S. HRG. 108–677

REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

ON

OVERSIGHT HEARING ON PENDING LEGISLATION TO REAUTHORIZE THE INDIAN HEALTH CARE IMPROVEMENT ACT

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REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

WEDNESDAY, JULY 21, 2004

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

The committee met, pursuant to notice, at 2:06 p.m. in room 216, Hart Senate Building, Hon. Ben Nighthorse Campbell (chairman of the committee) presiding.

Present: Senators Campbell, Domenici, Dorgan, Inouye, Johnson, and Murkowski.

STATEMENT OF HON. BEN NIGHTHORSE CAMPBELL, U.S. SENATOR FROM COLORADO, CHAIRMAN, COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. The committee will be in order. We will go ahead and start. Normally we try and make sure Senator Inouye is here, too, as the Ranking Member, but he has gotten kind of double-booked so he may drop in a little bit later. Right now, he is tied up.

Welcome to the committee hearing on legislation to reauthorize the Indian Health Care Improvement Act. I and some of the staff were just recently in my ancestral home of Lame Deer, MT, where I am a member of the Northern Cheyenne Tribe. I can tell you, after my visit up there, when I always visit home, it is one thing to read the statistics about Indian health, but it is another one to see the faces of the young kids or elders in particular who have health problems. In the case of elders, many times people who have had their legs amputated because of the complications of diabetes. It is not an easy thing to see when you recognize that so many Americans have so much better health care than people on reservations do.

It makes me, among many, to be somewhat angry because Indian people generally, they do not care about CBO scores or committee jurisdiction or controversial provisions or even the bickering that we get involved in here in Washington, the cross-party bickering. All they know is that they are sick and they are not getting enough help.

It does not have to be that way. Secretary Thompson is here, and I know he is a good man and a good friend of mine for many years. I know he is well aware of what is happening out there. I am interested in hearing his testimony.

This act was last reauthorized in 1992 when President George H. W. Bush, signed a bill into law. Beginning in the mid-1990's, Indian tribal leadership has conducted hundreds of meetings and consultation sessions aimed at putting together the kind of legislation proposal that is required to update the act, and to address the health care problems facing native peoples.

Since the late 1990's, Senator Inouye and I repeatedly introduced legislation to reauthorize this key statute. We have held untold numbers of hearings and any number of formal meetings with our colleagues on other committees. With the number of legislative days quickly dropping, I think we only have about 23 or 24, something of that nature, of actual working days, we are honored to have the Secretary of Health and Human Services with us to discuss his views on this pending legislation. We certainly hope that we are going to, with your help, be able to move this bill.

Senator Inouye is not here, but I would first, before I go to you, J.D., I would like to call on Senator Johnson if he has any comments.

STATEMENT OF HON. TIM JOHNSON, U.S. SENATOR FROM SOUTH DAKOTA

Senator JOHNSON. Just very briefly, Mr. Chairman. I am very appreciative of your holding this hearing today. I welcome our colleague from the House side, Representative Hayworth here, and of course Secretary Thompson and Dr. Grim is welcome as well to this hearing. Dr. Grim was kind enough to spend some time in Eagle Butte, SD with me, talking to leaders of our Cheyenne River Tribe relative to health care needs on that particular reservation, one of nine Indian reservations in the State of South Dakota, where we have a new IHS facility that is being planned and at the early stages. Dr. Grim was very cooperative and I appreciated his willingness to join me in Eagle Butte.

I am pleased that the Department of Health and Human Services is now prepared to share their views, I hope, with us on reauthorization of the Indian Health Care Improvement Act. We have been holding off and holding off for a long time to be in a position to markup this act. This legislation is absolutely critical to the health and welfare of Native Americans all across America, certainly in my State of South Dakota. Mr. Chairman, I think your hearing today was a further assistance in moving things along and getting the comments from the administration.

I am pleased as well that the Department of Health and Human Services has conveyed to us that they are committed to reauthorization, to improvements in the Indian health care programs. It is important to me to note their willingness to work not only with our committee and other committees, but with the National Tribal Steering Committee and other representatives of Indian country to develop a bill that all stakeholders can support.

I am very committed to a consultative role that the Federal Government necessarily has with our tribes. Our tribes have a very unique government-to-government relationship, of course, and it is important that in the course of developing a reauthorization that our relationship with the tribes recognizes their sovereignty, recog-

nizes the need for a consultative role in coming together with legislation that we all can support.

We have treaty and trust responsibilities. I think we also have a moral obligation. As you note in your experience, Mr. Chairman, all across Indian country, certainly in my State of South Dakota, the rates of diabetes, the rates of suicide, the rates of injury, the rates of virtually every disease are high. They are at third-world levels in some instances. The IHS budget historically has run along probably half of what it really ought to be if we are to provide a quality of health care for every Native American that we have obligations to do.

So we have a lot of catching up to do. We have a lot of work to do. It is my hope that this hearing and the cooperation of Health and Human Services and our colleagues on the House side can help make some very positive things happen, albeit with a very short legislative opportunity here remaining of this 108th Congress.

Thank you again for conducting this hearing. I look forward to the testimony of the witnesses today.

The CHAIRMAN. Thank you.

We will first hear from the Honorable J.D. Hayworth from the great State of Arizona. Welcome, J.D., before the committee.

STATEMENT OF HON. J.D. HAYWORTH, U.S. REPRESENTATIVE FROM ARIZONA

Mr. HAYWORTH. Chairman Campbell, thank you very much for those words of welcome. Senator Johnson, thank you as well for your comments. I thank you for the opportunity to testify here today.

As you both have noted, this is an excellent opportunity to really have bicameral, bipartisan cooperation to move forward this very important piece of legislation. The Indian Health Care Improvement Act Amendments of 2003, or as we refer to it in the other body, H.R. 2440, the subject of my remarks today.

As you know, the original Indian Health Care Improvement Act, or the acronym IHCIA, became law in the 94th Congress, back on September 30, 1976. The purpose of that act was to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging the maximum participation of Native Americans and Alaska Natives in such programs.

The IHCIA provides for health care delivery to over 2 million American Indians and Alaska Natives, many of whom live in my home State, the great State of Arizona. Appropriations for Indian health have continued through the Snyder Act, a permanent law authorizing expenditures of funds for a variety of Native American programs, including health.

But year-by-year appropriation is not the optimal way to fund Indian health services. The tribes do not like it. Fiscal conservatives do not like it. I get the feeling the IHS really does not like it. And those of us who sit on authorizing committees need to exercise our authority to produce a stable plan for Indian health.

In short, the IHCIA requires reauthorization this year. Reauthorizing this legislation will address some of the problems you and I have been hearing about back home on the respective reservations.

Unfortunately, today's health care delivery to Native American communities remains disproportionately less than what the general population receives here in the United States. Native Americans continue to suffer from diabetes, alcoholism, tuberculosis and heart disease at far higher rates than the rest of our population. IHCIA reauthorization addresses these issues.

This bill is based largely upon the recommendations made by the Indian health community, including tribal leaders, tribal health directors, health care experts, native patients themselves, and the Indian Health Service. The proposed legislation builds upon the basic framework of the IHCIA. It gives tribes a greater role in health care delivery, strengthens behavioral health programs, expands assistance available to urban areas, provides innovative options for funding Indian health facilities, and increases the number and availability of Indian health care professionals.

I would credit Representative Don Young, Congressman of all Alaska, who introduced the House version of the bill, of which I am a cosponsor; and also House Resources Committee Chairman Richard Pombo of California who is working to move the legislation. We have stayed in close contact with the Indian health community to help address concerns at every step of what has indeed become a long legislative process. Through that collaboration, I believe we have produced a sound and important bill.

Now, a few words on just where we stand in the House. As with this distinguished body, we are waiting anxiously for comments back from the Administration. That is why I join you in welcoming my good friend, the Secretary of Health and Human Services Tommy Thompson as he addresses the committee today. He can shed some light on the progress of the Administration. The HHS Secretary was just in my home State this week on the Navajo Nation, so I know these issues are important to the Secretary and to his Department. He has shown his dedication to improving Indian health and he is to be commended.

My staff and I have met with the very capable people the Secretary has put in place at IHS and HRSA. They have great ability and serious intent, and I would like to publicly thank the Administration for its dedication.

Accompanying that commendation, I simply ask that the Administration give us its views on this legislation just as quickly as possible. We have three committees of jurisdiction with claim on this bill in the House. I am hopeful we can get it moved this year in the days that remain. I sit on two of those committees, the Committee on Resources and the Committee on Ways and Means. I commit my full energies to moving the legislation through those respective committees.

I think we need to accomplish some significant work at the staff level during the August recess if we hope to finish anything this year. So we will be listening with more than casual interest to the Administration views.

Secretary Thompson spoke during his time in Arizona of the bright future of the Navajo Nation and of his commitment to advocating for the tribes' health funding here in Washington. I am confident we are on the same page. I look forward to working together with the Secretary, with the Administration, with this committee,

with your distinguished body in reauthorizing this important piece of legislation.

Thank you, Mr. Chairman and thank you, Senator Johnson.

The CHAIRMAN. Thank you, J.D. Just as a background matter, I am sure you are aware of it, but for maybe our colleagues or visitors who are not, this reauthorization is long overdue. I introduced a reauthorization bill in the 106th Congress, in fact, along with Senator Inouye and Senator McCain. We got it out of committee, but could not get it through the Senate. I reintroduced it in the 107th Congress and had Senator Johnson, Senators Dorgan, Daschle, Feinstein, Murray, all cosponsoring, as well as Senators Inouye and McCain who were prime sponsors with me.

We did not get that one out of committee. In the 108th Congress, we did it again. I introduced it along with Senator Inouye again and Senator McCain again and Senator Johnson, Senator Murray, Senator Daschle, a number of people that support this bill. About this time right after that, Congressman Young, as you mentioned, did introduce H.R. 2440.

Well, we did a first hearing in the 108th Congress on April 2. I do not know if Senator Murkowski is on it or not yet. We did a first hearing in the 108th on April 2. We did a second hearing in 2003 on July 16 of that year; a third hearing on July 23 of that year. So this is another hearing, and we still haven't gotten this thing done yet. I think everybody I talk to knows it is overdue and Indian people are sick and suffering. We need to get the thing done with, and with only 23 days left, we are just not going to do it unless we have a lot of help from both sides of the Hill and the Administration too.

Mr. HAYWORTH. Mr. Chairman, I would concur. While a private citizen, I remember the remarks of General Schwarzkopf when he compared the legislative bodies here on Capitol Hill to a daycare center. I do not think that is the case. I think it is more a situation like college where sometimes when we have deadlines, we can actually get things done. It seems at times we work at cross-purposes. We are, after all, deliberative bodies. But given the legislative record you chronicled, the hearing here, likewise the hearings and the effort we have made in the House, there is no time like the present to move forward.

I remain optimistic, even though the days start to dwindle, that certainly this must be a priority and we need to get this done before the conclusion of the 108th Congress.

The CHAIRMAN. Interesting you should use an educational analogy, because my wife used to teach the fifth grade. She said there is a distinct similarity between what we do here and her fifth grade class sometimes.

Thank you for appearing here.

Mr. HAYWORTH. Thank you very much.

The CHAIRMAN. Senator Murkowski, did you have any opening statement before we go to our next witness?

Senator MURKOWSKI. Thank you, Mr. Chairman.

I understand that the Secretary is up next. Is that correct?

The CHAIRMAN. That is correct.

Senator MURKOWSKI. If it is appropriate, I will go ahead and include my introduction in advance of his testimony then.

The CHAIRMAN. That will be fine.

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

Senator MURKOWSKI. I thank you, Mr. Chairman, for the hearing this afternoon. I welcome you, Mr. Secretary, to the committee and look forward to welcoming you again in Alaska when you come up and visit us next week.

The Alaska Native health care delivery system is one of the crown jewels of Alaska, from the village health aids spread among clinics in the remote villages, to the rural telemedicine system which allows the health aids to work collaboratively with physicians in Alaska's hub cities. From the regional hospitals to the state-of-the-art Alaska Native Medical Center in Anchorage, it is clear that our native people are cared for. You, Mr. Secretary, are no stranger to this, having visited our native health care delivery system on many occasions.

You know that the Alaska Native health system does not only deliver health care, but it delivers economic opportunity. To our young native people, it represents an open door to a lifelong career in health care. To Alaskans, native and non-native alike, it is an employer of choice. And to the large number of Alaska businesses that benefit from the millions of dollars it invests in the Alaska economy, it is an economic engine.

We are here today to discuss the reauthorization of the Indian Health Care Improvement Act. Mr. Secretary, I am going to tell you that Alaska needs this reauthorization to occur. I am also going to tell you that this viewpoint is held by Indian health providers throughout the Nation.

The bill before us is the product of years and years of hard work by a national steering committee. It is not a self-governance bill, a direct services tribes bill, an urban bill or indeed, an Alaska bill. It is all of these things, but what is most important is that it is the glue that holds the Indian health care delivery system together. It may be, Mr. Chairman, the most important piece of legislation that the Indian Affairs Committee will take up this year. I hope, Mr. Secretary, that you will assist us in its passage.

Mr. Chairman, I thank you for the opportunity to make a few comments.

The CHAIRMAN. Thank you.

With that, we will now turn to Tommy Thompson, Secretary of Health and Human Services, accompanied by Dr. Charles Grim, Director of the Indian Health Service.

Mr. Secretary, thank you for appearing, my friend of so many years, and not only from a political standpoint, a professional standpoint, but my occasional riding buddy, too. I might tell you I saw our friend Max Baucus yesterday on crutches around here, and reminded him of that old saying that there are two types of bikers, the ones that have gone down and the ones that are going to go down. So he has been baptized. [Laughter.]

But hopefully he will recover very shortly and get back out and ride with us sometimes.

Please proceed, and we will have a few questions for you.

STATEMENT OF TOMMY THOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY CHARLES GRIM, DIRECTOR OF THE INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. THOMPSON. Thank you very much, Mr. Chairman.

Let me first congratulate you for holding the hearing and thank you, Senator Johnson, for being here. Senator Murkowski, I will see you next week in Alaska when I make my annual trip to Alaska and spend 1 week among the Alaska Natives. Senator Inouye, I am sorry he cannot be here because he, too, is a friend of mine. I was hoping he would be here.

I have gone down several times, Senator, so I have already been under the baptism of fire as far as a motorcycle is concerned. I thank you and I congratulate you also, Senator Campbell, for the new post office that is going to be named after you.

The CHAIRMAN. Someone told me that.

Mr. THOMPSON. I was very honored and pleased to see that, and I also read with a great deal of delight your story in the Washington Post, and thought that was a wonderful tribute to a great Senator. I think it is a real loss, will be a loss to the U.S. Senate when you retire, Senator Campbell. You have been an excellent Senator, a great public servant, and a wonderful friend of mine. I thank you very much for holding this hearing.

It is great to have this opportunity to discuss the reauthorization of the Indian Health Care Improvement Act with you and the other members of this committee. Senator Inouye, it is great to see you here as well. Thank you so very much, my friend.

This act forms the backbone of the system through which many Federal health programs serve American Indians and Alaska Natives. I am please to share with you today the Administration's support for the reauthorization of the Indian Health Care Improvement Act during this Congress. I think all of you have indicated the necessity, and I agree with that necessity and want to work with you enthusiastically and wholeheartedly to get that accomplished, the result of our efforts to improve services provided by the Indian Health Service, the tribes, the tribal organizations, Alaska Native villages and urban health programs.

From the day I first arrived at the Department of Health and Human Services, I have made the health and well-being of American Indians and Alaska Natives a priority of my Department. I have traveled widely to Indian country over the past several years. I have visited with the Chippewa Indians throughout the Midwest, the Sioux Tribe, and can remember going to the Oglala Sioux Tribe on Pine Ridge and saw on a Saturday, Senators, the devastation of individuals waiting in line in regards to kidney dialysis because of sugar diabetes. It is an epidemic. I will talk about that later.

Alaska Native villages, I have been all over Alaska. Every year, I spend 1 week in Alaska going to different Alaska Native villages, and see the need first hand of what is needed. Earlier this week, I spent 2 days with the Navajo Nation, the first Secretary of Health that has been on that nation and 2 wonderful days in which we had the opportunity to meet with the tribal leaders. We actually went into elderly homes, as you have indicated, Senator Campbell, and met with individuals who are suffering from diabetes and

other circulatory problems and need all the help the Government can give them.

Next week, as I have indicated to Senator Murkowski, I will meet with native leaders in Anchorage and representatives of the Southeast Alaska Rural Health Consortium in Juneau. Since arriving at HHS, Deputy Secretary Claude Allen and I have traveled to all 12 of the Department's IHS service areas. We are the only Secretary of Health and Human Services to have ever done that, and the first Secretary who has been at the Navajo Nation, and I have spent each year a week in Alaska.

As Secretary of Health and Human Services, it has been my goal to improve coordination among the operating and staff divisions of my Department, and to encourage collaboration between HHS and tribes in all the programs that affect their members. I reactivated the Intra-Departmental Council on Native American Affairs in order to provide a consistent policy when working with more than 560 federally recognized tribes. Since 2001, we have increased spending on tribes 17 percent or $541 million. This, of course, is not nearly enough, but it has shown the inclination and the increases of the Department when we have had to zero out other divisions in the Department.

The Medicare Modernization Act of 2003 includes two provisions which are identified by the Indian health programs as high priorities. The major medical assistance allows Indian health programs to use Medicare's bargaining power when purchasing care for contract carriers from hospitals that participate in Medicare for patients not on Medicare. This is a wonderful new addition for the tribes. It is going to save them lots of money and allow them to expand for further care.

The MMA, the Medicare Modernization Act, also allows IHS and tribal hospitals and clinics to build for additional Medicare part B services between 2005 and 2008. The Medicare Modernization Act also includes provisions to help ensure that pharmacies which are operated by Indian health programs, as well as other pharmacies, can participate in the temporary drug discount card and the permanent part D drug benefit programs. These are provisions in the MMA that are going to be very beneficial to the tribes.

I am also exercising my authority, Mr. Chairman, to provide health professionals to IHS-served communities with longstanding vacancies. We are currently assigning 275 commission core officers to serve in IHS facilities. As I said, my Department is strongly committed to the reauthorization of the IHCIA during this Congress in order to improve the health and well-being of American Indians and Alaska Natives. This legislation should provide increased flexibility for the Department in order to work with tribes to improve the quality, availability, and the scope of their health care.

Accordingly, I commend Congress and especially you, Mr. Chairman and Senators Inouye, Johnson, and Murkowski, for including in H.R. 2440 various changes that respond to concerns previously expressed in the bill. I would like to highlight several areas of interest.

I am very pleased with the other ways that H.R. 2440 strengthens other program areas including, number one, providing for improved health services to eligible Indians; expanding behavioral

health programs to provide for prevention and treatment for child sexual abuse, family violence, mental health and suicide and other serious problems. We all know the disproportionate number of tribal members that are afflicted by these type of abuses and these type of abuses.

H.R. 2440 also proposes to allow qualified scholarships to be treated as tax exempt. This is going to help in the recruitment and the retention of health professionals. As Senator Murkowski says, this is a vocation of choice, especially with Alaska Natives. We need to get more tribal members to get involved in the health fields. There is such a shortage and we need to encourage more of it. By allowing for these qualified scholarships to be treated as tax exempt, it is going to allow us to be give at least 50 more scholarships out to Indian country. It will ultimately improve the delivery of long-term care and similar services to Indians. I would like to encourage you to extend this exemption even further to certain qualified loans, as well as the scholarships.

Mr. Chairman, it is no secret that I am personally passionate about reducing the incidence of preventable diseases in this country, particularly among our most vulnerable and hardest-hit communities. Having access to the health care system, to doctors, to screenings, and to necessary medicines and treatments is critical to a successful prevention strategy. Yesterday in the Navajo Nation, there was almost 20 percent, 18.9 percent of the 300,000 Navajo Indians that are suffering from type II diabetes. This is a huge problem, and we have to get back to cultural foods, cultural information in getting involved in training tribal members about eating properly and exercising, not only on Navajo Nation, but across all of the Indian reservations.

We have to come up with a very successful prevention strategy. That is why it is so important to me to support H.R. 2440's provisions to exempt eligible Native American families and individuals from the cost-sharing in the premium requirements under Medicaid. We all know, and I was at an elderly couple's house yesterday. They could not afford to make the cost-sharing of Medicaid, and therefore they went without medical assistance. We have to make sure that we extend that to allow the tribal members to be able to get this coverage.

There continues to be a problem in Indian country with underenrollment in Medicaid and SCHIP. This provision is going to a long ways toward eliminating a barrier to that particular care. In families currently enrolled, but who forego care due to the out-of-pocket costs they simply cannot meet, would no longer bear that burden if you exempt it.

While we need to continue to dialogue on the complexities of the other entitlement provisions in the bill, which have programmatic effects that implicate the states' programs, we can all agree that paving the way for access to Medicaid services is something we should act to do right now.

This leads me to the broader issue of improving outreach, enrollment and the interaction of the tribes with the entitlement programs at HHS. The legislation proposes to address this issue by establishing a commission to study how entitlement programs impact and serve American Indians. While in theory I do not object to hav-

ing an commission, I firmly believe that I can engage in a much more productive and certainly more expedited dialog with the tribes to better and faster identify workable solutions and eliminate barriers to quality care.

If this committee and this Congress decides that a commission is the right way to go, we will support it and work with it and do everything we possibly can to make it successful. But the commission would take possibly 1 year to get up and started and running, and I think it is much faster and better to expedite it and get started right now. I think we can do that throughout the Department. If this committee so directs, we will be more than happy to work with you in any way possible.

I commend you, Mr. Chairman and members of this great committee, for your swift effort to enact legislation this year. It is time to pass this legislation. It will expand access to services and lay the groundwork for an ongoing productive dialog on the matters of broader entitlement programs. We look forward to working with this committee, the National Tribal Steering Committee, and all American Indian and Alaska Native communities as we work to reauthorize and improve Indian health care programs.

To that end, I will strongly suggest that our staffs meet as soon as possible, Mr. Chairman, so that HHS experts may provide the committee with technical comments and assistance in all of the provisions of H.R. 2440.

Thank you for giving me this opportunity. Before I yield back to you, I would like to introduce Dr. Charles Grim, who does an excellent job running IHS. I am very happy that he is with me today in order to help answer any questions that this committee may have.

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

The CHAIRMAN. Thank you, Mr. Secretary.

Dr. Grim has been before the committee several times in fact, and we appreciate him being here.

I certainly appreciate your going out to visit Indian country, Secretary Thompson. You mentioned the Navajos have an 18-percent type II diabetes rate. Let me tell you, in Indian country that is probably even low compared to some tribes. The Pima, I understand, have over 50 percent, 1 out of every 2 people, 1 out of every 2 people suffer some degree of diabetes.

I guess it is one thing to look at diabetes on a chart or a wall or a graph or something of that nature, but when you see people laying in the hospital with their legs cut off because of the advanced stages of diabetes or what diabetes brings on in terms of gangrene and so on, I think it really comes home to roost.

Dr. Grim knows I have two or three times questioned him about the availability of dialysis machines, dialysis machines closer to the source of the problem, because we know many, many Indians have to spend 3 days a week out of their 7-day week on the road to get to wherever a machine is. They will drive icy roads, tough conditions, half-a-day to get somewhere to get their treatment for dialysis and then have to drive back. They just live to be on the road to get to the machine so they can stay alive.

There is something wrong with that. If we put most Americans through that, there would be some kind of a rebellion on our hands. I think we can do better.

One of the other problems in my view is that we know we are putting more resources into the Indian Health Service. You mentioned that. But the problem seems to be growing faster than the resources. For one thing, on Indian reservations there is a fast birth rate, as you know. Sooner or later those kids are going to grow up, and without proper nutrition or preventive methods that you mentioned, they are going to end up with the same thing.

It is one thing to be able to say, well, we need to try to make sure they improve their diet and do certain things. That is great. But what we have to remember is that on the reservations, a lot of the reservation people, they do not have a choice. They live on what are called commodities, which means government surplus canned goods, beans, rice, starches and so on, low protein. If they had a choice, I think some of them would improve their diets, but when you have almost no jobs on many of those reservations, they just have nowhere to turn.

So it is either eat the commodities, starchy foods, or not stay alive. There is no question what they are going to do. They are going to eat what is available there, and then they, in turn, risk getting diabetes from the very diet that they are forced into consuming.

So it is a catch-22 in a lot of respects. Somehow we have to find a way to break that cycle and improve their health from the federal government, which is our responsibility, in my view.

Thank you for agreeing to have your staff meet with our majority and minority staff, too. I think it is really important. I know for some months we have been trying to get a meeting, but for whatever reason we have not been able to do that. So I take you at your word that we would do that as soon as possible. I will relay that to staff and hopefully we will be able to get a meeting very shortly, in the next few days perhaps, and try and find some consensus about what we can do to improve this bill.

Let me ask you a couple of questions.

Mr. THOMPSON. Senator, they are ready to sit down with you next week at any time and go line by line through the bill. OMB has finally given us the green light to get things done. So I want to expedite this as soon as possible. My staff is available to go anytime you want to, Senator.

The CHAIRMAN. You mentioned the scholarship loan program. It has been increasing, did you say, the number of people?

Mr. THOMPSON. It is increasing, but what happens is that under the current law, we have to pay about 30 percent into the Department of Treasury for taxes on the fringe benefits. Under the Indian Health Improvement Act, that is exempted. That 30 percent of the money that we put in there, which was——

Mr. GRIM. You mean the number of scholarships?

Mr. THOMPSON [continuing]. We have about 150, but we could expand it, because 30 percent of that money goes into the Treasury again. By exempting it, we can roll that money back into expanded scholarships for the health care, the health professions.

The CHAIRMAN. Okay, good.

Let me skip around a little bit. I had a number of questions, but there are so many Senators here, I think we will maybe do it in rounds.

Your testimony recommends that we strike all references to consultation, yet when you spoke a minute ago I thought I heard you say the importance of consultation. As you know, Indian tribes, they think very highly of some consultation with the Government before we implement things in Washington and sort of drop it on them. Did I hear you right?

Mr. THOMPSON. No, Senator; we have already started the consultation process through budgets and through everything else. In fact, in every one of the IHS, we have set up voluntary consultation. My concern is the prescriptive language that you put in there, you shall do this and that. We feel that we are already doing it and we are doing it in a way in which the tribes have bought into it and like it, and we do not know why you have to statutorily prescribe that we do it in a certain way. We feel that we are doing it.

If you decide to do it, we will do it. We will comply, but we are already doing it on a voluntary basis, and that is why we do not think it is necessary.

The CHAIRMAN. I may have misread my notes, I might have because as I understand your testimony, you believe that the consultation with tribes is already provided for through the Indian Self-Determination and Education Act.

Mr. THOMPSON. And we have already set it up. We have expanded that throughout the Department. The tribes now have a consultative process in every one of the IHS regions. In fact, we are holding on in Billings, MT I believe next week, and we just got done in Oklahoma. The tribes go there and it is working out.

We have already set up the framework, and that is why we do not think we need statutory language to tell us to do it. That is the question.

The CHAIRMAN. I see. And in there, I understand that working with the tribes somewhat is a little different because of different cultural values. Have you, when you were in Oklahoma and your other meetings, had the occasion to discuss how you fit traditional healing practices in with the grand plan of the Indian health care system?

Mr. THOMPSON. Yes; we have.

The CHAIRMAN. I think that is really extremely important, particularly to our senior citizens.

Mr. THOMPSON. Absolutely.

The CHAIRMAN. We are going to do this in rounds, I think. I would like to yield to Senator Inouye for a few questions, and then we will take questions in order of who got here first. Then we will do a second round. Go ahead, Senator Inouye.

Senator INOUYE. Mr. Secretary, I wish to commend you for the service you have rendered as Secretary of the Department of Health and Human Services.

Mr. THOMPSON. Thank you, Senator.

Senator INOUYE. We here are very pleased with what you have done.

Mr. Chairman, regretfully I have other committees I have to attend, so if I may, may I submit questions for your response, sir?

Mr. THOMPSON. Absolutely.

Senator INOUYE. And once again, thank you. It is always good to see you.

Mr. THOMPSON. It is always a pleasure. I can remember when I met with you in Madison, Wisconsin at the Governor's resident.

Senator INOUYE. Can I still call you Governor?

Mr. THOMPSON. I would much rather have you call me Tommy, Senator. [Laughter.]

Senator INOUYE. Thank you, sir.

The CHAIRMAN. Thank you, Mr. Vice Chairman.

Senator Murkowski, you were next in order of appearance.

Senator MURKOWSKI. Thank you, Mr. Chairman.

I do look forward to our visit next week up in the State. I am sure it will be a good one, as they all have been for you.

I appreciate the comments that you have made about prevention, and then the followup that you have made, Mr. Chairman, about the diet and nutrition. I was in the small village of Norvik just last weekend, on Saturday. Norvik is an Eskimo community just beyond Kotisivu, about 700 people. I went into the store there, as I always do when I go into the villages, to see what their availability is of fruits and vegetables and milk.

There is no milk in the store. There is no powdered milk in the store. I asked when the last time was they got milk in the store, and if they got it, how much. The clerk could not remember the last time they had milk there.

Dr. Grim, you and I have had numerous opportunities to talk about the dental issues that we have with so many of our Alaska Natives. Our children's teeth are literally rotting out of their head. Well, they do not have access to milk. Many do not have access to good sanitary drinking water, so they drink pop. When I was asking the clerk, what is your most popular item, she pointed me to the freezer section where they keep the hot pockets. As a mother of teenage boys, this is the quickie lunch thing that you put in a microwave. They are selling two hot pocket sandwiches for $4.50.

This is what the families are eating. They are moving off of the good traditional subsistence foods that have provided for generations. The junk food aisles in the stores are picked clean. We simply have so far to go when it comes to educating about the proper nutrition, and then furthermore providing it for them. When you do not have the fruits and vegetables, when you do not have the milk products, it is really difficult to talk about that food pyramid and what you should be eating.

Mr. Secretary, I know we have talked a little bit in the past also about Alaska being on the leading edge of public health preparedness programs. Our native hospital there is a key player in the program. Several weeks ago, I had heard that funding for Alaska's bioterrorism program could be reprogrammed somewhere else. I sent you a letter on this and I am wondering if you have any update for me, or if you can let me know what the status is of that.

Mr. THOMPSON. Alaska has received quite a bit of money from the Department of Health and Human Services on bio-preparedness. There is a small portion that is going to be reprogrammed

into cities. It was because the states had not used the money. There was appropriated money going back to 2001–04. Alaska had not used the money from 2002 and 2003, so some money was reallocated into major cities in order to expand bio-preparedness, especially for surge capacity. Alaska was one of those that had, but Alaska still has money that it has not used.

Senator MURKOWSKI. So with those funds that you intend to reprogram, what does that do for the future? Are you suggesting that because we have not used it in the past, we will not be eligible for those funds?

Mr. THOMPSON. No; it does not. This is just a 1-time thing to get cities better prepared for bio-preparedness. The legislation that was passed, Senator Murkowski, was set up so that I had the discretion of putting the money into either the cities or in the States. After it passed in 2001, I directed the money to go to the States. In 2001–03, the States were to use that. Now, I have reprogrammed some of the money because the money was not getting down to the cities. I reprogrammed it into the major cities because the States had not used all of the money that was available to them. In fact, it goes back to since the program was started, and Alaska was one of those that had not used all of its money.

Most of the States had not used all their money. When I went to the National Governors Conference 1 year ago and again this year, I told the States that they had to use this money, because if they did not use it, Congress was going to take a look at these particular money and re-appropriate it. Since we needed money for the cities in this particular time, I took some of that money. It was a very small portion of that money, to reallocate it into the cities for bio-preparedness, surge capacity for hospitals. And that is the reason. That does not mean it is a permanent fix. It just means it was reallocated this year to take care of a particular problem.

In regard to the nutrition and diabetes, we have expanded that program. If you would like, Dr. Grim would be more than happy to explain that as well. But diabetes is a passion of mine. I speak about it all over the country, and especially in Indian country we have to do a better job. We have to, as Senator Campbell says, we have to get more diversity, and as you have said, better foods into the grocery. You cannot expect them to eat five helpings of fruits and vegetables if there are no fruits and vegetables. I am sorry about that. If you would like to comment. I do not know if you have the time, Senator Murkowski.

Mr. GRIM. I would just add to that, Senator, that we are in the process at the Indian Health Service of providing an interim report to Congress. It should be available very, very soon. It is going to give an update to you of what we have been spending and what the tribes have been spending the special diabetes program for Indian funds on. I think you will be very impressed with the amount of primary prevention services that have increased in Indian communities; the amount of nutritional education, physical activity.

We also have in that report some clinical indicators that we have been tracking on our patients to show you that the clinical indicators are moving in the right direction and that we are better controlling the diabetes in our patients from a clinical perspective. So

that will be full of information for you, and as soon as it is available we will get it to you.

Senator MURKOWSKI. Thank you.

I have to go preside now, Mr. Chairman. If there are other questions, I would like to be able to submit those.

Mr. Secretary, we will be following up with you. I will talk with the folks at the state level about the bio-preparedness money and how we can make that work. As you know, we are a long ways away from the rest of the world and we are kind of on our own when it comes to taking care of ourselves. We want to make sure that we have the moneys that we need to provide for our security.

Mr. THOMPSON. And I will be talking to your wonderful Governor next week as well.

Senator MURKOWSKI. Thank you.

The CHAIRMAN. Who would that be? [Laughter.]

Senator Dorgan, you were next in order of appearance.

Senator DORGAN. Mr. Chairman, thank you.

STATEMENT OF HON. BYRON L. DORGAN U.S. SENATOR FROM NORTH DAKOTA

Mr. Secretary, thank you very much, and Mr. Surgeon General, thank you for being here.

First of all, I think this is awfully important work. I think all of us understand we are talking about authorization bills here. The real question is how much funding is available for these programs.

I think the first hearing that I did on diabetes on Indian reservations was a hearing at which Congressman Mickey Leland and I and Congressman Tim Penny flew to the Three Affiliated Tribes in North Dakota and did a hearing. They had a diabetes rate that was I believe 12 times the national average. These were American Indians who were living on the lowlands of the fertile Missouri River bottomlands raising fruits and vegetables and eating berries and so on. Then when the Pick–Sloan project came in and they flooded all that and towns like Elbowoods did not exist anymore, they were under a large 500,000-acre reservoir, they moved the American Indians to the top of the bluffs up there where you do not grow fruits and vegetables and berries, and their diet changed dramatically.

So this is a long tortured trail, this issue of dealing with Indian health care, especially diabetes. I have worked hard on it for a long, long time. There is so much to do. There is so much funding that is necessary for that, and for so many other issues.

I would like to just focus on one quick issue. Mr. Secretary, there is a young girl who recently took her own life on the Spirit Lake Nation. Her name was Avis Little Wind. Avis Little Wind was a seventh grader. She liked riding horses and she liked playing basketball and listening to music when they found her hanging in her closet one morning. She was laying in a fetal position in her bed for 90 days, missing school. Her sister had taken her own life. Two weeks after they found her, her other sister drowned driving under the influence of alcohol. Her father had died of a self-inflicted bullet wound.

I went to that reservation just some weeks ago to meet with school administrators, and met with some of the classmates of this young girl. What I found there is pretty much what I found in

other areas as well. It is a profound lack of resources. One psychologist, one worker who also works in this area that is not professionally trained, a social services worker and a psychologist, that is it. They talk about even having to borrow a car to take a kid someplace to get them treatment. They have to beg and borrow a vehicle.

This is so typical of the problems. There was a young girl named Tamara who some long while ago I got involved in. She was 3 years old and she was beaten severely, nose broken, hair torn out by the roots, arms broken. She was put in a foster home on the Standing Rock Reservation by a woman who was handling 150 cases, 150 cases. She put a 3-year-old girl in a home without checking the home out. The result is in a drunken brawl, this 3-year-old girl was beaten severely. It will have an impact on her the rest of her life.

So these things, when you get to the bottom of what is happening, almost always it is a case that the resources are not available. Now, in the Standing Rock Reservation, we do not have one person handling 150 cases anymore. I fixed that. One by one, you try to fix some of these things. But we have in my judgment, Mr. Secretary, a bona fide crisis in education, housing and health care on the reservations in this country. This is an authorization bill. We need to do this and much, much, much more.

My understanding is that we have trust responsibility for two groups of people for health care in this country. One are prisoners in the Federal prison system and the other a trust responsibility for Native Americans. My understanding further is that we spend exactly twice as much per person on health care for Federal prisoners as we do to make available health care for American Indians.

We just have to stop it, and start over and go in the right direction. No one has been a stronger champion for that than the chairman, Chairman Campbell. I regret that he is leaving the Senate because we are losing a great champion.

Mr. THOMPSON. So do I.

Senator DORGAN. I am not asking a question. I wanted to mention that to you that I have been deeply involved in these issues of suicide, and there is a rash of them on some of these reservations. It comes from I think a kind of desperation and a whole series of other issues. We just have to provide the funding. It is unforgivable for us not to adequately fund these kinds of issues such as psychologists and social service representatives and others who can reach out and help these kids.

I will give you a chance to comment on that in just 1 moment. Mr. Secretary, as long as you are here, you know that I would want to ask you about something you are working on, and I am waiting for an answer on. That is, the pilot project on prescription drugs that I suggest for reimportation of prescription drugs from Canada. I think it was March 31 that I brought that to you. I want to know what the status is and when I might see a decision coming from your agency on that issue.

Mr. THOMPSON. First off, you are a very good man and I thank you very much for your comments.

You were not here when I made my presentation. I just came back from the Navajo Nation. I spent 2 days out there, the first and only Secretary of Health that has ever been there. Next week,

I go to Alaska. Every year, I go to Alaska and spend 1 week in Alaska touring Native Alaskan villages and seeing the despair; seeing and talking to kids and talking about the suicide problems. Your example is replicated in many reservations across the country.

We have to do something about it. On the Navajo Nation yesterday, we went to see a clinical psychologist who was the first Navajo psychologist in the State of Arizona, and the only one. She was there and she had about 15 young girls ages from 9 to 17. She was just doing a wonderful job. I asked you about the rate of recidivism. She said that it is very good. She says we have very few young ladies that graduate from the program that retrogress back into the program; that they go back into school and do so well.

I talked to a young girl who had dropped out of high school and now was doing so well in the program she wanted to finish high school and then go on to become an architect. She was a very talented young lady and made me feel very good.

I asked the clinical psychologist if she was a benevolent dictator, what would be the first thing she would do. She said, I would have a lot more clinical psychologists on the reservation talking to the young people; I can only do so much and the need is so great that we need more.

In regard to the question that you are so passionate about, and I thank you for your passion and I thank you for coming over to the Department and giving me your first-hand persuasive arguments on it. I would tell you that we are working on it. I would tell you that the Surgeon General has held hearings about this, and right now we are working on a report to you and to Congress and hopefully I will be able to get it to you soon.

I have to get some clearance for it, but I want to thank you for it, and I will keep you up to date better than I have in the past. I am sorry about that, but I will get you an answer relatively soon.

Senator DORGAN. Mr. Secretary, thank you very much.

The CHAIRMAN. Thank you. Before I turn to Senator Domenici, thanks for the nice words.

I know, Mr. Secretary, that this problem is not all your own problem. We are dealing with an authorization bill here, but clearly it does not do any good to authorize a bill if we are not going to pay for the thing later. We have to be able to have better support from our colleagues on increasing the amount of money that goes into Indian health care, but we also need help in the Administration when they send a budget over here, regardless of who is in the White House at the time.

I think around here, we too often very frankly end up getting caught up in the blame game. It is the Administration's fault or the other party's fault or it is somebody else's fault, when in my view it is all of our fault a little bit because we do not seem to be working together on trying to improve it as much as it needs to be improved.

But thank you, Senator Dorgan.

Senator Domenici, did you have a statement?

Mr. THOMPSON. Senator Campbell, if I could just say you are absolutely correct. There is enough blame to go around. Let's stop pointing the fingers. Let's sit down and get a good Indian health

reauthorization law through. Let's see if we can get it done. Let's see if that can be the first step toward a bipartisan, bicameral, Administration and Congress, a congressional response to the needs in Indian Land. I am committed to do that, Senator.

The CHAIRMAN. Thank you, thank you.

Senator Domenici.

STATEMENT OF HON. PETE V. DOMENICI, U.S. SENATOR FROM NEW MEXICO

Senator DOMENICI. First of all, I wanted to thank the Secretary for coming here and indicate a few other areas of appreciation. First of all, we want to thank you from New Mexico for assisting us in mediating a recent disagreement between the University of New Mexico and the Indian Health Service, because you got involved and understood that it was only technical and we should not cease to build a major hospital because of that technicality. We will soon start to build a hospital that will end up taking care of our Indian people who qualify and be a tremendous asset for the State.

Second, I would like to say while Senator Dorgan is here that starting a long time ago, we pressed very hard for the construction of Indian schools. I want to tell you that something marvelous has happened since President Bush took office. He met with us, Senator Campbell, in Las Cruces, NM. We had the Indian leaders of New Mexico there. There were two issues, but one was, why aren't we building schools, since we are the only one who can build those schools. They are not State responsibility or county. The President made a commitment.

And guess what happened? We have built 15 new schools in Indian country, and theretofore, we used to build one a year. That truly is outstanding.

Senator DORGAN. Senator Domenici, would you yield on that point?

Senator DOMENICI. Yes, sir.

Senator DORGAN. On Saturday last, we did a groundbreaking on the Ojibwa school on the Turtle Mountain Indian Reservation that has been 18 years in the offing. It has been needed for a long, long, long time. Finally, there was a groundbreaking. So I understand your point. We are making some progress.

Senator DOMENICI. Mr. Secretary and fellow Senators, I want to tell you about the diabetes issue because do you know nobody paid any attention to it until the time we were balancing the budget, believe it or not. Representative Gingrich and I were representing the Congress with Administration people. When we finished it all, we had $100 million left over, if you can believe it, just floating there in this billions of dollars. He said to me, what should we use it on? I said to him, how about diabetes? He says, how about it? I said, why don't we split it? What do you mean? Let's put $50 million in Indian diabetes and $50 million for the rest of the country. He said, it is a deal.

That was the first money ever put in diabetes. It came from that arrangement. A couple of years later, we put $150 million in. I do not say that indicating that we have solved that problem. I know research is going on. It is hard to get done, but genetic research is going on. I think you know that, at a very high level, because

there is something very important and very frightening about how many Indian people get diabetes versus others.

We can explain it away saying there is no milk on the reservation. There is coca-cola, but the number if startlingly high for it to just be that. So I would like to ask you, do you know how much we are actually spending, either you or the Doctor, on Indian diabetes in the United States this year? Doctor?

Mr. GRIM. We can tell you what we have put in since 2002 with the moneys that you have helped make available, over $500 million now. The $150 million that started this year, a substantial portion of that is out in Indian country right now. The thing that I cannot give you additionally, these are targeted grant funds that are going directly to tribes throughout the country, over 300 tribes and Indian organizations now have successful programs running with those grants.

What I can tell you specifically today is how much we are spending in our Indian health care system and our hospitals and clinics. We are spending a significant amount of funds just to treat the ravages of diabetes in our hospitals and clinics. We have greatly appreciated the special funds that Congress made available to target prevention in that effort.

Senator DOMENICI. Mr. Secretary, while you were on Navajo land, did you happen to go to any centers where diabetic people were being take care of with the big machines that keep them alive?

Mr. THOMPSON. We went to several hospitals and several clinics. We did not go to any dialysis centers. I did that in the Oglala Sioux a year ago, and I did that up in Alaska Native settlements, but I did not do that in the Navajo region yesterday.

Senator DOMENICI. Mr. Chairman, I want to tell you that we cannot currently as a Nation build dialysis facilities as fast as the cases are showing up.

Mr. THOMPSON. That is right.

Senator DOMENICI. There are centers all over Navajo country where 40 or 50 dialysis people are taken care at one time. It is like a school full of diabetic Indians, the most startling and pathetic thing you ever saw. It looks like a war had been waged.

Mr. THOMPSON. Absolutely depressing.

Senator DOMENICI. Mr. Secretary, I want to conclude by telling you that I am very thrilled that you went to Indian country, but I think that we have to get commitments earlier out of Administrations to go after these Indian health problems. I also tell you, the problems surrounding alcohol, gangs, and health are truly beyond what we understand.

Mr. THOMPSON. That is true.

Senator DOMENICI. They are going to have to get so bad before we decide to do something that it is almost shameful. Indian people come to us saying, what are we going to do about drugs? We wonder, why are there drugs in small Indian villages? They come and tell us alcoholism is rampant. The next thing we have is there are going to be crimes being committed.

We are underfunded, too few people enforcing the law on Indian reservations. I am sure you, Doctor, know that, that the people are getting scared to death about crime.

So Mr. Secretary, you are doing your share. I want to encourage that wherever you can, you urge this Administration, and if you are fortunate enough to be around, I hope you will start early to see if we cannot address these issues some way.

Would you care to comment?

Mr. THOMPSON. I certainly will. But first let me just thank you, Senator Domenici, for all that you have done. You have been a friend of mine for a long time. I always am impressed by whenever you speak, you come out with such wonderful commonsense. It is a tremendous tribute to you that you are able to do that.

In regards to Indian country, there are so many problems. I have been there. I have traveled all over this country. Every time I go there I get more depressed, but at the same time when I am there I also find some very good things that are happening. Yesterday in the hospital in Chinle, they had a huge program there of information. They had a wellness center set up that they went right out into the communities to teach people about nutrition and about exercise. They have this whole semi full of information and equipment that goes out and test people.

These are the kind of things we have to do. We have to find the resources. I told the delegates who were assembled in Window Rock, the first Cabinet Secretary that has ever talked to all of the delegates. They told me all of the things they needed. I said, you have to prioritize. You have to tell me what are the four or five things that we need to work on right now, and then find the money to do that. I think we are going to start that dialogue, and hopefully we will be able to come up with it.

I do not think I will be here in the next Administration, Senator. I have already indicated I am leaving. But I certainly am going to stay committed in this fight, especially on diabetes, not only on Indian reservations, but across this country. It is an epidemic that all of us have to face, and we have to do something about it.

Senator DOMENICI. Thank you very much, Mr. Secretary.

Mr. THOMPSON. Thank you. Thank you for your cooperation.

Senator DOMENICI. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Speaking of wellness centers, I happened to live on the Southern Ute Reservation, where they got tired of waiting for Government help on building a wellness center. They finally built it themselves. They not only have the gym and classes on diets and healthful living, but they actually give cooking classes in the wellness center, too. I think that is really, very frankly, on the forefront of what we need to be doing on more reservations because I think most of us recognize prevention is vital.

Mr. THOMPSON. It is interesting, the Navajo Nation, Senator Campbell and Senator Domenici, were having their delegate meetings this week. They were talking about bonding I think it was $375 million to expand economic development on the Navajo Nation. They said they are the first ones to do this. It is a huge undertaking by them, but they want to become self-sufficient. They are tired of waiting. They want to be able to go out and create economic development and jobs on the reservation.

I applauded them. I thought it was a wonderful thing.

The CHAIRMAN. I do, too.

Let me ask just another maybe one or two more questions, and we will wrap it up.

According to the Department of Health and Human Services information, the data on the State children's health insurance program is either not complete or not reliable. Yet the states and the Department are required by law to get this data. What good is it if it is unreliable? Why are we doing this?

Dr. Grim.

Mr. GRIM. The information that we have on SCHIP in Indians, we just feel like they are not accessing it appropriately. We have worked with CMS through the Department, and we are trying to increase the outreach efforts for Indian children in SCHIP. We have waived the co-pay provisions for them in case that was an access barrier. We are doing all we can to increase our data on how many children are enrolled and what we can do.

The CHAIRMAN. Could you take a period of time, maybe over 6 months or so, and get back to the committee? I will not be here. Senator McCain will be chairing or Senator Akaka, to give them, if you have some results on your outreach, if it has helped? Get more people involved in it?

Mr. GRIM. Yes, sir; we will do that.

The CHAIRMAN. The other question for you, Dr. Grim, you know, years ago the relocation policy in which Indians were pretty much uprooted and moved from all the reservations to downtown cities, has created some real problems. We have talked about this a couple of times. We created urban Indian health clinics because we found that the regular clinics a lot of times do not want to deal with Indians. They say, wait a minute; you are an Indian from Arizona or New Mexico; go back to your reservation and get treated.

Well, you cannot go 1,000 miles and get treated. You are there in the city and you are sick, you have to go wherever you can. That is what the Indian health programs were supposed to be about. Have those programs improved at all, the health care of Indians? Have you noticed any kind of reliable data on that?

Mr. GRIM. Yes, sir; we have data that we could show you from the urban Indian programs on the health status. The urban Indians face the same problems as far as health disparities as the rest of our population do, and sometimes greater because of their isolation from their culture. But the programs that we have, we have a number of very, very successful programs that our grants have funded across the Nation. We have them in 34 different cities across the Nation. They range from outreach efforts to full ambulatory care facilities. They are doing an excellent job of providing care to that population.

The CHAIRMAN. Maybe another sidebar, too, on updating the progress that you have done with Indian tribes are the National Institutes of Health and the Centers of Disease Control. Has there been any additional care going toward the uranium miners that suffered, the Navajo uranium miners of some years ago?

Mr. GRIM. There is no specific earmarks that have been put forth for that in our budget, but we have been treating the uranium miners in our facilities and taking care of them and their families as the issues arise.

The CHAIRMAN. Okay, thank you.

As I understand it, the IHS professionals, if they are licensed in one state they can practice anywhere. Is that correct?

Mr. GRIM. Yes, sir.

The CHAIRMAN. If they can do that, is there a way we can apply those same principles to tribal health care professionals operating under a 638-contract?

Mr. GRIM. Right now, under current authorities, we have not thought that possible, but in the reauthorization in H.R. 2440, I believe that that is recommended and the Department will work with you on that.

The CHAIRMAN. Okay. So finally, then I conclude, and hopefully I am right, that you are in support of H.R. 2440, both of you?

Mr. THOMPSON. Absolutely.

The CHAIRMAN. Okay. I appreciate it.

Mr. THOMPSON. And enthusiastically, Senator.

The CHAIRMAN. With only 23 or 24 working days, I do not know how far we can go, but we are going to try and get this thing as far as we can before we are out of here. If we cannot, hopefully next year whoever replaces you and replaces me, while we are out riding together, we will pursue this.

Mr. THOMPSON. We are going to get it passed this year, Senator. This is going to be our capstone, you and I.

The CHAIRMAN. That is great. I hope so.

Thank you for appearing. This committee is adjourned.

[Whereupon, at 3:15 p.m. the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF TOMMY G. THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good afternoon, Mr. Chairman, Senator Inouye and members of the committee. I am honored to testify before you today on the important issue of reauthorization of the Indian Health Care Improvement Act [IHCIA]. Accompanying me today is Dr. Charles Grim, Director of the Indian Health Service [IHS]. This landmark legislation forms the backbone of the system through which numerous Federal health programs serve American Indians and Alaska Natives [AI/ANs] and encourages participation of eligible AI/ANs in these programs. Legislation pending before this committee and over in the House has been given the highest degree of consideration by the Department. My staff has worked tirelessly to respond to this Committee's and the House Resource Committee's request for our views on H.R. 2440. I am pleased to share with you today the result of our efforts to improve services provided by the Indian Health Service, Tribes, Tribal Organizations, Alaska Native Villages, and Urban Health Programs.

As Secretary of the Department of Health and Human Services [HHS], it has been my goal to improve coordination to the maximum extent possible among the operating and staff divisions at the Department and to encourage collaboration between the Department and Tribes on the many programs impacting their members. As you know, upon my arrival at HHS, I reactivated the Intradepartmental Council on Native American Affairs [ICNAA] to provide a consistent HHS policy when working with the more than 560 federally recognized tribes.

I am also proud of the many achievements over that past 3 years in the areas of access, consultation, collaboration, organization, education, sanitation facilities construction, and Medicare reform. And, I have traveled widely to Indian country over the past 3 years and visited with tribes from the Chippewa Indians and Oglala Sioux Tribe, to Alaska Native Villages including Point Hope and Kwethluk. I just arrived back from a visit with the Navajo Nation and will return again to Alaska later this month to meet with Native leaders in Anchorage and representatives of Southeast Alaska Rural Health Consortium in Juneau. Through my travels, I have recognized the need for improvements in facilities that provide the base from which so many health care needs are met. In this area, I would like to work closely with Congress to continue to address this need.

The Department has improved tribal access to HHS resources in both appropriated funding as well as to non-earmarked funds and increases in discretionary set asides. Between fiscal year 2001 and fiscal year 2003, HHS resources provided to tribes or expended for the benefit of tribes increased from $3.9 billion in 2001 to $4.4 billion in 2003. This reflects an 11-percent increase in access to HHS funding for tribes during just a 2-year period.

In response to tribal leader comments at the regional tribal consultation session, we have honored many requests including:

- Establishing a Center for Medicare and Medicaid Services [CMS]-Technical Tribal Advisory Group [TTAG], which held its first formal meeting at the Department on February 10, 2004;
- Revising the existing HHS tribal consultation policy and involving tribal leaders in this process;
- Helping to bridge tribal/State relations for HHS programs administered through States: HHS, the National Congress of American Indians [NCAI] and the American Public Human Services Association [APHSA] have now entered into a Federal/State/Tribal collaborative project to work together on health and human services provided to Indian tribes and native organizations. HHS is forming a workgroup to focus on key areas of priorities identified by tribes [TANF, Child Welfare, Information Systems, et cetera].;
- Improving outcomes of Indian children and families with diabetes by increasing education and physical activity programs; and,
- Recommending that funding be increased for the IHS Sanitation Facilities Construction [SFC]: The President's fiscal year 2005 Budget request for IHS includes an increase of $10 million for SFC.

Moreover, I am pleased that the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [MMA], passed by Congress last year, included two provisions identified by Indian health programs as high priorities. First, the MMA allows Indian health programs to use Medicare's bargaining power when purchasing care from Medicare participating hospitals for their non-Medicare patients, thus stretching contract health and Urban Indian health funding further. Second, the MMA allows IHS and tribal hospitals and clinics to bill for additional Medicare Part B services for the period 2005–08. Finally, we are pleased that the MMA includes special provisions designed to help assure that pharmacies operated by Indian health programs, as well as other pharmacies, can participate in the temporary drug discount card and the permanent Part D drug benefit programs.

The Department is strongly committed to the reauthorization of the IHCIA during this Congress in order to improve the health status of American Indian people and to increase the availability of health services for them. We believe that reauthorizing legislation should provide increased flexibility to enable the Department to work with tribes to improve the quality of health care for American Indian people, to better empower the tribes to provide quality health care, to increase the availability of health care, including new approaches to delivering care, and to expand the scope of health services available to eligible American Indians and Alaska Natives.

Accordingly, I commend Congress for including in H.R. 2440 various changes that respond to concerns raised in our September 27, 2001 bill report to the Senate Committee on Indian Affairs on S. 212, a similar IHCIA reauthorization bill in the 107th Congress. Moreover, I would like to note our particular interest in, and support for, certain provisions of H.R. 2440. I am impressed with the strengthening of provisions in all program areas including:

No. 1, improving recruitment and retention of qualified providers, which are the foundation upon which all services are provided by the IHS, Tribes and Tribal Organizations and Urban Health Programs [ITUs];

No. 2, providing for improved health services to eligible Indians;

No. 3, exempting Indians from cost sharing in the Medicaid and SCHIP programs, consistent with our current treatment of eligible Indian children under SCHIP; and,

No. 4, expanding behavioral health programs to provide for much needed prevention and treatment in the areas of child sexual abuse, family violence, mental health, and other problems.

In addition, we believe that H.R. 2440, by proposing to protect eligible Indians from cost-sharing under the Medicaid and SCHIP programs, reflects the unique government-to-government relationship of the United States to federally recognized Indian tribes. We would support such a proposal as consistent with current HHS policy to exempt eligible Indian children in SCHIP from premiums and cost-sharing. The proposed policy on cost-sharing would go far toward addressing the continuing under-enrollment of eligible Indian individuals and families in Medicaid.

In the area of behavioral health, H.R. 2440 provides for the needs of Indian women and youth and expands behavioral health services to include a much needed child sexual abuse and prevention treatment program. The Department supports this effort, but we recommend you permit the Secretary the flexibility to provide for these important programs in a manner that supports the local control and priorities of tribes to address their specific need.

The Department does have concerns about provisions affecting the Medicare statute. Given the magnitude of the changes and new programs required by the recently enacted MMA and the challenges in implementing these changes by the statutory deadlines, we do not believe it is feasible to make additional modifications to Medi-

care at this time. We also have concerns about provisions impacting the Medicare trust funds, which, as you know, face significant financial challenges in the future. Finally, we have several serious concerns about the impact of H.R. 2440 on the Medicaid and SCHIP programs. Specifically, we do not believe that requiring access to unused SCHIP allotments is appropriate because it would set a precedent within SCHIP of prioritizing a population that is already eligible for services under current law, within a fixed amount of funds.

Additionally, the Department is concerned with several provisions included in the bill related to consultation requirements. H.R. 2440 proposes requirements for Federal agencies to consult with federally recognized Indian tribes and tribal organizations into statute. As exemplified by the successful outcomes of the Department's consultative process with the tribes, the Administration remains strongly committed to consultation with tribes as provided in Presidential Executive Order 13175. Furthermore, consultation with tribes is provided for in the Indian Self-Determination and Education Assistance Act of 1975 [ISDEAA]. We, therefore, recommend striking all language regarding consultation requirements.

I reiterate our strong commitment to reauthorization and improvement of Indian health care programs, and I hope to work with this committee and other committees of the Congress, the National Tribal Steering Committee, and other representatives of Indian country to develop a bill that all stakeholders in these important programs can support. To this end, my staff will be communicating with your staff in the near future to share additional comments and suggestions regarding reauthorization.

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