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Good Morning.

I am Michel Lincoln Acting Director of the Indian Health Service (IHS) .This morning I will discuss how the Health Security Act proposes to deal with American Indians and Alaska Natives, the health care system currently in place to serve them, and tribal governments which have a unique status within our Constitutional system.

There are a number of principles affecting Indian concerns which the framers of this bill have adopted in drafting this legislation. These principals are: individual Indians should not have to pay for services that they now receive without charge; supplemental services guaranteed by earlier legislation should continue under health care reform; and the rights of tribes to assume operations of Federal programs through the Indian Self-Determination and Education Assistance Act, Public Law (P .L. 93-638) must be maintained and affirmed. The specifics should be evaluated with these principals in mind.

First, I will describe what the Health Security Act offers to American Indian and Alaska Natives (AI/ AN) as individual health care consumers. Second, I will describe the proposed Indian health services delivery system and how it interrelates with alliances. Third, I will describe those provisions that relate to Tribal governments and tribal organizations. I will conclude with a brief description of the consultation process IHS has undertaken with Indian tribes, Indian organizations, and Indian people.

I will begin by providing a very brief summary of the historic Federal health care obligations to Indian Tribes and the health conditions and needs of Indian people. Any reconfiguration of health care services and/or financing for AI/AN people must appropriately address the Federal government's historic responsibility to provide adequate health care to Indian people. The basic legislation encompassing this responsibility is the 1921 Snyder Act which grew out of the historical and Constitutional relationship.

The 1921 Snyder Act was the culmination of the historical provision of services to Federally recognized Indians which grew out of the Constitutionally based primacy of Congress over Indian affairs.

The close involvement of the Public Health Service (PHS) with the Indian health program began in 1926 and was based on the Indian program's need for medical personnel and health service expertise, particularly in communicable disease. The 1955 transfer of programs to the PHS was based on these needs, coupled with the benefits of being located in an agency focusing exclusively on health.

The IHS has developed a health care delivery system and model that combines clinical services for individuals with community and public health programs. Within the limits of IHS' annual funding base, the service delivery system includes the integration of:

- comprehensive, curative, preventive and rehabilitative health care
- supplemental services to improve access and appropriate utilization
- public health, community and population-based programs
- capacity-building programs
- traditional AI/AN beliefs and approaches to personal, spiritual and community health.

The 1990 Census identified approximately two million American Indians and Alaska Natives. This population is growing 2.3 percent annually. Indians live throughout the United States, in urban areas, and on or near rural reservations. The current total AI/AN service population of the IHS is 1.3 million spread throughout 33 states. Services are delivered under circumstances that are overwhelmingly rural and isolated, focusing on relatively small numbers of people in any given area.

According to national estimates, approximately 28 percent of the IHS service population is covered by private health insurance (this figure includes employer provided insurance), and this proportion includes those holding both supplemental policies (e.g., medigap, long-term care, etc.) as well as those with more comprehensive policies. Among AI/ANs in the IHS service population who are employed full time, it is estimated that only 47 percent have employment related insurance. Financial, cultural, and language barriers frequently reduce access to, use of and acceptability of private health care facilities available near Indian reservations and communities.

Health reform will not change the need these small communities have for: public health and other services not part of health care reform proposals; training, recruitment and retention of health professionals.

The IHS addresses the needs of this diverse population through a partnership with more than 500 federally recognized tribes and 34 urban Indian organizations, collectively operating 50 hospitals, 140 service units, 164 health centers, 7 school health centers, 112 health stations, 172 Alaska village clinics, and 28 urban clinics. Services funded by IHS in urban areas range from provision of outreach and referral services to deliver of comprehensive ambulatory health care.

The Indian population is poorer and more disadvantaged than most Americans. More than thirty percent of Indian households live below the poverty level. Indians experience elevated risk for disease and injury that accompanies conditions associated with poverty and cultural dislocation. This risk is reflected in higher rates of illness and death for many diseases and injuries. Despite remarkable gains in the last 35 years, disproportionate numbers of Indian people die prematurely compared to the US all races average.

Indian people experience significant barriers that limit their access to health care services. Low incomes and high rates of unemployment push affordable private insurance out of the reach for many Indian households. Seventy-two percent of the IHS service population have no private

insurance (this figure includes employer provided insurance). Many depend on the IHS and other public insurance such as Medicaid as their sole source of health care.

Many Indian people live in remote and isolated areas. Many reservations are located in the most remote and harshest environments in the United States. Many Indians in these areas must travel long distances to reach a health care facility .Indian people often do not have reliable means of personal transportation and public transport is virtually non-existent in most rural areas. Harsh weather and impassable roads prevent travel altogether during parts of the year.

Indian tribes and Indian people are culturally and linguistically diverse. Non-Indian health care professionals frequently need translators to communicate with Indians who maintain their native language. Trained indigenous members of Indian communities are needed to blend western scientific medical practice with traditional cultural beliefs and ways.

To open my discussion of the Health Security Act, it is worth noting that American Indians and Alaska Natives receive unique treatment under the Health Security Act in recognition of the historic obligations of the government-to-government relationship that exist between the Federal government and Indian tribes. Other health care reform proposals before the Congress contain few, if any, references to Federal health care programs for Indians.

The Health Security Act offers significant new benefits to Indians, as it does for all Americans. Under the Health Security Act, Indian individuals and families receive the same guarantees of universal coverage for comprehensive benefit services as other Americans. Universal coverage will expand health insurance coverage to many Indian people who are currently not covered by any form of private health insurance. Universal coverage is especially beneficial to those Indians who do not reside near IHS facilities.

Like other Americans, Indians will choose a health plan. Eligible Indians may elect to enroll \ with a health program of the IHS or with a health plan offered through an alliance. An Indian eligible to enroll with a health program of the IHS is the same as defined in the Indian Health Care Improvement Act. It also extends full coverage to Indians living in urban areas in which urban Indian health programs are offered. Indians residing in a geographic area in which a health program of the IHS is not offered must enroll in an alliance health plan.

Consistent with existing Federal policy, the Health Security Act preserves free health care for Indians electing a program of the IHS. Indians enrolled with a program of the IHS will receive the comprehensive benefit package services at no cost. Cost sharing provisions in the Act will apply to Indians enrolling in an alliance health plan. Indians electing alliance plans will be eligible for cost sharing discounts on the same basis as other Americans.

A health program of the IHS may open enrollment to non-Indian family members if enrolled as a family unit by an eligible Indian. Non-Indian family members must pay normal premiums and other cost sharing.

Other non-Indians may not enroll in a program of the IHS. However, IHS programs may optionally serve non-enrollees by entering into contracts with alliance health plans to serve their enrollees if the local IHS program determines that services to enrolled Indians will not diminish and the alliance plan reimburses the Indian program as an essential community provider. This is especially important for Public Law 93-638 contractors who wish to compete more broadly in the health care market place.

The comprehensive benefits package defined in the Health Security Act assures a range and scope of medical care that exceeds what the IHS is currently able to provide. While enhancing preventive and curative medical services, the Health Security Act also preserves supplemental IHS programs that are not included in the comprehensive benefits package. Examples of these vitally important programs are public health nursing, community health representatives, environmental health services, and safe water and sanitation facilities. Indians retain their eligibility for supplemental programs regardless of which plan they elect.

I will now turn to the health care delivery system proposed to serve enrolled Indians. The Health Security Act proposes Indian Health Service programs that are distinct and separate from State or alliance control. Programs of the IHS would be operated by the IHS, or under contract with a Tribe or tribal organization or an Urban Indian program.

Indians enrolled with an IHS, tribal, or urban Indian program will receive comprehensive benefit package services either directly from the program's providers or from other providers under contracts arranged by the program. Conversely, the local IHS, tribal, or Urban Indian program may contract with alliance plans to serve their Indian or non-Indian enrollees under conditions I described earlier.

All health programs of the IHS must offer the comprehensive benefits package by January 1, 1999. Many states are proceeding on a faster health care reform track. To assure the financial viability of the IHS programs under reform, the health programs of the IHS should be able to offer the benefit package as states implement reform.

Because the programs of the IHS operate outside of the normal alliance framework, financing for the comprehensive benefits package is somewhat different from that described elsewhere in the Health Security Act. Revenues to fund the comprehensive benefit package will consist of a blend of employer premiums collected by alliances, non-Indian family member premiums, cost sharing discount equivalents for low-income non-employed Indians, reimbursements for services provided to other plans, and Federal appropriations for the comprehensive benefits package.

The Health Security Act authorizes new appropriations of \$40 million in FY 1995, \$180 million in 1996, and \$200 million thereafter for enabling services such as transportation, outreach, translation, and for construction and renovation of facilities to enable the delivery of the comprehensive benefits package. Additionally, the Health Security Act authorizes a new revolving loan program and/or loan guarantees to finance capital improvements and other infrastructure development.

I will turn next to provisions relating to tribes and tribal governments. The Health Security Act recognizes and expressly preserves health related Federal Indian law. This includes the rights of tribes and tribal organizations to contract or compact for Federal Indian programs under the Indian Self-Determination and Education Assistance Act.

The government-to-government principle is recognized and retained. The federal framework is retained by organizing the programs of the IHS outside the jurisdiction of the States and regional health alliances. Whether IHS operated, operated by a tribe or tribal organization, or operated by an Urban Indian program, basic Federal jurisdiction flows through the Secretary of Health and Human Services (HHS). The Secretary of HHS will determine which health plan requirements of the Health Security Act will apply to the programs of the IHS. Health programs of the IHS must meet health plan certification requirements specified by the Secretary by January 1, 1999.

Another principle underlying these provisions is that health care reform will not shift health care costs that are now borne by the federal government to tribal governments. Consequently, the Health Security Act waives employer contributions for Tribal governments and tribal organizations.

Finally, I want to briefly describe a process of consultation that the IHS has undertaken with regard to health care reform. The Health Security Act requires the Secretary of HHS to consult with representatives of Indian tribes, tribal organizations, and urban Indian organizations annually concerning health care reform initiatives that affect Indian communities. Up to now, the IHS has focused on providing information about the Health Security Act throughout Indian country. These efforts have included special presentations to tribes, tribal organizations, and Indian communities throughout Indian country. Health reform has been on the agenda and discussed at virtually every business meeting and conference for 6 months. Additionally, IHS has contracted with the National Indian Health Board to publish an ongoing newsletter and analysis of health reform proposals that affect Indian communities. These are distributed through a mailing list of over 800 tribes, Indian organizations, and Indian leaders.

Recently, Dr. Philip Lee, Assistant Secretary for Health has scheduled a series of public meetings with tribal leaders in four different regions. These 3 day sessions began February 2 in Albuquerque, New Mexico. Similar forums are scheduled for March in Portland, Oregon, for April in Billings, Montana and for Washington, DC in May. Together with senior HHS and IHS officials, Dr. Lee will consult intensively with tribal leaders regarding their views on national health care reform and other issues affecting Indian tribes and Indian people.

This concludes my remarks. Thank you. I will be pleased to answer any questions that you may have.