TESTIMONY OF MELISSA MCNIEL
EXECUTIVE OFFICER, OFFICE OF PRINCIPAL CHIEF
CHEROKEE NATION
BEFORE THE SENATE COMMITTEE ON INDIAN AFFAIRS
HEARING ON S. 2526
A BILL TO REAUTHORIZE THE
INDIAN HEALTH CARE IMPROVEMENT ACT
July 26, 2000

Good afternoon Mr. Chairman and Members of the Committee, my name is Melissa McNiel, and I am the Executive Officer in the Office of the Principal Chief for the Cherokee Nation. I appear here at the request of Principal Chief Chad Smith to deliver the Cherokee Nation's strong support for S. 2526, the Indian Health Care Improvement Act Reauthorization of 2000. With me are Cherokee Councilwoman Stephanie Wickliffe and Dr. Mim Dixon, Executive Director, Health Services for the Nation.

The Cherokee Nation represents over 213,000 tribal citizens, nearly half of whom live within our 7,000 square mile jurisdictional area. The Cherokee Nation has approximately 1,800 tribal employees (making it one of the largest employers in Northeast Oklahoma), about one-third of whom work in the Nation's health services division.

The Cherokee Nation was one of the first tribes in the United States to execute a self-determination contract under the original 1975 Indian Self-Determination Act and was also the very first tribe to execute a self-governance agreement under Title III of that Act. Since 1994 all of our self-determination programs have been administered under self-governance compacts with the Department of Health and Human Services (DHHS) and the Department of the Interior (DOI).

Under our self-governance compact with DHHS the Cherokee Nation operates six rural outpatient clinics with very limited resources. The Cherokee Nation also operates the inpatient and outpatient contract health services associated with Indian Health Service's (IHS) W.W. Hastings Hospital in Tahlequah, Oklahoma.

The Cherokee Nation applauds this Committee's effort to ensure that the many positive benefits of the Indian Self-Determination Act apply with full force to Indian health care. The

President, Secretary Shalala, and Congress, including this Committee, have all recognized that the federal policy of tribal self-determination and self-governance has been the most successful federal Indian policy in our Nation's history. Congress has an important role to play in protecting and preserving these policies. You have once again done this through the introduction of this legislation.

Twenty-five years ago the Cherokee Nation began the process of self-determination contracting to operate IHS programs to streamline, redesign and enhance federal services for our people. As a result of our vision and our determination, the Cherokee Nation has succeeded in substantially reducing the federal bureaucracy, enhancing local control and making vast improvements in the efficiency of these programs for the benefit of our people.

As you, Senator Campbell, stated in your Introduction Statement for this bill, it "re-affirms the core principles that were part of the 1976 legislation: (1) that federal health services are consistent with the unique federal-tribal relationship; (2) that a goal of the U.S. is to provide the quantity and quality of services to raise the health status of Indians, and (3) that Indian participation in the planning and management of health services should be maximized."

We strongly support the provisions of S. 2526 to continue this self-determination effort. This reauthorization not only strengthens the tribes, but also enables the IHS and other health agencies to better serve tribal members. These federal agencies will become stronger, not weaker, once they stop resisting the natural desire of Indian tribes to govern themselves and start figuring out ways to become true partners, strong advocates and helpful resources for all tribes.

The reauthorization of this Act was conducted under the Tribal Consultation Policy. Indian Health Service convened a Roundtable in June 1998 to begin the discussion of the reauthorization and to give guidance to the consultation process, which included all stakeholders, IHS/Tribes/Urban (IHS).

Coordinators from the 12 IHS Areas formed workgroups of stakeholders and National Indian Health Board representatives. These meetings were to inform the stakeholders about the reauthorization process, and provide opportunities to discuss and reach consensus on recommendations for the Act.

Four regional consultation meetings were held to provide further opportunities for the stakeholders to provide input, share recommendations from the Areas, and build consensus among participants for a unified position. The final report entitled "**Speaking with One Voice"** identified areas of consensus and differences.

The IHS Director convened a National Steering Committee (NSC) to be responsible for the final drafting of the report on the IHCIA recommendations. The NSC is composed of one elected and one alternate tribal representative from each of the 12 Areas, a representative from the NIHB, National Council of Urban Indian Health (NCUIH), and the Self-Governance Advisory Committee. During the course of the 4 meetings, this group's tribal responsibility evolved from compiling a final report of recommendations to the drafting of the actual IHCIA reauthorization bill language.

A National Forum, which was co-sponsored by this Committee, provided time for tribal leaders, urban health representatives, national organizations, related federal agencies and other friends of Indian health, to provide feedback on the draft of the IHCIA reauthorization bill.

With this bill being the product of what we consider to be true tribal consultation, we believe that it will improve the current health care delivery system in many positive ways, including local control and flexibility, and responsiveness to the health needs of Indian people.

We are very happy that this bill sets the tone by focusing on the health status objectives for Indians and by stating that they should be at least as good as the U.S. population as a whole.

Since today's hearing is to focus on Title IV, V, and VI, let me now speak briefly about each:

Title IV - Access to Health Services

Title IV provides some very constructive ways to assure that the American Indian and Alaska Native people benefit from Medicaid, Medicare, Child Health Insurance and other federally-funded health care programs in addition to the IHS delivery system. With a history of federal funding that is significantly below the needs of the American Indian populations, it is important the Indian health care delivery system maximize funding from these sources.

If health care for American Indians was treated as an entitlement, we would not have to talk about supplemental sources of funding. If Indian health care was treated as an entitlement,

the federal funding would automatically be adjusted to accommodate population increases and inflation. However, this has not happened. Each year the inflation-adjusted per capita funding for Indian health declines. So, we must have alternative sources of revenues. Even with Medicaid and Medicare and Child Health Insurance, the funding for personal medical services in the Indian health system is 40 percent less than the health care funding for federal employees. So the provisions in Title IV are essential to preventing the further deterioration of the Indian health care system.

As a whole, we support the provisions in this section; however, we also offer some suggestions for strengthening the language and concepts in Title IV.

Sec. 409. IHS, Department of Veteran's Affairs, and Other Federal Agency Health Facilities and Services Sharing

(c) Agreements for Parity in Services. We are pleased that Congress is considering parity in services in this section. However, there are other issues of parity that should also be considered in the reauthorization of the Indian Health Care Improvement Act.

The Level of Need Funded Study published in December 1999 established that the personal medical services funding for Indian health was only 60 percent of the comparable services for federal employees used as a benchmark. It also compared funding needs within the 12 Areas of the IHS. This study shows that the Oklahoma Area receives the least per capita funding of any Area in the IHS. The Oklahoma Area per capita funding is only $856, compared to an average of $1,495 for all Areas of the IHS, which is only 60 percent of the $2,980 needed to have parity with the federal employee health care benefits.

The Cherokee Nation is served by two of the most underfunded Service Units in the country. Just to bring these two Service Units up to the 60 percent average funding level for the entire IHS requires additional federal funding of $16.6 million for the Claremore Service Unit and $11.6 million for the Tahlequah Service Unit. Thus a total of 28.2 million dollars more in federal appropriations is needed just to bring the Cherokee Nation up to the IHS average of 60 percent of the personal medical service needs. To fully fund these two Service Units would take $66 million.

We note that these two Service Units provide health care for 52,780 users, including some from other tribes.

So, we urge you to expand your consideration of parity issues somewhere in this legislation.

Sec. 419. Co-insurance, Co-payments, Deductibles and Premiums

(b) Exemption from Premiums

We think that the concept here is good. However, the provisions in paragraph 1 should also apply to Medicare in paragraph 2.

(2) Medicare Enrollment Premium Penalties

We certainly support the wording in this section, but we believe it does not go far enough to assure that Indian elders have access to Medicare. As with the previous paragraph, we believe that members of federally-recognized tribes should have their Medicare Part B premiums and co-pays waived. Furthermore, many Indian elders have lived their entire lives in areas of extremely high unemployment where they have been unable to work the required quarters in jobs that would qualify them for Medicare. We believe that all Indian elders should be deemed eligible for Medicare. This is especially important in relation to the high rate of diabetes and end stage renal disease for which Medicare coverage is essential.

Sec. 423. Provisions Relating to Managed Care

This section is extremely important in the current health care environment in which managed care is the dominant form of third party payment.

(a) Recovery from Managed Care Plans

We support the intent of this section, but we believe that the wording needs some clarification. While the right of recovery is an important concept, we think it applies specifically to private sector health plans. It is confusing to roll the private sector plans in with the public sector plans with regard to billing for off-plan services. We support the provision in paragraph (e)

which states that the Indian health organizations shall have the right to be paid directly by the State agency administering Medicaid and Child Health Insurance Plans. Paragraph (a) could be read to suggest that Indian health organizations would bill the plans rather than the states for these programs.

The wording "reasonable costs" is subject to interpretation. We think it should be tied to a specific standard, such as not less than the amount Medicare would pay the IHS for the same service.

(g) Prohibition

This section addresses the default assignment of Indians to Medicaid and Child Health Insurance managed care plans. We think this section should be strengthened in two ways, which would provide access to culturally competent care:

1. If an American Indian does not choose a plan, the default assignment will be to an Indian health provider; and
2. If an American Indian does choose a plan, they can change their assignment to an Indian health provider without being subject to a lock-in period.

Sec. 425. Indian Advisory Committees

While we support the provisions in this section, we want to see a statement that the advisory committees do not replace the requirement for government-to-government consultation between HCFA and tribal governments.

(b) Indian Medicaid Advisory Committees

Because each state has a different Medicaid program, we endorse the concept of a separate Indian Medicaid Advisory Committee for each state where there is an Indian health system. However, we believe this legislation should stipulate that the tribes in each state shall be part of the decision-making to determine the membership structure of the state advisory committee, along the lines of negotiated rule-making.

Title II - Conforming Amendments to the Social Security Act

Our copy of the legislation has a second Title II at the end of the bill. Many of the provisions in this section relate to the financing issues in Title IV. Therefore, we would like to take the opportunity to comment on portions of this section. Specifically, we want to add our strongest endorsement to the following sections:

Sec. 202 (e) Treatment of Certain Programs

This technical amendment to the Social Security Act that would allow tribes to bill Medicare for outpatient services has been needed for a long time. We urge you to act on it even before passage of the Indian Health Care Improvement Act.

Sec. 203. Qualified Indian Health Program

Using a payment method that provides for full cost recovery is necessary in the Indian health system because there is nowhere to shift costs. Very few patients who seek services from the Indian health care system have private health insurance. The IHS is so underfunded that it should not be asked to absorb the costs of providing services to beneficiaries of other federal programs.

Title V - Health Services for Urban Indians

This title establishes urban Indian health programs so that health care services are accessible to urban Indians. This title gives the Secretary of DHHS, through the IHS, the authority to enter into contracts or grants to urban Indian organizations to help these agencies with establishing and administering health programs.

Approximately one-half of the Cherokee Nation tribal members live outside of our service area due to federal policies that encouraged relocation by the BIA as well as the lack of employment opportunities in rural Oklahoma. These Indians should not be penalized for living in urban areas. Therefore, the Cherokee Nation supports the urban Indian programs, in general, and the enhancements made in Title V. Specifically, we would like to comment on two of the sections:

Sec. 516. Urban Youth Treatment Center Demonstration. With the erosion of the quality of life from alcohol and substance abuse, especially in Indian youth, the Cherokee Nation supports this section whole-heartedly. With Native communities being plagued by alcohol and substance abuse, it is causing havoc on Native families across the country. Alcohol continues to be an important risk factor associated with the top three killers of Native youth: accidents, suicide, and homicide. Native Americans have higher rates of alcohol and drug use than any other racial or ethnic group. Eighty-two percent of Native adolescents have used alcohol, compared to 66 percent of non-Native youth. Indian youth face many challenges in the urban setting and for the urban Indian programs to offer culturally competent residential settings for urban Indian youth will be much more effective. New monies are needed to fund this effort as well as adequate funding for the Youth Regional Treatment Control, one of which is operated by Cherokee Nation.

Sec. 518. Grants for Diabetes Prevention, Treatment and Control. Diabetes continues to be a growing problem in many American Indian and Alaska Native (AI/AN) communities with rates increasing rapidly. Diabetes is an epidemic among AI/AN and has been identified as a top health problem in all areas of the IHS. AI/AN are at a risk of 231 percent greater for diabetes mellitus than the U.S. all races' population. Diabetes is a major cause of morbidity (such as blindness, kidney failure, lower-extremity amputation, and cardiovascular disease) and premature mortality in AI/AN. Diabetes is the leading cause of patient visit to Cherokee Nation clinics.

In 1996, an estimated 63,400 AI/AN who receive care from IHS had diabetes. The prevalence of diabetes increases with age and is greater among women than men. With these alarming rates of diabetes among AI/AN, Cherokee Nation supports all diabetes programs. Increased funding is needed for the prevention and treatment of diabetes throughout Indian Country.

Title VI - Organizational Improvements

Indians have tried for many years to bring the much needed national attention and focus on the health status of AI/AN. There have been many failed attempts, but with our perseverance we believe that one day we will be able to achieve our goals.

The Cherokee Nation believes that the provisions in this will assist in our endeavors.

Sec. 601. Establishment of the IHS as an Agency of the Public Health Service. This section addresses the establishment of the IHS as an agency of the PHS. It covers the appointment of the Assistant Secretary of Indian Health by the President and confirmed by the Senate.

There is no doubt that in the competition for a priority in the federal budget; the IHS is losing out each year. Tribal governments have long supported elevating the status of the IHS Director in the hope that greater stature will enable IHS to more effectively advocate for the health needs of AI/AN. This is an accomplishment that will not only decrease the bureaucratic overhead, but will help Indian Country reach its health care goals.

This elevation is needed in order to further the unique government-to-government relationship between Indian tribes and the United States, facilitate advocacy for the development of Indian health policy, and promote consultation on matters related to Indian Health. This elevation will not only provide the necessary leadership within the Administration on Indian health issues, but will bring the much needed focus, national attention, and parity to the devastating health care status of AI/AN.

Sec. 602. Automated Management Information System. This section authorizes the Secretary through the Assistant Secretary of Indian Health to establish an automated management information system for all Indian health care providers to utilize.

This system is essential so as to record health data, justification for budget requests, and documentation of the level of need for IHS.

New language is proposed authorizing the IHS to enter into contracts, agreements or joint ventures with other federal agencies. It is our recommendation that tribal governments be included in this authorization, which would enhance the government-to-government relationship.

Furthermore, we must recognize that this will be a costly endeavor. Funding should not be diverted from our all to meager attempts at patient care. This item should be funded in the context of an appropriations bill that makes progress to close the gap created by unmet needs.

Conclusion

When the people living in the 14 counties of the Cherokee Nation turn on the news, they hear that the federal government has more than a trillion dollars in surplus and is spending billions on a missile defense system that doesn't work, and billions to provide health care for people living in other countries. We wonder why the good people in our Congress have forgotten their commitment to provide health services to American Indian and Alaska Native people. Could we just exchange one anti-ballistic missile for funding to alleviate the illness, pain and suffering in Indian Country? The reauthorization of the Indian Health Care Improvement Act is an important step forward. But it can only make a positive impact on the health of AI/AN if it is accompanied by an appropriations bill that provides funding to carry out the goals of the Act.

It has been said, "great nations, like great men, keep their promises." As I see it, S. 2526 simply allows Congress to fulfill the promises it has made to tribal leaders. The health of Indian people continues to lag that of other Americans. The members of this Committee are well aware that the health program is woefully underfunded. The total unmet need is $1.2 billion. This amount is needed to eliminate the *current* health deficiencies in Indian country. Indian tribes throughout the country, the National Congress of American Indians, the National Indian Health Board, and regional tribal organizations all strongly support this bill. The Cherokee Nation therefore urges the Committee to enable Congress to fulfill the promises it made to the Indian people in P.L 93-638.

After all, Cherokee families, our children and our elders are the ones who need health care. The Cherokee Nation takes great pride in delivering health services in our area just as well as, if not much better, than any federal agency or private provider ever could. This bill will enable us to make our health system more efficient and more responsive to the needs of our tribal members.

The Cherokee Nation looks forward to the day when it can come to this Committee with nothing but positive reports about the elevation of the health status of American Indians and about a true partnership between the IHS, Indian tribes, and urban Indian organizations.

S. 2526 furthers and strengthens Congress' historic self-determination, self-governance

and tribal policies. It should become law.

Thank you Mr. Chairman and Members of the Committee, for the opportunity to testify in strong support of this important legislation.