Chairman Inouye, Vice Chairman Campbell and Members of the Indian Affairs Committee. I am Jami Hamel. I have the honor of serving as the Vice Chair of the Tribal Council of the Confederated Salish and Kootenai Tribes of the Flathead Nation (CSKT). I bring you warm greetings from our Tribal Council where you are well-regarded. We greatly appreciate you taking the time to schedule this hearing and to seek our views. I am accompanied today by Anna Whiting Sorrell who is the Director of our Office of Support Services.

There are many issues that we could bring to your attention but we are going to focus on Indian health care in general and a particular aspect of tribal contracting with the Indian Health Service. First, I wish to address a particular problem for Tribes assuming management of health programs with the IHS wherein we believe tribal contractors are being treating in a discriminatory fashion by the IHS.

As you know, under the Indian Self-Determination Act, an Indian tribe can contract (which also pertains to Self-Governance compacting) with the Indian Health Service to provide health care delivery that the IHS would otherwise be legally obligated to provide directly. Some tribes contract while others allow the IHS to directly operate their clinics or hospitals (Service Units).

CSKT's health care delivery system is unique in Indian country. No other CHS dependent tribe has a reservation in excess of one million acres and a population of over 10,600 IHS eligible beneficiaries.[1] Most service units serving such a large user population provide care through their own doctors at their own hospitals or clinics. In these locations, only the most serious cases are referred to private sector for treatment, which is then paid for with Contract Health Service (CHS) funds.

Congress has appropriated Catastrophic Health Emergency Fund (CHEF) to assist IHS in the payment of extremely high cost CHS cases. The CHEF fund, by law, is managed by the IHS Headquarters, which sets the operating policy and procedures. When health care costs for a single incident are extraordinarily high (from an auto accident or complicated surgery for instance) and exceed the threshold amount of $20,800 in costs, Tribes or Service Units are reimbursed with CHEF funds. Because the CHEF is underfunded, IHS usually runs out money around the 10th month of the fiscal year forcing Tribes and IHS to look to other resources to pay for these necessary services.

When a tribe operating its own program under contract has a case that would normally qualify for CHEF funding reimbursement and the national CHEF fund has run dry, THAT tribe is told that it is out of luck and must either pay for the doctor bill themselves or stall the doctor or hospital and pay for with the next fiscal year's funds. However, when a Service Unit being run directly by the IHS has a case that would qualify for CHEF funds at that same time of year, i.e., when CHEF funds are gone, the IHS simply reimburses the doctor/hospital with other IHS dollars (generally from pooled Contract Health Service - CHS - funds from the region or nationally). Federal procurement policy restricts IHS from using different fiscal year funds to pay for these cases, although IHS urges Self-Determination Tribes to do so.

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[1] As a self-governance tribe, we have a signed compact and negotiate an Annual Funding Agreement (AFA) with the IHS. Because there are a large number of already existing hospitals and clinics both on and immediately off our reservation, the IHS at some point determined that it would not make sense to fund the construction of a facility at Flathead. As a result, we do not have an IHS funded hospital or clinic and therefore must purchase our health care on the open market through the Contract Health Service (CHS) budget of the IHS.

This is simply unfair to tribes that contract and we believe is contrary to the Indian Self Determination Act and most certainly violates the Congress' intent and the spirit of P.L.93-638. Having to take on this risk - combined with an insufficient allocation of funding by the IHS - caused our Tribes to come within a hair of retroceding our entire health care compact back to the IHS last month.

We do not believe the Congress ever intended a contracting tribe to take on risk that an IHS directly operated Service Unit would not be asked to take. But, IHS is doing so and causing a major obstacle to tribes to assume management and operation of this health program. Think of what would happen if after the CHEF fund ran dry we had a few costly emergencies late in the year. We could be looking at bankrupting ourselves by compacting with the Federal government. Surely the Indian Self Determination was not intended to be implemented in such an arbitrary fashion.

25 USC Section 1680a specifically states that contracting tribes should be provided funding:

> "…on the same basis as such funds are provided to programs and facilities operated directly by the Service."

In the area of CHS and CHEF funds, this is not happening and we believe this must be corrected. We ask this Committee's help in further clarifying - and if necessary amending - the Indian Self Determination Act, the cornerstone of the federal Indian policy for the past quarter of century, to make it clear that tribes exercising their rights are not forced to assume this unmanageable risk. Tribes must be allowed to access the same pools of funds that IHS direct service units can access. It is only fair and it is what we believe Congress and the Act intended.

Mr. Chairman, if the Indian Health Service were properly funded, this wouldn't be as much of a problem but the fact is that the Congress tremendously underfunds the IHS. Senate Majority Leader Tom Daschle and our Senator Max Baucus acknowledged this earlier this session when they and others proposed an over $4 billion increase in funding for IHS as a part of the Budget Bill. Although this request passed the Senate, it was not agreed to in Conference Committee.

I realize that it is not the Indian Affairs Committee that appropriates funds for the IHS and that the members of this Committee are understanding of the extend of the unmet need, but it must be stated that the extent of the inequity between the Indian Health Service versus what the Appropriations Committees fund for health care at the Veterans Administration - and other agencies - is simply breathtaking.

You have seen the comparative data. IHS is funded so that we are getting around $1,440 a year per capita for Indian people eligible to receive funding. The Veterans Administration receives funding at level in excess of $5,000 per capita for Veterans who are eligible to receive health services. This means that the First Americans, who gave up hundreds of millions of acres of land so that the United States could exist, and who bargained in treaty negotiations for the provision of health care, are being given such short shrift by the Congress as to be relegated as the least healthy population of persons in the United States.

It is time the Congress stopped acknowledging the extent of the inequity and took action to rectify it. Thank you.