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INDIAN HEALTH CARE AMENDMENTS OF 1987

DECEMBER 8, 1987.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

together with

DISSENTING VIEWS

[To accompany H.R. 2290 which on May 5, 1987, was referred jointly to the Committee on Energy and Commerce and the Committee on Interior and Insular Affairs]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 2290), entitled, the "Indian Health Care Amendments of 1987", having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

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The amendments (stated in terms of the page and line numbers of the introduced bill) are as follows:

Page 7, line 10, strike out "338G" and insert in lieu thereof "338F".

Page 7, line 12, strike out "338H." and insert in lieu thereof "338G.".

Page 8, line 22, insert "and health promotion and disease prevention services" after "health care".

Page 8, beginning on line 25, strike out "paraprofessional training" and insert in lieu thereof "training for paraprofessionals".

Page 9, line 2, insert "and health promotion and disease prevention services" after "health care".

Page 9, line 11, strike out "particularly—" and all that follows through "evaluated," on line 15 of page 10 (and redesignate paragraph (6) as paragraph (3)).

Page 14, strike out lines 9 through 17 and redesignate succeeding subsections accordingly.

Page 16, line 8, strike out "submitted" and insert in lieu thereof "described".

Page 17, at the end of line 16, insert "and any amounts deposited pursuant to section 204(f) of the Indian Health Care Amendments of 1987".

Page 20, after line 25, add the following: "For the purposes of this subsection, the term 'Service' does not include a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act."

Page 21, line 10, strike out "(a)" and all that follows through line 22 and redesignate succeeding subsections accordingly.

Page 24, line 6, insert "(including activities relating to the prevention, treatment, and control of diabetes under section 204)" after "services".

Page 24, strike out lines 8 through 10, and insert in lieu thereof the following:

> "(2) provide for health promotion and disease prevention services under the comprehensive plan described in paragraph (1).

Page 24, at the end of line 21 strike out "," and insert in lieu thereof a period; and strike out line 22 and all that follows through line 16 on page 25 and redesignate succeeding paragraphs accordingly.

Page 25, line 17, strike out "(3)(A) The" and insert in lieu thereof "(2) Each".

Page 25, line 20, strike out "(i)" and insert in lieu thereof "(A)"; strike 21, strike out "(ii)" and insert in lieu thereof "(B)"; and line 23, strike out "(iii)" and insert in lieu thereof "(C)".

Page 265, strike out lines 1 through 8.

Page 26, line 10, strike out "the" and insert in lieu thereof "each"; and line 12, strike out "The" and insert in lieu thereof "Each".

Page 26, after line 21, insert the following:

DIABETES PREVENTION, TREATMENT, AND CONTROL

SEC. 204. (a)(1) The Secretary, in consultation with the tribes, shall determine—

(A) by tribe and by service unit of the Service, the incidence of, and the types of complications resulting from, diabetes among Indians; and

(B) based on subparagraph (A), the measures (including patient education) each Service unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among tribes within that service unit.

(2) Within eighteen months after the date of enactment of the Indian Health Care Amendments of 1987, the Secretary shall prepare and transmit to the President and the Congress a report describing the determinations made and measures taken under paragraph (1) and making recommendations for additional funding to prevent, treat, and control diabetes among Indians.

(b) The Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions which indicate a high risk that the individual will become diabetic. Such screening may be done by a tribe or tribal organization operating health care programs for facilities with funds from the Service under the Indian Self-Determination Act.

(c)(1) The Secretary shall continue to maintain during fiscal years 1988 through 1991 each of the following model diabetes projects which are in existence on the date of enactment of the Indian Health Care Amendments of 1987:

(A) Claremore Indian Hospital in Oklahoma;

(B) Fort Totten Health Center in North Dakota;

(C) Sacaton Indian Hospital in Arizona;

(D) Winnebago Indian Hospital in Nebraska;

(E) Albuquerque Indian Hospital in New Mexico;

(F) Perry, Princeton, and Old Town Health Centers in Maine; and

(G) Bellingham Health Center in Washington.

(2) The Secretary shall establish in fiscal year 1989, and maintain during fiscal years 1989 through 1991, a model diabetes project in each of the following locations:

(A) the Navajo Reservation;

(B) the Papago Reservation;

(C) the States of Alaska, Minnesota, and Montana;

(D) the Zuni Reservation; and

(E) the States of California, Oregon, and Utah.

(d) The Secretary shall—

(1) employ in each area office of the Service at least one diabetes control officer who shall coordinate and manage on a full-time basis activities within that area office for the prevention, treatment, and control of diabetes; and

(2) establish in each area office of the Service a registry of patients with diabetes to track the incidence of diabetes and the complications from diabetes in that area.

(e) There is authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Funds appropriated under subsection (c) in any fiscal year shall be in addition to base resources appropriated to the Service for that year.

Page 26, line 22, strike out "(f)(1)(A)" and insert in lieu thereof the following (and make conforming changes to the succeeding paragraphs and cross references therein):

NATIVE HAWAIIAN HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 205. (a)(1).

Page 36, line 17, insert "(but not through a tribe or tribal organization operating health care programs or facilities with funds from the Service under the Indian Self-Determination Act)" and "Service".

Page 38, after line 4, insert the following:

(f) Any amount recovered pursuant to subsection (a) shall be deposited into the Indian Health Care Improvement Fund.

Page 38, strike out lines 5 through 20.

Page 43, strike out line 9 and all that follows through line 6 on page 44, and insert in lieu thereof the following (and redesignate succeeding subsections accordingly):

SEC. 302. (a)(1) The Congress reaffirms the primary re-

Page 48, line 22, strike out "(b)(2)" and insert in lieu thereof "(a)(2)".

Page 49, line 3, strike out "(b)(2)" and insert in lieu thereof "(a)(2)".

Page 52, strike out line 15 and all that follows through line 5 on page 53.

Page 53, strike out lines 12 through 15 (redesignate succeeding sections accordingly amd make conforming changes to cross references).

Page 65, after line 3, insert the following:

MANAGEMENT INFORMATION SYSTEM

Page 66, line 23, strike out "1989" and insert in lieu thereof "1988".

Page 73, strike out lines 2 through 9 and insert in lieu thereof the following:

SEC. 712. (a) The Secretary of Health and Human Services shall not—

(1) remove a member of the National Health Service Corps from a health facility operated by the Indian Health Service or by a tribe or tribal organization

under contract with the Indian Health Service under the Indian Self-Determination Act, or

(2) withdraw funding used to support such member, unless the Secretary, acting through the Service, has ensured that the Indians receiving services from such member will experience no reduction in services.

(b) The amendment made by subsection (a) of this section shall take effect as of January 1, 1988.

Page 78, line 22, strike out "area office" and insert in lieu thereof "service unit",

Page 79, line 2, strike out "area office" and insert in lieu thereof "service unit".

Page 79, beginning on line 7, strike out "syndrome" and all that follows through line 13, and insert in lieu thereof "syndrome in each service unit of the Service to one per one thousand live births.".

Page 81, strike out line 23 and all that follows through line 22 of page 82 (all of section 711) and redesignate succeeding sections accordingly.

Page 83, strike out lines 2 and 3, and insert in lieu thereof "the pending litigation in McNabb against Heckler (628 F. Supp. 544 (D. Mont. 1986); affirmed, McNabb against Bowen (No. 86-3711 (9th Cir. 1987).".

Page 83, line 6, strike out "district court decision" and insert in lieu thereof "district and appellate court decisions".

Page 84, after line 14, add the following new sections:

PUEBLO SUBSTANCE ABUSE TREATMENT PROJECT FOR SAN JUAN PUEBLO, NEW MEXICO

SEC. 713. Title VII, as amended by section 710 of this Act, is further amended by adding at the end thereof the following new section:

"PUEBLO SUBSTANCE ABUSE TREATMENT PROJECT FOR SAN JUAN PUEBLO, NEW MEXICO

"SEC. 717. (a) The Secretary, through the Service, shall make grants to the Eight Northern Indian Pueblos Council, San Juan Pueblo, New Mexico, for the purpose of providing substance abuse treatment services to Indians in need of such services.

"(b) There are authorized to be appropriated to carry out this section $250,000 for each of the fiscal years 1988 and 1989.".

STUDY WITH RESPECT TO NUCLEAR RESOURCE DEVELOPMENT HEALTH HAZARDS

SEC. 714. (a) The Secretary of Health and Human Services (acting through the Director of the Indian Health Service), the Secretary of the Interior (acting through the Bureau of Indian Affairs), and the Secretary of Energy shall jointly conduct a study for the purpose of determining—

(1) the number of active nuclear resource development sites on Indian land in the United States;

(2) the Federal agencies that carry out Federal responsibilities with respect to each such site;

(3) the health hazards that exist as a result of such sites;

(4) the remedial actions which have been undertaken with respect to such health hazards;

(5) remedial actions that are needed with respect to such health hazards; and

(6) the amount of funds that would be necessary each year to implement and maintain such needed remedial actions and the date by which the remedial actions would be implemented if sufficient funds were to be provided for the remedial actions.

(b) Not later than two years after the date of the enactment of this Act, a report shall be submitted to the Congress describing the findings and conclusions made as a result of carrying out the study required in subsection (a).

RESTRICTIONS ON THE USE OF INDIAN HEALTH SERVICE APPROPRIATIONS

SEC. 715. (a) Unless otherwise specifically provided, any restriction placed on the use of appropriations for Indian health services shall not be interpreted—

(1) to apply to the use of funds other than such appropriated funds by an entity with a contract with the Indian Health Service;

(2) to prohibit the support of litigation with such other funds; or

(3) to prohibit the support of public support for or opposition to any legislative proposal with such other funds.

(b) The Service may not offset or limit the amount of funds obligated to any entity under contract with the Service because of the use of funds, other than funds appropriated to the Indian Health Service, by such entity for the purposes described in paragraphs (1) through (3) of subsection (a).

Page 84, strike out line 15 and all that follows through line 8 on page 92.

PURPOSE AND SUMMARY

The Committee bill would revise and extend, through fiscal year 1991, the Indian Health Care Improvement Act. The central purpose of the Act is to raise the health status of the American Indian and Native Alaska people to a parity with that of the general population. The authorizations of appropriations contained in the Act expired on October 1, 1984.

The Committee bill would revise and extend current programs to increase the supply of Indian health professionals, to construct and renovate health facilities, to operate and maintain sanitation facilities, and to provide health care and referral facilities to urban Indi-

ans. The Committee bill would also authorize new initiatives relating to health promotion and disease prevention, diabetes prevention and control, health services for Native Hawaiians, and supplemental funding for tribes deficient in health care resources. In addition, the bill would elevate the Indian Health Service (IHS) to the level of an agency within the Public Health Service of the Department of Health and Human Services; the Director of the IHS would be appointed by the President, subject to confirmation by the Senate.

The authorizations under the Committee bill would, according to the Congressional Budget Office, total $66 million in fiscal year 1988, $92 million in fiscal year 1989, $95 million in fiscal year 1990, and $99 million in fiscal year 1991.

Background and Need for the Legislation

The Indian Health Care Improvement Act, Public Law 94-437, was enacted in 1976. It is one of several statutory authorities on which appropriations for Indian health are based. (The other major authorities are The Snyder Act, 25 U.S.C. Sec. 13; The Transfer Act, 42 U.S.C. Sec. 2001 et seq.; and the Indian Self-Determination Act, 25 U.S.C. Sec. 450f et seq.).

The Indian Health Care Improvement Act was enacted in response to documented deficiencies in the health status of the Indian people. The legislation authorized additional funds for Indian health care, in part to reduce unmet needs under existing programs, and in part to establish specific new initiatives, such as health manpower training and urban projects. A major purpose of the 1976 Act was to raise the health status of the American Indian and Alaska Native people, over a seven year period, to a level comparable to that of the general U.S. population. In 1980, the Congress revised and extended the legislation through September 30, 1984.

The Committee has twice reported, and the House has twice approved, legislation to revise and extend the Indian Health Care Improvement Act. In the 98th Congress, the Committee ordered reported a similar bill, the Indian Health Care Amendments of 1984, H.R. 4567 (H. Rept. 98-763, Part 2), which would have revised and extended the Act through fiscal year 1987. The conference report on this legislation, S. 2166 (H. Rept. 98-1126), was approved by both the House and the Senate. However, on October 19, 1985, the President announced his decision to withhold approval of S. 2166.

In the 99th Congress, the Committee again ordered reported a similar bill, the Indian Health Care Amendments of 1985, H.R. 1426 (H. Rept. 99-94, Part 2), which would have revised and extended the Indian Health Care Improvement Act through fiscal year 1989. On September 18, 1986, the House passed H.R. 1426, as amended. On October 18, 1986, the last day of the 99th Congress, the Senate agreed to the House provisions with amendments, and the House took no further action.

The need for this legislation is as pressing now as it was during the 98th Congress. Based on an exhaustive analysis of the available data, the Office of Technology Assessment (OTA) concluded that "the health of American Indians on average has improved on many

measures over the past 15 years, but in almost every IHS service area and on almost every measure it is still far behind that of the U.S. all races population." Indian Health Care at 151 (April, 1986).

Indians die younger than other U.S. populations. According to OTA, from 1980 to 1982, the age-adjusted mortality rate (from all causes) for American Indians and Alaska Natives was 1.4 times that of the U.S. all races. Of all deaths in the general U.S. population in 1981, only 5.5 percent occurred in those under age 25, and only 32.2 percent occurred in those under age 65. Among American Indians and Alaska Natives, the corresponding percentages were 19 percent in the under 25 age group and 61.6 percent in the under 65 age group.

Indians are more likely than the rest of the U.S. population to die of tuberculosis, chronic liver disease and cirrhosis, accidents, diabetes, pneumonia and influenza, homicide, and suicide. The age-adjusted tuberculosis death rate for American Indians and Alaska Natives in 1980 to 1982 was seven times greater than that for the general U.S. population. In the same years, the age-adjusted Indian death rate from chronic liver disease and cirrhosis was more than four times greater than that for the general population; for diabetes, nearly 3 times greater; and for pneumonia and influenza, more than two times greater.

The causes of this differential in health status are numerous. Among the major contributing factors are the lack of adequate water supply and sewage disposal systems; the high incidence of poverty and unemployment among the Indian population; the prevalence of alcohol and other substance abuse; a lack of access to health care practitioners and facilities; and a shortage of financial resources to meet identified health needs.

In the view of the Committee, the Federal Government has a responsibility to assure that the health status of the Indian people is at parity with that of the general U.S. population. The purpose of the Indian Health Care Improvement Act, is amended by the Committee, is to discharge that responsibility.

TITLE I. INDIAN HEALTH MANPOWER

Indian health professionals

Title I of the Indian Health Care Improvement Act contains a number of different programs designed to increase the number of Indian health professionals; recruitment, preparatory scholarship, extern, and continuing education programs. In addition, section 338G of the Public Health Service Act authorizes an Indian health scholarship program to finance the training of Indians to become physicians, osteopaths, dentists, veterinarians, nurses, optometrists, podiatrists, pharmacists, clinical psychologists, public health personnel, and allied health professionals. Upon graduation, scholarship recipients have an obligation to deliver care to Indian people, either through the IRS, a tribally-operated program, and urban Indian clinic, or private practice in health manpower shortage area.

In fiscal year 1987, an appropriation of $563,000 for the recruitment program was used to make grants to five universities to identify Indians interested in returning to their tribes to provide serv-

ices as health professionals. An appropriation of $1,848,000 for the preparatory scholarship program was used to fund 161 scholarships for compensatory education to enable Indian students to quality for health professions schools. An appropriation of $3,612,000 for the health professions scholarship program was used to fund 315 scholarships. Finally, an appropriation of $995,000 for the extern program was used to provide employment for Indians enrolled in health professions schools with IHS, tribal, or urban Indian health programs during nonacademic periods. The continuing education program did not receive a separate appropriation, but was instead funded with $100,000 from the IHS clinical services budget.

Under the Committee bill, the recruitment program would be reauthorized at the following levels: $550,000 in fiscal year 1988, $600,000 in fiscal year 1989, $650,000 in fiscal year 1990, and $700,000 in fiscal year 1991. The prepratory scholarship program would be revised to prohibit the Secretary from denying, on the basis of scholastic achievement, scholarship assistance to an eligible applicant who has been admitted to, or maintained good standing at, an accredited institution. The program would be reauthorized at the following levels: $3 million in fiscal year 1988, $3.7 million in fiscal year 1989, $4.4 million in fiscal year 1990, and $5.1 million in fiscal year 1991. The extern program would be reauthorized at $300,000 in fiscal year 1988, $350,000 in fiscal year 1989, $400,000 in fiscal year 1990, and $450,000 in fiscal year 1991. The continuing education allowances program would be reauthorized at $500,000 for fiscal year 1988, $526,300 for fiscal year 1989, $553,800 in fiscal year 1990, and $582,500 in fiscal year 1991.

The Committee bill would revise the authorization for the Indian health scholarship program, currently found at section 338G of the Public Health Service Act, and recodify the program at section 104 of the Indian Health Care Improvement Act. Under current law, applicants who are Indians are to be accorded priority in the award of scholarships. In view of the continuing shortage of Indian health professionals and the limited scholarship resources available, the Committee bill provides that only Indians would be eligible to receive scholarships. The authorization levels provided by the Committee bill would be $5.1 million in fiscal year 1988, $6 million in fiscal year 1989, $7.1 million in fiscal year 1990, and $8.234 million in fiscal year 1991.

Native Hawaiian health scholarships

The Committee bill would establish a health professions scholarship program for Native Hawaiians. Authorization levels would be set at $1.8 million for each of the fiscal years 1988 through 1991. Native Hawaiians are defined as citizens who are descendents of the aboriginal people who, prior to 1778, lived in Hawaii. The program would be operated on the same principles as the Native Health Service Corps (NHSC) Scholarship program; thus, Native Hawaiians receiving scholarship assistance would, upon completion of their education as a physician, dentist, nurse, or other health professional, provide services in a health manpower shortage area for a specified period. This program would not be administered by the IHS; instead, the Committee expects that this program would

be administered by the Health Resources and Services Administration, which currently operates the NHSC program.

Community health representatives

Under current law, the IHS operates a community health representative (CHR) program, under which trained Indian health workers deliver what the IHS describes as "community-oriented primary care services, including traditional native concepts in multiple settings." CHRs staff tribal ambulance programs as emergency medical technicians, provide transportation to health services for the elderly, and provide health information to their communities. Although there is no specific authorization for this program in the Indian Health Care Improvement Act or any other statute, $26 million was appropriated for the CHR program in fiscal year 1987.

The Committee bill would authorize, under the Snyder Act (25 U.S.C. Sec. 13), a CHR program to provide training of Indians as health paraprofessionals and to use these paraprofessionals to provide health care and health promotion and disease prevention services to Indian communities. The bill would require the IHS to train CHRs in the delivery of health care and health promotion and disease prevention services. The Committee expects that this training would include not just initial orientation but also continuing education. The delivery of services by CHRs would have to be consistent with the traditional health care practices and cultural values of the Indian tribes they serve. Health promotion services would include ending smoking and substance abuse, improving nutrition and physical fitness, and controlling stress. Disease prevention services would include immunization, control of high blood pressure, and prevention and control of diabetes. While paraprofessionals cannot, within the scope of State licensure laws, perform every health promotion or disease prevention service—e.g., pregnancy and infant care—the Committee expects that CHRs be trained to deliver all of the services that do not require professional training and licensure.

TITLE II. HEALTH SERVICES

Improvement of Indian health status

Title II of the Indian Health Care Improvement Act currently authorizes the Indian Health Service (IHS) to provide health care services for the purpose of eliminating backlogs in Indian health services and to fill known but unmet health needs. A total of $82.4 million was authorized to be appropriated in fiscal year 1984 for a number of different categories of services, including patient care (direct and indirect), field health, dental care, mental health, alcoholism treatment and control, and maintenance and repair. These funds were designated as additional resources, above and beyond the regular or "base" IHS appropriations, for the purpose of raising the health status of Indians. At least 1 percent of the funds appropriated in each of these categories is to be spent on research.

The available evidence indicates that, despite some important gains, the health status of the Indian people continues to lag behind that of the general population. In addition, it is abundantly clear that, within the Indian population, serious inequities in IHS

funding allocations have left some tribes with relatively fewer health resources than others.

This resource allocation inequity is documented in Chapter 6 of the 1986 OTA report, Indian Health Care. Table I, drawn from Table 6-4 of the OTA report, compares, on a per eligible Indian basis, the allocation of funding in fiscal year 1985 among the 12 IHS Area offices, through which the IHS programs are administered. The average amount per capita budget allocation in fiscal year 1985 was $793.13. However, per capita spending varied widely from area to area, with the lowest spending in California ($425.58 per eligible Indian) and the highest in the Alaska area ($1,633.14 per eligible Indian).

TABLE I.—IHS BUDGET ALLOCATIONS BY AREA, FISCAL YEAR 1985

Area	Service population	Budget allocation	Per capita allocation
Aberdeen	72,679	$74,270,100	$1,021.89
Alaska	73,351	119,792,600	1,633.14
Albuquerque	52,471	53,365,300	1,017.04
Bemidji	48,245	39,332,100	815.26
Billings	41,326	51,495,000	1,246.07
California	73,414	31,243,300	425.58
Nashville	36,413	32,421,600	890.39
Navajo	166,493	106,834,600	641.68
Oklahoma	195,346	98,540,400	504.44
Phoenix	84,516	88,369,600	1,045.60
Portland	98,996	49,198,500	496.97
Tucson	18,332	17,796,000	970.76
Totals	961,582	762,659,100	793.13

There is also wide variation among the eligible tribes with respect to IHS health spending, both within and among the different IHS areas. The IHS has developed a methodology for ranking tribes based upon their "deficiency levels." This is essentially a measure, expressed as a percentage, of the additional dollar resources that a tribe would need in order to purchase the facilities and staff to meet its projected demand for inpatient and outpatient services. For example, a tribe which has only half the funds it would need to meet its projected demand for services would be considered 50 percent deficient (additional resources required divided by total resources required), and would fall into the 41 to 60 percent level of deficiency. Table II, derived from Table 6-6 in the OTA report, sets forth the IHS ranking of tribes, by deficiency level, as of March, 1985. About 45 percent of the tribes were considered more than 40 percent deficient.

TABLE II.—IHS RANKING OF TRIBAL GROUPS BY DEFICIENCY LEVEL, MARCH 1985

Percent deficiency	Level	Number of tribes
Less than 20	I	46
21 to 40	II	99
41 to 60	III	101
61 to 80	IV	20

TABLE II.—IHS RANKING OF TRIBAL GROUPS BY DEFICIENCY LEVEL, MARCH 1985—Continued

Percent deficiency	Level	Number of tribes
81 to 100	V	0
Total		266

The wide variations among IHS areas and tribes with respect to resource allocations and deficiency levels led to the creation of an "Equity Health Care Fund" by the Appropriations Committees; from fiscal year 1981 through fiscal year 1984, the Equity Fund was the source of a total of $32.4 million of additional IHS funds for resource-deficient tribes throughout the country. The Appropriations Committees did not earmark a specific amount for the Equity Fund in fiscal year 1985, but the IHS set aside $5 million (0.6 percent of total IHS appropriations in fiscal year 1985) for this purpose.

The origins of the Equity Fund can be traced back to 1974, when some California Indian tribes filed a class action suit against IHS alleging that they had been illegally denied health care services comparable to those offered Indians elsewhere in the U.S. The U.S. District Court ruled in favor of the California Indians, finding that, among other things, while 10 percent of the national IHS service population lived on or near reservations in California, the IHS had since 1965 allocated to California no more than 2 percent of its total funds in any one year. The Court ruled that IHS was obligated "to adopt a program for providing health services to Indians in California which is comparable to those offered Indians elsewhere in the United States." On appeal, the District Court ruling was affirmed by the Court of Appeals for the Ninth Circuit. *Rincon Band of Mission Indians* v. *Harris,* 464 F. Supp. 934 (N.D. Cal. 1979), aff'd on other grounds, 618 F. 2d 569 (9th Cir., 1980). The Equity Health Care Fund was initiated in fiscal year 1981 to assist the IHS in complying with this decision. For each year during the fiscal year 1981 through fiscal year 1985 period, the amounts available through the Fund to resource deficient tribes in California and elsewhere averaged about 1 percent of total IHS appropriations.

In fiscal year 1986, the IHS, using what it terms a Resource Allocation Methodology (RAM), distrubuted $15 million in funds appropriated for hospital and clinic and contract health service funds, plus $2 million in funds appropriated for tribal administrative cost, to resource-deficient areas. These funds were derived from increases in appropriation levels from the previous year. No funds from the "base" funding levels for each area were involved.

In fiscal year 1987, the IHS assessed a two percent "tap" against "base" hospital, clinic and dental funding for each area and established a pool with the resulting funds for redistribution to resource-deficient areas using the RAM. A total of $9.3 million in hospital, clinic, and dental funding was reallocated in this manner, with the four most deficient areas (Aberdeen, California, Oklahoma, and Tucson) receiving a net increase in "base" funding, and the remaining areas experiencing a net loss. After this reallocation, substantial disparities remained among areas, and all areas remained

underfunded relative to need. The average area resource deficiency level was 72 percent; the area most deficient in resources was California (61 percent of need met), and the area least deficient was Albuquerque (85 percent of need met), according to May, 1987, IHS data.

It is evident that the redistribution of funds by the IHS through RAM is, in and of itself, inadequate to the task of achieving equity in health care resources among areas and among tribes in an acceptable period of time. To supplement RAM distributions, the Committee bill would establish a new Indian Health Care Improvement Fund for the purpose of directing resources to the most deficient tribes. The Committee stresses that the Health Care Improvement Fund is not a substitute for a RAM distribution. Instead, the Committee expects that the Fund will be used to augment a RAM distribution of a pool of funds that is based on a "tap," or assessment against the "base" funds of each area. The Committee bill expressly provides that the creation of the Improvement Fund is not intended to discourage the IHS from undertaking additional efforts, such as the RAM distributions, to achieve parity among Indian tribes.

The Committee would observe that the RAM methodology is not without its shortcomings. The process of distributing funds to resource-deficient areas using RAM has proven to be unnecessarily cumbersome and complex. In addition, the RAM methodology itself does not take sufficient account of operating costs such as malpractice premiums, maintenance and repair, and facility construction costs, which are incurred by tribally-operated programs. Finally, the health status data on which the RAM formula relies is not of equal quality in all areas. The Committee expects that, in all future RAM distributions, the IHS will make every effort to repair these methodological weaknesses, and to simplify the RAM distribution process so that it can be more easily understood by tribes and tribal contractors and so that funds can be more expeditiously applied to meeting the needs of resource-deficient areas and tribes.

The Health Care Improvement Fund established under the Committee bill would target funds on those tribes with the highest health resource deficiency levels, whether those tribes receive services from IHS-operated facilities or whether they operate their own health care programs. Thus, amounts in the Fund would first be used to raise any tribes with a resource deficiency of more than 60 percent (level IV or V) to a level III resource deficiency (41 to 60 percent). Any amounts remaining in the Fund would then be used to raise all tribes at level III deficiency to level II. Only after all tribes at deficiency levels III, IV, or V were raised to level II could any amounts in the Fund be allocated to tribes at deficiency level II. Any tribe dissatisfied with the determination of its resource deficiency level could petition the IHS for review. Any funds allocated to a tribe from the Improvement fund would be included in the base budget for that tribe and for the IHS for the purpose of determining subsequent year allocations and appropriations.

Under the Committee bill, funding for the Improvement Fund would come from two sources. First, a total of $19 million in fiscal year 1989, $19 million in 1990, and $20 million in fiscal year 1991 would be authorized to be appropriated to the Fund. These appro-

priations could not be used to offset or limit other appropriations made to the IHS. Second, all funds recovered under section 204 of the Committee bill from third party insurers and other payors would be placed in the Improvement Fund. It is the Committee's hope that these third-party recoveries, in combination with direct appropriations, will, at a minimum, be sufficient to raise all tribes to a level II deficiency within the next two years.

Within 60 days of enactment, the Secretary would be required to submit to the Congress the current IHS health services priority system report for each tribe or service unit setting forth, among other things, the methodology for determining tribal health resource deficiencies, the level of deficiency for each tribe, and the amount of health resources allocated to each service unit. For this purpose, a service unit includes a tribe or tribal organization operating health care programs under the Indian Self-Determination Act. The IHSD would be required, in cooperation with each tribe, to update the tribal-specific health plans based on the methodology for determining health resource deficiencies. These updated tribal health plans would, in turn, form the basis for the health services priority systems report submitted by the IHS for fiscal years 1989, 1990, and 1991, within 30 days after the President's annual budget submission.

Catastrophic health emergency fund

Currently, the IHS allocates health service funds appropriated to it among its various Area and Program Offices, which in turn reallocate the funds among their various service units. This applies both with respect to funds for direct care provided by IHS or tribal organizations under contract with the IHS, and with respect to funds for "contract care," that is, services purchased from private hospitals and physicians and other non-IHS providers. Because the funds are distributed geographically, and because many service units are underfunded, the occurrence of a catastrophic illness (such as biliary atresia in a child resulting in a need for a liver transplant) or medical disaster (such as a motor vehicle accident involving serious injuries to several persons) in a particular geographic area can result in a high-cost case that depletes the funds allocated to that service unit for contract health care. This means either that the affected service unit must further ration the funds available to meet routine health care needs for that fiscal year, or that the IHS must reallocate funds from other service units. In either case, the result is a further reduction in available health care.

In Indian Health Care (1986), the OTA analyzed the causes of nearly 1300 high-cost cases in the IHS contract care program for 1982, 1983, and 1984. The major causes of high-cost cases were trauma from motor vehicle accidents, violence, and burns (24 percent of all cases), premature births (13 percent), heart attacks (11 percent), and infections (11 percent). Based on a review of IHS management practices with respect to high-cost cases, the OTA concluded that a revolving fund, centrally administered, could be a "feasible interim approach to easing the problem of high-cost cases in the IHS contract care program." In fiscal year 1987, the Con-

gress appropriated $10 million to the IHS for a Catastrophic Health Emergency Fund.

The Committee bill would establish an Indian Catastrophic Health Emergency Fund, to be administered by the central office of the IHS, for the purpose of meeting the extraordinary medical costs associated with the treatment of the victims of disasters or catastrophic illness. The Fund would reimburse costs incurred by IHS service units or facilities, or non-service facilities or providers, in delivering care to eligible Indians in high-cost cases. The IHS would define high-cost cases, setting the threshold cost at some point between $10,000 and $20,000. The IHS would be required to assure that the Fund does not make any payments on behalf of an eligible Indian unless all other potential public and private sources of payment have been exhausted.

Funding for the Catastrophic Health Emergency Fund would derive from three sources: (1) reimbursements to which the IHS is entitled from any public or private source for any high-cost case; (2) recoveries under the Medical Care Recovery Act in high-cost cases; and (3) appropriations. The Committee bill would authorize the appropriation of $12 million for the Fund in fiscal year 1988 and, in each of the next two fiscal years, the amounts necessary to maintain the Fund at $12 million. Amounts in the Fund would remain available until expended. The maximum that would be appropriated in any given year would be $12 million, although if the amount of reimbursements and recoveries in a given year exceeded $12 million, the amount in the Fund itself could exceed $12 million. Any amounts appropriated for the Fund could not be used to offset or limit other appropriations to the IHS.

The Committee stresses that this Emergency Fund is merely an interim approach to the problem of high-cost cases in the IHS contract care program. As the OTA report points out, there are some IHS areas, such as California and perhaps Bemidji, that will not benefit from this Fund because they do not have the contract care allocations that would enable them to spend up to the $10,000 to $20,000 threshold to qualify for assistance from the Fund. Since California and Bemidji also have high-cost cases, the Fund is clearly not a tenable long-term solution for them. In addition, the IHS data base with respect to numbers, demographics, and causes of high-cost cases is, according to OTA, "inadequate or nonexistent." The Committee expects the IHS to use the Fund to develop the necessary information on which to base an effective, long-term approach to managing high-cost cases that meets the needs of tribes in all IHS areas.

Health promotion and disease prevention

In 1979, the U.S. Surgeon General issued Healthy People, a landmark report on health promotion and disease prevention. The report set forth health status goals for the nation in 1990, and outlined health promotion, health protection, and disease prevention strategies to achieve those goals. Thirty years ago these strategies may not have been relevant to the Indian people. However, as the IHS demonstrated in its 1986 report, "Bridging the Gap," the mortality and morbidity patterns among Native Americans are similar in type (though considerably worse in degree) to those of the U.S.

population as a whole. Many of the leading causes of mortality and morbidity among Indians—heart disease, accidents, liver disease/cirrhosis stemming from alcoholism and alcohol abuse, and diabetes—are responsive to health promotion and disease prevention strategies.

In addition to the CHR program authorized under Title I, the IHS currently operates three system-wide programs with a health promotion and disease prevention focus: environmental health (including injury control and fluoridation), public health nursing, and health education. In fiscal year 1987, the IHS applied $22.8 million to environmental health, $13.3 million to public health nursing, and $4.0 million to health education. In view of the potential of health promotion and disease prevention activities to improve the health status of the Indian people, the current level of IHS activity in this area is not sufficient.

The Committee bill would direct the IHS to provide health promotion and disease prevention services to Indians. Health promotion services would include those services identified by the Surgeon General: cessation of tobacco smoking, reduction in alcohol and substance abuse, improvement of nutrition, physical fitness and exercise, and control of stress and violent behavior. Disease prevention services would include those services categorized by the Surgeon General as preventive services and health protection services: high blood pressure control, family planning, pregnancy and infant care, immunization, control of sexually transmitted diseases, control of toxic agents, occupational safety and health, accident prevention and injury control, fluoridation of water, and control of infectious diseases.

Not all of these health promotion and disease prevention services will be relevant to each tribe. The Committee bill therefore requires that the IHS develop a comprehensive plan for the provision of these services that is based on health plans developed by, and specific to, each tribe. The IHS comprehensive plan must be completed within one year of enactment. The IHS would then be required to provide health promotion and disease prevention services in the manner described by the plan. The comprehensive plan would have to include activities relating to the prevention, treatment, and control of diabetes.

The Committee bill would also require the Secretary to establish at least one, but no more than four, demonstration projects. The purpose of these projects would be to determine the most effective and cost-efficient means of (1) delivering health promotion and disease prevention services, (2) encouraging Indians to adopt good health habits and (3) reducing health risks to Indians, particularly the risk of heart disease, cancer, stroke, diabetes, anxiety, depression, and lifestyle-related accidents. Each demonstration project would have to be conducted in association with a health profession school, and allied health profession or nursing school, or any public or private entity that provides health care, including a tribally-operated health program. Each project would start no later than one year after enactment and would end two and one half years after enactment. The bill would authorize $500,000 in fiscal year 1988 for the purpose of implementing these demonstration projects; funds appropriated would remain available until expended.

Diabetes prevention, treatment, and control

According to data compiled by OTA, diabetes was the 7th leading cause of death among American Indians in 1980–1982; Indians died from diabetes at nearly 3 times the rate of the U.S. population as a whole. Diabetes is a chronic metabolic disease that results in the inability of the body to properly maintain and use carbohydrates, fats, and proteins. It is characterized by high blood glucose levels caused by a deficiency in insulin production or use. About 5 to 10 percent of all diabetes patients have insulin-dependent diabetes mellitus, which usually appears in childhood or adolescence. Most other diabetes patients have noninsulin dependent diabetes mellitus, which usually appears after age 40, is frequently associated with obesity, and may be controlled by diet and exercise. The consequences of diabetes include end-stage renal disease, amputation, blindness, heart disease, hypertension, and complications of pregnancy.

According to the National Diabetes Advisory Board, "diabetes in some tribes has achieved epidemic proportions. A startling 50 percent of Pima Indians over the age of 35 have diabetes, and prevalence rates greater than 20 percent among adults have been reported in several tribes in Arizona, Florida, Nevada, New Mexico, New York, North Carolina, and Oklahoma." The IHS currently operates 7 model diabetes care programs at a cost of about $2.9 million. In view of the prevalence of diabetes among the Indian people and the health status gains to be achieved through effective interventions, the Committee believes that the IHS must substantially expand upon its current efforts to prevent, treat, and control diabetes.

In its National Long-Range Plan to Combat Diabetes (1987), the National Diabetes Advisory Board set forth a number of recommendations for the expansion of IHS prevention, treatment, and control activities. The Committee bill incorporated a number of these recommendations. Under the bill, the IHS would be required to maintain, during fiscal years 1988 through 1991, each of the seven model diabetes projects currently in operation. In addition, consistent with the recommendation of the Advisory Board that each IHS area have at least one model diabetes care and education program, the Committee bill would also require the IHS to establish in fiscal year 1989 a model diabetes project in each of the following locations: (1) the Navajo Reservations, (2) the Papago Reservation, (3) the Zuni Reservation, (4) Alaska, (5) Minnesota, (6) Montana, (7) California, (8) Oregon, and (9) Utah. These new model clinics would be comparable in scope, funding, and function to the existing projects, and, like the existing projects, would be maintained during fiscal years 1989, 1990, and 1991.

The Committee bill would, as recommended by the Advisory Board, direct the IHS to employ at least one diabetes control officer in each area office to coordinate and manage on a full-time basis the activities within that area for the prevention, treatment, and control of diabetes, especially data collection and analysis. In addition, the bill would require the IHS to establish in each area office a registry of patients with diabetes to track trends in the incidence of the disease and the complications from the disease in that area, including amputations, end-stage renal disease, laser therapy, hos-

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pitalizations, and the outcomes of pregnancies of women with diabetes.

The Committee is informed that perhaps one third to one half of all adult Indians have diabetes, but that many of these individuals are undiagnosed. Early detection of diabetes will improve the ability of the IHS to treat and control the disease and to prevent or reduce the incidence of its complications, such as blindness, amputations, heart attacks, and kidney disease. The committee bill would therefore require that each Indian patient not already identified as having diabetes be screened for the disease (through the use of a simple blood glucose test) and for conditions which indicate a high risk that the individual will become diabetic. Screening would be carried out either by IHS facilities or by tribes or tribal organizations operating health care programs under the Self-Determination Act.

The National Institutes of Health has for many years studied diabetes among the Pima Indians. However, far less is known about the incidence of diabetes, the types of complications, and effective interventions among other tribes. Given the complexity of the disease, the findings of the Pima studies may not necessarily apply to other tribes. The Committee bill would direct the Secretary to submit to the Congress within 18 months after enactment a report describing (1) the incidence of, and the types of complications resulting from, diabetes among Indians, by tribe and by IHS service unit, and (2) the measures (including patient education) that each service unit should take to reduce the incidence of, and prevent, treat, and control the complications resulting from, diabetes among tribes. The Committee anticipates that the data in this report would be drawn from, among other sources, the registries established under the Committee bill and analyses conducted by the diabetes control officers. Based on these data, the Secretary would be directed to include in this report recommendations for additional funding to prevent, treat, and control diabetes among Indians. The Committee expects that the diabetes prevention, treatment, and control measures in each IHS service unit will be coordinated with other health promotion and disease prevention activities under the comprehensive plan required by the Committee bill.

For purposes of the diabetes screening, the model diabetes clinics, the area registries, and other diabetes prevention, treatment, and control efforts, the Committee bill would authorize the appropriation of such sums as are necessary. These funds would be in addition to base resources appropriated to the IHS in any given year.

Native Hawaiian health promotion and disease prevention

According to the Office of Technology Assessment, during the period 1980 through 1985, about 185,000 Native Hawaiians lived in Hawaii, representing about 19 percent of the total population of that State. Current Health Status and Population Projections of Native Hawaiian Living in Hawaii (April, 1987). Of the Native Hawaiians, an estimated 8,000 were Hawaiians, identified as being essentially of pure Hawaiian blood, and 177,000 were Part-Hawaiians, identified as having a significant degree of Hawaiian blood. The mortality data assembled by the OTA documents the inferior

health status of the Native Hawaiian population. The death rate among Native Hawaiians (both Pure and Part-Hawaiians) is 34 percent higher than that for the general U.S. population. Pure Hawaiians have a death rate 146 percent higher than that U.S. population; Part-Hawaiians have a death rate 17 percent higher.

Native Hawaiians are at particular risk for diabetes mellitus, the fifth leading cause of death among this population. Hawaiians are nearly 7 times as likely to die of diabetes as the U.S. population as a whole; Part-Hawaiians are over 2½ times as likely to die of this disease as the general U.S. population. Diabetes is responsive to health promotion and disease prevention strategies, and a comprehensive effort to prevent, treat, and control this disease among the Native Hawaiian population would make a major contribution to improving its health status. The Committee bill would therefore direct the Public Health Service to establish in Hawaii a Native Hawaiian Program for Health Promotion and Disease Prevention. The bill would authorize $750,000 for each of the fiscal year 1989, 1990, 1991, and 1992 to fund this demonstration project. The Public Health Service would not be permitted to administer the project through the IHS, and no IHS appropriations could be used to fund the project.

The primary purpose of the Native Hawaiian Program for Health Promotion and Disease Prevention would be to undertake a comprehensive effort to reduce the incidence of diabetes among Native Hawaiians, including both Hawaiians and Part-Hawaiians, through the provision of necessary preventive-oriented health services. To implement this program, the Secretary would be required to contract with Native Hawaiian organizations for the following purposes: (1) to study the incidence of diabetes among Native Hawaiians and the approaches to preventing, treating, and controlling the disease; (2) to inventory all health care programs in Hawaii for the prevention, treatment, and control of diabetes; (3) to implement, on the basis of the study and inventory, a diabetes control program, including the screening of Native Hawaiians at high risk of contracting diabetes; (4) to promote coordination and cooperation of health care providers in the delivery of diabetes prevention, treatment, and control services to Native Hawaiians; (5) to develop and implement an outreach program to Native Hawaiian communities relating to diabetes prevention and control; (6) to develop a standardized system to collect and report data regarding diabetes and related complications among Native Hawaiians; and (7) to conduct research regarding the causes, diagnosis, treatment, and prevention of diabetes and related complications among Native Hawaiians. For purposes of these contracts, the bill would define a Native Hawaiian organization as one which services and represents the interests of Native Hawaiians, is recognized by the State Office of Hawaiian Affairs and E Ola Mau, and has the participation of Native Hawaiian health professionals.

Reimbursement from certain third parties of costs of health services

The IHS provides health and health-related services to nearly one million Indians who live on or near reservations at no cost to the individual Indian, without regard to the individual's ability to pay, and without regard to whether the individual has private

health insurance coverage or is entitled to payment for health expenses under workers' compensation or automobile accident insurance. It is the understanding of the Committee that private health or accident insurance policies and workers' compensation programs often contain exclusionary clauses that deny payment in cases where the insured individual does not have to pay. Since the IHS does not charge eligible Indians for services it renders, insurers commonly do not pay bills submitted by the IHS for services to insured Indians on the grounds that the individual was never required to pay. The effect of this coverage exclusion is to enable the insurer or workers' compensation underwriter to avoid payment on a claim which, had it been submitted by a private physician or hospital, would have been reimbursed.

The Committee can see no justification for using scarce IHS funds to subsidize private insurers or workers' compensation programs. The Committee bill would therefore clarify that the Federal Government has the right to recover reasonable expenses incurred by the IHS in providing, directly through its own facilities or personnel, health care to any individual under the following circumstances. The U.S. could recover to the same extent that the individual receiving IHS care would be eligible to receive reimbursement or indemnification for the costs of care if the services had been delivered by a nongovernmental health care provider and if the individual had been required to, and did, pay for the care. The Committee bill would expressly preempt any State or local laws, as well as any contracts entered into after the date of enactment of this Act, which would impair in any way this right of recovery.

The Committee bill would authorize the Federal government to enforce this right of recovery by (1) intervening or joining in any civil action or proceeding brought by the individual who received direct IHS services, or by that individual's representative or heirs, or (2) instituting a separate civil action. The Federal government could bring an action against the insurer or other entity underwriting or administering the coverage, and, in the case of workers' compensation laws or no-fault automobile accident insurance, could bring an action against the appropriate State or local governmental entity. Recovery actions taken by the Federal government would not affect the right of any person to damages other than damages for the cost of health services provided directly by the IHS.

The Committee bill would affect only the costs of services provided to individuals directly by the IHS through its own facilities. Tribes and tribal organizations that operate health care programs or facilities with funds from the IHS under the Indian Self Determination Act, Public Law 93–638, currently bill private insurers, Medicare, Medicaid, workers' compensation programs, and other third party payors for the cost of services delivered to eligible Indians. The Committee bill does not give the Federal government a right of recovery in these circumstances, since the "638" tribal programs or facilities already have this right. The Committee intends that any reimbursement or indemnification for which an individual who has received services from a tribal "638" contractor is eligible would continue to be subject to recovery solely by the tribal con-

tractor, and, upon recovery, remain in the sole control of the tribal contractor.

Any amounts recovered by the Federal government under this provision would be deposited into the Indian Health Care Improvement Fund established under section 201 of the Committee bill. This would enable additional resources to be made available to assist the most underfunded tribes without reducing Federal appropriations for other IHS activities.

TITLE III. HEALTH FACILITIES

Title III of the Act currently authorizes such sums as may be necessary for the construction and renovation of hospitals, health centers, health stations, staff housing, and other IHS facilities. It also authorizes such sums as may be necessary for the construction of safe water and sanitary waste disposal facilities in existing and new Indian homes and communities. In fiscal year 1987, appropriations for health facilities construction, modernization, and repair totalled $51.1 million, while appropriations for sanitation facilities amounted to $20 million. In the view of the Committee, there remains a continuing need to upgrade both the health and the sanitation facilities available to the Indian people. The need far exceeds the resources available in the short run; accordingly, the Committee bill requires the Secretary to establish funding priorities for Congressional consideration.

Health facilities

The Committee bill requires the IHS to submit to the Congress, within 6 months of enactment, a health facilities priority system report. This report must identify and justify the ten highest priority inpatient care facilities (along with required staff quarters), and the ten highest priority ambulatory care facilities (and required staff quarters), and estimate the cost of each of these projects. In addition, the report must set forth the current IHS health facility priority system and the methodology adopted by the Service in establishing priorities under this system. Similar reports must follow the President's budget submissions in 1989 and subsequent years, and must be developed in consultation with Indian tribes and tribal organizations, including those operating programs or facilities under a "638" contract.

In its 1986 report on Indian Health Care, the Office of Technology Assessment reviewed the IHS facilities construction program, finding that planning for individual facilities "does not represent health system planning based on an assessment of health problems, service needs, and utilization patterns throughout the IHS area or overall service populations." The OTA concluded that facilities construction and maintenance funds "would be better spent if facilities planning were coordinated with planning to meet present and projected health service needs. The loss of NHSC physicians and the potential for serious medical staffing shortages in the 1990s also indicate a need to reevaluate IHS facility construction plans." The Committee expects that the IHS health facility priority system will be revised in a manner consistent with the OTA recommendations.

Under the Indian Health Care Improvement Act, health facilities construction and renovation funds are currently authorized only for facilities operated directly by the IHS. With the enactment of the Indian Self-Determination Act (Public Law 93-638), however, the Congress established the policy that, where a qualified Indian tribe so requests, the tribe itself must be allowed to deliver health services to its members under contract with the Secretary, rather than depending on the IHS to deliver the services. In order for this principle of self-determination to be given full effect, tribes or tribal organizations contracting with the IHS must be treated on the same basis as tribes receiving care directly from IHS-operated facilities. Otherwise, tribes will be discouraged from seeking to operate their own health care programs.

The Committee bill would therefore require that, in preparing the health facilities priority system report, the IHS consult with, and review the facilities needs of, tribes or tribal organizations delivering health services under contract. The bill would further require that, in conducting this review and identifying its priorities, the IHS apply exactly the same objective criteria as it uses to evaluate the needs of its own facilities. The IHS is without authority to exclude from the list of the ten highest priority inpatient and ten top priority ambulatory care facility projects those operated by tribes and tribal organizations solely on the grounds that these projects are not operated directly by the IHS. Furthermore, the IHS is without authority to exclude from its priority lists projects in areas, such as California, where the IHS does not operate its own health facilities solely on the grounds that those projects are located in such areas. In developing its health facility priority system, the IHS must ensure that the planning, design, construction, and renovation needs tribal "638" contractors are given full consideration and equal weight with the needs of the IHS itself.

The Committee bill would not amend the Indian Health Care Improvement Act to authorize the appropriation of any funds for the construction or renovation of health facilities. Instead, the Committee bill would clarify that the authorization for such appropriations is to be found in the Snyder Act (the Act of November of 1921). The Committee bill would also clarify that the funds appropriated for health facility planning, design, construction or renovation under the Snyder Act are subject to contract under the Indian Self-Determination Act. Thus, if a tribe applies for health facility construction funds under the terms of the Self-Determination Act, and if the tribe is qualified to contract and its facility project is one of the priority projects under this section, then the Secretary must contract with the tribe under the Self-Determination Act to undertake the project.

The Committee bill would also establish procedures with respect to both the construction and the closure of health facilities. Prior to the expenditure or commitment of any funds for the planning, design, construction, or renovation of any health facility, the IHS would be required (1) to consult with any affected Indian tribe and, whenever practicable, to honor tribal preferences regarding the facility; and (2) to ensure that the facility will, within one year of completion of construction or renovation, meet the standards of the Joint Commission on Accreditation of Hospitals. With respect to

closures, other than temporary closures for medical, environmental, or safety reasons, the IHS would be required to give Congress 12 months' notice of the proposed closure and an evaluation of its impact on access to care, cost, and quality, as well as the views of affected tribes.

Safe water supply and sanitary waste disposal facilities

The health status of the Indian population, no less than that of the rest of the U.S. population, is directly related to the availability and adequacy of the water supply and sanitary waste disposal facilities. Because of this strong relationship, the provision of water supply and sanitation facilities to the Indian people has traditionally been viewed as primarily a health function within the responsibility of the IHS. In recent years, the Office of Management and Budget has taken the position that the provision of safe water and sanitation facilities is primarily a construction function, and the responsibility for building and maintaining these facilities should lie with the agency responsible for housing programs, the Department of Housing and Urban Development (HUD). Thus, in 1982, an interagency agreement was revised to specify that funding or sanitation facilities in HUD-sponsored Indian housing projects would come from HUD. OMB has held this position despite the clear language in the Transfer Act (the Act of August 5, 1954) authorizing the Surgeon General to "construct, improve, extend, or otherwise provide and maintain, by contract or otherwise, essential sanitation facilities, including domestic and community water supplies and facilities, drainage facilities, and sewage- and waste-disposal facilities."

In the view of the Committee, the IHS cannot reasonably be directed—as this bill would direct it—to improve the health status of the Indian peoples without also giving it the ability to improve the water supply and sanitation systems that are critical determinants of the health status of the disproportionately poor and rural Indian population. Accordingly, the Committee bill expressly reaffirms that the primary responsibility for providing necessary sanitation facilities and services rests with the IHS. Much remains to be done; according to the Office of Technology Assessment report, Indian Health Care (1986), the IHS estimated that about 22,000 existing Indian homes have not received water supply and/or sewage disposal systems.

The Committee bill would clarify the Secretary's existing authority to construct, improve, and maintain, essential sanitation facilities for Indian homes, communities, and lands under the Transfer Act by explicitly authorizing the IHS to provide financial and technical assistance to Indian tribes and communities in connection with the establishment, training, and equipping of utility organizations to operate and maintain Indian sanitation facilities. The Committee bill would also give the IHS express authority to provide operation and maintenance assistance for, and emergency repairs of, tribal sanitation facilities when necessary to avoid a health hazard or protect the Federal government's investment. The Committee bill does provide an additional authorization of $3,850,000, in each of the fiscal years 1989, 1990, and 1991, to enable the Secretary to carry out these responsibilities. Of this amount, $850,000 each year would be authorized for the purpose of providing 30 new full-time

equivalent staff for the IHS; these new positions would be in addition to the 350 FTE positions currently funded for IHS sanitation functions.

Within 6 months of enactment, the IHS would be required to submit to the Congress the first of a series of annual reports containing the following information: (1) the current IHS sanitation facilities priority system; (2) the methodology used by the IHS for objectively determining sanitation deficiencies; (3) the level of sanitation deficiency for each Indian tribe or community, ranked from level I to level V, as specified in the Committee bill; (4) the amount of funds necessary to raise all Indian tribes and communities to a level I deficiency (i.e., the sanitation system complies with all applicable water supply and pollution control laws and has only routine replacement, repair, or maintenance needs); and (5) the amount of funds necessary to raise all Indian tribes and communities to zero sanitation deficiency. Beginning in 1989, these annual reports would be submitted within 60 days after the submission of the President's budget, and would be prepared in consultation with all Indian tribes and tribal organizations, including those operating health care programs or facilities under the Indian Self-Determination Act.

The Committee bill would require, and the Committee wishes to emphasize that, in determining sanitation deficiencies for each Indian tribe or community, the IHS must apply its objective methodology for determining sanitation facilities uniformly to all Indian communities or tribes, regardless of whether the tribe receives health services directly from the IHS or delivers services itself under a Self-Determination Act contract. Similarly, the IHS must consult with each tribe or tribal organization in determining the extent of sanitation deficiencies and needs.

Based on the tribal-specific levels of sanitation deficiencies identified during fiscal year 1988, the IHS would be required to develop and implement a 10-year plan, beginning in fiscal year 1989, to provide safe water supply and sanitary waste disposal facilities to existing Indian homes and communities and to new and renovated Indian homes. The Committee bill would not amend the Indian Health Care Improvement Act to authorize the appropriation of funds for the implementation of this 10-year plan, or for other construction, operation, maintenance, or repair of Indian sanitation facilities. The authorization for such appropriations is already found in the Transfer Act (the Act of August 5, 1954), and the Committee believes that the enactment of additional authorizations for this purpose would be unnecessarily duplicative.

The Committee bill would clarify that all funds appropriated under the Indian Health Care Improvement Act, the Transfer Act, or any other authority for the purpose of providing water supply and sewage disposal services, are subject to contract under the Indian Self-Determination Act on an equal basis with programs administered directly by the IHS. Thus, if a tribe applies for sanitation facility construction funds under the terms of the Self-Determination Act, and if the tribe is qualified to contract and its project is one of the priority projects, then the Secretary must contract with the tribe under the Self-Determination Act to undertake the project.

Expenditure of nonservice funds for renovation

The Committee bill would authorize Indian tribes to renovate or modernize, at their own expense, any facility of the IHS or any facility operated by the tribe through a contract with the IHS under the Indian Self-Determination Act. The authorization would be effective only for renovations or modernizations that (1) do not obligate the Secretary to provide additional employees or equipment, (2) are approved by the appropriate IHS area director, (3) comply with applicable IHS regulations, and (4) would not require the diversion of IHS appropriations away from any project that has a higher priority under the IHS health facility priority system. If, within 20 years of completion of construction or moderization, an IHS facility modernized or renovated by an Indian tribe with its own funds ceases to be used as an IHS facility, the tribes would be entitled to recover from the Federal government a percentage of the value of the facility at cessation that reflects the proportional value of the tribe's contribution at the time of the construction or renovation.

Bethel, Alaska, hospital

The Bethel Native Corporation, a for-profit corporation organized by the Alaska Natives of Bethel, Alaska, pursuant to the Alaska Native Claims Settlement Act, selected certain Federal lands as its entitlement under that Act. Subsequently, in 1979, the IHS constructed a hospital on this land. In 1983, and again in 1984, the Bureau of Land Management of the Department of Interior determined that the Bethel Native Corporation was entitled to a conveyance of title to this land. An administrative appeal of this determination by the Department of Health and Human Services is currently pending before the Board of Hearings and Appeals within the Department of Interior.

The Committee bill would provide that, if a final administrative ruling by the Department of Interior sustains the Bureau of Land Management's determination, then the Department of Interior's ruling would be subject to judicial review. The Committee bill would authorize the Secretary of Health and Human Services to negotiate a land exchange with the Corporation. If, within 90 days after the issuance of the final administrative ruling, the Secretary of HHS and the Bethel Native Corporation have not entered into an agreement to exchange land, the Secretary would be directed to purchase the lands at fair market value.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

Title V of the Indian Health Care Improvement Act authorizes the IHS to enter into contracts with urban and rural Indian organizations to provide outpatient health services and referrals for Indians who are not residing on or near reservations served by the IHS. The Committee bill would delete the current authorization for rural Indian health contractors and revise and extend the authorization for urban Indian projects.

In FY 1987, the Congress appropriated $9.0 million under Title V to fund 35 urban Indian health projects. These projects provide a range of outpatient services, including medical and dental care,

and other services such as health education, nutrition, outreach, and social services; the precise mix of services varies from project to project. In general, these projects serve both Indians and non-Indians. Just under half their funding comes from the IHS; the remainder comes from Medicaid, patient collections, Community Health Center funds, WIC funds, and other Federal, State, and local funds. The Office of Technology Assessment, in its 1986 report, Indian Health Care, concluded that "urban Indian health programs are important because of the demographic changes that have taken place in the Indian population." Roughly half of all the Indians in the U.S. live in metropolitan areas. Without urban health projects, these Indians will often lack a culturally-sensitive source of primary care and referral services.

Under the Committee bill, the IHS would be directed to continue to contract with urban Indian organizations to provide health care or referral services for urban Indians. Under these contracts, urban Indian organizations would have to provide, or arrange for the provision of, health, care services for urban Indians; provide basic health education to urban Indians; and assist urban Indians in using other private or public health resources. All services covered under the contracts would have to be provided fairly and uniformly to urban Indians. Urban health projects would also be responsible for determining the health status and the health care needs of urban Indians in their areas and for reporting, on a quarterly basis, their activities under the contract and the purposes for which Federal funds were expended. The IHS would be responsible for developing procedures for evaluating compliance with, and performance under this contract, including an annual onsite evaluation of each project.

The Committee bill would also authorize the IHS to contract with urban Indian organizations to determine the health status and the unmet health needs of the Indians in their communities. The purpose of these contracts would be to determine whether additional urban projects are needed in areas that are not currently served.

The Committee bill would not amend the Indian Health Care Improvement Act to authorize the appropriation of funds for Title V urban Indian health programs, Instead, the bill would provide that the Secretary enter into, and fund, contracts with Indian health projects under the authority of the Synder Act (the Act of November 2, 1921).

TITLE VI—ORGANIZATIONAL IMPROVEMENTS

Establishment of the Indian Health Service as an agency of the Public Health Service.

The Indian Health Service (IHS) is currently located within the Health Resources and Services Administration (HRSA) of the Public Health Service (PHS) of the Department of Health and Human Services. The IHS has as its mission the discharge of the Federal trust responsibility to provide health care of American Indians and Alaska Natives. With some 10,700 permanent staff positions, the IHS operates the largest direct health delivery system within the Department of Health and Human Services. It adminis-

ters some 45 hospitals, 72 health centers, and several hundred smaller health stations and clinics. In addition, IHS contracts with tribes and tribal groups to operate a tribal health delivery system that includes 6 hospitals and about 300 outpatient health services. It also manages 35 urban health projects and has contracts with roughly 1,300 private providers, primarily for the delivery of specialty care not available through the IHS's own facilities.

The IHS is one of four bureaus within HRSA, which in turn is one of the five major agencies within the Public Health Service. (The other major PHS agencies are the Alcohol, Drug Abuse, and Mental Health Adminstration; the Centers for Disease Control; the Food and Drug Administration; and the National Institutes of Health). The IHS is by far the largest entity within HRSA; of the $2.1 billion in budget authority administered by HRSA in fiscal year 1987, about $900 million represents IHS spending. The IHS budget in fiscal year 1987 was larger than those of two PHS agencies, the Food and Drug Administration ($450 million) and the Centers for Disease Control ($553 million).

In the view of the Committee, the mission of the IHS and the scope of its programmatic responsibilities are commensurate with an organizational status equivalent to that of HRSA and the other major PHS agencies. The Committee bill would accordingly establish within the PHS a new agency, the Indian Health Service, effective 9 months after enactment. The Director of the new IHS agency would be appointed by the President, subject to approval by the Senate. The Director would report to the Secretary of the Department through the Assistant Secretary for Health. The new IHS agency would assume all the functions and reponsibilities that the IHS now exercises in connection with the discharge of the Federal government's trust responsibilities to provide health care to Indians.

Management Information System

In its 1986 report, Indian Health Care, the Office of Technology Assessment observed that "IHS depends on an array of uncoordinated service-specific data systems that has developed over the years in response to particular information needs. None of the IHS data systems has been designed specifically to provide consistent, reliable information for national program management and reporting requirements.* * * Many existing IHS data systems do not generate complete and consistent information for all 12 IHS areas. Some of the systems are automated, some are not; some systems are automated in certain IHS areas but not in others. Little effort has been made in the automated systems to use hardware and software that are compatible among the areas * * * " IHS data systems, the OTA noted, "are especially weak when it comes to data on the costs of providing specific health services through different IHS programs and facilities to different population groups."

This is not an acceptable state of affairs. A health delivery program that spends close to $1 billion to reach a needy population over nearly 1 million people simply must have an national management information system that provides reliable data that is consistent from area to area. The Committee bill would accordingly direct the Secretary to establish an automated management information

system for the IHS. This system should include (1) a financial management system to track and ensure the integrity of IHS expenditures; (2) a patient care information system for each area served by the IHS that protects the confidentiality of patient information held by, or on behalf of, the Service; and (3) a services-based cost accounting component that provides data on the costs associated with the provision of specific medical treatments or services in each area office of the Service.

It is the intention of the Committee that this management information system be developed only after the IHS has made a thorough evaluation of its own information needs and those of tribal contractors and local service units. The Committee further expects that the IHS, in developing its management information system, consult closely with tribes and tribal organizations and make every effort to integrate tribal information systems with the IHS system. Finally, the Committee intends that the privacy of patient information held by, or on behalf of the IHS, be the foremost consideration in the development of the management information system. In developing a privacy component, the Secretary is expected to limit unauthorized disclosure of identifiable patient medical information to the maximum possible degree, consistent with the essential needs of law enforcement and public health agencies.

With respect to the patient care information system (PCIS), the Committee notes that the OTA report identified the current IHS PCIS as "an example of the lack of consistency among IRS area data systems." The PCIS, according to OTA, was "not developed by IHS headquarters to meet national program management needs, but by one of the areas (Tucson) to meet its own particular research interests." It is the intent of the Committee that the IHS, in developing the management information system required by this bill, design the system to meet national as well as local program management needs in a manner that generates data that is accurate and comparable from area to area.

Under the PCIS mandated by the Committee bill, each patient whose care is provided or paid for by the IHS would be entitled to reasonable and prompt access to his or her medical or health records. The Committee understands medical or health records to include any material, whether or not in writing, that contains information relating to the health, examination, care, or treatment of a patient. The Committee intends that an IHS-operated or funded facility allow patients (or their designated representatives) to inspect and copy their own medical or health records except where, in the exercise of reasonable medical judgment, the facility determines that disclosure of the records would cause grave mental or physical harm to the patient. The Committee further expects that, in those areas when a facility denies a patient access to his or her records, the facility promptly provide a written explanation of the reasons for denial.

The Committee bill would also require that, by September 30, 1988, the IHS provide automated management information system to all tribal health organizations delivering care in California under the Indian Self-Determination Act, and to all urban health projects delivering care in California. These systems would have to meet the management information needs of each tribe or organiza-

tion as well as those of the IHS. The IHS would be required to reimburse the tribes, tribal organizations, and urban projects for that portion of the cost of the operation of the automated management information system attributable to the treatment of IHS patients.

In California, all IHS clinical services are provided through contracts with tribes or tribal health organizations in clinics that are not Federally owned. Although these tribal providers rely heavily on non-IRS third party revenues for fiscal stability, almost none of them has automated claims processing or patient records systems. As a result, the California tribal health programs have not had the billing and accounting capacity needed to fully examine alternate resources to supplement their IHS funds. Moreover, as the 1986 OTA report, Indian Health Care, repeatedly documents, the IHS is unable at this time to provide itself, the Congress, or the tribes with accurate, basic health status, cost, and utilization information for California Indians. An accurate, comparable data base is essential to the effective program management by the tribal organizations, by the IHS, and by the Congress.

Under the Committee bill, California tribal health organizations would retain the right to determine the necessary systems configuration most suited to their needs, consistent with Departmental procurement regulations. The language used by the tribal management information systems would, of course, have to be compatible with the system the IHS selects for its own facilities. Similarly, the tribal health organizations would be required to comply with any applicable reporting requirements established by the IHS for the facilities the IHS operates directly. However, the Committee bill is not to be construed to give the IHS the right to access data directly from the tribal health organization without the consent of the organization.

The Committee bill would not authorize additional funds for automated management information systems in California. The Committee expects that the necessary resources will be drawn from the funds allocated to the California program office for this and other administrative purposes. The Committee specifically intends that the IHS not redirect clinical care or other non-administrative funds to this purpose.

TITLE VII—MISCELLANEOUS

Leasing and other contracts

Under current law, the Secretary of Health and Human Services is authorized to lease tribal facilities for health purposes for periods not in excess of 20 years. In addition, the Secretary is permitted to reconstruct or renovate the leased facilities with the consent of the tribe. While it has always been the intent of Congress that this provision be given a liberal construction to further the improvement of Indian health and to provide a greater role for Indian tribes in the delivery of health care, some tribes have reported that they have encountered difficulty with the Department in the use of this authority, particularly in the area of allowable costs which could be included in the lease rentals.

The Committee bill would clarify the Secretary's authority, in leases with Indian tribes or tribal organizations of IHS or tribal fa-

cilities, to compensate tribes or tribal organizations for costs incurred by the tribes in using the facilities to administer or deliver health care services. These allowable costs would include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses as the Secretary determines by regulation.

Arizona as a contract health service delivery area

The Indian Health Care Improvement Act currently designates Arizona as a contract health service delivery area (CHSDA) for purposes of providing contract health care services to Indians in Arizona. The Committee bill would revise and extend this designation through fiscal year 1990. Under the statewide CHSDA, contract health care services would be available only to members of Federally recognized Indian tribes of Arizona. The Committee bill would strike the current authorization of appropriations for this purpose.

Eligibility of California Indians

The Indian Health Care Improvement Act currently provides that Indians in the State of California who are members or descendants of members of former Federally recognized tribes of the State of California are eligible for IHS services. On September 16, 1987, the Department issued final rules governing eligibility for IHS services, 52 Fed. Reg. 35044. These rules limit eligibility for direct and contract care services to persons of Indian descent who are members of a Federally-recognized Indian tribe or are natural minor children of a member of a Federally-recognized tribe. The rules take effect on March 16, 1988, except that in the case of those individuals who made use of an IHS-funded service within 3 years of publication, eligibility will be maintained through September 16, 1988.

The Committee is extremely concerned about the impact of these eligibility changes in California, where only about 22,000 of the more than 76,500 Indians that the IHS considers its service population are members of Federally-recognized tribes. Thus, well over 50,000 Indian men, women, and children who are now eligible for IHS services would, under these regulations, no longer qualify for services at the 20 IHS-funded, tribally-operated programs throughout the State. The long-term impact of these regulations on the health status of these families and individuals is difficult to ascertain, since the Department did not address this question. At a minimum, it is clear that the new eligibility rules would mean a radical drop in population-based IHS funding for the current network of tribally-operated clinics, threatening the fiscal viability of many of them. Closure of these clinics could only aggravate the difficulties now experienced by rural California Indians who are not members of Federally-recognized tribes in obtaining access to needed health care services.

In the preamble to the eligibility regulations, the Department acknowledges that 2400 commentators from California and other areas opposed its proposal to limit coverage to members of Federally-recognized tribes. It nonetheless insists that establishing separate eligibility requirements for California could set "a precedent."

However, this so-called "precedent," is, and since the early 1970's has been, IHS policy. The real issue is what impact the new rules will have on the health status of the California Indians who are currently eligible for and receiving IHS services but who are not members of Federally-recognized tribes. The Department concludes that, "absent specific Congressional direction to do so, it would be inappropriate for the Department to treat California Indians differently under this rule." The Committee bill would correct the Department's arbitrary and erroneous regulation.

Under the Committee bill, the following California Indians are and would continue to be eligible for care from the IHS, whether the funds for such care are appropriated under the Indian Health Care Improvement Act, the Snyder Act, the Indian Self-Determination Act, or any other authority: (1) any member of a Federally-recognized Indian tribe; (2) any descendant of an Indian who was residing in California on June 1, 1852, and who is living in California, is a member of the Indian community served by a local program (including programs that may be established in the future), and is regarded as an Indian by the community in which he or she lives; (3) any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California; and (4) any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such Indian. These eligibility rules would be effective on enactment. The purpose of this provision is to codify existing IHS policy and practice (prior to March 16, 1988, the effective date of the new eligibility rules) with respect to the eligibility of California Indians for IHS services.

This provision can only be understood in historical context. When Congress in the 1850's was first presented with treaties that the Federal government had entered into with Indian tribes in California, it failed to ratify them. Members of tribes whose treaties were not ratified were eventually recognized in Federal law as individual "Indians of California" for purposes of compensation, 25 U.S.C. section 651. Some were given allotments on public lands instead of tribal status. Others were belatedly recognized with the creation of "rancherias" for homeless Indians, only to have their status terminated a few decades later. Still others were placed on reservations and today remain members of Federally-recognized tribes.

The purpose of this amendment is to identify each of these categories of California Indians by reference to objective criteria which are readily ascertainable. While an individual may fall into more than one category, it is only necessary that he or she meet the requirements of one of the four categories in order to become eligible for health care through the IHS. The Committee bill is intended to protect members of the current IHS "service population" from any loss of eligibility as a result of the implementation of the new IHS eligibility rules published on September 16, 1987. However, the Committee bill should not be construed to expand the eligibility of California Indians for IHS services beyond the scope of eligibility that applied as of May 1, 1986.

The new eligibility rules do not take into account the impact of the loss of IHS eligibility on the health access or health status of California Indians. The Committee bill would direct the Secretary to submit a report to Congress setting forth, with respect to the California Indians who are currently eligibile for IHS services but are not members of Federally-recognized tribes, their (1) numbers, (2) geographic location, (3) tribes, (4) current health status and health needs, and (5) actual access to non-IHS health care resources. In preparing the report, the Secretary would have to consult with California tribal health programs delivering services to non-Federally recognized Indians. The report would be due 3 years from enactment.

California as a contract health service delivery area

The Committee bill would require the IHS to designate the entire State of California as contract health service delivery area (CHSDA) for the purpose of providing contract health services to eligible Indians in California, with the exception of the counties of Alameda, Contra Costa, Kern, Los Angeles, Marin, Merced, Monterey, Napa, Orange, Sacramento, San Benito, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Solano, Stanislaus, and Ventura.

Under current policy, the IHS purchases services that are not available to eligible Indians through the IHS or tribal delivery systems from other, generally private, providers. The IHS maintains approximately 1,300 contracts with health care providers, predominantly physicians in the private sector, for services on a daily basis. In addition, numerous purchase orders are issued during the course of a year for limited services, such as emergency care, from providers not used on a regular basis. In fiscal year 1987, the IHS will spend about $183.7 million on contract care, about 20 percent of the total IHS budget and about 25 percent of its clinical services budget.

Relative to the need of the Indian people and the cost of contract care services, funding is inadequate. In its 1986 report, Indian Health Care, OTA identified three ways in which the IHS is rationing contract care services: (1) restrictive eligibility criteria; (2) authorization of services according to medical needs priorities; and (3) treatment of IHS funds as a residual resource. "The primary rationing force behind these policies," the OTA observed, "is the limitation of annual area and service unit contract care budgets, the effects of which are felt more severely in some areas than in others." In fiscal year 1984, according to OTA, the contract care spending for all IHS areas averaged $168.58 per capita and 24.5 percent of clinical services outlays; in California, the comparable figures were $7.33 per capita and 2.5 percent of all clinical services expenditures. Noting that the IHS has no direct care facilities in California, and that tribes in that State do not receive compensatory contract care funding to offset the absence of direct care capabilities, OTA concluded that "it is difficult to dispute the contention of tribes in those areas that they are not receiving their fair share of total IHS resources in comparison with IHS direct care areas."

Under current IHS regulations, 42 G.F.R. section 36.23, contract health services are limited to eligible Indians who reside within a contract health service delivery area (CHSDA), as designated by the IHS. Currently, the entire States of Alaska, Arizona, Oklahoma, and Nevada are designated as CHSDA's. In other States, only certain counties or areas are designated as CHSDA's. In California, there are 38 different CHSDA's, composed of the following counties: Alpine, Amador, Butte, Calavaros, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Nevada, Placer, Plumas, Riverside, San Bernardino, San Diego, Santa Barbara, Shasta, Sierra, Siskiyou, Sonoma, Sutter, Tehame, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

In new rules published on September 16, 1987, IHS limits eligibility for contract care services to otherwise eligible Indians who live in a Health Service Delivery Area (HSDA), as medically indicated, to the extent that funds and resources allocated to the particular HSDA permit. 52 Fed. Reg. 35044. Under these regulations, the IHS will designate, and, after consultation with affected tribes, redesignate HSDAs. The Committee bill would codify the 38 California counties that are now CHSDA's as HSDA's for purposes of the current regulations as well as these new regulations, which are effective March 16, 1988, with a subsequent 6-month grace period. The purpose of this codification is to prevent the Department from further rationing contract care services in California by excluding counties that are currently CHSDA's from the list of HSDA's. Thus, if an individual is a California Indian as defined in this bill, lives in one of the current CHSDA/HSDA counties, and meets the medical services priority, he or she would be eligible for contract care services.

The Committee notes that a number of counties that are included in the California HSDA's under this provision are also served by urban Indian health projects receiving funds under Title V of the Act. These counties include Fresno, San Diego, and Santa Barbara. It is the intent of the Committee that the urban Indian health projects in these counties continue to serve the urban Indians residing in the urban centers in which the projects are located. This provision is not to be construed as limiting in any way the need for urban Indian health projects in California

Contract health facilities

The Committee bill would direct the IHS to fund programs and facilities operated by tribes and tribal organizations under contract with the IHS under the Indian Self-Determination Act on the same basis as the IHS funds the program and facilities it operates directly. The Committee bill would expressly require that this rule of equal treatment apply with respect to funding for (1) the maintenance and repair of clinics owned or leased by the tribes or tribal organizations; (2) employee training; (3) cost-of-living increases for employees; and (4) any other expenses relating to the provision of health services. The provision would be effective on enactment.

Section 106(h) of the Indian Self-Determination Act provides, in relevant part, that "the amount of funds provided under the terms of contracts entered in to [by the Secretary of Health and Human

Services with tribal organizations for the provision of health services] shall not be less than [the Secretary] would have otherwise provided for his direct operation of the programs or portions thereof for the period covered by the contract. * * *" This principle of equal treatment is essential to the achievement of Indian self-determination; if a tribe will receive less resources as a result of contracting, it obviously will have little incentive to request that the Secretary contract with it.

The purpose of the Committee bill is to clarify the meaning of this equal treatment policy in the context of health services. The Committee received testimony that, at least in California, where all health services are delivered by tribal organizations, the IHS does not provide funding to the tribal contractors for such items as maintenance and repair and staff training. In addition, according to testimony presented to the Committee, the IHS does not allocate its own health professional staff to tribally-operated programs on the same basis as it does to the programs it operates; as a result, tribal contracts often face great difficulty in recruiting and retaining health professionals.

The Committee understands that IHS-operated facilities in other areas do receive funding for these functions. The lack of such funding has a serious adverse impact on the ability of tribes in California and other areas to deliver quality health care under a "638" contract through their own organizations. The intent of the Committee bill is to eliminate any financial disincentive that a tribe might have to deliver services under contract rather than rely on IHS to deliver the services by assuring that tribes and tribally operated programs receive funding for all budget activities that is equivalent to that of IHS-operated programs and facilities.

As the Office of Technology Assessment points out in its 1986 report, Indian Health Care, "Tribal 638 contractors may have legitimate costs that are not required of IHS at the area or service unit level." Among such costs cited by OTA are medical malpractice insurance, legal and accounting expenses, budget development, procurement and contract administration, specialized technical assistance, data collection and processing, and facilities planning. In directing the IHS to provide funds to tribal contractors "for any other expenses relating to the provision of health services," the Committee intends that such expenses be fully reimbursed.

The Committee bill does not authorize appropriations for the purpose of achieving equal treatment of tribal contractors. It is the intent of the Committee that the costs of equalization be funded from current IHS resources.

National Health Service Corps

The Committee bill would prohibit the Secretary from removing a member of the National Health Service Corps (NHSC) who is performing obligated service from an IHS or tribally-operated health facility, or from withdrawing funds used to support a NHSC assigned at such a site, unless the Secretary, acting through the IHS, has assured that the Indians receiving care from the NHSC member will experience no reduction in services. The provision would take effect January 1, 1988.

According to a 1987 Office of Technology Assessment report, Clinical Staffing in the Indian Health Service, the NHSC is the main source of medical staff for the IHS, representing an estimated 45 to 50 percent of the total IHS physician force of 700 to 750, and 60 percent of the new physician recruits in recent years. OTA notes that, because of a Federal policy decision to phase out funding for NHSC scholarships, "the decline of NHSC scholars as a significant source of health manpower will be rapid after 1987," both for the IHS and for other medically underserved areas and populations. The Committee has ordered reported legislation, the National Health Service Corps Amendments Act of 1987, H.R. 1327, which would authorize a loan payback program to allow the NHSC to repay part of the educational loans of physicians and other health professionals in exchange for obligated service in manpower shortage areas, including IHS sites.

Whatever the supply of obligated NHSC physicians and other health professionals over the next decade, the number of health manpower shortage areas will in all likelihood far exceed the number of obligated practitioners, IHS facilities and tribally-operated programs will continue to be in competition for limited NHSC resources with community and migrant health centers, the homeless, and other underserved areas and population groups. The Secretary has adopted a policy of removing NHSC assignees from sites for which the IHS is responsible to non-Indian sites of high priority need. The basic rationale for this policy is that the IHS represents an "alternate resource" on which these sites can draw, and that limited NHSC obligees should be targeted on other health manpower shortage areas without similar resources.

It has come to the Committee's attention that, in a number of instances, the IHS has been unwilling to make up the loss of an NHSC assignee, either by providing the site with another practitioner or by making adequate funds available in a timely manner to enable the site to recruit and hire a replacement. The Committee is unwilling to see accessibility or continuity of care to Indians in underserved areas compromised due to the IHS's failure to provide the "alterative resources" on which the Secretary's NHSC relocation policy is premised. The Committee bill therefore prohibits the Secretary from removing a NHSC assignee until and unless the IHS has made available a replacement, or the IHS has given the site adequate funding and time to recruit a replacement. This applies to both sites operated directly by the IHS and sites operated by tribal organizations under contract with the IHS under the Indial Self-Determination Act. In referencing "a member of the National Health Service Corps," the Committee intends to include not just NHSC scholarship recipients, but also NHSC loan payback recipients (should the Committee recommendations in H.R. 1327 be enacted).

It is not the intent of the Committee to prevent the Secretary from removing a salaried NHSC member from an Indian site if the IHS has made sufficient funds available to that site to allow the retention of an NHSC assignee on a private practice option basis. Nor is it the intent of the Committee to prevent the Secretary from removing a NHSC assignee if the site is, based on accurate and current data, no longer a health manpower shortage area. It is, howev-

er, the intent of the Committee to prevent any loss or discontinuity of services to Indian sites as a result of the relocation of NHSC placements.

Service to ineligible persons

Under current regulations, the IHS will provide or pay for services for persons who are not eligible Indians only in the following cases: (1) to persons in need of emergency care; (2) to a non-Indian woman pregnant with an eligible Indian's child through the prenatal and postpartum period; and (3) to non-Indian members of an eligible Indian's household if the medical officer in charge determines that this is necessary to control acute infectious disease or a public health hazard. Emergency patients who are able to pay, as determined by the Service Unit Director, are liable for payment for the care they receive. In new eligibility regulations issued on September 16, 1987, which become effective March 16, 1988, the IHS added another category: non-beneficiaries residing within the Health Service Delivery Area when approved by the relevant tribes, but only to the extent that providing services does not interfere with or restrict the provision of services to eligible Indians. 52 Fed. Reg. at 35049. In this case, as with emergencies, care would be provided directly by IHS facilities on a fee-for-service basis.

The Committee bill would revise and codify policies governing the provision of IHS-funded or IHS-provided health care services to persons who are not otherwise eligible. These policies apply to services rendered by IHS-operated facilities, services furnished by tribal health organizations under Indian Self-Determination Act contracts, and services purchased from non-tribal providers on a "contract care" basis.

The Committee bill would authorize the IHS to provide health services to otherwise ineligible individuals to (1) achieve stability in a medical emergency; (2) prevent the spread of a communicable disease or otherwise deal with a public health hazard; (3) provide care to non-Indian women pregnant with an eligible Indian's child for the duration of the pregnancy through post-partum; or (4) to provide care to immediate family members of an eligible Indian if this care is directly related to treatment of the eligible Indian. Individuals receiving services from IHS facilities under this provision would be liable for the cost of those services in accordance with a fee schedule promulgated by the Secretary, or, in the case of a tribally-operated program, the tribe.

The Committee bill would also identify certain categories of otherwise ineligible persons who could, under certain circumstances, be served at IHS facilities. Under the Committee bill, children 18 years or younger who are natural, adopted, legal wards, or orphans of eligible Indians and are not otherwise eligible for IHS benefits, would be considered eligible for IHS-delivered or IHS-funded care without liability for payment. These individuals would have to be taken into account by the IHS in allocating resources among service units.

With respect to non-Indian spouses of eligible Indians, or spouses of Indian descent who are not otherwise eligible for IHS benefits, the Committee bill would provide that these individuals are not to be considered eligible for IHS-funded or IHS-delivered care unless

they are made eligible, as a class, by an appropriate resolution of the governing body of the relevant Indian tribe. If made eligible, these spouses would not be liable for payment. These spouses are not to be taken into account by the IHS in allocating resources among service units.

With respect to other ineligible persons living in the service area of an IHS facility or a tribally-operated program, the Committee bill would provide that they may be made eligible for services if certain conditions are met. In the case of IHS-operated facilities, those conditions are (1) the Indian tribe or tribes served by the service unit requests that such individuals be served and (2) the tribe or tribes and the IHS have jointly determined that (a) there is no reasonable alternative source of health care for such persons and (b) services to eligible Indians would not be compromised. The tribe or tribes could revoke their concurrence to the provision of services to this population; if a majority of the tribes in the service area do so, the IHS would have to discontinue serving this population at the end of the fiscal year following the fiscal year in which tribal concurrence was withdrawn. In the case of facilities operated by tribes under the Indian Self-Determination Act, the governing body of the contracting tribe or tribal organization would have to approve the provision of services to otherwise ineligible individuals.

With respect to both IHS-operated and tribally-operated facilities, otherwise ineligible individuals made eligible to receive services under this provision would be liable for payment under the terms of a fee schedule prescribed by the IHS. This schedule would provide for payment for at least the actual cost of the services. Fees collected from ineligible patients under this provision would be credited to the account of the IHS or tribally-operated facility providing the service, and would be used to provide health services through that facility. The Committee expects that, in prescribing fees for services rendered by tribally-operated programs, the Secretary would set forth the cost-reimbursement principles to be observed, and would allow the tribes themselves to determine their individual facilities' charges.

Finally, the Committee bill would authorize the IHS or tribal contractors to extend hospital privileges to non-IHS health care practitioners serving certain categories of otherwise ineligible individuals. For purposes of Federal tort claims, these practitioners would be treated as Federal employees, but only with respect to acts or omissions which occur in the course of providing services to eligible persons under the terms on which hospital privileges were granted.

Infant and maternal mortality

In 1980, the Surgeon General issued Promoting Health/Preventing Disease; Objectives for the Nation. This document sets forth specific, measurable, objectives, developed under Public Health Service sponsorship, in 15 national health priority areas. With regard to improving infant mortality, the Surgeon General specified that by 1990, no county and no racial or ethnic group of the population (e.g., black, Hispanic, Indian) should have an infant mortality rate in excess of 12 deaths per 1,000 live births. The Indian infant mortality rate for the base year, 1978, was 13.7 per

1,000 live births. With regard to maternal mortality, the Surgeon General specified that by 1990, the maternal mortality rate should not exceed 5 per 100,000 live births for any county or for any ethnic group (e.g., black, Hispanic, American Indian). In 1978, the overall rate was 9.6; the rate for Indians was 12.1.

In "The 1990 Health Objectives for the Nation: A Midcourse Review" (1986), the Department reviewed the progress made with respect to the Surgeon General's objectives. The Department found that, in 1983, the infant mortality rate for Indians and Alaska Natives was 11.9 per 1,000, just under the Surgeon General's objective of 12. That same year the maternal mortality rate for Indians and Alaska Natives was 12.0 per 100,000 live births, well above the Surgeon General's objective of 5, and virtually unchanged from the 1978 baseline rate of 12.1.

Data assembled by the OTA in its 1986 report, Indian Health Care, illustrates the wide variations among IHS areas with regard to infant mortality. In 1981, when the overall U.S. infant mortality rate was 11.9 per 1,000 live births, rates among Indians ranged from 8.9 in the Oklahoma City area to 21.7 in Aberdeen. Neonatal mortality rates (deaths during the first 27 days of life) ranged from a low of 4.2 per 1,000 live births in Bemidji and Navaho areas to 10.2 in Aberdeen. Postneonatal mortality rates (deaths occurring from the 28th day of life through the end of the first year) ranged from 3.8 in the Oklahoma City Area to 13.5 in Tucson. OTA notes that Indian postneonatal death rates exceeded that of the general U.S. population in every IHS area except Oklahoma City.

In "The Sixth Special Report to the Congress on Alcohol and Health" (1987), the Secretary of HHS documented a high prevalence of fetal alcohol syndrome in some American Indian populations. Fetal alcohol syndrome is a group of symptoms, principally small size for gestational age, small head circumference, and retardation, that characterizes the children of mothers with excessive alcohol intake during pregnancy. Studies indicate that the effects of fetal alcohol syndrome—mental retardation and growth deficiency—are permanent. According to the Secretary's report, Indians of the Apache and Ute tribes were imported to have an incidence of fetal alcohol syndrome of 9.8 infants per 1,000 live births, the highest prevalence yet recorded among any population. The Secretary estimates the prevalence of fetal alcohol syndrome among the general population at 1 to 3 cases per 1,000 live births.

While the Committee is encouraged that the overall Indian infant mortality rate has achieved the Surgeon General's objective, it can see no reason why this objective cannot, or should not, be achieved in each IHS area. The Committee is particularly concerned by the high postneonatal mortality rates in virtually all IHS areas, by the lack of progress made in reducing maternal mortality rates, and by the evidence of high rates of fetal alcohol syndrome among certain tribes.

Accordingly, the Committee bill would require that, no later than January 1, 1989, the Secretary develop and begin implementation of a plan to achieve the following objectives by January 1, 1993: (1) reduction of the rate of Indian infant mortality in each IHS Area or Program Office to the lower of 12 deaths per 1,000 live births, or that of the U.S. population as a whole; (2) reduction of

the rate of maternal mortality in each IHS Area or Program office to the lower of 5 deaths per one hundred thousand live births, or the rate of maternal mortality for the U.S. as a whole; and (3) reduction of the rate of fetal alcohol syndrome in each IHS Area or Program Office to one per one thousand live births.

The Committee bill would not authorize additional appropriations for these purposes. It is the intent of the Committee that these objectives be achieved through more focussed and effective management of current IHS resources.

Contract health services for the Trenton service area

The Committee bill would direct the IHS to provide contract health services to eligible members of the Turtle Mountain Band of Chippewa Indians residing in the counties of Divide, McKenzie, and Williams in North Dakota, or in the adjoining counties of Richland, Roosevelt, and Sheridan in Montana. No additional funds would be authorized. The provision should not be construed as expending the eligibility of members of the Turtle Mountain Band for IHS services beyond the scope of eligibility as of May 1, 1986.

Indian Health Service and Veterans' Administration health facilities and services sharing

Under current law and practice, IHS health facilities generally serve only eligible Indians, except in emergency cases and certain other limited circumstances. Similarly, Veterans' Administration facilities generally serve only eligible veterans, except in emergency cases. These patient service policies remain in effect even when an IHS or VA facility has excess capacity available to deliver care to other categories of patients. In New Mexico, for example, there is only one VA Hospital, but there are 8 IHS hospitals, many of which are located in rural medically underserved areas and have unused capacity. In this case, it appears to the Committee reasonable to consider allowing non-Indian veterans who prefer to do so to use a nearby IHS hospital that is able to provide the needed care rather than requiring them to travel great distances to the VA facility.

Accordingly, the Committee bill would direct the Secretary of Health and Human Services to study the feasibility of arrangements between the IHS and the VA for sharing medical facilities and services and to report to Congress with recommendations by September 30, 1990. The bill would expressly prohibit the Secretary from taking any action that would impair the priority access or quality of care available to any Indian through the IHS, or that would impair the priority access or quality of care available to any veteran through the VA. The bill would also prohibit the Secretary from taking any action that would adversely affect the eligibility of any Indian to receive health services through the IHS or the eligibility of any Indian who is a veteran to receive health services through the VA.

Provision of services in Montana

In its 1986 report, Indian Health Care, the Office of Technology Assessment (OTA) reviewed the contract care program, under which the IHS purchases services for eligible Indians that it cannot

provide directly through its own facilities and staff. Nationally, contract care represents about 25 percent of all IHS expenditures for hospital, physician, and other clinical services, although this proportion varies among IHS areas. The OTA made the following observation:

> In recent years, increases in annual contract care appropriations have been less than rates of general health cost inflation. As a result, the pressures of funding constraints are mounting, and the IHS contract care program currently is rationing services in several ways: (1) contract care eligibility criteria are more restructive than criteria for IHS direct services; (2) services may be authorized only according to each area's medical needs priority system; and (3) all other payers must be tapped before IHS can pay the remainder of a bill (the residual payer principal).

The long-established residual payer policy of the IHS is implemented through a regulatory requirement that eligible Indians apply for "alternate resources"—i.e., Medicare, Medicaid, private insurance, Veterans Administration coverage, and State and local programs—if there is a reasonable likelihood that they may be eligible. IHS payments are authorized only for charges not covered by these alternate resources. The IHS recently reaffirmed this policy in revising its eligibility regulations, 52 Fed. Reg. 35044 (September 16, 1987). New 42 C.F.R. section 36.13(c) provides that,

> Contract health services will not be authorized when, and to the extent that, alternate resources for payment: (1) are available and accessible to the beneficiary, or (2) would be available and accessible if the beneficiary were to apply for them, or (3) would be available and accessible under state or local law or regulation in the absence of the individual's eligibility for contract health services from the Indian Health Service or Indian Health Service funded programs.

The OTA report underscores the importance of "alternate resources" to the ability of the IHS, through the contract care program, to maximize the ability of its limited appropriations to purchase needed health care services for eligible Indians.

As IHS contract care budgets are increasingly stressed, OTA concludes,

> IHS will have to become more aggressive and efficient in collecting applicable third-party reimbursements for services provided to eligible Indians both in IHS facilities and by private providers under contract. Increased collections will tend to shift the cost of health care for Indians to State, county, and local programs, increasing existing conflicts over which level of government is ultimately responsible for Indian health.

On December 4, 1981, James McNabb was born eight weeks prematurely. Five hours after birth, he was flown to a hospital in Billings, Montana, where he spent much of the next six weeks in in-

tensive care. James' father, a Chippewa-Cree Indian, and his mother were indigent and lived on the Fort Peck Indian Reservation in Roosevelt County. According to the GAO, Montana State law makes county governments responsible for providing medical care to the indigent. Counties are authorized to levy and collect property taxes to fund indigent medical care, but Indian reservations and other Indian lands are not taxable. GOA, "Indian Health: Budgetary Effects of Indigent Indians' Medical Costs on Two Montana Counties" (March, 1986). Under this State law, Roosevelt County operates a medical assistance program for indigent residents.

To pay for James' hospital expenses, the McNabbs applied to both the IHS contract care program and to the Roosevelt County indigent care program. Both the IHS and Roosevelt County refused to pay, the IHS citing its "alternate resource" rule, and the county citing its "alternate resource" rule making the Federal government the primary payer for indigent Indians. The McNabbs sued both the IHS and the county. In *McNabb* v. *Heckler,* 628 F. Supp. 54 (D. Mont. 1986), the District Court ruled that the IHS must pay James McNabb's hospital bills from its contract care allocation. The judgment was stayed pending appeal. On appeal, this ruling was affirmed, *McNabb* v. *Bowen,* No. 86-3711 (9th Cir., 1987). The IHS has petitioned for rehearing.

The Committee bill would direct the IHS to provide services and benefits for Indians in Montana in a manner consistent with the current policy as allowed by the stay during the pending litigation in *McNabb* v. *Bowen.* The Committee bill would provide, and the Committee intends, that this provision shall not be considered to be an expression of the sense of Congress on the merits of either the district or circuit court opinions in this case. The Committee emphasizes that this provision would be limited to contract care services to eligible Indians residing in Montana; with respect to contract care services in any other States, IHS regulations and policies regarding "alternate resources" would continue to apply.

Tohono O'odham demonstration project

The Committee bill would authorize $275,000 for each of the fiscal years 1988, 1989, and 1990, and $75,000 in fiscal year 1991, for grants to the Tohono O'odham Tribe of Arizona to establish and operate a four-year demonstration project under which the tribe would assume responsibility for the IHS direct care facilities now serving its members. The Secretary would be authorized to waive provisions of Federal procurement law as are necessary to enable the tribe to develop and test administrative systems.

Pueblo substance abuse treatment project for San Juan Pueblo, New Mexico

The Committee bill would authorize $250,000 for each of the fiscal years 1988 and 1989 for grants to the Eight Northern Indian Pueblo Council, San Juan Pueblo, New Mexico, for the purpose of providing substance abuse treatment services. It is the Committee's understanding that the Eight Northern Pueblos, who number roughly 10,000 people, currently receive no funding from the IHS or any other Federal program to treat drug abuse. The Pueblos do

receive $139,000 from the IHS for alcohol treatment programs, but these funds are inadequate to meet the needs of this population. The funds authorized by the Committee would allow the Pueblos to contract for the provision of long-term residential treatment for alcohol and drug abuse at a facility on the San Juan Pueblo.

Study with respect to nuclear resource development health hazards

The 1980 amendments to the Indian Health Care Improvement Act directed the Secretary to conduct a study of the health hazards to Indian miners and Indians on or near Indian reservations associated with nuclear resource development. Rather than conduct the required study, the Secretary merely submitted to Congress a survey of existing literature on nuclear resource development. Accordingly, the Committee bill would require the Secretary of HHS (acting through the IHS) and the Secretary of Interior (acting through the Bureau of Indian Affairs) to conduct a joint study. The study would determine: (1) the number of active nuclear resource development sites on Indian lands; (2) the Federal agencies with responsibilities at each site; (3) the health hazards that each site poses to Indians and others; (4) the remedial actions that have been undertaken with respect to such health hazards; (5) the remedial actions that are still needed; and (6) the amount of funds necessary to implement the needed remedial actions. The results of the study are to be submitted to the Congress within 2 years of enactment.

Restrictions on the use of Indian Health Service appropriations

The Committee bill would provide that, unless otherwise specifically provided by law, any restriction placed on the use of appropriations for Indian health services shall not be interpreted (1) to apply to the use of funds other than Indian health services appropriations by an entity contracting will the Indian Health Service, or (2) to prohibit the support of litigation with such other funds, or (3) to prohibit the promotion of public support for, or opposition to, any legislative proposal with such other funds. The Committee bill would further prohibit the IHS from offsetting or limiting the amount of funds obligated to any tribe or tribal health organization under contract with the IHS because of the use of non-IHS appropriated funds for the purposes of litigation, lobbying or other forms of legislative advocacy.

Tribes and tribal organizations that provide health services under contract with the IHS under the Indian Self-Determination Act commonly receive funds from a variety of sources, including the IHS contract payments, other Federal grant funds, State or local funds, out-of-pocket payments by patients, and third party reimbursements, such as Medicare, Medicaid, and private health insurance payments. It has come to the Committee's attention that the IHS is, in some instances, attempting to restrict the use of non-IHS revenues received by tribal contractors with regard to lobbying and litigation, and has even threatened to reduce the contract award to a tribal organization by the amount on non-IHS funds spent on these and other advocacy activities.

The Committee is deeply disturbed by this. There is, of course, no question that the IHS has the duty to enforce statutory retrictions on lobbying and litigation by tribal contractors where these activ-

ities are directly financed with funds appropriated to the IHS and awarded to the contractors, and where those restrictions clearly apply to funds appropriated to the IHS. However, this duty does not give the IHS license to extend its regulatory reach into the lobbying, litigation, or other advocacy efforts of tribal health contractors when that conduct is financed from other public or private revenues that are not IHS appropriations. The current IHS policy poses a potential for oppressive control of tribes and tribal contractors that the Committee simply will not tolerate.

In response to an inquiry from the Committee, the IHS took the position that all "program income" is subject to IHS restrictions on the use of IHS funds for lobbying and litigation. The IHS defines "program income" as "income earned from any source, Federal or non-Federal, by a contractor from activities whose costs are properly allocable to contract funds." This evidently includes third-party reimbursements for health services, whether from public payors or private insurers, as well as patient out-of-pocket payments. The Committee bill expressly rejects this IHS policy.

The Committee intends that whatever statutory restrictions on lobbying and litigation the IHS enforces are applied only to the activities of tribal contractors that are to be directly financed by funds appropriated for the IHS. The IHS is without authority to reduce its funding to tribal contractors by the amount of lobbying, litigation, or other advocacy expenses that a contractor incurs and pays for from other, non-IHS revenues. To require a contractor to return IHS funds as an offset for lobbying or litigation activities pad for by non-IHS funds would be to penalize the contractor financially for exercising rights basic to this democracy; the right to vigorously assert one's interests, the right to petition one's elected representatives, and the right to secure redress of grievances in the courts. Of course, tribal contractors participating in Medicare and Medicaid, like other participating providers, are subject to any statutory restrictions applicable under those programs with regard to the use of those Federal program funds.

HEARINGS

The Committee's Subcommittee on Health and the Environment held a hearing on H.R. 4567, the predecessor legislation to H.R. 2290 in the 98th Congress, on March 15, 1984 (Serial No. 98-151). Testimony was received from national urban and rural Indian health organizations and tribal health organizations from California.

On March 8, 1985, the Subcommittee held a hearing on H.R. 1426, the predecessor legislation to H.R. 2290 in the 99th Congress. (Serial No. 99-27). Testimony was received from seven witnesses, representing seven organizations, including national rural and urban Indian health organizations and tribal health organizations from California, New Mexico, and Oregon. Additional material was submitted by four individuals and organizations.

On February 20, 1986, the Subcommittee held a hearing on the OTA report, Indian Health Care (Serial No. 99-97). The OTA study, a 371-page compendium of critical policy data, was requested in May, 1985, by the Chairman of the Subcommittee and the Chair-

man of the Committee. At the hearing, OTA staff reviewed their findings regarding the health status of Indians and Alaska Natives, and the health care available to them through the Indian Health Service.

On Febuary 27, 1987, the Subcommittee held a hearing on H.R. 1327, the National Health Service Corps Amendments Act of 1987. At the hearing, OTA staff presented the results of a report, "Clinical Staffing in the Indian Health Service," requested by the Subcommittee to follow up on issues raised by the 1986 OTA report, Indian Health Care. Testimony was also heard from a director of a tribally-operated program dependent on NHSC staffing.

COMMITTEE CONSIDERATION

On October 6, 1987, the Subcommittee on Health and the Environment met in open session and ordered reported the bill H.R. 2290 by a voice vote, a quorum being present. On October 20, 1987, the Committee met in open session and ordered reported the bill H.R. 2290, with amendment, by voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of Rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the cost incurred in carrying out H.R. 2290, stated in budget authority, would be $65.7 million in fiscal year 1988, $91.9 million in fiscal year 1989, $95.0 million in fiscal year 1990, and $99.0 million in fiscal year 1991.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, October 23, 1987.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 2290, the Indian Health Care Amendments of 1987, as ordered reported by the House Committee on Energy and Commerce on October 20, 1987.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

JAMES BLUM
(For Edward M. Gramlich, Acting Director).

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill No.: H.R. 2290.
2. Bill title: Indian Health Care Amendments of 1987.
3. Bill status: As ordered reported by the House Committee on Energy and Commerce on October 20, 1987.
4. Bill purpose: This bill would authorize and amend the Indian Health Care Improvement Act.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Estimated authorization levels:					
Health Professions Recruitment Program for Indians	0.6	0.6	0.7	0.7	.....
Health professions prep scholarship	3.0	3.7	4.4	5.1	.....
Indian Health Scholarship Program	5.1	6.0	7.1	8.2	.....
Indian Health Service Extern Program	.3	.4	.4	.5	.....
Continuing education allowance	.5	.5	.6	.6	.....
Native Hawaiian scholarships	1.8	1.8	1.8	1.8	.....
Community health representatives	27.3	28.2	29.2	30.1	31.1
Indian health care improvement fund	.....	19.0	19.0	20.0	.....
Indian catastrophic health emergency fund	12.0	12.0	12.0	12.0	.....
Demonstration project	.5	.....	.....	.....	.....
Health promotion	.....	.8	.8	.8	.8
Water and sanitation	.....	3.9	3.9	3.9	.....
Health services for urban Indians	9.6	9.9	10.3	10.6	11.0
Tohono O'odham Demonstration project	.3	.3	.3	.1	.....
Pueblo substance Abuse Treatment project	.3	.3	.....	.....	.....
Diabetes prevention	4.4	4.5	4.5	4.6	2.6
Total estimated authorization levels	65.7	91.9	95.0	99.0	45.5
Total estimated outlays	51.2	83.5	93.3	98.0	57.1

Basis of estimate: Most authorization levels are stated in the bill. CBO assumes that all authorized amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spend-out rates computed by CBO on the basis of historical spending data.

The bill authorizes $12 million in fiscal year 1988 for the Indian Catastrophic Health Emergency Fund. It authorizes such sums as may be necessary in fiscal years 1989, 1990 and 1991 to return the Fund to a level of $12 million. CBO assumes that this authorization would not allow repeated draining and refilling of the Fund during any one fiscal year. Rather the authorization simply will limit aggregate annual appropriations to the Fund to $12 million.

The bill also authorizes such sums as may be necessary to provide diabetes prevention and control services to Indians through a diabetes care program. Diabetes screening would be provided at an estimated cost of about $200,000 each year. Nine new model diabetes clinics would be authorized through fiscal year 1991 in areas specified in the bill. The Indian Health Service currently supports

seven such clinics at a cost of about $200,000 for each clinic a year. If the six new clinics provide the same level of services as the current clinics, additional costs to the federal government could be about $1.8 million each year. An additional 15 full-time equivalents (FTE's) could be required to administer the diabetes care program. The alcoholism program currently operated by IHS is managed by 5 FTE's at the agency office and by about 10 FTE's in the service areas. If a similar level of program administration is used for the diabetes care program, an additional 15 FTE's would be needed at a cost of about $800,000 each year.

The bill would authorize an 18 month study on the incidence of diabetes among Native Americans and how to reduce it. Costs of the study are expected to be about $300,000 for the 18 months. Salary and overhead for at least one full-time diabetes control officer in each area office would also be authorized. CBO estimates the cost of this provision to be about $1 million in each year. A registry of patients with diabetes would also be established in each area office. Costs could be about $500,000 for this type of registry assuming no technical data collection or analysis is involved.

The bill would establish two current Indian Health Service (IHS) activities as permanent programs authorized under the Snyder Act of 1921. The Snyder Act of 1921 is a permanent, open-end authorization "for relief of distress and conservation of health" for Indians and provides the basic authority for the Indian Health Service. Under the bill, the Community Health Representative program and health services for urban Indians would be permanently authorized. Specific reauthorizations of these programs would no longer be necessary. The authorization levels shown in the table for these programs reflect the permanent addition to the current level of IHS services. These levels were estimated by increasing the 1987 appropriation levels for these activities by the appropriate inflator.

Several other activities are authorized in the bill but no authorization levels are specified. Some of these activities have not been previously authorized by the Indian Health Care Improvement Act. Such activities might be carried out today under the general authorization of the Snyder Act, but have never been funded. Since it is not clear whether the bill newly authorizes some of these activities, we have estimated authorization levels that might be needed, but have not included them in the table. These additional activities, if funded, could increase the fiscal year 1988 costs of this bill by $13 million to $33 million. All authorization levels would be subject to subsequent appropriations action.

The bill authorizes the Secretary of Health and Human Services (HHS) to enter into an agreement with the Bethel Native Corporation (BNC) for the settlement of a land dispute. If the Department of the Interior makes a final administrative ruling that entitles the BNC to the property in question, the Secretary would have 90 days to negotiate an exchange of that property for other specified land. If an agreement could not be reached within 90 days, the Secretary would purchase the property from the BNC. A final ruling has not yet been made. The cost to the federal government of a land exchange cannot be estimated until the property to be exchanged is determined. If the Secretary were to purchase the land, the cost to

the federal government would be about $9 million. This estimate is based on a 1985 appraisal by the United States Fish and Wildlife Service.

The bill would extend through 1990 Arizona's designation as a contract health service delivery area. This activity was authorized in the 1980 extension of the Indian Health Care Improvement Act at $2 million for fiscal years 1982 through 1984. No authorization level is stated in this bill. If a similar level of resources were allocated to Arizona in fiscal years 1988 through 1990, costs could be between $2.3 and $2.5 million each year.

The bill would newly designate parts of the state of California as contract health service delivery areas. No specific authorization level appears in the bill. This provision could make an additional 40,000 Indians eligible for contract care. It is not clear how many would actually require contract health services. In 1985, $534,000 was allocated for contract health care in California. About 70,000 people are currently eligible for service in California. The number of people actually using contract care services is unknown. Providing a similar level of services to an additional 40,000 eligible persons could require an extra $300,000 each year. The bill would also authorize a three year study of these newly eligible Indians at an estimated cost to the federal government of $100,000 in each fiscal year 1988 through 1990.

Contract health services would also be provided to the Turtle Mountain Band of Chippewa Indians who live in counties not currently included in the Trenton service area. An estimated 1,600 people would be made newly eligible by this provision. $282,000 was allocated to the Trenton area in 1985 for contract health to serve an eligible population of about 11,000. Providing the current level of services to the newly eligible could require an additional $40,000 each year.

The bill would authorize the Secretary of HHS to provide management information systems to all tribes, tribal organizations, and urban Indian organizations that provide health services. The federal government would pay for the portion of the system's operation attributable to patients of the Indian Health Service. Costs to the federal government could range from $2 million to $20 million in each year depending on the type of system developed. This cost range assumes that a management information system could be as simple as a personal computer provided for each tribal operated facility or as sophisticated as the Medicaid Management Information System (MMIS) used for claims processing and information retrieval.

The bill would authorize the Secretary of HHS to conduct a three year study on IHS and Veterans' Administration facilities and services sharing, as well as a four year demonstration project allowing direct billing of third party payors. Costs to the federal government are estimated to be about $1 million in 1988 through 1991 for both activities. The bill would also authorize the Secretary of HHS to conduct a two year study of health hazards to Indians resulting from nuclear resources development. CBO estimates this study could cost $100,000 in each fiscal year 1988 and 1989.

The bill would authorize payments to tribal owned or operated clinics for maintenance and repair, employee training, and cost-of-

living adjustments for employees on the same basis as funds for these activities are provided to facilities operated by IHS. CBO has no basis on which to estimate the possible cost of this provision.

CBO estimates that no additional cost to the federal government would result from enactment of the bill language relating to preventive health services and infant and maternal mortality as the IHS currently conducts similar activities in these areas.

6. Estimated cost to State and local government: None.

7. Estimate comparison: None.

8. Previous CBO estimate: On February 17, 1987, CBO prepared an estimate for S. 129, the Indian Health Care Amendments of 1987 as ordered reported by the Senate Select Committee on Indian Affairs. On June 15, 1987, CBO prepared an estimate for H.R. 2290, the Indian Health Care Amendments of 1987 as ordered reported by the House Committee on Interior and Insular Affairs. Authorization levels and certain provisions differ in these bills.

9. Estimate prepared by: Carmela Dyer.

10. Estimate approved by: C. A. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of Rule XI of the Rules of the House of Representatives, the Committee states that, in its view, the bill would have no inflationary impact on the economy. The funds authorized to be appropriated under the proposed legislation represent an insignificant share of the budget of only one department of the Federal Government. To the extent that the funds made available under this bill prevent serious illness among the American Indian and Native Alaska population, and thereby obviate the need for more expensive treatment at Federal, State, or private expense, the effect of the bill would be anti-inflationary.

Agency Views

The Committee received no views from the Department of Health and Human Services on this bill.

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Indian Health Care Improvement Act

* * * * * * *

JOINT RESOLUTION OF OCTOBER 12, 1984

Making continuing appropriations for the fiscal year 1985, and for other purposes.

* * * * * * *

TITLE I

That the following sums are hereby appropriated, out of any money in the Treasury not otherwise appropriated, and out of applicable corporate or other revenues, receipts, and funds, for the several departments, agencies, corporations, and other organizational units of the Government for the fiscal year 1985, and for other purposes, namely:

SEC. 101. (a) * * *

* * * * * * *

(c) Such amounts as may be necessary for programs, projects or activities provided for in the Department of the Interior and Related Agencies Appropriations Act, 1985, at a rate of operations and to the extent and in the manner provided as follows, to be effective as if it hs been enacted into law as the regular appropriation Act:

* * * * * * *

TITLE II—RELATED AGENCIES

* * * * * * *

DEPARTMENT OF HEALTH AND HUMAN SERVICES

* * * * * * *

ADMINISTRATIVE PROVISIONS, HEALTH SERVICES ADMINISTRATION

Appropriations in this Act to the Health Services Administration, available for salaries and expenses, shall be available for services as authorized by 5 U.S.C. 3109 but at rates not to exceed the per diem equivalent to the rate for GS-18, and for uniforms or allowances therefor as authorized by law (5 U.S.C. 5901-5902), and for expenses of attendance at meetings which are concerned with the functions or activities for which the appropriation is made or which will contribute to improved conduct, supervision, or manage-

ment of those functions or activities: *Provided*, That none of the funds appropriated under this Act to the Indian Health Service shall be available for the initial lease of permanent structures without advance provision therefor in appropriations Acts: *Provided further*, That non-Indian patients may be extended health care at all Indian Health Service facilities, if such care can be extended without impairing the ability of the Individual Service to fulfill its responsibility to provide health care to Indians served by such facilities and subject to such reasonable charges as the Secretary of Health and Human Services shall prescribe, the proceeds of which shall be deposited in the fund established by sections 401 and 402 of the Indian Health Care Improvement Act: *Provided further*, That funds appropriated to the Indian Health Service in this Act, except those used for administrative and program direction purposes, shall not be subject to limitations directed at curtailing Federal travel and transportation: *Provided further*, That with the exception of service units which currently have a billing policy, the Indian Health Service shall not initiate any further action to bill Indians in order to collect from third-party payers nor to charge those Indians who may have the economic means to pay unless and until such time as Congress has agreed upon a specific policy to do so and has directed the IHS to implement such a policy: *Provided further*, That hereafter the Indian Health Service may seek subrogation of claims including but not limited to auto accident claims, including no-fault claims, personal injury, disease, or disability claims, and workman's compensation claims except as otherwise limited by the fourth proviso of this section[: *Provided further*, That hereafter, notwithstanding any other law, an Indian tribe may acquire and expend funds, other than funds appropriated to the Service, for major renovation and modernization, including planning and design for such renovation and modernization of Service facilities, including facilities operated pursuant to contract under the Indian Self-Determination and Education Assistance Act (Public Law 93–638) subject to the following conditions:

(1) the implementation of such project shall not require or obligate the Service to provide any additional staff or equipment;

(2) the project shall be subject to the approval of the Area Director of the Service area office involved;

(3) the tribe shall have full authority to administer the project, but shall do so in accordance with applicable rules and regulations of the Secretary governing construction or renovation of Service health facilities; and

(4) no project of renovation or modernization shall be authorized herein if it would require the diversion of Service funds from meeting the needs of projects having a higher priority on the current health facilities priority system].

* * * * * * *

SECTION 5316 OF TITLE 5, UNITED STATES CODE

§ 5316. Positions at level V

Level V of the Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title:

Administrator, Agricultural Marketing Service, Department of Agriculture.

* * * * * * *

Director, Indian Health Service, Department of Health and Human Services.

DISSENTING VIEWS ON H.R. 2290—INDIAN HEALTH CARE AMENDMENTS OF 1987

With the passage of H.R. 2290, this Committee has approved legislation reauthorizing and amending the Indian Health Care Improvement Act for the third time in four years. We have passed this legislation despite the objections of the Administration which has correctly taken the position that a simple reauthorization of the Act, with some key deletions of unnecessary programs, is the appropriate action at this point.

H.R. 2290 contains new authorities which are too prescriptive and do not allow the Department the necessary flexibility to provide health services to Indians according to local needs.

This legislation contains new authority for a diabetes prevention and control program. This authority directs the Indian Health Service to continue to operate several specific model diabetes clinics already in existence and to establish and maintain new model clinics in several specific locations. We strongly believe that this kind of prescriptive approach will disadvantage those who receive Indian Health services. The Indian Health Service has the expertise to determine whether model clinics are accomplishing their objectives and should have the discretion to open and close clinics in accordance with the Service's limited resources and its priorities.

We are also disappointed that the catastrophic health emergency fund is authorized in this legislation. Again, this is authority that ties the hands of the Indian Health Service in responding quickly to extraordinary needs. The size of the fund and threshold for what constitutes a catastrophic expense are arbitrary and could be counterproductive in ensuring that funds are shifted to sites expeditiously. We recognize that an appropriation of $10 million for this fund was made in FY 1987, but do not regard the action taken by the appropriations committees, as being dispositive on this issue.

We would support a simple reauthorization of the Indian Health Care Improvement Act and recognize that it is a necessary adjunct to the Snyder Act in assuring that the health needs of Native Americans are met. But we cannot support H.R. 2290 because it contains extraneous, prescriptive authorities that will inhibit the ability of the Indian Health Service to respond to those most in need.

NORMAN F. LENT.
ED MADIGAN.
BILL DANNEMEYER.
TOM TAUKE.
DON RITTER.
DAN COATS.
THOMAS J. BLILEY, Jr.
JACK FIELDS.
MICHAEL G. OXLEY.
DAN SCHAEFER.
JOE BARTON.

○