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3 HEARING ON ``H.R. 2708, THE INDIAN HEALTH CARE IMPROVEMENT

4 ACT AMENDMENTS OF 2009''

5 TUESDAY, OCTOBER 20, 2009

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The Subcommittee met, pursuant to call, at 2:10 p.m., in
11 Room 2318 of the Rayburn House Office Building, Hon. Frank
12 Pallone, Jr. [Chairman of the Subcommittee] presiding.

13 Members present: Representatives Pallone, Schakowsky,
14 Baldwin, Christensen and Shimkus.

15 Staff present: Andy Schneider, Chief Health Counsel;
16 Bobby Clark, Policy Advisor; Alli Corr, Special Assistant;
17 Mitchell Smiley, Special Assistant; Matt Eisenberg, Staff
18 Assistant; Brandon Clark, Minority Professional Staff; Aarti

19 Shah, Minority Counsel; and Chad Grant, Minority Legislative
20 Analyst.

|
21 Mr. {Pallone.} The hearing of the Health Subcommittee
22 is called to order and today we are having a hearing on H.R.
23 2708, the Indian Health Care Improvement Act Amendments of
24 2009. And I will yield to myself for an opening statement
25 initially and then we will get to the other members.

26 For over the past 10 months our country has been engaged
27 in an important debate about how to reform our nation's
28 healthcare system. But what few people realize is that for
29 over the past 10 years a similar debate has been going on in
30 Indian country as well as in Congress about how to reform the
31 healthcare system that serves American Indians and Alaska
32 Natives. Since 1999, legislation has been pending before the
33 Congress to reauthorize the Indian Health Care Improvement
34 Act which is the cornerstone legal authority for the
35 provision of healthcare to American Indians and Alaska
36 Natives. I know for those testifying before us today and for
37 many of those in the audience, it is well known that the
38 Federal Government has a legal, and I would say moral
39 responsibility to provide free and quality healthcare to this
40 country's Native peoples.

41 This responsibility often referred to as the trust
42 responsibility is born from a legal doctrine consisting of
43 various treaties, contract and court decisions. Putting all

44 the legal aspects aside, I think the trust responsibility can
45 be summed up by saying that something is owed to American
46 Indians for the lands that they were both voluntarily given--
47 that they voluntarily gave to the United States or were
48 forcefully taken as well as the atrocities that were
49 committed against their peoples. And what is owed to them is
50 a pledge from this government to ensure that their wellbeing
51 is taken care of after centuries of mistreatment. But the
52 Federal Government has consistently failed to live up to this
53 responsibility in almost every aspect. They have mismanaged
54 the lands that they hold in trust for Native peoples and
55 American Indian students struggle to receive a proper
56 education that is on par with their peers who are non-Indian,
57 and most important, the quality of healthcare services
58 available to American Indians certainly falls well-below the
59 rest of the general population which in turn has resulted in
60 worse outcomes for Native communities.

61 Now, I can't tell you how many times I have recited the
62 statistics I am going to now give you and I am sure everyone
63 in this room has heard them too many times as well but I do
64 want everyone to understand what is at stake. For Native
65 Americans ages 15 to 44 years, mortality rates are more than
66 twice those of the general population, and American Indians
67 and Alaska Natives have substantially higher rates of disease

68 than the rest of the U.S. population. Based on recent
69 statistics, American Indians and Alaska Natives have seven
70 times the rate of tuberculosis, more than six times the rate
71 of alcoholism, nearly three times the rate of diabetes and a
72 62 percent higher rate of suicide. The Indian Health Service
73 also estimates that more than two-thirds of healthcare that
74 is needed for American Indians and Alaska Natives is simply
75 denied.

76 Over the course of the health reform debate, some
77 opponents have used these statistics and pointed to the
78 Indian Health Service as an example of the failures that
79 would occur under a government-run healthcare system. I even
80 had this in some of my town meetings but these portrayals of
81 the IHS are unfortunate, gratuitous and misleading. The IHS
82 has not failed. Rather the Federal Government has
83 historically failed to properly fund the IHS. A 2004 report
84 on Native American health issued by the U.S. Commission on
85 Civil Rights found that inadequate Federal funding was the
86 major obstacle to eliminating disparities in Native American
87 healthcare. The report stated that annual increases in
88 funding for the Indian Health Service did not include
89 adjustments for inflation or population growth and were
90 significantly less than those allocated to other arms of the
91 Department of Health and Human Services. And this is an

92 important point, in being less is spent on providing
93 healthcare to American Indians per capita than any other
94 subpopulation. In fact, we spend more money to provide
95 healthcare to Federal inmates than we do for American Indians
96 and I think that is probably the most shocking statistic of
97 all.

98 We have made some headway in recent months. Provisions
99 relating to Indian health were included in legislation
100 enacted earlier this year including CHIP or SCHIP as I call
101 it and the ARRA, the Recovery Act or the Stimulus Bill. In
102 both bills we were able to include provisions that would
103 improve outreach in enrollment of American Indians eligible
104 for Medicaid and CHIP. In addition, the Recovery Act
105 included a substantial increase in funding for the Indian
106 Health Service and in May of this year the IHS released 500
107 million of those funds to be used for health facilities
108 construction or maintenance and improvements, health
109 information technology, sanitation facilities, construction
110 and health equipment that will help improve healthcare in
111 Indian country.

112 In addition to these funds, President Obama proposed a
113 13 percent increase for the IHS in his fiscal year 2010
114 budget proposal, and I am happy to say that both the House
115 and the Senate are on track to approve the level of funding

116 requested by the President or even exceed it. Simply by
117 adequately funding the Indian Health Service we can
118 substantially increase the health and well-being of Native
119 communities. But we can't simply say we are going to
120 increase funding for the IHS and call it a day because it is
121 not just a matter of funding. It is a matter of making sure
122 these programs work well and can meet the needs that are
123 present in those communities. The bill we are looking at
124 today would make important changes to the delivery of
125 healthcare services in Indian communities to make sure needs
126 are being met. That is why we must make sure this bill is
127 passed this Congress. It has languished around here for far
128 too long.

129 I want to say I think many of you know that this effort
130 to try to include as much of the Indian Health Care
131 Improvement Act in various legislation as well as in the
132 healthcare reform bill that is moving is an ongoing effort,
133 and we are still trying to do that as much as possible. But
134 I do think that we needed a hearing today because whatever
135 isn't included obviously we would like to move as separate
136 legislation if that becomes necessary and so having the
137 hearing today is which is a legislative hearing as our effort
138 to continue down that path as quickly as possible.

139 I want to thank our witnesses for testifying. We have

140 some new faces including Dr. Yvette Roubideauz, who is the
141 new Director of the IHS. We also have some returning
142 witnesses including Rachel Joseph, who is the co-chair of the
143 National Tribal Steering Committee to reauthorize the Indian
144 Health Care Improvement Act, and thank you, Rachel, for all
145 you have done on this bill. So I want to welcome our
146 witnesses.

147 [The prepared statement of Mr. Pallone follows:]

148 ***** COMMITTEE INSERT *****

|
149 Mr. {Pallone.} And I will now--well, I was going to
150 recognize--I will have to recognize Mr. Shimkus for an
151 opening statement if he likes.

152 Mr. {Shimkus.} Thank you, Mr. Chairman, and I want to
153 welcome our guests here, also. I want to first apologize.
154 This is a day when I conduct a monthly tour for Army veterans
155 and their families at the Capitol which I am already 15
156 minutes late for so but I wanted to make sure that the
157 hearing got off on time with members from the Minority Party
158 here too to welcome you and I look forward to your testimony.

159 The only point that we will add to this debate and it
160 has been a debate in the last reauthorization, and it was
161 addressed in the Senate legislation and we have this debate
162 now with the overall healthcare reform, is the issue of
163 taxpayer funds that would go to abortion and abortion
164 services. There are many of us who will not--will want us to
165 maintain the position of the Hyde language amendment which
166 has been very important in the past legislation. It is under
167 challenge today and so it is important for you all to know
168 that they will be many of us in the pro-life community and it
169 is really a bipartisan group of members, Republicans and
170 Democrats, who will make--want to really ensure that taxpayer
171 dollars not go for those specific type services.

172 So with that, I appreciate the time, Mr. Chairman. I

173 apologize for departing but I have dual commitments.

174 [The prepared statement of Mr. Shimkus follows:]

175 ***** COMMITTEE INSERT *****

|
176 Mr. {Pallone.} Thank you. Donna, the gentlewoman from
177 the Virgin Islands, Ms. Christensen, who has actually both
178 the two both of my colleagues who are here today have had
179 major roles in pushing this legislation. So I appreciate
180 both of your being here and all that you have done.

181 The gentlewoman from the Virgin Islands.

182 Mrs. {Christensen.} Thank you. Thank you, Mr.
183 Chairman, and thank you for holding this hearing.

184 You know, preparing for this hearing today just
185 rekindled my indignation over the way indigenous people of
186 this country have been treated. I don't think it even rises
187 to the level of benign neglect. It really can't when one
188 looks at the tragic impact it has had on individuals,
189 families, tribes and Native populations over the centuries.
190 But H.R. 2708, the Indian Health Care Improvement Act
191 Amendments of 2009 is a good and welcome start however it
192 just scratches the surface.

193 Disease, illness or in the converse, health and
194 wellbeing don't exist in a vacuum. They are the consequences
195 of genetics to some degree, and behavior as well, but the
196 most influential factor is the environment, for the
197 environment affects behavior for sure and can even have some
198 impact on the genetics. Given the deterioration of the

199 environment in which Native people are now confined to, there
200 are extremely poor health, no life expectancy and adverse
201 health behavior resulting in high rates of injuries, suicide,
202 alcoholism and other substance abuse would be expected
203 outcomes of any population group.

204 Having had no change in Indian Health Service provisions
205 since 1976 despite the dire health indicators and given the
206 many advances of health knowledge and technology is truly a
207 shame. The fact that we have not been able to pass a
208 reauthorization since 2001 is also unacceptable. So I am
209 glad that we are having this hearing today following on the
210 one in the Committee on Natural Resources where the chairman
211 and I are both also members and I am also pleased that in
212 addition to the provisions in CHIP and ARRA that H.R. 3200
213 includes some eye care provisions and I am proud to say that
214 the tri-caucus has included eye care provisions in our health
215 equity bill and that we have fully included concerns of our
216 American Indian, Alaskan and Hawaiian Native brothers and
217 sisters in our efforts and our initiatives. But these can
218 only be considered first steps in the effort that we owe to
219 these first members of the American family.

220 So I look forward to working with you, Chairman Pallone
221 and Ranking Member Deal, to make sure that the Indian Health
222 Care Improvement Act Amendments of 2009 are finally passed in

223 2009. So thank you for holding this hearing. Thank you to
224 the witnesses who are here with us today, not only for being
225 here but for all of the work that you have done over the
226 years to improve upon the bill that we have before us today.

227 Thank you. I yield back the balance of my time.

228 [The prepared statement of Mrs. Christensen follows:]

229 ***** COMMITTEE INSERT *****

|
230 Mr. {Pallone.} Thank you.

231 The gentlewoman from Wisconsin, Ms. Baldwin.

232 Ms. {Baldwin.} Thank you, Mr. Chairman. Thank you for
233 convening us and convening this hearing on The Indian Health
234 Improvements Act. I know that this is a major priority for
235 you, Mr. Chairman, and for this subcommittee and I am eager
236 to lend my support and help achieve the goal of
237 reauthorization during this Congress.

238 One of my primary concerns like the gentlelady from the
239 U.S. Virgin Islands, one of my primary concerns is the stark
240 disparities experienced by minority populations in the United
241 States in the healthcare system and with healthcare outcome
242 and access. The American Indian and Alaska Native people
243 have long experienced lower health status when compared with
244 other Americans, and a recent report from the Agency for
245 Health Research and Quality outlined a number of areas in
246 which American Indians and Alaska Natives lag behind others
247 and the specific areas where these disparities are growing
248 worse. The report uses a number of measures to assess access
249 to care including prenatal care, rate of preventative
250 screening and other basic services that are key to preventing
251 illness and disease.

252 One of the most alarming and difficult issues to address

253 is the rampant spread of diabetes in Indian country. Lack of
254 public health initiatives leave families without the
255 information they need to get healthy and to stay healthy, and
256 diabetes ends up being a persistent chronic disease that
257 costs the Indian Health Service an extraordinary amount of
258 money but much more importantly too many Native Americans
259 their lives.

260 That is why I am especially proud of a facility I want
261 to boast about it in the district that I represent run by the
262 Ho-Chunk Nation. The House of Wellness is a state-of-the-art
263 facility designed to offer a full range of health services
264 with the focus on prevention and wellness. It is a fitness
265 and aquatic facility featuring a range of programs designed
266 to promote exercise, a professionally trained staff, indoor
267 walking track and studio lifestyle classes. The House of
268 Wellness also offers childcare services for parents who need
269 a little bit of time to take care of their own health and it
270 also offers a health clinic and pharmacy services to help
271 meet the needs of the community, both Native and non-Native.
272 Through promotion of exercise and helping people of all ages
273 focus on prevention, facilities like this one can change the
274 health trajectory of many Native American families.

275 The Indian Health Service also provides vital water and
276 sanitation assistance to members of the Ho-Chunk Nation. As

277 you know, ensuring that housing is safe and provides access
278 to safe and clean water is one of the most important steps we
279 can take towards improving the health of communities. It is
280 unacceptable to me that we have languished so long without
281 reauthorizing this incredibly important legislation. I want
282 to thank our witnesses here today who will help us understand
283 how much more pressing the need becomes with each passing
284 day.

285 Again, Mr. Chairman, thank you for convening this
286 hearing and I also must apologize. I am going to be skipping
287 between two simultaneous hearings this afternoon but I hope
288 to be here as long as I can to hear your testimony.

289 [The prepared statement of Ms. Baldwin follows:]

290 ***** COMMITTEE INSERT *****

|
291 Mr. {Pallone.} Thank you.

292 And we will now move to our witnesses and on our first
293 panel we have the Director of the Indian Health Service,
294 Yvette Roubideaux, thank you for being here today. I guess I
295 normally say that we have 5 minutes but since you are the
296 only witness, I am not going to worry about it too much but
297 thank you and if you would like to begin.

|
298 ^STATEMENT OF YVETTE ROUBIDEAUX, M.D., M.P.H., DIRECTOR,
299 INDIAN HEALTH SERVICE

300 } Dr. {Roubideaux.} Thank you, Mr. Chairman and members
301 of the committee.

302 Good afternoon. My name is Dr. Yvette Roubideaux and I
303 am the new Director at the Indian Health Service. I am
304 accompanied by Mr. Randy Grinnell, the Deputy Director of the
305 Indian Health Service. I am really pleased to have this
306 opportunity to testify on H.R. 2708, the Indian Health Care
307 Improvement Act Amendments of 2009. I am looking forward to
308 working with you to ensure passage of this important
309 authorizing legislation for the Indian Health Service.

310 As you know, the Indian Health Service plays a unique
311 role in the Department of Health and Human Services because
312 it is a healthcare system that was established to meet the
313 Federal Trust Responsibility to provide healthcare for
314 American Indians and Alaska Natives. The mission of the
315 Indian Health Service is a partnership with the American
316 Indian and Alaska Native people to raise the physical,
317 mental, social and spiritual health to the highest level.
318 The Indian Health Service provides high quality,
319 comprehensive primary care and public health services through

320 a system of IHS, tribal and urban operated facilities to
321 nearly 1.5 million American Indian and Alaska Natives through
322 hospitals, health centers, clinics located in 35 States.
323 However, meeting the mission of the Indian Health Service has
324 become increasingly challenging over time. Population
325 growth, increased demand for services, rising medical costs
326 and the growing burden of chronic disease have place
327 significant strain on the system.

328 In the opening statement of my confirmation hearing
329 before the Senate Committee on Indian Affairs, I stated that
330 despite these challenges I see evidence of hope and change.
331 I have worked on a variety of projects and national
332 initiatives over the past 16 years that have shown me the
333 great potential that exists to improve access and quality of
334 healthcare. I know that thousands of dedicated and committed
335 career staff in the Indian Health System work hard everyday
336 to provide healthcare to their patients in the face of all
337 these challenges and I have seen support from tribes and
338 Congress for change and improvement in the Indian Health
339 Service. I believe we are at a unique moment in time where
340 we have the opportunity to take great strides towards
341 fulfilling the mission of the Indian Health Service and
342 improving the health of American Indian and Alaska Natives.

343 President Obama's commitment to improve healthcare for

344 American Indian and Alaska Native people is reflected by a
345 significant funding increase for the Indian Health Services
346 you mentioned and the fiscal year 2010 budget. While the
347 President, the Secretary and I all understand that money
348 alone is not the whole answer, the significant increase in
349 resources for IHS recommended in the President's budget is
350 essential for the agency to increase services and effectively
351 fulfill its mission.

352 Now is the time to begin the important work of bringing
353 change to the Indian Health Service to improve healthcare
354 quality, to modernize and upgrade IHS facilities, to expand
355 health promotion and disease prevention, and to ensure that
356 American Indians and Alaska Natives are able to get the
357 healthcare that they deserve. Passage of the Indian Health
358 Care Improvement Act will be an important step towards these
359 goals. The Department strongly supports reauthorization of
360 the Indian Health Care Improvement Act and supports the
361 effort to ensure that IHS is able to meet the healthcare
362 needs of American Indians and Alaska Natives and takes into
363 account increased tribal administration of health programs.
364 It is within this context today that we offer our views on
365 H.R. 2708. We will provide a few comments today and we will
366 provide additional comments once we have had an opportunity
367 to conduct complete review of this important reauthorizing

368 legislation.

369 First, we note that the authority for the Catastrophic
370 Health Emergency Fund or CHEF fund included in title 2 of the
371 existing authority has actually been excluded from this bill.
372 We recommend its inclusion because the CHEF program is a key
373 component of the contract health program administered by the
374 IHS and tribal health programs. CHEF provides funding for
375 high-cost cases which cannot be absorbed by local service
376 units contract healthcare programs.

377 Our next comments are in title 1. IHS offers health
378 profession scholarships to American Indian and Alaska Native
379 students who agree to sign a legal contract agreeing to a
380 service obligation upon completion of their health
381 professional training. Unfortunately, a small number of
382 students default on their service obligation. We believe the
383 determination of whether to discharge or suspend a defaulted
384 obligation should remain entrusted as is under current law to
385 a review board charged with making impartial case by case
386 decisions based on a detailed review of the requests. We
387 recommend that the new consultation requirement in this
388 section of title 1 be dropped. Defaulting on this obligation
389 is a serious breach of a legal contract and a resolution must
390 be decided in an impartial manner.

391 The IHS also offers a loan repayment program to health

392 professionals who agree to work in areas of high vacancy or
393 need and a list of priority sites is developed each year. In
394 title 1, H.R. 2708 changes current law to require the
395 Secretary to approve loan repayment of where it is not
396 withstanding the priority ranking of positions for which
397 there is a need or a vacancy required under the section.
398 This modification means that award and approvals would be
399 based on other priorities undermining the development of our
400 annual priority list. So to keep the intent of the loan
401 repayment program consistent with the goal of improving
402 recruitment and retention of health professionals in areas of
403 high vacancy or need, we recommend the term notwithstanding
404 be replaced by terms consistent with the priority list.

405 My next comments are on title 3, the sanitations
406 facility deficiency definitions. H.R. 2708 would provide
407 ambiguous definitions of sanitation deficiencies used to
408 identify and prioritize water and sewer projects in Indian
409 country. Our written testimony provides examples of the
410 problems with these definitions. We recommend retaining
411 current law to distinguish the various levels of deficiencies
412 which determine allocating existing resources.

413 In addition to the comments I have made today on certain
414 provisions of H.R. 2708 there will be additional comments
415 once we have had an opportunity to conduct a complete review

416 of this important reauthorizing legislation. Mr. Chairman,
417 that concludes my testimony. I appreciate the opportunity to
418 appear before you to discuss the reauthorization of the
419 Indian Health Care Improvement Act of 2009. We are committed
420 to working with you to ensure the reauthorization of this key
421 legislative authority. I will be happy to answer any
422 questions that you have. Thank you.

423 [The prepared statement of Dr. Roubideaux follows:]

424 ***** INSERT 1 *****

|
425 Mr. {Pallone.} Thank you and now we will take questions
426 from the panel. I will start with myself.

427 First of all let me thank you for actually getting
428 specific because unfortunately and I know it sounds partisan
429 but in the previous administration we--I don't remember any
430 of the open testimony at all being, you know, specific about
431 the bill. And I also appreciate the fact that you are going
432 to get back to us quickly because as I said I would like to
433 see as much of this included in the healthcare reform as
434 possible and so, you know, as we move with that whatever
435 comments we can get from the administration will be very
436 important, you know, over the next few weeks or the next few
437 months.

438 I want to try to get in three questions here quickly if
439 I can. You know, obviously this legislation has languished
440 for many years in Congress so could you tell us why it is so
441 important to reauthorized the Act and what are the
442 consequences to the IHS and those who rely upon it that we
443 have other than if we continued not to reauthorize?

444 Dr. {Roubideaux.} Well, reauthorization of the Indian
445 Health Care Improvement Act is extremely important. It is
446 important to our patients and our tribes because they view it
447 as their version of healthcare reform and what the Act does

448 is modernizes and updates the Indian Health Service so that
449 we can provide better care for the patients that we serve.
450 The consequences of not acting are that again are our
451 patients and tribes are waiting for this important
452 legislation to be reauthorized so we strongly support its
453 passage.

454 Mr. {Pallone.} Okay and then the second question, you
455 know, I wanted to thank you and for the President obviously
456 for making, you know, the additional funding available that
457 is in the budget. Clearly, that is very important but IHS
458 doesn't rely solely on its annual appropriations to finance
459 services to tribes. It collects reimbursements from
460 Medicare/Medicaid and private payer so how important is it to
461 make sure that tribal members are enrolled in other public
462 programs like Medicare and Medicaid or private insurance when
463 they are eligible for such coverage? And what types of
464 barriers do tribal members face in enrolling in these other
465 programs? How can we overcome those barriers that exist?

466 Dr. {Roubideaux.} Right, well, as I had stated the
467 resources that we have available in the Indian Health System
468 make it difficult for us to meet our mission and so we rely
469 on the ability of serving patients who have other resources
470 in terms of insurance or Medicare and Medicaid coverage.
471 Third party reimbursements from these sources are extremely

472 important. For some of our facilities, over half of their
473 operating budget comes from third party reimbursements so
474 they serve an extremely important source of care for us. I
475 think some of the barriers that we have to having some of our
476 patients enroll in these forms of coverage is that the
477 paperwork can be confusing. There may be a misunderstanding
478 of why they need to provide the information that they do for
479 the applications. And with regard to private insurance, I
480 think that for many of our patients they just can't afford to
481 pay the premiums or can't afford to pay the co-pays. That is
482 why a national health reform provides an opportunity to
483 perhaps American Indians and Alaska Natives have access to
484 better coverage as well.

485 Mr. {Pallone.} Thank you. And then my third question
486 was about the, you know, some of the changes. I know you
487 were able to offer us some of the administration's positions
488 on organizational structural changes and you said you are
489 going to get back to us with more which again, I would
490 appreciate as soon as possible. But did you want to talk a
491 little more about any of these organizational structural
492 changes, say particularly the elevation of the IHS Director
493 to the position of assistant secretary because that is the
494 important part of this legislation for a long time?

495 Dr. {Roubideaux.} Right, we understand that the

496 proposal to elevate the Director of the Indian Health Service
497 to an assistant secretary level is extremely important to our
498 tribes and it has been a recommendation by them because they
499 would like their healthcare needs to be addressed at the
500 highest levels in the Department. I am working with the
501 Secretary and her staff on exploring this issue and once we
502 receive--once we develop a position on it we will let you
503 know but we definitely understand that the health needs of
504 American Indians and Alaska Natives need to be addressed at
505 the highest levels in the Department of Health and Human
506 Services and we are committed to that.

507 Mr. {Pallone.} And that is obviously one that if you
508 could get back to us as quickly as possible. Thank you.

509 The gentlewoman from the Virgin Islands, Ms.
510 Christensen.

511 Mrs. {Christensen.} Thank you, Mr. Chairman, and
512 welcome, Dr. Roubideaux. I missed you at the first hearing.

513 My first question refers to some of the recommendations
514 that Dr. Rock has made that the urban Indians be restored in
515 section 1 and 6 of section 3 be included in the women's
516 health section and in the section that deals with payments
517 under Medicare and Medicaid and SCHIP. Would your office be
518 supporting those recommendations again? Are you aware of
519 them?

520 Dr. {Roubideaux.} Well, while I can't comment on the
521 specific provisions of the bill I can tell you that we are
522 supportive of the needs of urban American Indians and Alaska
523 Natives. We know that many of our American Indians and
524 Alaska Native people choose to leave the reservation and go
525 to urban areas but unfortunately that leaves them in many
526 cases uncovered by the Indian Health Service. So fortunately
527 in some communities we do have the 34 Urban Indian Health
528 programs that are funded by the Indian Health Service and
529 those programs are supported by title 5 of this particular
530 Act, and certainly other provisions apply to them as well.
531 So we recognize these clinics as extremely important sources
532 of healthcare for Native people who go to urban areas.
533 Especially because it is the only source of culturally
534 appropriate care that they can receive in urban areas and
535 these places often help them have a sense of community and a
536 sense of home while they are away from the reservations. And
537 so with regard to the specific provisions what we will
538 include that in our review but we are very supportive of
539 generally doing what we can to support the urban Indian
540 population.

541 Mrs. {Christensen.} Thank you. The bill has provisions
542 to help and recruit and retain health professionals and I
543 believe that the best providers are those from our community-

544 -from the community themselves. In the African-American
545 community the biggest barrier to achieving that kind of
546 diversity in the health workforce is the K through 12. I
547 know this is not specifically related to the bill but is
548 there some commensurate thing from the initiative happening
549 with K through 12 to ensure that this provision to train and
550 recruit them and retrain perhaps Native American providers
551 would not be an empty promise?

552 Dr. {Roubideaux.} Well, there are a number of programs
553 that are already funded by various agencies to deal with the
554 health professional shortages in our communities. One
555 program that we find is the Indians Into Medicine program
556 that looks at recruiting young American Indians and Alaska
557 Native individuals into the health professions. We have a
558 site in North Dakota and we also have a site in Arizona and
559 those address the K through 12 population to try to get them
560 interested in science careers. One of the most innovative
561 projects that we have been involved with is the diabetes and
562 science and education project in tribal schools that was
563 developed in partnership with the National Institute of
564 Diabetes, Digestive and Kidney Diseases. And a curriculum
565 was developed by tribal colleges to be given to students in
566 the K through 12 grades to expose them to science but using
567 diabetes as the example not only to expose them to the

568 science of the disease but also how to be healthy and in that
569 process helps them learn about health professional careers
570 and we are very excited that curriculum is just now available
571 and will be disseminated throughout Indian country. So I
572 think there is some opportunities to improve the exposure of
573 students to science and to health careers in our communities
574 but we clearly need more efforts.

575 Mrs. {Christensen.} Thanks. The bill makes reference
576 to under sanitation facilities the inordinately high
577 incidence of disease, injury and illness directly attributed
578 to the absence or inadequacy of sanitation facilities. And
579 it also says that the long term cost is far greater than the
580 short term cost of providing those sanitation facilities. Is
581 the bill language strong enough to provide the services that
582 would be needed in terms of the sanitation to create those
583 savings not only in money but in terms of illness and lives?

584 Dr. {Roubideaux.} Well, one of the important functions
585 of the Indian Health Service is to provide sanitation
586 facilities. The Indian Health Care Improvement Act has
587 provided the foundation for that. With this bill we have
588 discussed some problems that in the definitions of how they
589 are defining those.

590 Mrs. {Christensen.} Right.

591 Dr. {Roubideaux.} And I think that reauthorization of

592 this bill is important in terms of what services we could
593 provide for our communities.

594 Mrs. {Christensen.} Thank you.

595 Thank you, Mr. Chairman.

596 Mr. {Pallone.} Thank you and thanks so much for your
597 testimony. I appreciate it.

598 Dr. {Roubideaux.} Thank you.

599 Mr. {Pallone.} Good luck with everything.

600 Dr. {Roubideaux.} Thank you very much.

601 Mr. {Pallone.} I would ask the second panel to come
602 forward.

603 Our second panel has four witnesses and I will introduce
604 them starting on my left is the Honorable Jefferson Keel who
605 is Lieutenant Governor of the Chickasaw Nation and President-
606 Elect of the National Congress of American Indians. And then
607 is Rachel Joseph who is Co-Chair of the National Tribal
608 Steering Committee for the Reauthorization of the Indian
609 Health Care Improvement Act. And then we have another
610 Joseph, Andrew Joseph, Jr. who is Chairman of the Human
611 Services Committee, Direct Services Tribe Advisory Committee.
612 And finally, Dr. Patrick Rock who is Executive Director of
613 Indian Health Board of Minneapolis and President-Elect of the
614 National Council of Urban Indian Health. Thank you for being
615 here and thank you for all that you have done over the years

616 on this legislation.

617 As I said, you know, we have 5 minutes but there is not
618 a lot going on today so we are not going to stick to that too
619 much and we will start with Mr. Keel.

|
620 ^STATEMENTS OF HONORABLE JEFFERSON KEEL, LIEUTENANT GOVERNOR
621 OF THE CHICKASAW NATION AND PRESIDENT-ELECT OF THE NATIONAL
622 CONGRESS OF AMERICAN INDIANS; RACHEL JOSEPH, CO-CHAIR,
623 NATIONAL TRIBAL STEERING COMMITTEE FOR THE REAUTHORIZATION OF
624 THE INDIAN HEALTH CARE IMPROVEMENT ACT; ANDREW JOSEPH, JR.,
625 CHAIRMAN, HUMAN SERVICES COMMITTEE, DIRECT SERVICES TRIBE
626 ADVISORY COMMITTEE; AND PATRICK ROCK, M.D., EXECUTIVE
627 DIRECTOR, INDIAN HEALTH BOARD OF MINNEAPOLIS, PRESIDENT-
628 ELECT, NATIONAL COUNCIL URBAN INDIAN HEALTH

|
629 ^STATEMENT OF JEFFERSON KEEL

630 } Mr. {Keel.} Thank you, Mr. Chairman.

631 Good afternoon and first I want to begin by just saying
632 as the President of the National Congress of American Indians
633 I am honored to be asked to present testimony to our friends
634 at the Health Subcommittee of the Energy and Commerce
635 Committee. On behalf of the National Congress of American
636 Indians I greatly appreciate the opportunity to again provide
637 comments and support for a House bill on the Indian Health
638 Care Improvement Act.

639 I want to begin by thanking you Congressman Pallone for
640 your continued efforts to improve the healthcare services

641 delivered to American Indians and Alaska Natives. The Indian
642 country extends its thanks for your hard work over the last
643 several years on the Indian Health Care Improvement Act. We
644 appreciate all that you and the committee have done. Now it
645 is time to get this bill out of committee and passed by the
646 full House of Representatives.

647 My colleagues today will be providing you testimony on
648 duty, rights and obligations for Indian health. They will
649 also provide you with the shocking statistics on health
650 disparities in our communities and why the reauthorization is
651 so desperately is needed, all of which the committee is very
652 familiar with. What I would like to do today is simple. I
653 would like to ask the committee to set a schedule and
654 procedure for when the bill will be passed and enacted.

655 Over the last 10 years, NCAI has worked side-by-side
656 with the National Steering Committee for the Reauthorization
657 of the Indian Health Care Improvement Act and the National
658 Indian Health Board for the same procedures. We work with
659 numerous committee staff on drafting language, watch
660 leadership in the House change and have seen two Presidents
661 come and go in office. With each passing year there seems to
662 be a new must-pass priority and the Indian Health Care is
663 relegated to the sidelines. The nation is now focused on
664 reforming the health insurance industry. As with the rest of

665 the country, this issue is of critical importance to tribes
666 and we support the efforts of the Obama Administration and
667 Congress. Speaker Pelosi and Mr. Pallone have recognized the
668 importance of protecting and preserving the Indian healthcare
669 delivery system during this reform effort and the National
670 Congress of American Indians thanks you for your commitment
671 to Indian country.

672 The Indian Health Service as you well know is in need of
673 updates and modernization. The current House Bill H.R. 2708
674 is a starting point for reforming the IHS. As with the
675 national health reform bills its goal is to provide cost-
676 saving features for healthcare delivery by shifting the
677 healthcare delivery paradigm in the IHS to preventative
678 health. Indian country has been waiting for and asking for
679 these updates for over 10 years. We do not believe the
680 national health insurance reform should be used as an excuse
681 for abandoning the effort to reauthorize the Indian Health
682 Care Improvement Act. We now come before the committee to
683 ask for an assurance that as the nation moves forward with
684 health reform the Indian country will be included and our
685 bill the Indian Health Care Improvement Act will be passed.
686 What I ask again to the committee is, what is your strategy
687 for passing the Indian country's health modernization bill?
688 The National Congress of American Indians knows what this

689 committee can do when it sets its mind to it. We all saw how
690 quickly you came together to write and pass the Affordable
691 Health Choices Act. We witnessed the hard work of the staff
692 in drafting the Indian protections needed within that bill
693 and the dedication of the committee in passing those key
694 provisions. We now ask that that same enthusiasm and
695 commitment be provided for the Indian Health Care Improvement
696 Act.

697 The National Congress of American Indians stands ready
698 as I do and I am sure the other members of this panel do to
699 do whatever it takes to get this bill passed. Again, thank
700 you for this opportunity and I look forward to working with
701 you for passage of this important bill. Thank you.

702 [The prepared statement of Mr. Keel follows:]

703 ***** INSERT 2 *****

|

704 Mr. {Pallone.} Thank you, Mr. Keel.

705 Ms. Joseph.

|
706 ^STATEMENT OF RACHEL JOSEPH

707 } Ms. {Rachel Joseph.} Good afternoon, Mr. Chairman, and
708 distinguished members of the committee.

709 I am Rachel Joseph, Shoshone Paiute of the Lone Pine
710 Paiute-Shoshone Tribe of California and Co-Chair of the
711 National Steering Committee for the Reauthorization of the
712 Indian Health Care Improvement Act, the NSC. I appreciate
713 the opportunity to testify today and to state our strong
714 support for H.R. 2708. On behalf of the NSC and National
715 Indian Health Board, we appreciate your ongoing support for
716 improving healthcare for Indians. I also acknowledge the
717 contribution of tribal leaders who have served on the NSC
718 over the past 10 years.

719 The foundation of our participation in this
720 reauthorization is based on two principles. One, that the
721 legislation allow no regression from current law and that the
722 healthcare system be modernized and strengthened.

723 In the Chairman's opening statement he recited the
724 health status and the statistics of our population. No other
725 segment of the American population experiences greater health
726 disparities than the American Indian and Alaska Native
727 populations. The heartbreaking aspect of these statistics is

728 the knowledge that a majority of illnesses and deaths are
729 preventable if additional funding and modern programmatic
730 approaches to healthcare were available. Despite two
731 centuries of treaties and promises, American Indians and
732 Alaska Natives endure health conditions and a level of
733 healthcare that would be unacceptable to most Americans.

734 Today I respectfully request Congress to fulfill our
735 nation's responsibilities to Indian people by reauthorizing
736 the Indian Health Care Improvement Act this year. The Indian
737 Health Care Improvement Act also needs to be a permanent law,
738 thus we urge the committee to amend H.R. 2708 to remove the
739 sunset dates and permanently authorize appropriations for the
740 Act's programs. Our request for a permanent authorization is
741 not unique. Congress has permanently authorized other
742 Federal Indian Laws such as The Snyder Act, The Indian Self-
743 Determination and Education Assistance Act and other laws
744 which I listed in my written testimony.

745 There are many provisions in the bill which embody the
746 improvements needed for the Indian healthcare system. I
747 would like to highlight just three of them. Section 208
748 recognizes a need for tribal epidemiology centers to be
749 expressly authorized to access the data they need to monitor
750 the incidents of diseases in Indian communities and to help
751 tribes in urban Indian organization design programs to attack

752 those diseases. Complete fulfillment of this mission
753 requires epicenters to operate like public health authorities
754 and to access Indian country data compiled by HHS agencies.

755 Secondly, we strongly support the bill's revisions to
756 current law authorizing a comprehensive system of behavioral
757 health programs. Title 7 authorizes the integration of
758 programs for mental health, social services, domestic and
759 child abuse, youth suicide and substance abuse. Attacking
760 these chronic problems is vital to improve the quality of
761 life in Indian country and strengthening Indian families.

762 Lastly, section 807 addresses a serious issue in Indian
763 country when tribes are compelled to try to fill the funding
764 gap by expanding direct services, augmenting contract
765 healthcare, paying premiums for Medicare part B and D, and
766 developing self-insurance plans for their members.
767 Unfortunately, the tax consequence of such efforts are
768 unclear. Section 807 will clarify that these benefits are
769 tax-exempt as they should be. They were prepaid through the
770 cessation of over 400 million acres of tribal lands and other
771 resources. American Indians and Alaska Native people are
772 entitled to healthcare and should not be taxed when their
773 tribes step in to assist them in obtaining care.

774 While the NSC is extremely supportive of this bill there
775 are a few provisions that require revision and additional

776 provisions we would like to see inserted into the bill. Our
777 proposals are outlined in the section by section revisions
778 document which was included with my written testimony
779 submitted for the record.

780 I would like to conclude by sharing my personal
781 observations and experiences with this reauthorization which
782 have been the most positive and uplifting experience in my
783 life and at the same time the most frustrating experience.
784 During the consultation with the tribes that began in 1998
785 and continued through 1999, tribal leaders across the country
786 made some strong commitments that we would spend long hard
787 hours--no cell phones was one of my ground rules which was
788 pretty exciting as the tribes developed consensus on the
789 proposal that we submitted to Congress. We believe that
790 consensus was necessary so that, you know, we would not be in
791 a divide and conquer position but as you balance the diverse
792 and the varied needs of our tribes it was a tremendous
793 project and undertaking and we did it and we have been able
794 to maintain consensus through all these years.

795 The disappointment part of course is that our job is not
796 done. Mr. Chairman, we appreciate your sponsorship of this
797 bill and we particularly appreciate our relationship that we
798 have been able to have. Excuse the--no pun intended, frank
799 and forthright discussions about the need for reauthorization

800 and we are fortunate that we have that kind of communication.
801 I also would be remiss if I did not acknowledge the support
802 and ongoing efforts of Chairmen Rayhall, Waxman and Rangel
803 and former Chairman Don Young and Dingell and of course
804 Chairman George Miller who has never wavered in his support
805 since he first introduced Indian Health Care Improvement Act
806 when he was chairman of the Natural Resources Committee.
807 Together with our many sponsors who have consistently stayed
808 with us throughout the years, there is no reason in our view
809 that this legislation should not be enacted this year.

810 I would be happy to respond to any questions that you
811 have and look forward to working with you to get this job
812 done. Thank you.

813 [The prepared statement of Ms. Rachel Joseph follows:]

814 ***** INSERT 3 *****

|

815 Mr. {Pallone.} Thank you.

816 Mr. Andrew Joseph.

|
817 ^STATEMENT OF ANDREW JOSEPH, JR.

818 } Mr. {Andrew Joseph.} Chairman Pallone and distinguished
819 members of the committee.

820 My name is Badger in my language. I am Andrew Joseph,
821 Jr. I Chair the Health and Human Services Committee of the
822 Colville Federated Tribes. I Chair the Portland Area Indian
823 Health Board and the Vice-Chair for IHS-DST, Direct Service
824 Tribes.

825 Thank you for inviting the Direct Service Tribes to
826 testify today. The Direct Service Tribes are tribes that
827 have decided to receive their healthcare services directly
828 from the IHS. The Direct Service Tribes consider the
829 decision as an exercise of self-determination and the
830 fulfillment of the Federal Trust Responsibility. Out of 564
831 federally recognized tribes, IHS provides direct healthcare
832 services for over 100 tribes and accounts for over 50 percent
833 of the total IHS population served. Since 1999 tribes have
834 been seeking reauthorization of the Indian Health Care
835 Improvement Act. However for reasons it is difficult to
836 understand, passage of the Indian Health Care Improvement Act
837 Reauthorization Bill has been obstructed each year by
838 concerns of unrelated non-Indian issues. I hope the

839 committee will work with us to ensure that this bill is not
840 sidetracked this year and the bill is passed as soon as
841 possible.

842 For the Indian people, Federal responsibility to provide
843 health services represents a prepaid right. Tribes hold and
844 affirm that the treaties with the Federal Government ensure
845 that healthcare will be delivered effectively in our
846 communities to exchange for the millions of acres of valuable
847 land that are ancestors ceded. Today the Indian Health Care
848 Improvement Act continues to be a vital important policy
849 with--that honors these treaties and serves as a foundation
850 for delivery of healthcare to Indian people.

851 I would like to speak on a few provisions of H.R. 2708
852 that would have significant impact for Direct Service Tribes.
853 First, section 212 provides express authority for IHS and
854 tribes to operate hospice, long term care, assisted living
855 programs to supply health services in homes and community-
856 based settings. All such delivery methods are common in the
857 rest of the country but are rare in Indian country.

858 Second, the elevation of the IHS director as an
859 assistant secretary level that is in the Department of Health
860 and Human Services would be a strong step in creating a
861 direct link to address the needs of tribes especially Direct
862 Service Tribes. With an assistant secretary position, the

863 collaborative efforts of tribes and IHS would be enhanced
864 through true government to government dialog.

865 Additional recommendations--in my remaining time, I also
866 would like to touch on two recommendations for H.R. 2708,
867 permanent authorization of the Indian Health Care Improvement
868 Act. The process of having the Indian Health Care
869 Improvement Act authorized has been long. Tribes have
870 invested into the process for over 10 years. As a tribal
871 leader I need to justify the resources of my--that my tribe
872 puts into trips to Washington, D.C. I know that these vital
873 resources could be put towards critical patient care, however
874 I and my tribe also understand the importance of ensuring
875 that the Indian Health Care Improvement Act is reauthorized.
876 To honor our treaties and to ensure the continual authority
877 for our healthcare system, the bill should be amended to
878 ensure that the authorization for appropriations is
879 permanent.

880 Establishing an office of Direct Service Tribes, H.R.
881 2708 should also be amended to include the establishment of
882 an office of Direct Service Tribes located within the
883 proposed office of assistant secretary. The responsibilities
884 of this office would honor the relationship with tribes by
885 providing technical support to Direct Service Tribes in
886 serving as a point of contact for tribal consultation.

887 I wish to thank the committee for the opportunity to
888 provide these comments and I will be pleased to answer any
889 questions the committee may have. Thank you.

890 [The prepared statement of Mr. Andrew Joseph follows:]

891 ***** INSERT 4 *****

|

892 Mr. {Pallone.} Thank you.

893 Dr. Rock.

|
894 ^STATEMENT OF PATRICK ROCK, M.D.

895 } Dr. {Rock.} Thank you. Good afternoon.

896 My name is Dr. Patrick Rock, Leech Lake Band enrollee
897 and also the President-Elect for the National Council of
898 Urban Indian Health, and also the CEO of my organization
899 called the Minneapolis Indian Health Board.

900 On behalf of the National Council of Urban Indian Health
901 and the 9,000 patient visits that my clinic serves annually,
902 I would like to thank Representative Pallone for introducing
903 this important bill. I would also like to thank the
904 subcommittee for holding this hearing.

905 The Urban Indian Health Program serves over 150,000
906 American Indians and Alaska Natives annually through 36 urban
907 Indian programs across the county. It is a comprehensive
908 health delivery system that integrates public health,
909 preventative health measures, behavioral health and primary
910 care services. The urban Indian programs providing health
911 services are at various levels of services dependent upon the
912 needs of the community and the funding. Our programs are
913 both innovative and cost effective. As a whole, the urban
914 Indian health program leverages \$2 for every dollar of Indian
915 health service investment.

916 We are also a unique system of care designed to fulfill
917 the trust responsibility to Indian people living in urban
918 areas. Congress has repeatedly stated that the government's
919 trust responsibility extends to American Indians and Alaska
920 Natives living away from their tribal homes. From the
921 original Snyder Act of 1921 to the Indian Health Care
922 Improvement Act Congress has affirmed and reaffirmed its
923 commitment to ensure that trust responsibility to Indian
924 people is met regardless of where they reside.

925 Despite this commitment, the trust responsibility to
926 Indian people has not been fully met. The Indian healthcare
927 delivery system is innovative and well-situated to address
928 the health disparities suffered by Indian people in a
929 comprehensive, culturally appropriate manner. However, the
930 Indian health delivery system needs full funding and
931 modernization promised by this bill in order to meet its
932 mission.

933 H.R. 2708 provides a number of new tools and updates for
934 the Indian health providers. These programs and
935 modernizations will help the Indian health delivery system
936 tackle the serious health disparities facing our people.

937 I would like to take the opportunity to highlight three
938 provisions that I believe will greatly benefit urban Indian
939 health providers such as myself. First, in section 515,

940 conferring with urban Indians, in order to--in order of the
941 trust responsibility to urban Indians are fully met, urban
942 Indians need the opportunity promised by this section to
943 discuss the health needs of urban Indians with the Federal
944 Government.

945 Second, section 521, authorization for urban Indian
946 organizations, H.R. 2708 creates tools and programs to
947 address behavioral health disparities suffered by Indian
948 people, especially with regard to Indian youth suicide. This
949 provision assures that urban Indian programs will have such
950 programs available through them through title 5 of IHCA.

951 Third, section 522, health information technology,
952 health information technology is the future of health
953 delivery. Any provider that does not develop HIT
954 infrastructures and systems now will be behind the advances
955 of medicine to the detriment of their patients. This
956 provision assures that title 5 programs will have the support
957 and the opportunities they need.

958 There are also three revisions that the National Council
959 of Urban Indian Health seeks. First, NCUIH strongly supports
960 the National Steering Committee's recommendation that IHCA
961 be made permanent Federal law. There are several major laws
962 which Congress has permanently authorized. We believe that
963 the time has come to give IHCA the same permanency.

964 Second, NCUIH also asks the committee to restore urban
965 Indians to section 3, the Declaration of National Indian
966 Health Policy. Removing urban Indians from this provision is
967 a regression from current law. By not including urban
968 Indians, Congress opens the door to inferences that it no
969 longer believes that the trust responsibility extends to
970 urban Indians. We believe that dropping urban Indians from
971 this provision was done in error and ask the committee to
972 restore urban Indians.

973 Third, NCUIH asks the committee to restore urban Indians
974 to section 201 of title 2. These provisions pertain to
975 third-party billing, a critical necessity for any health
976 provider. Including urban Indians in this section would
977 greatly help urban Indian organizations strengthen their
978 third-party billing capacity which could be a difference
979 between fiscal stability and instability for many programs.

980 As President-Elect of the National Council of Urban
981 Indian Health and the CEO of Minneapolis Indian Health Board,
982 I would like to give Representative Pallone, the committee
983 and the sponsor of the H.R. 2708 my deepest and most sincere
984 thanks for producing this bill. H.R. 2708 provides the
985 necessary modernization for Indian health delivery system and
986 all Indian health providers from the Indian health service to
987 urban Indian health providers will benefit greatly from this

988 passage. While there are few provisions--important
989 provisions for urban Indians that NCUIH feels should be
990 reconsidered we believe that this bill truly reflects the
991 priorities of tribes and of urban Indian health programs.

992 Thank you.

993 [The prepared statement of Dr. Rock follows:]

994 ***** INSERT 5 *****

|
995 Mr. {Pallone.} Thank you, Dr. Rock.

996 And we will take questions from myself initially and
997 then my colleague from the Virgin Islands.

998 Let me address some of the things you mentioned. First,
999 Mr. Keel talked about schedule and procedure for moving the
1000 bill and I would just, you know, like to reiterate what I
1001 said before which is that, you know, I would like to see as
1002 much of this included in the larger healthcare reform as
1003 possible, and so it may very well be that until we know where
1004 we are going with that in the next few weeks that, you know,
1005 we would have to wait until that is sort of resolved.

1006 And then I wanted to mention with regard to Ms. Joseph,
1007 I am very much supportive of what you suggested about not
1008 taxing health benefits provided by tribes. I mean my view of
1009 going back to what I said in the opening statement is that,
1010 you know, since we have a responsibility on the part of the
1011 Federal Government to provide healthcare completely for
1012 Native Americans, if and we are not doing it, if the tribes
1013 set in to make up for that difference it is even more
1014 outrageous to consider taxing them for it when we are
1015 supposed to be providing the benefit completely. So I have
1016 sent letters to IRS and of course, you know, co-sponsored the
1017 legislation that would change--that would make it clear that

1018 they are not taxable. Now, that is the Ways and Means issue
1019 as you know. It doesn't actually come before this committee
1020 but it is something that we are mindful of as well, you know,
1021 as we move forward with the healthcare reform.

1022 I wanted to ask you because several of you mentioned
1023 about the, you know, making the Act permanent and I was going
1024 to ask Ms. Joseph initially, I mean there is some precedent
1025 for that especially with respect to Indian law but tell me in
1026 a little more detail why you think there is a need for
1027 permanent authorization. I mean why is that needed as a--I
1028 mean normally we don't do it so would be your justification?

1029 Ms. {Rachel Joseph.} Well, thank you, Mr. Chairman, for
1030 the question.

1031 I think after this long 10-year experience of course,
1032 you know, the expenditure of resources that Chairman Joseph
1033 spoke to, we certainly, you know, don't want to have to go
1034 through that exercise. But more importantly, we think if we
1035 have a permanent authorization and Congress we know can
1036 revisit that and revise and amend it as necessary, we think
1037 that in the future we would have an opportunity to focus on
1038 one or two or three issues that need to be addressed, and
1039 have some extensive conversations and dialog spent on those
1040 issues, and we think that we should do more of that.

1041 Mr. {Pallone.} Okay, I wanted to ask Mr. Joseph a

1042 different question and that is about long term care services.
1043 You raised that in your testimony and this is something that
1044 I am very interested in, you know. There is probably not
1045 going to be much in the healthcare reform, the larger
1046 healthcare reform on that because of the expense but I am
1047 curious to know more about, you know, those long term care
1048 supports and services provided in Indian country. I mean how
1049 are the American Indian elders provided long term care now
1050 and how would the revised authority under this bill change
1051 the delivery of care?

1052 Mr. {Andrew Joseph.} Honorable Mr. Pallone, right now
1053 our tribe we have--the Colville tribe has a rest home. We
1054 have a area agency on aging and we have some of the people
1055 that take care of our elders at home. Some of our elders,
1056 you know, because of sanitation reasons need to be cared for
1057 24 hours a day, you know, everyday of the year. And, you
1058 know, we all would like to take our last breath in our own
1059 home but for some of us, you know, we are not able to do
1060 that. Some people are really physically impaired and some
1061 elders are trying to take care of elders. So what we would
1062 like to be able to do is figure out, you know, put an
1063 amendment in the bill that would be able to help us, you
1064 know, take care of our elders. The Makah tribe has elders in
1065 rest homes that are over an hour, an hour and a half away

1066 from their reservation. In order to be able to go and visit
1067 them it is a long commute. And by having this in the bill,
1068 we can provide that care for ourselves and it would provide
1069 jobs and it would be allowed for if we can bill through IHS
1070 an Indian counter-rate through Medicaid or Medicare. To me,
1071 our convalescence and our elder rest home is culturally run.
1072 We have our cultural ceremonies there and our elders feel
1073 more at home there.

1074 Mr. {Pallone.} Well, that is what I was going to ask
1075 you. I would imagine your biggest concern is that if, you
1076 know, elders have to be taken to a nursing home or some
1077 institution off the reservation is that very common now
1078 amongst tribes? I imagine you try to prevent that but is
1079 that--is it very common that they have to actually go to a,
1080 you know, or what I call a mainstream nursing home off the
1081 reservation?

1082 Mr. {Andrew Joseph.} Because of the lack of sufficient
1083 funding for IHS, a lot of our elders become into more of a
1084 critical need by the time they, you know, find that their
1085 illnesses take them to a rest home facility and because it is
1086 not in the bill right now tribes aren't able to really, you
1087 know, help fund, you know, for those services to build their
1088 own and take care of their own.

1089 Mr. {Pallone.} All right, thank you.

1090 Let me just ask Dr. Rock, you of course talked about the
1091 urban Indian health program primarily and you mentioned that
1092 the urban Indian health program and how the last
1093 Administration tried to eliminate it from the bill. Of
1094 course, I never quite understood that. Can you talk about
1095 how that urban Indian program why it is so important that it
1096 stays in place and needs to be expanded the way this bill
1097 proposes? And, you know, we hear various things that there
1098 are more and more, you know, Native Americans that are moving
1099 off reservations, living in cities but then we also hear that
1100 a lot of them are coming back. Well, maybe that is less so
1101 now with the recession or maybe more so, I don't know. I
1102 mean I guess it depends upon whether there is economic
1103 opportunities on the reservation but do you want to comment
1104 on that in terms of, you know, particularly now with the
1105 recession or where we are going in the next few years?

1106 Dr. {Rock.} Certainly, well that makes two of us that
1107 we didn't understand why we were zeroed out to begin with but
1108 we play a really important part as far as this healthcare
1109 system that Indian Health Service provides. We see a number
1110 of patients that are either in transition that are moving in
1111 and through the Twin Cities, specifically my program the Twin
1112 Cities, Minneapolis and Saint Paul. People are looking for
1113 work. I see a number of patients of mine, I still practice

1114 medicine, that have lost their jobs that have no insurance
1115 and they have absolutely nowhere to go. They have no access
1116 to care. Even though we--our clinic is right smack in the
1117 middle of several hospitals, we have the university system
1118 there. We have a couple of private hospital systems there
1119 that offer clinical services too, but our patients feel like
1120 they don't have the access there because they don't have the
1121 funding to pay for healthcare, and we often see folks that
1122 come in that have really advanced disease. They are
1123 diabetes, take for example, is to the point to where now they
1124 are starting to see kidney problems or eye problems and we
1125 try our best to get people to the care they need but we are
1126 often at that level of where we are just putting a Band-Aid
1127 on something that could be addressed more appropriately if
1128 the funding sources were there.

1129 Mr. {Pallone.} Has the recession resulted in more
1130 people moving back to the reservation, moving off or both?
1131 Is there--I mean I know I am asking you anecdotally but?

1132 Dr. {Rock.} Yeah, that is exactly right. It is just
1133 through my anecdotal experience of seeing patients one-on-one
1134 everyday. We do see a number of folks that are just moving
1135 to the Twin Cities looking for opportunities for work.
1136 Again, some statistics that we see these days that are 60
1137 percent of Native populations live in urban settings and I

1138 will be interested to see what the new census data will show
1139 as we head into the census as to what that is now currently
1140 but anecdotally, I have a number of patients who have lost
1141 their jobs. I have had one gentleman who worked in the
1142 foundry, lost his job, his insurance. He was a Native man.
1143 He was enrolled in the White Earth Band of Ojibwe in Northern
1144 Minnesota, and his wife recently--was recently diagnosed with
1145 cancer so she was--the family was struggling, and let alone
1146 him losing his job and presenting to me with new onset
1147 congestive heart failure which requires, of course, treatment
1148 and therapies that he couldn't afford. So that is one person
1149 that I see but everyday, everyday we are open we see this.

1150 Mr. {Pallone.} Okay, thank you very much. Thank all of
1151 you.

1152 Before I move to our other panels, let me just ask
1153 unanimous consent that a statement from Congressman Dale
1154 Kildee and also from the California Rural Indian Health
1155 Board, if those would be entered into the record, and without
1156 objection, so ordered.

1157 The gentlewoman from the Virgin Islands.

1158 Mrs. {Christensen.} Thank you again, Mr. Chairman.

1159 President Keel, just from the frustration that hint in
1160 your testimony I would imagine that you support the permanent
1161 reauthorization of IHCIA?

1162 Mr. {Keel.} Absolutely, yes, I do.

1163 Mrs. {Christensen.} Thank you. I just wanted to get
1164 your--that on the record.

1165 And, Dr. Rock, you talked about HIT and the importance
1166 of improving healthcare but do you see this technology as
1167 being really important to linking the urban Indian to the
1168 tribes and to services? Do you think that it can be
1169 assistance because I understand that we don't even know how
1170 many American Indians are living in urban centers and the
1171 difficulties that they have when they need services?

1172 Dr. {Rock.} I think it does have a potential. I know
1173 the current thought behind health information technology is
1174 the key word of interoperability of how the system is
1175 actually going to work together, and we have an invested
1176 interest also from an urban standpoint of being part of that
1177 system. We think that we could provide really a real high
1178 quality of care to our patients with the utilization of a
1179 system as well even cutting our costs as far as healthcare if
1180 we have an interoperable system and a system that is workable
1181 with their providers.

1182 Mrs. {Christensen.} Well, I was on Homeland Security
1183 before I came to Energy and Commerce and interoperability is
1184 something that we are still working on over there and that
1185 has been what, 7 years.

1186 Let me see, I guess let me see who I would ask, Ms.
1187 Joseph, maybe or anyone can really answer this. I am a
1188 strong believer and supporter of primary prevention and the
1189 high prevalence of deaths from injury, from auto accidents,
1190 from suicide has always been something that I have been
1191 concerned about. And I notice similar patterns in not only
1192 in the American Indian but the Alaska Natives and I wonder
1193 if--I don't think that just treating something to the use of
1194 alcoholism is enough because there are all kinds of
1195 conditions as I said in my opening statement but is there
1196 anywhere that you can see that we could do something within
1197 this reauthorization that would address maybe some of the
1198 social determinants as well. We talked about the
1199 modernization of approaches of medicine and to me one of the
1200 more the newer, some of the newer thinking is about the
1201 social determinants to health. But does anybody have any--to
1202 what would you attribute the high prevalence of death and
1203 injury and suicide on the reservation and how could we better
1204 address that?

1205 Ms. {Rachel Joseph.} Well, we always--I hesitate to
1206 say, of course we need more money and but we need more money
1207 for one thing. We are opposing a comprehensive approach to
1208 behavioral health which addresses a number of those issues
1209 you raise and we think, you know, with a comprehensive

1210 approach we are able to use our money more efficiently which
1211 would be some. I do believe that some of the safety funding
1212 related to ambulances and so forth and so on, that comes
1213 through another agency and HHS and through the States, and
1214 some States, you know, have a better working relationship
1215 with their tribes and some don't. So some of that, you know,
1216 accident prevention, you know, auto accidents.

1217 Mrs. {Christensen.} Services when you have had an
1218 accident.

1219 Ms. {Rachel Joseph.} Yes, that money needs to flow
1220 directly to the tribes and not through the States.

1221 Mrs. {Christensen.} Is there enough in the bill that
1222 supports the traditional healers or is there a need for us to
1223 incorporate the traditional healers more in this legislation?

1224 Ms. {Rachel Joseph.} Yes, there--thank you, Councilman,
1225 there is language in the bill that addresses traditional
1226 healers and it is, you know, a tribe by tribe situation and
1227 patient by patient and, you know, as the patients and the
1228 doctors view that traditional healing as necessary, there is
1229 authorization to provide for that.

1230 Mrs. {Christensen.} So you are satisfied with it with
1231 the way it is treated in 2708?

1232 Ms. {Rachel Joseph.} We are satisfied with it. We do
1233 have a little definition recommendation that we would like

1234 to, you know, we would like to include in a revision.

1235 Mrs. {Christensen.} Okay, I don't have any further
1236 questions, Mr. Chairman.

1237 Mr. {Pallone.} Thank you.

1238 The gentlewoman from Illinois, Ms. Schakowsky.

1239 Ms. {Schakowsky.} Thank you.

1240 First, let me apologize for coming in at the last minute
1241 but I didn't want to miss the opportunity to let you all know
1242 that I am a big supporter of the Indian Health Care
1243 Improvement Act amendments and I am a partner with you in
1244 trying to get better healthcare.

1245 I am from Chicago where in my district there is the
1246 American Indian Center and in my Chicago office, which isn't
1247 far from there, I have a star quilt that was given to me by
1248 the Chicago Indian Health Service, and I work very closely
1249 with them and, you know, want to make sure that the resources
1250 that are needed are always available. The organization does
1251 operate a health clinic, conducts education and outreach in
1252 diabetes, provides home visits to people with diabetes to
1253 ensure they are managing the disease correctly. In Illinois,
1254 there is about 73,000 American Indian and Alaska Natives and
1255 the really there is a big concentration in my district. So I
1256 just really wanted to congratulate you on your advocacy on
1257 the good work that you have been doing and to make sure that

1258 I didn't miss the opportunity to tell you that I am grateful
1259 for your advocacy, for the care that you provide and for the
1260 chance to work with you to make it even better.

1261 Thank you. I yield back.

1262 Mr. {Pallone.} Thank you and thank you all. I know
1263 this was short hearing today but I don't--I want you to know
1264 that doesn't in any way take away from, you know, our efforts
1265 to try to move this bill or as I said before, include it in
1266 the larger healthcare reform. And I know all of you have
1267 been playing a major role in all of this and will continue to
1268 as we move forward over the next few weeks.

1269 Did you have a question? Sure.

1270 Mr. {Andrew Joseph.} Chairman Pallone, Dr. Roubideaux
1271 talked about the CHEF and not being included in this and to
1272 me it is really important that it be included into the bill.
1273 One of the reasons why is we are in the CHS dependent area
1274 and are--my tribe's reservation is in a remote location as
1275 some of the Alaska Native villages and some of the other
1276 Direct Service Tribes are in remote locations, and by not
1277 having that in the bill, I would be afraid that we would be
1278 losing a whole lot more lives. The distance that our people
1279 have to travel to get to a hospital facility, if we don't
1280 have hospitals in our area, you know, we have a real need for
1281 these funds. My own grandbaby had to be heart flighted out a

1282 little over a year ago into to Spokane and that cost over
1283 \$10,000. That is where the CHEF funds money comes into play.
1284 It is almost like sending our troops to war and not paying
1285 for the helicopters to bring them in, you know, once they get
1286 wounded. So it is really important.

1287 Mr. {Pallone.} Now, I am glad you brought it up and my
1288 assistant tells me that that was basically a drafting error
1289 and we are conscious of it and we are going to try to correct
1290 it, you know, as we move along because I know how important
1291 it is so thank you for bringing it to our attention again.

1292 All right, thanks very much and we do intend to move
1293 forward. Thank you.

1294 [Whereupon, at 3:25 p.m., the Subcommittee was
1295 adjourned.]