TESTIMONY OF DUKE McCLOUD
to the
SENATE COMMITTEE ON INDIAN AFFAIRS
Regarding
REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

SUBMITTED FOR THE RECORD OF MARCH 8, 2007 HEARING

Introduction

Good morning Chairman Dorgan and Members of the Committee.

My name is Duke McCloud. In 2003, I retired after a long career as a Federal government attorney. For the last 25 years of my career, I served as Chief Counsel to the Indian Health Service. I am now Of Counsel to Hobbs, Straus, Dean & Walker, a law firm that specializes in American Indian law. I am honored to have been invited to address some concerns raised last year by the Department of Health and Human Services and Department of Justice about S. 1057 and S. 4122, the 109th Congress bills to reauthorize the Indian Health Care Improvement Act.

In my long tenure as Chief Counsel to IHS, I was proud to help further the IHS mission to fulfill the Federal Government's legal responsibility to provide health care to Indian people and to raise their health status to the highest level. Several significant advancements toward meeting this obligation occurred during my decades of Federal service: enactment of the Indian Self-Determination and Education Assistance Act; enactment of the Indian Health Care Improvement Act; extension of the Federal Tort Claims Act to tribal contractors under the ISDEAA; and the development of Indian self-determination regulations using the Negotiated Rulemaking process. These historic events gave substance to the Federal policy of Indian self-determination and self-governance and contributed significantly to pursuing the IHS mission of improving the health status of Indian people.

It is in this context that I now address some concerns raised by HHS and DOJ about S. 4122, particularly issues regarding FTCA coverage; use of traditional health care practices; the definition of the term "Indian"; and use of Negotiated Rulemaking procedures.

Background of FTCA Coverage for Tribal Contractors

Originally, contracts with Indian tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), as enacted in 1975, were considered Federal procurement contracts, although subject to special provisions to foster tribal self-determination. The original law authorized the Secretaries of HHS and Interior to require

contracting tribes and tribal organizations to obtain liability insurance to protect the Federal government from liability claims. HHS regulations promulgated in 1975, after the law's enactment, required inclusion of an indemnity and insurance clause in each contract requiring the tribal contractor to indemnify and save and keep harmless the Government against any loss, cost, damage, claim, expense, or liability whatsoever by providing insurance. Insurance costs were to be paid with funds provided to the contractor by IHS.

Application of procurement laws to Indian self-determination contracts -- where tribes took over Federal program operation obligations -- did not work well, however. Furthermore, insurance costs added significantly to the amount which IHS was obligated to provide to tribes and siphoned off funds that could otherwise be used for the provision of health services.

Thus, in 1988, Congress amended the ISDEAA to provide that contracts under the Act would no longer be considered procurement contracts. Congress also repealed the insurance and indemnity requirement and added a provision deeming tribal contractors and their employees to be part of the Public Health Service in carrying out ISDEAA contracts for purposes of coverage under the Federal Tort Claims Act (FTCA). This provision made the Federal government the exclusive defendant with respect to medical related claims. The legislative history to this amendment explains that this was done so that the United States, under the FTCA, would shoulder the full responsibility for liability claims arising out of the ISDEAA contracting process.

The rationale for this, as explained in the Senate Indian Committee Report[1], is that the United States has assumed a trust responsibility to provide health care to American Indians and Alaska Natives. The intent of the Senate Committee was to prevent the Federal government from divesting itself, through the self-determination contracting process, of the obligation properly to carry out this Federal trust responsibility. Congress did not view extension of FTCA coverage to ISDEAA tribal contractors as increasing the Federal government's exposure under the FTCA. Rather, Congress viewed this as maintaining what would otherwise be the Federal government's FTCA exposure if there were no ISDEAA, and the health services were provided by the Indian Health Service directly.

Thus, extending FTCA coverage to tribal contractors and their employees marked a significant change in congressional policy based upon consideration of the government's trust responsibility to Indians for health care. The tribes and tribal organizations were no longer to be treated as arms-length procurement contractors, but rather as full partners in carrying out Federal programs and responsibilities. Congress later, in Section 314 of the Department of the Interior and Related Agencies Appropriations Act, 1991, Public Law 101-512, extended general liability (non-medical) coverage under the FTCA to tribal contractors and their employees.

In the 1994 Amendments to the ISDEAA, Congress directed the Secretaries of HHS and Interior to promulgate joint regulations, through the negotiated rulemaking process, relating to FTCA coverage and other matters. The joint regulations promulgated by the Secretaries on June 24, 1996 include a comprehensive subpart governing FTCA coverage for tribal contractors.

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[1] S. Rep. No. 100-274, at 26-28, *reprinted in* 1988 U.S.C.C.A.N. at 2645-2647.

Prior to publication, these regulations went through the Office of Management and Budget clearance process, which included review by the Department of Justice (DOJ).

These regulations deal with both medically related and general liability claims under the FTCA. The regulations contain notification and other procedural requirements that tribes and tribal organizations must adhere to upon receipt of a claim. They also contain specific provisions requiring tribes and tribal organizations to cooperate with and assist the DOJ in defending claims against the Federal government under the FTCA.

DOJ Concerns about FTCA Coverage

The DOJ "White Paper" distributed in September, 2006, notes that "as a general matter" the DOJ "opposes legislation which would make the American taxpayer liable for the torts of persons who are not Federal employees." In October, 2006, I attended a meeting at DOJ arranged by tribal representatives to discuss White Paper issues. The DOJ officials indicated that while this is their view as a general matter, they were not advocating repeal of FTCA coverage for tribes and tribal organizations and their employees carrying out ISDEAA agreements. I was pleased to learn this.

Nonetheless, the DOJ White Paper expressed concern about authorizing the IHS and tribal programs to provide hospice, assisted living, long term care, and home and community based services. In DOJ's view, this would inappropriately extend FTCA coverage to care provided in domestic settings and thus making it more difficult to defend liability claims. It is disappointing that DOJ's analysis focuses solely on their fear of liability claims and does not take into consideration the importance of assuring these forms of health care delivery are available in the Indian health system. Experience in the mainstream health system has fully demonstrated that these modern methods for delivering care are very effective and cost-efficient alternatives to the far more expensive facility-based care.

Section 813 of S. 4122 would have authorized the Secretary to issue standards for the provision of these services; or to apply the standards of the State in which the services are performed. This should fully satisfy DOJ's concern that a standard of care must be available in the event a negligence claim is filed against an IHS or tribal program. I would also like to point out that this does not represent an "expansion" of services as the DOJ White Paper asserts; actually, this provision builds upon existing practices. The IHS, tribes and tribal organizations have for a long time delivered health care in non-institutional settings -- through Community Health Representatives and Alaska Community Health Aides who provide services in domestic settings. These providers must be certified by the IHS. The CHR and Alaska Community Health Aide programs have been authorized by the Act and operated by IHS and tribal programs for many years.

The White Paper also asserted concerns about expanding potential tort liability for the Federal government with respect to services provided to ineligible persons. This is perplexing, as Section 807 of both bills is essentially the same provision that has been in the law for nearly 20 years. 25 U.S.C. 1680c. Thus, it is not an expansion of authorities or services. The current law provision and Sec. 807 of the bill allows the IHS, tribes and tribal organizations to provide

services to persons ineligible for IHS services on a fee for service basis if: (1) providing the services will not result in denial or diminution of health services to eligible Indians, and (2) there are no reasonable alternative health facilities or services, within or without the Service Unit, available to meet the health need of the ineligible individuals. This provision recognizes that there is a need for the IHS system to serve non-Indian individuals, particularly in remote areas where IHS or tribal health care facilities are the only ones available.

DOJ also expressed concerns about bill Sec. 807(e), which is identical to current law. 25 U.S.C. 1680c(d). It authorizes the IHS, tribes and tribal organizations to extend hospital privileges to "non-Service health care practitioners" in IHS or tribal health facilities for the purpose of treating persons authorized to receive IHS services under Sec. 807. As a part of the credentialing process, Sec. 807(e) authorizes non-Service health care practitioners to be designated as federal government employees for purposes of FTCA coverage, but only for acts and omissions that occur in treating eligible persons. It does not grant such practitioners FTCA coverage for acts or omissions in treating ineligible persons. This would not change in current law.

Traditional Health Care Practices. The DOJ White Paper objected to the mention of "traditional health care practices" in several places in the bills, again on FTCA grounds. The Department asserts that it would be very difficult to defend an action under the FTCA involving such practices. Both IHS and tribes consider traditional methods of healing to be an important part of culturally appropriate care where treatment programs should be relevant and effective for the Indian population being served. They have been included as adjuncts to IHS and tribal health care delivery for many years. The few references to traditional health practices that appear in current law simply reflect this realty. The bill's few new references to traditional health practices should be read in the context in which they appear, as their purpose is to help make programs more relevant and effective for the Indian population served, such as in Chairman Dorgan's demonstration program to address the very real problem of teen suicide in Indian Country.

I believe that the risk of tort litigation arising over traditional health care practices is very remote, given that these practices are provided only if requested by the patient, and are part of the traditional culture of Indian patients. Traditional health care services are often arranged by family members and provided by a traditional healer who is unlikely to be an FTCA covered employee of the IHS or a tribe.

With respect to DOJ's concerns about the lack of a standard of care for traditional healing practices in the event of a tort action, it is important to remember that the FTCA only allows an individual to sue the United States on the same terms that a private entity could be sued under state law. If state law does not recognize an action as one to which a defined standard of care applies, any claim would be subject to dismissal for failure to state a claim on which relief can be granted. Thus, if state law does not recognize a cause of action related to traditional healthcare practices, the United States could not be held liable under the FTCA. In my long tenure as Chief Counsel to IHS, I do not recall that any patient ever filed a claim arising from any traditional healing practice, nor am I aware of any instance where a court held the Government liable with respect to such practices. Due to the unlikelihood of such suits, the risk to the Government under

current law is negligible. Thus, there is no need for exempting traditional health care services from FTCA coverage as DOJ would like, and this would be a regression from current law.

Definition of "Indian"

The DOJ White paper also discusses what the DOJ characterizes as a constitutional issue with respect to the definition of "Indian" for purposes of identifying individuals who are eligible for certain scholarship programs and the urban Indian program. It is important to point out that neither S. 1057 nor S. 4122 changes the definition of "Indian" that has existed in the IHCIA since its original enactment in 1976.

The term "Indian" essentially consists of two parts. The first part is a "member of a federally recognized Indian tribe." DOJ has no concern about that portion of the definition. Rather, DOJ expresses concern about the second part of the law's definition which includes members of terminated tribes and state-recognized tribes; Eskimos, Aleuts and other Alaska Natives; and persons considered to be Indian by the Secretary of the Interior or under IHS regulations. This second part of the definition of "Indian" applies only for two carefully defined purposes: eligibility for certain health scholarship programs and for defining an urban Indian.

The DOJ White Paper suggests that under the Supreme Court holdings in *Rice v. Cayetano*, 528 U.S. 495 (2000), and *Adarand Constructors, Inc., v. Pena*, 515 U.S. 2000 (1995), the second part of the definition of Indian for these limited purposes might not survive a strict scrutiny equal protection analysis by the Federal courts and could be struck down as an impermissible racial classification.

I disagree entirely with this view.

Rice v. Cayetano concerned a voting restriction enacted by the State of Hawaii limiting voting for trustees overseeing a state agency to individuals who were descendants of people who inhabited the Hawaiian Islands in 1778. The Supreme Court struck down this state law as violating the Fifteenth Amendment to the United States Constitution because the state law used descent as a proxy for race. The Court was careful to note that its decision rested entirely on the Fifteenth Amendment, observing that it was staying "far off that difficult terrain" of deciding whether Congress may treat the native Hawaiians as it does Indian tribes or authorize States to give native Hawaiians that special status.

The majority holding in *Rice v. Cayetano,* therefore, is not a limitation on Congress's plenary power to legislate for American Indians and Alaska Natives under the Indian commerce clause of the Constitution. The Court did not tread on that "difficult terrain" and there is no reason to accept DOJ's invitation to do so here.

I note, however, that the concurring and dissenting opinions in *Rice v. Cayetano* did discuss the fact that Federal statutes enacted for the benefit of American Indians and Alaska Natives often define "Indian" or "Native" in terms of the ability to trace one's ancestry to a

particular group at a particular time. The Indian Reorganization Act and the Alaska Native Claims Settlement Act are cited in those opinions as examples where descent is used for that purpose. This is permissible under Congress's plenary constitutional power to legislate in the area of Indian affairs.

In the landmark case *Morton v. Mancari,* 417 U.S. 535 (1974), the Supreme Court discussed the plenary power at length and concluded that law enacted for the benefit of Indians will be upheld so long as the special treatment can be tied rationally to the fulfillment of Congress' unique trust responsibility to Indians. The existence of this trust relationship has long been recognized in statutes, regulations, case law, Presidential executive orders and agency policies, and the general course of dealings between Indian tribes and the Federal government. In its role of guardian, the United States provides a variety of services to Indian people because of their status as *Indians* -- that is, *Indians* as a political distinction, not as an ethnic or racial classification. Indians are, of course, also considered to be an ethnic, racial or minority group in our social fabric. But the Court in *Mancari* emphasized that when Congress legislates to carry out its trust responsibility to Indians, it is relating to Indians in their political status vis-à-vis the United States. It is within the power of Congress to exercise its plenary power to enact laws to carry out this trust responsibility.[2]

The Court's 1995 decision in *Adarand Constructors, Inc. v. Pena*, cited in the DOJ White Paper, applied a strict scrutiny equal protection test to strike down preferential treatment for disadvantaged minority owned subcontractors on a Federal highway construction project. However, *Adarand* does not overturn *Mancari* to apply a strict scrutiny equal protection analysis to decide the constitutionality of Federal Indian legislation.

While DOJ raises concerns about inclusion of members of terminated and state recognized tribes for the limited purpose of scholarship aid and the urban program, Congress can restore terminated tribal members to Federal recognition for certain purposes and can extend Federal recognition to state recognized tribes for certain purposes. This part of the definition has been included in the IHCIA for over *thirty years*. It has not been challenged as an impermissible racial classification in all that time because it is an example of Congress exercising its plenary power over Indian affairs and relating to Indians in a political context. This is not the occasion -- nor is there any valid reason -- to disturb this provision of the law.

Negotiated Rulemaking

Section 802 of S. 1057 and S. 4122 requires the Secretary of HHS to use the negotiated rulemaking process to develop regulations for some provisions of the bill. The list of provisions subject to negotiated rulemaking has been pared down significantly from earlier bills in response to HHS objections to the use of negotiated rulemaking. I would urge the Committee to retain the negotiated rulemaking requirements of Sec. 802.

Negotiated rulemaking is a formal process established by the Negotiated Rulemaking Act of 1990, and subsequently reauthorized by the Administrative Dispute Resolution Act of 1996.

[2] In *Morton v. Mancari,* the Court upheld law requiring Indian preference in hiring in the Bureau of Indian Affairs against the contention that this special hiring preference was contrary to Equal Employment Opportunity Act.

The fundamental theory of this process is that rules developed through a consensus process by a Federal agency and the entities significantly affected by the rules can produce better regulations and ones less likely to spawn challenges through litigation. The process involves establishing a formal negotiated rulemaking committee -- in this case, composed of HHS and Indian tribal representatives -- to negotiate regulations through consensus and recommend them to the Secretary for promulgation.

Requiring negotiated rulemaking for the IHCIA builds on successful past experience. The ISDEAA required use of negotiated rulemaking to develop regulations governing self-determination contracts and self-governance compacts. I can attest from personal experience as a member of Federal negotiated rulemaking teams that this process led to very successful outcomes. It demanded a great deal of patience and persistence on the part of federal and tribal representatives, but the experience of listening to each other and searching for common ground led to consensus on almost all issues. I can say without reservation that the resulting regulations were well worth the effort.

Not only does negotiated rulemaking work well from a programmatic perspective, it also furthers the important objective of fostering the government-to-government relationship with the Indian tribes. In this regard, I believe that when Congress requires a Secretary to promulgate regulations governing an Indian program, Congress should also, by law, require use of negotiated rulemaking to develop the regulations. The decision whether to use negotiated rulemaking should not be left to the discretion of the Federal agency. I reach this conclusion from my personal experience with negotiated rulemaking in the self-determination and self-governance contexts.

I write the Committee to pose follow-up questions on these or other issues that arise in consideration of IHCIA reauthorization legislation.

Duke McCloud
March 16, 2007

Whyte Hirschboeck Dudek
Government Affairs, LLC

Senator Dorgan
Chairman, Committee on Indian Affairs
United States Senate
Washington, DC 20510

Dear Chairman Dorgan,

The Ho-Chunk Nation would like to submit the following recommendations to the record regarding the Indian Health Care Improvement Act Amendments of 2007.

Whyte Hirschboeck Dudek Government Affairs has been retained to assist the Nation regarding the proposed Indian Healthcare Improvement Act. A delegation of Ho-Chunk Nation representatives met with General Counsel Heidi Frechette of the committee on Wednesday, February 28th, and she suggested we submit written commentary for the record.

The Nation thanks the committee for the opportunity to provide the attached statement for the record regarding the Act. Feel free to contact me directly with any questions at (608) 669-3240 or via email at sgreendeer@whdga.com.

Sincerely,

Samantha Greendeer
Legislative Counsel

Enclosure

HO-CHUNK NATION

Ho-Chunk Nation Division of Health
Indian Health Care Improvement Act

The Ho-Chunk Nation Division of Health operates two ambulatory clinics and five satellites health offices to serve its over 6500 tribal members and other natives living in our 16-county service area. We operate with funds from the tribe, state and federal grants, and the Indian Health Services (IHS). Previously, IHS provided close to 54% of our total health budget. In this past 2006 year, IHS funds provided for 39% of our health budget. It is for these reasons, we are advocating the passage of the Indian Health Care Improvement Act and wish to call for the attention of greater funding allocating to provide sufficient health care for our patients at home.

1) Ho-Chunk Health receives its funds from the allocated IHS budget to the Bemidji Area Office. This budget is shared with 36 other tribes and urban organizations in the region. The overall budget for our region is the lowest funded of the 12 IHS areas and also has the highest rate of chronic disease and disparities in comparison to the other 11 IHS regions in the United States. **The long term solution to improving the health care of American Indians rests in moving IHS out of the United States discretionary budget and place into an entitlement budget that is not subject to the rescissions of events such as the War on Terror and natural disaster relief.**

2) As noted, Ho-Chunk Health Division receives grant awards from the state and federal entities. These grants, at minimum, offer the Nation a taste of possible preventive health programs. It is difficult to sustain any long-term benefits with these short-term grants. **Prevention is a proven strategy to reducing chronic diseases rates and disparities, therefore advocating for a fully-funded IHS budget its most suitable than then the competitive grants offered.**

3) Contract Health Services (CHS) programs are notoriously under funded and the Ho-Chunk Nation had to supplement $1.8 million over the last two years. The non-member natives were eliminated from services and these funds were only dedicated to life or limb – priority 1 cases for Ho-Chunk tribal members. CHS cannot even address those patients whose care is considered medically necessary. **We request**

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funds appropriated for these CHS programs to be greater than funds provided to cover the health care of our federal prison inmates. We also request the fast-tracking of the Medicare Modernization Act, Section 506 which will allow for Medicare like rates to apply to all tribal members, similar to benefits enjoyed by the Department of Defense and the Veterans Administration.

4) The IHS appropriations are through the Department of Interior yet the program is administered through HHS. Therefore, when there is a budget rescission, the Indian Health Service (IHS) is subject to a dual Rescission: one through Interior an one through HHS. It is troublesome that an IHS budget that can barely provide a 39% support of health care is in double jeopardy through of an overall budget cuts. Unlike other programs, IHS is a direct provider of Medicaid services and should not be subject to any rescissions. **Do not allow the IHS budget to be impacted by any budget rescissions.**

5) With the elimination of the Urban Indian Programs, our relocated Ho-Chunk tribal members and other natives will return home and impose greater demands on already under funded system. This demand will also impact our Contract Health Services (CHS) programs. **We oppose the elimination of the Urban Indian Health programs.**

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