



Indian Health Service: Health Care Delivery, Status, Funding, and Legislative Issues

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Summary

The Indian Health Service (IHS), an agency in the Department of Health and Human Services (HHS), provides health care for eligible American Indians/Alaskan Natives through a system of programs and facilities located on or near Indian reservations and in certain urban areas. The IHS health delivery program is organized into 12 regional area offices and 161 local service units, and serves federal reservations, Indian communities, and urban Indians. In general, persons eligible for IHS services must be in IHS service areas and belong to federally recognized tribes.

The IHS-served population generally has a higher incidence of illness and premature mortality than the U.S. population as a whole. Several IHS publications compare the health conditions and causes of death of the IHS service population with those for the entire U.S. population. According to the latest of these, the average life expectancy at birth for the IHS service area population in 1999-2001 was 74.5 years, or 2.4 years less than the 76.9 years for the total U.S. population.

IHS appropriations are separated into two budget categories: health services and health facilities. For FY2008, the total appropriation for IHS was \$3.35 billion, of which \$2.97 billion (89%) was for health services and \$374.6 million (11%) was for health facilities. Other sources of IHS funding include a special diabetes program and reimbursements from Medicare, Medicaid, and private insurance. Total IHS “program-level” funding, including all sources, was \$4.28 billion in FY2008. Indian health advocates argue that IHS funding falls short of the need.

Although a number of legislative issues concerning IHS face the 111th Congress, the primary focus has been on the reauthorization of the Indian Health Care Improvement Act (IHCIA). Two bills (S. 1200 and H.R. 1328) were introduced in the 110th Congress to reauthorize the IHCIA. Both reauthorization bills would have expanded health services, eased processes for reimbursements from Medicaid and other federal programs, coordinated behavioral health programs, and authorized other actions. S. 1200 was reported, amended, by the Senate Indian Affairs Committee on October 17, 2007 (S.Rept. 110-197). S. 1200 was passed, amended, by the Senate February 28, 2008, and sent to the House. H.R. 1328 was reported, amended, by the House Natural Resources Committee on April 4, 2008 (H.Rept. 110-564, part 1). Separately H.R. 1328 was forwarded, amended, by the House Energy and Commerce Committee’s Health Subcommittee to the full Committee on November 7, 2007. H.R. 1328 was discharged by the Energy and Commerce and Ways and Means Committees on June 6, 2008, and the Natural Resources version reported in April was placed on the calendar. Concerns continue about many issues in the IHCIA bills, including provisions on Medicaid and other issues listed in a January 2008 Statement of Administration Policy on S. 1200, which threatened a veto of that bill. Neither S. 1200 nor H.R. 1328 were passed by Congress. No IHCIA bill has been introduced in the 111th Congress as of the date of this report, but certain Medicaid-related provisions have been included in draft economic-stimulus legislation. This report will be updated.

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Introduction

The Indian Health Service (IHS), part of the Public Health Service (PHS) of the Department of Health and Human Services (HHS), funds health services to about 1.8 million Indians, members of the nation's 562 federally recognized American Indian and Alaska Native (AI/AN)¹ tribes in IHS service delivery areas.² Health services are available to eligible residents of reservations, of non-reservation areas of those counties that overlap or abut reservations, and of some urban areas with a significant AI/AN population. Eligible Indians receive free IHS health services regardless of their ability to pay (except in certain urban programs, or when a tribe chooses to charge for services).³ The federal government considers its provision of these health services to be based on its trust responsibility for Indian tribes, a responsibility derived from federal statutes, treaties, court decisions, executive actions, and the Constitution (which assigns authority over Indian relations to Congress).⁴ Congress, however, has only a moral obligation, not a legal one, to provide Indian health care.⁵ The Supreme Court has rejected the idea (absent congressional statement to the contrary) that IHS is under an obligation to provide any specific health program to Indians.⁶

This report provides an overview of the Indian Health Service and how it provides for the health care problems and needs of AI/AN. It also shows IHS appropriations for recent years and discusses its current statutory authorities and legislative issues, including the reauthorization of appropriations in the Indian Health Care Improvement Act (IHCIA) and several other policy issues.

Health Care Delivery

The federal government's delivery of health services to Indians, and funding of tribal and urban Indian health programs, has developed over more than a century. (**Appendix** provides a brief history of the Indian Health Service.)

¹ In this report, the terms "AI/AN" and "Indian" will be used interchangeably. They both mean American Indians and Alaska Natives ("Alaska Natives" includes the American Indians, Eskimos (Inuit and Yupik), and Aleuts of Alaska).

² Certain other AI/AN including urban Indians may be eligible for health services. (See later discussion on eligibility.)

³ The IHS is forbidden to charge Indians (see 25 U.S.C. 1681 and 25 USC 458aaa-14) but a recent federal district court decision allows tribes providing certain IHS-funded services to bill Indians (*Susanville Indian Rancheria v. Leavitt et al.*, 2008 U.S. Dist. LEXIS 365). See the discussion under "Charges for Health Care Services," below.

⁴ "The Congress hereby declares that it is the policy of the Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy" (§3, P.L. 94-437, act of September 30, 1976, as amended; 25 U.S.C. 1602).

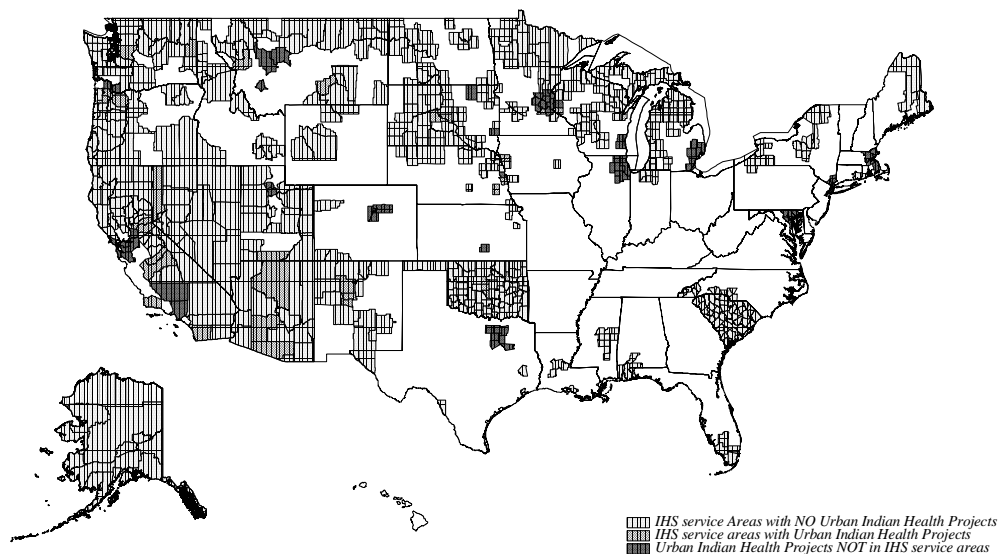
⁵ See Felix S. Cohen, *Felix S. Cohen's Handbook of Federal Indian Law* (1982 edition), Rennard Strickland, editor-in-chief (Charlottesville, VA: Michie Bobbs-Merrill, 1982), p. 677; and Felix S. Cohen, *Cohen's Handbook of Federal Indian Law* (2005 edition), Nell Jessup Newton, editor-in-chief (Newark, NJ: LexisNexis [Matthew Bender & Company], 2005), §22.01[3].

⁶ See *Lincoln v. Vigil*, 508 U.S. 182, 194-195 (1993). This sentence was prepared by (name redacted), Congressional Research Service Legislative Attorney, 2005.

Organization of the IHS Health Delivery System

Currently, the IHS health care delivery system, a largely rural system, is organized into regional area offices and, within each region, local service units. As of 2006, there were 12 regional area offices and 161 local service units. The IHS system serves federal reservations, Indian communities in Oklahoma and California, and Indian, Eskimo (Inuit and Yupik), and Aleut communities in Alaska. Service units, as geographic entities, may be made up of both whole counties and parts of counties.⁷ All counties in the national IHS service area are covered by one or more service units.⁸ The map in **Figure 1** shows the counties served by IHS-funded programs (as of 2001), including both IHS service areas and IHS-funded urban projects. As a whole, the IHS national service area roughly matches the distribution of federal Indian reservations and communities, although in five states (Alaska, Arizona, Nevada, Oklahoma, and South Carolina) every county is served by the IHS.

Figure 1. Counties Served by IHS-Funded Programs: IHS Service Areas and Urban Indian Health Projects



Source: Information provided by United States Geological Survey, National Atlas, and Indian Health Service. Map prepared by Library of Congress, Geography and Map Division, November 2001.

⁷ IHS service units are administrative entities within a defined geographical area through which services are directly or indirectly provided to eligible Indians. A service unit may cover a number of small reservations, or, conversely, some large reservations may be covered by several service units.

⁸ As discussed below, the overall national area of contract health service delivery areas is identical to that of IHS service areas.

Range of Health Care Services

The IHS provides an array of medical services, including inpatient, ambulatory, emergency, dental, public health nursing, and preventive health care.⁹ The IHS does not have a defined medical benefit package that excludes or includes specific conditions or types of health care. Besides providing general clinical health services, the IHS also focuses on such special Indian health problems as maternal and child health, fetal alcohol syndrome, diabetes, hepatitis B, alcoholism, and mental health. The IHS provides these services directly, and through tribes, tribal organizations, and urban Indian organizations. In addition, both the IHS and tribes may contract for health services from private providers.

Health Administration

As noted, IHS-funded health care is provided in facilities administered through regional offices and service units. Service units and specific health facilities (but not IHS regional offices) may be managed either by the IHS directly, or by Indian tribes and tribal organizations and consortia through self-determination contracts and self-governance compacts negotiated with the IHS under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA).¹⁰ Tribes and tribal organizations have taken over from IHS the responsibility for operating many service units and health facilities. (The ISDEAA is discussed at greater length below, under “Statutory Authority.”) Currently, 100 of the 161 service units (62%) are operated by tribes under ISDEAA, as are 522 of the 646 IHS-funded health facilities (81%) (see **Table 1**).

Table 1. Number of Facilities Operated by IHS and Tribes
(as of October 1, 2008)

Type of Facility	Total	IHS Operated	Tribally Operated		
			Total	Under ISDEAA Contracts and Compacts	Under Non- ISDEAA Contracts ^a
Hospitals	45	31	14	14	0
Ambulatory (out-patient) facilities	601	93	508	499	9
Health centers	288	61	227	225	2
School health centers	15	2	13	13	0
Health stations	132	30	102	102	0
Alaska village clinics	166	0	166	159	7
Health facilities, total	646	124	522	513	9

Source: U.S. Department of Health and Human Services, Indian Health Service, unpublished table, transmitted Jan. 9, 2009. Health facilities totals calculated by Congressional Research Service.

⁹ See 42 CFR 136.11, “Services available.”

¹⁰ P.L. 93-638, act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 et seq.

Notes: ISDEAA = Indian Self-Determination and Education Assistance Act (P.L. 93-638), as amended.

- a. Used in Alaska to fund Alaska Native-operated clinics not eligible for funding under ISDEAA. Sometimes these funding sources are called “non-638 contracts.”

Contract Health Services (CHS)

In addition to care received from IHS and tribal providers, health services are purchased by IHS and the tribes through contracts with more than 2,000 private providers, if the local facility is unable to provide the needed care.¹¹ Not all areas of the country are covered by this service. Areas where this IHS-funded contract health care is available are known as “contract health service delivery areas” (CHSDAs), and are the same as the IHS service areas shown in **Figure 1**. CHS providers may not bill Indians for CHS services authorized by the IHS.¹²

Urban Indian Health Projects

Although most IHS facilities are located on or near reservations, IHS also funds, with approximately 1% of its budget, 34 urban Indian health projects (UIHPs), with operations at 41 locations.¹³ UIHPs are funded by IHS with grants and contracts. In 2000 UIHPs served an estimated 669,970 urban Indians living in IHS’s urban service areas.¹⁴ UIHPs also receive funding from other sources, including state, private, and non-IHS federal programs, and from patient fees.¹⁵ **Figure 1** displays the areas served by urban Indian health projects. Some urban projects are inside CHSDAs and some are not.

Other Health-Related Activities

The IHS funds the construction, equipping, and maintenance of hospitals, health centers, clinics, and other health care delivery facilities, both those operated by the IHS and those operated by tribes. Tribes may handle these activities under self-determination contracts or self-governance compacts.

Since 1960, under the authority of the Indian Sanitation Facilities Act,¹⁶ the IHS has also funded the construction of water supply and sewage facilities and solid waste disposal systems, and has provided technical assistance for the operation and maintenance of such facilities. According to the IHS in 2005, about 12% of AI/AN homes lack safe drinking water supplies and adequate

¹¹ Contract health services are provided by non-IHS facilities or providers principally for members of tribes who live in contract health service delivery areas. 42 C.F.R. §136.23.

¹² 25 U.S.C. 1621u.

¹³ Funding for UIHPs is authorized under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1651-1660d), which directs the HHS Secretary to make grants to or contracts with UIHPs under the authority of the Snyder Act (25 U.S.C. 13). Such grants or contracts are not ISDEAA self-determination grants or contracts. See also Forquera, *Urban Indian Health*, pp. 12-13.

¹⁴ U.S. Department of Health and Human Services, Indian Health Service, *Trends in Indian Health, 2000-2001* (Washington: GPO, 2004), p. 39.

¹⁵ IHS, Office of Urban Indian Health Programs, *Urban Indian Health Program Statistics, FY2005* ([Rockville, MD]: IHS, October 16, 2007), p. 4. Under Title V of the Indian Health Care Improvement Act, UIHPs are not prohibited from charging their patients (IHS, personal communication, November 20, 2007).

¹⁶ P.L. 86-121, act of July 31, 1959, 73 Stat. 267; 42 U.S.C. 2004a.

waste disposal facilities, compared to about 1% of all U.S. homes.¹⁷ Because of improved access to sanitation facilities, there has been about an 80% reduction in gastrointestinal disease among AI/AN since 1973, according to the IHS.¹⁸

Limitations in Health Services

The IHS does not provide the same health care services in each area it serves. Services vary from place to place and from time to time.¹⁹ In general, the services provided to any particular Indian community will depend on financial resources (i.e., appropriations and third party reimbursements) and available personnel and facilities.²⁰ IHS has stated that its funding does not allow it to provide all the needed care for eligible Indians.²¹ As a result, according to Indian health organizations, some services are “rationed,” with the most critical care given first.²² IHS regulations require that, when resources or funds are insufficient, the agency must set priorities for both direct and contract health care based on “relative medical need.”²³ In addition, the drugs and medicines available from IHS pharmacies may not include all drugs and medicines needed, although IHS says its pharmacies will stock most drugs that have proven to be cost-effective and beneficial.²⁴

IHS shortfalls in medical personnel contribute to this unevenness in health care delivery. Where a health professional position is vacant, either the health care may not be available or the facility will have to use CHS funds, which according to IHS raises the costs of the care. In January 2008, the IHS had job vacancy rates of 31% for dentists, 18% for nurses, 17% for physicians, 13% for optometrists, and 11% for pharmacists.²⁵

¹⁷ U.S. Indian Health Service, “Health and Heritage Brochure: Safe Water and Waste Disposal Facilities,” available at http://info.ihs.gov/Infrastructure/2_SafeWaterAndWaste-Jan2005.doc, last accessed February 20, 2006.

¹⁸ U.S. Department of Health and Human Services, Indian Health Service, *Justification of Estimates for Appropriations Committees, Fiscal Year 2007*, pp. IHF-9-IHF-10.

¹⁹ See U.S. Government Accountability Office, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, GAO-05-789, August 2005; and U.S. Department of Human Health and Services, Indian Health Service, Office of Public Health, *Level of Need Funded Study, LNF Workgroup Report II*, December 1999, p. 2; available at <http://www.ihs.gov/NonMedicalPrograms/Lnf/contP2Sum.htm>.

²⁰ 42 C.F.R. §136.11(c).

²¹ U.S. Indian Health Service, News Release, *Indian Health Service Receives 5% Funding Increase for FY2002*, December 17, 2001; available at http://www.ihs.gov/PublicInfo/PublicAffairs/PressReleases/Press_Release_2001/Release_22_FY2002_IHS_Budget.asp.

²² “Tribes forced to ration funds for health services,” *Indianz.com*, February 2, 2007, available at <http://www.indianz.com/News/2007/000701.asp>. See also U.S. Congress, Senate committee on Indian Affairs, *Partnership for a New Millennium: Addressing the Unmet Health Care Needs in Indian Country*, hearings, 105th Cong., 2nd sess., May 21, 1998 (Washington: GPO, 1998), pp. 15, 297.

²³ 42 C.F.R. §§136.11(c), 136.23(e).

²⁴ See <http://www.ihs.gov/GeneralWeb/HelpCenter/CustomServices/approp.asp>

²⁵ Randy Grinnell, Deputy Director, Management Operations, Indian Health Service, “Indian Health—Challenges and Changes,” presentation at National Combined Councils Meeting, February 4, 2008 (February 15, 2008), pp. 12-13; available at <http://www.ihs.gov/MedicalPrograms/ClinicalSupportCenter/docs/2008NCCGrinnell.pdf>, last accessed April 1, 2008; and testimony of Robert G. McSwain, Acting Director, IHS, before the House Interior, Environment, and Related Agencies Appropriations Subcommittee, April 2, 2008.

Eligible Population

In general, persons eligible for IHS services are members of federally recognized tribes. They must also live on or near federal Indian reservations or in traditional Indian communities, or within a county where IHS contract health services are available. Eligible Indians include those of Indian descent belonging to the Indian community who are regarded as Indian by the community in which they live. Eligibility also is indicated by: (1) location within an IHS health service delivery area; (2) residence on tax-exempt land or ownership of property on land for which the federal government has a trust responsibility; (3) active participation in tribal affairs; or (4) meeting other relevant factors in keeping with general Bureau of Indian Affairs (BIA) practices in the jurisdiction for determining eligibility.²⁶ Urban Indian health programs funded by IHS may serve a wider range of eligible persons, including members of terminated²⁷ or state-recognized tribes and their children and grandchildren.²⁸

In addition, eligible persons may also include a non-Indian woman pregnant with an eligible Indian's child. She would be eligible for care during the pregnancy and six weeks following birth, as long as paternity is acknowledged. The IHS also serves non-Indians in specific circumstances particularly when an acute infectious disease is involved.²⁹

Most IHS services are intended for members of federally recognized tribes. Since federal law does not restrict state recognition of tribes, some states grant recognition to Indian groups that are not recognized by the federal government. Members of such state-recognized tribes are ineligible for most IHS health services, but are eligible for services at IHS-funded urban Indian health projects.

For the most part, tribal membership is determined by the tribe. Many tribes require recognized descent from a particular tribal roll for membership. In tracing descent, tribes follow paternal or maternal bloodlines, or both. Some tribes require minimum percentages of genealogical descent, and others require only proof of descent. For a few tribes, Congress has set membership criteria in statute.³⁰

The IHS service population (as calculated by IHS) is not evenly distributed throughout Indian country. In 2003, approximately 35% of the population served by IHS resided in two IHS regions: 14.4% lived in the Navajo region (northwestern New Mexico, southeastern Utah, and northeastern Arizona, excluding the Hopi Reservation), and 20.7% lived in the Oklahoma region (Kansas, Oklahoma, and part of Texas).³¹

²⁶ 42 C.F.R. §136.12(a).

²⁷ "Terminated" tribes are tribes whose federal recognition was withdrawn by statute.

²⁸ 25 U.S.C. 1603(f), 1651-1660d.

²⁹ 25 U.S.C. 1680c: Health Services for Ineligible Persons.

³⁰ For instance, the act recognizing the Pascua Yaqui Tribe of Arizona set certain membership criteria (see §3, P.L. 95-375, act of September 18, 1978, 92 Stat. 712; 25 U.S.C. 1300f-2), and an earlier act specified membership criteria for the Confederated Tribes and Bands of the Yakama Nation of Washington (§1, act of August 9, 1946, Chap. 933, 60 Stat. 968; 25 U.S.C. 601).

³¹ IHS, *Trends in Indian Health, 2000-2001*, p. 33. Percentages calculated by CRS.

Population Data

Determining the actual number of people eligible for IHS services is problematic. There is no U.S. census of members of federally recognized tribes (or, for that matter, of members of terminated and state-recognized tribes who might be eligible for UIHP services). IHS makes annual estimates of its eligible “service population” based on decennial census data, adjusted for birth and death rates and for the areas IHS serves (see **Figure 1**).³² The census, however, asks respondents only to identify themselves by race,³³ not by confirmed membership in a federally recognized tribe.³⁴ Hence IHS service population data are based on self-identification as AI/AN by race, not on tribal membership. Not all persons self-identifying as AI/AN are members of federally recognized tribes, so not all AI/AN counted by the census are eligible for IHS services. The IHS also estimates its “user population,” based on registered AI/AN patients who used IHS-funded services at least once in the most recent three years,³⁵ but this figure does not include all eligible AI/AN. The BIA publishes biennial estimates of its own service population, based on estimates received from BIA agencies and federally recognized tribes, but these estimates are not based on actual censuses and cover only persons on or near reservations.³⁶ The BIA also lists tribes’ reports of their enrollment totals, but the BIA conducts no census to confirm these figures, and its publication does not show whether the enrollees enumerated live on or near reservations or inside or outside IHS service areas. **Table 2** compares recent IHS, BIA, and census population figures.

Determining the *urban* Indian population eligible for UIHP services is equally inexact. As noted above, UIHPs serve a wider range of eligible persons, including members of terminated or state-recognized tribes and their children and grandchildren. They are not, however, authorized to serve anyone who merely identifies themselves as racially Indian.³⁷ BIA figures for service population and tribal enrollment do not help determine the urban UIHP population, because, in addition to the problems already mentioned, the BIA data are not broken down by urban or metropolitan residence, nor do they cover terminated or state-recognized tribes. Nor is an answer provided by Census Bureau data on Indians, since, although the data are broken down by urban, metropolitan, city, and other types of residence, they are still, as noted above, based on self-identification by race, not on tribal membership, whether in federal, state, or terminated tribes. IHS figures for urban Indian populations are based on these Census data.

While IHS, Census, and BIA figures for Indians, whether resident in urban areas or not, may not be definitive for the IHS-eligible population, they provide useful approximations of the population that IHS serves. Census data suggest that most AI/AN live outside reservations and other census-identified Indian areas, that the movement out of these areas is many decades old,

³² Ibid., pp. 32-33.

³³ In the 2000 decennial census, respondents were for the first time permitted to identify themselves by more than one race.

³⁴ The census allows respondents to identify their tribe, but this is still self-identification. The census does not confirm a respondent’s enrollment (or eligibility) in a federally recognized tribe.

³⁵ U.S. Department of Health and Human Services, Indian Health Service, Office of Public Health, Division of Community and Environmental Health, Program Statistics Team, *Regional Differences in Indian Health, 1998-99* [Rockville, MD: IHS, (2000)], p. 11.

³⁶ U.S. Department of the Interior, Bureau of Indian Affairs, Office of Tribal Services, *Indian Labor Force Report, 1999* (Washington: BIA, n.d.), pp. I-iii.

³⁷ See 25 U.S.C. 1603(f), 1651 *et seq.*

and that a majority of census-identified Indians live in census-identified urban areas.³⁸ Many urban areas are within CHSDAs, however, so further analysis may be needed to determine what proportion of census-identified urban Indians are eligible for general IHS services.

Table 2. Differing Indian Population Figures, Selected Years, 1990-2006

Year	Indian Health Service		Bureau of Indian Affairs		Census Bureau	
	Service Population (in IHS service areas; est.)	User Population (at IHS facilities)	Service Population (on or near reservations; est.)	Tribal Enrollment (national; est.)	AI/AN race alone	AI/AN Race Alone or in Combination with Other Races
1990	1,207,236	1,104,693	—	—	Decennial: 1,959,234	—
1991	1,242,745	1,134,655	1,001,606	—	—	—
1997	1,427,453	1,300,634	1,442,747	1,654,433	—	—
1999	1,489,341	—	1,397,931	1,698,483	—	—
2000	1,515,594	—	—	—	Decennial: 2,475,956	4,119,301
					Estimates: 2,673,624	4,236,599
2001	1,542,450	1,345,242	1,524,025	1,816,504	Estimates: 2,712,506	4,281,458
2003	Projections: 1,594,433	1,383,664	1,587,519	1,923,650	Estimates: 2,786,400	4,364,430
2006	1,829,792	1,461,639	—	—	Estimates: 2,902,851	4,497,895

Sources: IHS service population, 1990-2003: IHS, *Trends in Indian Health*, 1998-2003, various pages. IHS service population, 2004: IHS, personal communication, Feb. 22, 2006. IHS user population, 1990-2001: IHS, *Regional Differences in Indian Health*, 1992-2001, various pages. IHS user population, 2003: IHS, *IHS Budget Breakout—Medical & Non-Medical [for 2003]*. IHS user population, 2006: IHS, personal communication, Oct. 22, 2007. All IHS publications are authored by U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation, and Legislation, Division of Program Statistics, and published in Rockville, MD.

BIA service population, 1991: *Indian Service Population and Labor Force Estimates (1991)*, Table 1 (recalculated by CRS). BIA service population and tribal enrollment, 1997: *Indian Labor Force Report: Portrait 1997*, “National Totals” table. BIA service population and tribal enrollment, 1999: *Indian Labor Force Report, 1999*, “National Totals” table. BIA service population and tribal enrollment, 2001: *Indian Labor Force Report, 2001*, “National Totals” table. BIA service population and tribal enrollment, 2003: *Indian Labor Force Report, 2003*, “National Totals” table. All BIA publications are authored by U.S. Department of the Interior, Bureau of Indian Affairs, and published in Washington, D.C.

Census Bureau: 1990-2000 (April 1): U.S. Bureau of the Census, American Factfinder website http://factfinder.census.gov/home/saff/main.html?_lang=en; 2001-2006 (July 1): Population Estimates <http://www.census.gov/popest/national/asrh/NC-EST2006/NC-EST2006-03.xls>.

³⁸ Forquera, *Urban Indian Health*, p. 1; and Appendix 1; and Marlita A. Reddy, ed., *Statistical Record of Native North Americans* (Detroit: Gale Research, 1993), p. 420.

Health Status

IHS comparisons of mortality measures indicate that the IHS service population has historically had a greater incidence of illness and higher mortality rates than the general U.S. population. The disparities in mortality rates have diminished in recent years in such areas as infant and maternal mortality, and mortality associated with homicide, suicide, injuries, firearms, tuberculosis, pneumonia, and other conditions.³⁹ In comparison with the general population, however, Indians are 6.5 times more likely to die from alcoholism, 6 times more likely to die from tuberculosis, almost three times more likely to die from diabetes, and 2.5 times more likely to die in accidents (see **Table 3**). Indians are less likely to die from some other major causes of death, such as heart disease (0.97 chance) and cancers (0.94 chance). In terms of life expectancy, IHS has found that “American Indians and Alaska Natives born today have a life expectancy that is 2.4 years less than the U.S. all races population (74.5 years to 76.9 years, respectively; 1999-2001 rates).”⁴⁰ Studies suggest the higher mortality rates for a number of leading causes of death among AI/AN are related to alcohol abuse, including not only alcohol-related deaths but also accidents, suicide, and homicide.⁴¹

Diabetes⁴²

Indians suffer from a disproportionately high and growing rate of Type 2 diabetes, with its prevalence increasing 41% between 1997 and 2003 in all service areas, particularly among young adults (persons aged 25-34). Between 1990 and 2003, for instance, the incidence of diabetes among these young AI/AN adults grew 135%.⁴³ Diabetes mortality is 3.1 times higher in the AI/AN than in the general U.S. population.⁴⁴ Diabetes is a major cause of AI/AN morbidity, leading to blindness, kidney failure, lower-extremity amputation, and cardiovascular disease.⁴⁵

³⁹ IHS, *Trends in Indian Health, 2000-2001*, pp. 162-163.

⁴⁰ U.S. Indian Health Service, *Facts on Indian Health Disparities*, IHS Fact Sheet, January 2007, available at <http://info.ihs.gov/Files/DisparitiesFacts-Jan2007.doc>, last accessed November 17, 2007.

⁴¹ Philip A. May, “Overview of Alcohol Abuse Epidemiology for American Indian Populations,” in Gary D. Sandefur *et al.*, eds., *Changing Numbers, Changing Needs: American Indian Demography and Public Health* (Washington: National Academy Press, 1996), pp. 243-245.

⁴² Diabetes is a disease in which the body either does not produce the hormone insulin (Type I) or does not produce enough insulin or does not properly use insulin (Type 2). Insulin converts sugar, starches, and other foods into energy. About 90-95% of diabetics have Type 2 diabetes. See <http://www.diabetes.org/about-diabetes.jsp> and http://main.diabetes.org/stepup/diabetes_facts.pdf.

⁴³ U.S. Department of Health and Human Services, Indian Health Service, *Justification of Estimates for Appropriations Committees, Fiscal Year 2007*, p. IHS-71.

⁴⁴ *Ibid.*, p. 71.

⁴⁵ U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System* (Washington: The Commission, September 2004), p. 10 n.20; available at <http://www.usccr.gov/pubs/nahealth/nabroken.pdf>.

Table 3. Mortality Rates for Indians in IHS Service Areas and for U.S. Population (All Races), Total and for Selected Causes, 2001-2003

(Age-adjusted rates per 100,000 population unless otherwise noted)

Cause of Death	IHS Service Population (Average, 2001-2003)	U.S. All Races (2002)	Ratio of IHS Rate to U.S. Rate
All Causes	1042.2	845.3	1.23
Alcohol-related	43.6	6.7	6.51
Tuberculosis	1.8	0.3	6.00
Diabetes	75.2	25.4	2.96
Accidents (unintentional injury, including motor vehicle)	93.8	36.9	2.54
Motor vehicle accident	51.1	15.7	3.25
Homicide	12.7	6.1	2.08
Suicide	17.1	10.9	1.57
Pneumonia and influenza	33.3	22.6	1.47
Heart diseases	234.5	240.8	0.97
Cerebrovascular diseases (affecting blood supply to the brain)	54.7	56.2	0.97
Cancers (malignant neoplasms)	181.8	193.5	0.94
Cervical cancer (females)	4.4	2.6	1.69
Breast cancer (females)	15.4	25.6	0.60
HIV (human immunodeficiency virus) infection	3.2	4.9	0.65
Birth-Related Mortality			
Maternal mortality (per 100,000 live births)	12.7	8.9	1.43
Infant mortality (per 1,000 live births)	9.8	7.0	1.40

Sources: U.S. Indian Health Service, *Facts on Indian Health Disparities*, IHS Fact Sheet, January 2007, table entitled "Mortality Disparity Rates," at <http://info.ihs.gov/Files/DisparitiesFacts-Jan2007.doc>; and U.S. Indian Health Service, Division of Program Statistics, spreadsheet transmitted October 19, 2007.

Note: Mortality rates are age-adjusted to the national 2000 standard population. IHS service population's mortality rates are computed by applying the age-specific death rate for a given cause of death using the AI/AN population residing in counties that make up the IHS service area. The rates were also adjusted for the miscoding of Indian race on death certificates. Previously the national and AI/AN mortality rates were age-adjusted to the national 1940 standard population. Ratios were calculated by CRS.

With the 1997 Balanced Budget Act, Congress began a Special Diabetes Program for Indians (SDPI) as part of IHS's ongoing National Diabetes Program. With SDPI grant monies, the IHS, tribal health programs, and UIHPs have set up diabetes programs to create an extensive support network that gives training, "best practices," and the latest scientific findings with area diabetes consultants, model diabetes programs and other grant programs in 318 AI/AN communities in 35 states.⁴⁶ The funding has enhanced patient care and education and created a needed infrastructure

⁴⁶ U.S. Indian Health Service, National Diabetes Program, *Interim Report to Congress: Special Diabetes Program for* (continued...)

for diabetes programs. With SDPI funding, IHS, Urban Indian Organizations (UIOs), and tribes are able to support prevention programs which have been shown to delay the onset of the disease through lifestyle changes or use of medication.⁴⁷ The program's disease performance measures have tracked the success of the SDPI efforts to fight diabetes. So far the program's efforts have seen an increase in the percentage of Indian diabetics maintaining blood sugar control from 25% in FY1997 to 34% in FY2004. In addition, there are other decreases in the number of health incidents related to diabetes including kidney disease and retinopathy. Other programs are tying diabetes screening with other diseases. For example, on May 16, 2005, the National Institutes of Health announced the beginning of an educational campaign to promote the message that AI/AN can reduce the risk of a heart attack or stroke if they keep under control their blood glucose, blood pressure, and cholesterol.⁴⁸

Appropriations and Funding

IHS funding is separated into four budget categories: health services, facilities, collections (reimbursements from Medicare and Medicaid, as well as private insurance), and SDPI. Health services and facilities appropriations constitute IHS's *budget authority*; its budget authority plus collections and SDPI constitute IHS's *program-level funding*. **Table 4** below shows detailed funding for IHS programs for FY2000-FY2008, with the administration's request for FY2009.⁴⁹ Funding for FY2009 to March 6, 2009, under the continuing resolution is 43.01% of the FY2008 amount for each budget item.⁵⁰ Trends in IHS budget authority and program-level funding for FY1994-FY2008 are shown in **Figure 2**, in current dollars and constant 1994 dollars.⁵¹

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Indians, December 2004, p. 161.

⁴⁷ Diabetes Prevention Program Research Group, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin," *The New England Journal of Medicine*, vol. 346, no. 6, February 7, 2003, pp. 393-403.

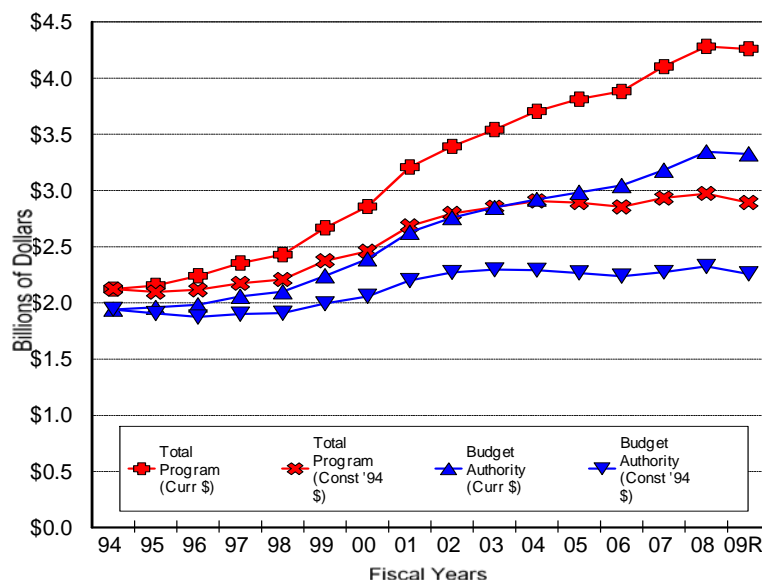
⁴⁸ U.S. Department of Health and Human Services, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, "National Diabetes Education Program Tailors Cardiovascular Disease Message for American Indians and Alaska Natives," *NIH News*, May 16, 2005.

⁴⁹ For further information on IHS FY2009 appropriations, see CRS Report RL34461, *Interior, Environment, and Related Agencies: FY2009 Appropriations*, by (name redacted) et al.

⁵⁰ Telephone conversation with an IHS spokesperson, January 14, 2009. The FY2009 continuing resolution funds federal agencies to March 6, 2009; see the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, Division A, Continuing Appropriations Resolution, 2009, P.L. 110-329 [http://www.congress.gov/cgi-lis/bdquery/R?d110:FLD002:@1\(110+329\)](http://www.congress.gov/cgi-lis/bdquery/R?d110:FLD002:@1(110+329)), act of September 30, 2008, 122 Stat. 3574.

⁵¹ Current dollars were deflated to constant dollars using the Consumer Price Index for All Urban Consumers (CPI-U) for All Items. Different price indexes are used to deflate medical cost increases. IHS often uses the CPI-U for Medical Care. For this report, CRS considered the CPI-U for All Items the most applicable price index.

Figure 2. IHS Funding: Total Program Funding and Budget Authority, in Current and Constant 1994 Dollars, FY 1994-FY2009R



Sources: Table 4. Constant dollar figures calculated by the Congressional Research Service using Consumer Price Index data provided in U.S. President, *The Economic Report of the President, 2008* (Feb. 2008), Table B-60, and U.S. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2008 to 2018* (Jan. 2008), Table 2.1.

Note: R = Request.

Collections

Indians are U.S. citizens, and hence many are eligible for Medicare and Medicaid. Congress has authorized IHS and tribes operating IHS-funded health facilities to collect reimbursements from Medicare and Medicaid, as well as from non-federal sources (see “Statutory Authority”, below). Collections funding has grown from 9% of the IHS program-level budget in FY1995 to 18% in FY2007. Because many Indians on or near reservations lack employment-related health insurance benefits, IHS collections come mostly from the Medicaid and Medicare programs, of which Medicaid provides the majority. Medicaid payments grew from 55% of collections in FY1995 to 71% in FY2003 (falling slightly to 69% in FY2007). “Overall,” said IHS in 2005, “Medicaid and Medicare collections represent up to 50% of the hospital and clinic operating budgets.”⁵² (The Medicaid program as a whole is funded by both state and federal governments, but states receive 100% federal reimbursement for Medicaid services provided to eligible Indians through facilities owned or operated by IHS or by tribes.⁵³)

⁵² U.S. Indian Health Service, “FY2006 Indian Health Service Budget Hearing: Questions for the Record: Additional Committee Questions,” in U.S. Congress, House Committee on Appropriations, *Interior, Environment, and Related Agencies Appropriations for 2006*, hearings, Part 6, 109th Cong., 1st sess. (Washington: GPO, 2005), p. 270.

⁵³ See 42 U.S.C. 1396d(b), third sentence.

Diabetes Funding

In the Balanced Budget Act of 1997 (P.L. 105-33), Congress amended the Public Health Service Act⁵⁴ to create the IHS's Special Diabetes Program for Indians (SDPI). To fund SDPI, the act reduced the State Children's Health Insurance Program (SCHIP) appropriation for FY1998 through FY2002 by \$30 million each year and transferred the funds to SDPI.⁵⁵ In 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (part of P.L. 106-554) increased annual SDPI funding to \$100 million for FY2001-FY2003. Under the 2000 act, for FY2001-FY2002, \$30 million of the \$100 million for SDPI came from the SCHIP appropriation and \$70 million came from the general Treasury, while for FY2003 the whole \$100 million was drawn from the general Treasury.⁵⁶ This funding from the general Treasury is separate from regular IHS appropriations (as noted in **Table 4**). In 2002, Congress increased the annual funding for SDPI to \$150 million and extended the appropriation to FY2004-FY2008.⁵⁷ Last year Congress extended the appropriation to FY2009.⁵⁸ Legislation in the 110th Congress (H.R. 2762 and S. 1494) would increase the annual SDPI appropriation to \$200 million and extend the appropriation to FY2013.

Funding Disparities

Groups supporting Indian health care have argued that IHS per capita expenditures on health services are often less than per capita expenditures in other federal health-related programs. The private nonprofit National Indian Health Board, for example, pointed out that, in FY1997, IHS's per capita expenditures were \$1,430 as compared with \$3,489 per capita under the federal Bureau of Prisons (BOP) and \$5,458 under the Department of Veterans Affairs (VA).⁵⁹ Three years later, however, in FY2000, IHS per capita spending had risen 9% to \$1,577,⁶⁰ while BOP's had fallen 19% to \$2,840⁶¹ and VA's had fallen 7% to \$5,063.⁶² By FY2006, IHS per capita expenditures had risen 5% to \$1,664⁶³ while VA's had risen 13% to \$5,799.⁶⁴ Comparisons of per capita

⁵⁴ P.L. 78-410, act of July 1, 1944, 58 Stat. 682, as amended; 42 U.S.C. 201 et seq.

⁵⁵ P.L. 105-33 [http://www.congress.gov/cgi-lis/bdquery/R?d105:FLD002:@1\(105+33\)](http://www.congress.gov/cgi-lis/bdquery/R?d105:FLD002:@1(105+33), §4922, act of August 5, 1997, 111 Stat. 251, 574; 42 U.S.C. 254c-3, as amended. Sec. 4921 of P.L. 105-33 <a href=) created a similar special program for research on type I diabetes in the National Institutes of Health (NIH).

⁵⁶ P.L. 106-554, §1(a)(6), enacting H.R. 5661 [App. F; §931(b)], act of December 21, 2000, 114 Stat. 2763, 2763A-585.

⁵⁷ P.L. 107-360, act of December 17, 2002, 116 Stat. 3019.

⁵⁸ P.L. 110-173, §302(b), act of December 29, 2007, 121 Stat. 2492, 2515.

⁵⁹ "Statement of Buford Rolin, Chairman, National Indian Health Board," in U.S. Congress, Senate Committee on Indian Affairs, *Partnership for a New Millennium* (1998), op. cit., pp. 279-280, 293. The IHS per capita figure is based on direct appropriations (including construction but excluding reimbursements) divided by the IHS service population. See also Jo Ann Kauffman, *Reauthorization of the Indian Health Care Improvement Act: Background and Issues* (Henry J. Kaiser Family Foundation, October 1999), available at [<http://www.kff.org/minorityhealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13244>].

⁶⁰ Calculated by CRS, in current dollars, using the same method as the National Indian Health Board cited above. Appropriations figure is from Table 4; population data are from Table 2.

⁶¹ Annual medical costs per inmate, as calculated by BOP. U.S. Federal Bureau of Prisons, "1990-2000 Medical Per Capita Costs," unpublished table transmitted to CRS February 2002.

⁶² VA medical care obligations per unique patient, in current dollars; per-capita calculated by CRS. U.S. Department of Veterans Affairs, FY2002 Budget Submission. Medical Programs, vol. 2 of 6. Office of the Assistant Secretary for Financial Management, pp. 2-39, 2-42.

⁶³ Calculated by CRS using same method and sources as for FY2000.

spending under different federal health programs are problematic, however, because—as with BOP and VA—the programs may serve different populations, with differing demographic characteristics and health needs, and may provide different sets of health care services.

A multi-part study initiated in 1998 showed the disparities that exist in personal medical services between IHS and mainstream health care systems. Initially called the “Level of Need Funded” (LNF) study, and retitled the “FEHP Disparity Index” (FDI) study, the study was produced by a tribal-IHS workgroup of 16 people (15 tribal representatives and one IHS official) charged with the responsibility by IHS, and assisted by experts and consultants.⁶⁵ The workgroup chose the Federal Employees Health Benefits Plan (FEHBP) as the benchmark mainstream personal medical services plan against which to compare IHS health services.⁶⁶

The latest FDI study available on the IHS website found that in FY2004, the total cost to give each AI/AN in the IHS user population coverage comparable with that received by federal employees under the FEHBP would be \$3,753 per AI/AN. Of this amount, \$2,815 would be from IHS appropriations and the rest from reimbursement programs such as Medicare, Medicaid, private insurance, and other payments. FEHBP-level coverage for the 1.44 million IHS user population, according to the FDI study, would call for IHS appropriations of about \$3.97 billion in FY2004 for personal medical services. The study found that actual FY2004 IHS appropriations for personal medical services would provide 56.8% of the appropriations needed to give IHS users personal medical services equivalent to the FEHBP, and that an additional \$1.7 billion would be needed to raise the level of IHS personal medical services to 100% of the FEHBP’s.⁶⁷

IHS Funding Allocations and Disparities

Most IHS funding for health services is not allocated based on formulas but rather on historical patterns of recurring base funding as adjusted by annual built-in increases to maintain programs at current levels of service. Each year IHS area and service units receive their previous year’s base funding, with built-in adjustments (if appropriated) allocated by a fixed percentage increase that is the same across IHS. If Congress makes appropriations above the adjusted base to increase particular services or meet unmet needs, IHS allocates such increases using formulas, which have been developed in consultation with tribes.⁶⁸ Some IHS programs or parts of programs are allocated solely by formulas, such as routine maintenance of facilities, some SDPI grants, some sanitation facilities funds, the Indian Health Care Improvement Fund (discussed below), and

(...continued)

⁶⁴ VA medical care obligations per unique patient, in current dollars. U.S. Department of Veterans Affairs, FY2008 Budget Submission. Medical Programs, vol. 4 of 4. Office of the Assistant Secretary for Financial Management, pp. 1-46.

⁶⁵ See the latest FDI report on the IHS website at <http://www.ihs.gov/NonMedicalPrograms/Lnf/index.cfm>. Earlier reports are available at <http://www.ihs.gov/NonMedicalPrograms/Lnf/index.htm>.

⁶⁶ The Federal Employees Health Benefits Plan is the program under which all non-military federal employees obtain federal health coverage.

⁶⁷ IHS, “FY2004 FDI Summary Results,” available at <http://www.ihs.gov/NonMedicalPrograms/Lnf/2005/2004%20FDI%20Summary.pdf>, last accessed October 27, 2007.

⁶⁸ U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Budget Execution Policy (Allocation of Resources), Indian Health Service Circular No. 92-5, effective June 19, 1992, available at http://www.ihs.gov/publicinfo/publications/ihsmanual/Circulars/Circ92/Circ92_05/circ92_05.htm, last accessed October 28, 2007.

others. If Congress appropriates funds for specific facilities, the funds are usually added into, and become part of, the base funding for the relevant service unit and area.

Basing IHS allocations on historical patterns of base funding means the allocations do not fully take into account changes in population, health needs, and health services. One result has been that different IHS areas and service units receive widely varying levels of funding, as measured by per-capita funding.⁶⁹ FDI studies found significant funding variations within the IHS—estimating, for instance, that in FY2004 161 (61%) of the 266 operating units were funded at or below 60% of FEHBP-equivalent services, while 49 (18%) operating units were funded at over 80% of need.⁷⁰

IHS's internal funding disparities have long been known. They were the subject of a 1980 court case involving inequitably low funding allocations to the California area,⁷¹ which were studied by GAO in 1982 and 1991⁷² and were studied by the Office of Technology Assessment (OTA) in its 1986 report on Indian health care.⁷³

The IHS and Congress have made several attempts to deal with the problem, usually by appropriating additional “equity” funds for allocation according to needs-based formulas, with the additional funds becoming part of the recipients’ recurring base funding.⁷⁴ The appropriations for such equity funds, however, were too low—2% of total IHS funding between 1980 and 1990, GAO found—to make a significant change in area-by-area allocation disparities.⁷⁵ Major methodology problems also became apparent, including how to measure health status and health care needs, determine the services provided, and define the IHS-eligible population whose needs must be met. Congress established a permanent equity fund in 1988, the Indian Health Care Improvement Fund (IHCIF),⁷⁶ to provide additional funding to operating units that are most in need. (The FDI is the most recent methodology developed to allocate these funds.) But when IHS had attempted in 1987 to apply needs-based allocation formulas to part of areas’ *base* funding, some tribes and IHS areas had lost funding and objected strongly.⁷⁷ So Congress in 1988 also added a partial “hold harmless” provision, prohibiting any allocation of IHS funding that reduced any service unit’s recurring programs by 5% or more from the previous fiscal year, unless HHS had reported to the President and Congress on the proposed change and its likely effects.⁷⁸

⁶⁹ U.S. General Accounting Office, *Indian Health Service: Funding Based on Historical Patterns, Not Need*, GAO/HRD-91-5, February 1991, p. 1.

⁷⁰ IHS, “FY2004 FDI Summary Results,” available at <http://www.ihs.gov/NonMedical Programs/Lnf/2005/2004%20FDI%20Summary.pdf>, last accessed October 27, 2007; and IHS Congressional and Legislative Affairs Office, personal communication, October 29, 2007.

⁷¹ *Rincon Band of Mission Indians v. Harris*, 618 F.2d 569 (9th Cir. 1980)

⁷² U.S. General Accounting Office, *Indian Health Service Not Yet Distributing Funds Equitably Among Tribes*, GAO/HRD-82-54, July 2, 1982; and GAO, *Indian Health Service: Funding Based on Historical Patterns, Not Need*, op. cit..

⁷³ U.S. Congress, Office of Technology Assessment, *Indian Health Care*, OTA-H-290 (Washington: GPO, 1986), pp. 27-30, 229-238, 345-349.

⁷⁴ OTA, *Indian Health Care*, p. 28.

⁷⁵ GAO, *Indian Health Service: Funding Based on Historical Patterns, Not Need*, p. 4; OTA *Indian Health Care*, p. 238..

⁷⁶ Indian Health Care Amendments of 1988, P.L. 100-713, §201(a), act of November 23, 1988, 102 Stat. 4784, 4800, amending §201 of IHCA; 25 U.S.C. 1621.

⁷⁷ GAO, *Indian Health Service: Funding Based on Historical Patterns, Not Need*, pp. 1, 5.

⁷⁸ Indian Health Care Amendments of 1988, P.L. 100-713, §711, act of November 23, 1988, 102 Stat. 4784, 4833, (continued...)

Although urban Indian health programs are not usually included in discussions of IHS area funding disparities, FDI methodology has been applied to urban Indian health needs. According to the IHS, FDI calculations for FY2000 suggested that the urban Indian health program provided 4% of the FEHBP-equivalent funding needed.⁷⁹

The IHS has previously identified funding shortfalls in other service areas. For instance, facilities maintenance was funded at 27.5% of need for FY2004; replacement of biomedical equipment was funded at about 20% of need in FY2004; sanitation facilities for new homes is funded at 70%, and for existing homes at 5%, of need in FY2005; and health professions scholarships are projected to be funded at 10% of new applications in FY2005.⁸⁰

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adding §717 of IHCA (later renumbered §817); 25 U.S.C. 1680g.

⁷⁹ U.S. Indian Health Service, "House Interior Appropriations, Committee Questions for the Record," in U.S. Congress, House Committee on Appropriations, Department of the Interior and Related Agencies Appropriations for 2001, hearings, part 8, 106th Cong., 2nd sess. (Washington: GPO, 2000), pp. 364-365.

⁸⁰ U.S. Indian Health Service, personal communications, June 30 and July 1, 2005.

Table 4. Indian Health Service Funding, FY2000-FY2009R

(in millions of dollars)

	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009R
Budget Authority (total)	2,390.7	2,628.8	2,758.1	2,849.7	2,921.7	2,985.1	3,045.3	3,180.1	3,346.2	3,324.9
Health Services (subtotal):	2,074.2	2,265.7	2,388.6	2,475.9	2,530.4	2,596.5	2,692.1	2,818.9	2,971.5	2,971.5
Clinical Services:	1,632.3	1,796.2	1,891.4	1,973.8	2,024.9	2,090.6	2,176.2	2,288.9	2,433.8	2,475.9
Hospitals and Health Clinics	1,005.4	1,084.2	1,153.2	1,212.0	1,249.8	1,289.4	1,339.5	1,411.3	1,484.0	1,521.9
<i>Ind. Hlth. Care Improvmt. Fd.</i>	10.0	30.0	23.0	26.2	0	11.3	0	0	\$13.8	24.0
Dental Health	80.1	91.0	95.3	99.6	104.5	109.0	117.7	125.4	133.6	137.9
Mental Health	43.2	45.0	47.1	50.3	53.3	55.1	58.5	60.9	63.5	65.8
Alcohol and Substance Abuse	96.8	130.3	135.0	136.8	138.3	139.1	143.2	148.2	173.2	162.0
Contract Health Services	406.8	445.8	460.8	475.0	479.1	498.1	517.3	543.1	579.3	588.2
Preventive Health:	91.9	95.7	99.7	102.6	106.9	110.4	117.1	123.3	127.6	131.1
Public Health Nursing	34.5	36.1	37.8	39.6	42.6	45.0	49.0	52.4	55.9	58.3
Health Education	9.6	10.1	10.6	11.0	11.8	12.4	13.6	14.3	15.0	15.2
Community Health Reps	46.4	48.1	49.8	50.4	51.0	51.4	52.9	54.9	54.9	55.8
Immunization (Alaska)	1.4	1.5	1.5	1.5	1.6	1.6	1.6	1.7	1.7	1.8
Urban Indian Health	27.8	29.8	30.9	31.3	31.6	31.8	32.7	33.7	34.5	0
Indian Health Professions	30.5	30.5	31.2	31.1	30.8	30.4	31.0	31.4	36.3	21.9
Tribal Management	2.4	2.4	2.4	2.4	2.4	2.3	2.4	2.4	2.5	2.5
Direct Operations	51.0	52.9	54.8	60.2	60.7	61.6	62.2	63.6	63.6	62.6
Self Governance	9.5	9.8	9.9	5.6	5.6	5.6	5.7	5.8	5.8	5.9
Contract Support Costs	228.8	248.2	268.2	269.0	267.4	263.7	264.7	269.7	267.4	271.6

	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009R
Facilities (subtotal):	316.6	363.1	369.5	373.7	391.4	388.6	353.2	361.2	374.6	353.3
Maintenance and Improvement	43.4	46.3	46.3	49.5	48.9	49.2	51.6	54.7	52.9	52.9
Sanitation Facilities	92.1	93.6	93.8	93.2	93.0	91.8	92.1	94.0	94.3	94.3
Health Care Facilities Construction	50.4	85.5	86.3	81.6	94.6	88.6	37.8	25.7	36.6	15.8
Facilities & Envtl. Health Support	116.3	121.3	126.8	132.3	137.8	141.7	150.7	165.3	169.6	169.1
Equipment	14.3	16.3	16.3	17.2	17.1	17.3	20.9	21.6	21.3	21.3
Collections (total)	437.0	479.5	534.8	591.7	634.4	677.6	687.7	773.2	786.0	786.0
Medicare	109.1	114.7	109.4	119.2	129.4	136.5	142.0	161.0	162.1	162.1
Medicaid	283.3	316.1	375.3	417.7	446.0	472.5	464.4	515.8	527.5	527.5
Private Insurance	39.4	43.1	44.4	48.9	52.8	62.4	75.1	90.2	90.2	90.2
Personnel Quarters	5.3	5.5	5.7	5.9	6.2	6.3	6.3	6.3	6.3	6.3
Special Diabetes Program for Indians	30.0	100.0	100.0	100.0	150.0	150.0	150.0	150.0	150.0	150.0
Program level (grand total)	2,857.7	3,208.2	3,392.9	3,541.4	3,706.1	3,812.7	3,883.0	4,103.3	4,282.2	4,260.9

Sources: U.S. Department of Health and Human Services, Indian Health Service, *Justification of Estimates for Appropriations Committees, Fiscal Year 2009* (Feb. 2008, pp. CJ-3), and previous years' IHS budget justifications; CRS Report RL32893, *Interior, Environment, and Related Agencies: FY2006 Appropriations*, by (nae redacted) et al. and CRS Report RL34011, *Interior, Environment, and Related Agencies: FY2008 Appropriations*, by (nae redacted) et al. (except collections data); and collections and IHCIF data (FY2000-FY2006) from IHS Congressional and Legislative Affairs Office, Oct. 22 and 29, 2007.

Notes: Appropriations are after supplemental appropriations and rescissions. R = Request.

Statutory Authority and Committee Jurisdiction

Over the last eight decades, Congress has enacted a number of statutes providing general or specific authorizations for health services to AI/ANs. Before that, Congress directed the BIA to provide Indian health care and construct Indian health facilities through annual Indian appropriations acts.

Statutory Authority

Currently, the IHS administers funds and policies under several statutes.

Snyder Act of 1921 ⁸¹

This act provides a broad and permanent authorization for federal Indian programs, including for “conservation of health.” In 1921 all such programs were under the management of the BIA. The act was passed because Congress had never enacted any specific statutory authorizations for most of the many BIA activities that had developed after the Civil War as more and more tribes were placed on reservations. Instead, Congress had made detailed annual appropriations for these BIA activities. Authority for Indian appropriations in the House had been assigned to the Indian Affairs Committee after 1885 (and in the Senate to its Indian Affairs Committee after 1899). Rules changes in the House in 1920, however, moved Indian appropriations authority to the Appropriations Committee, making Indian appropriations vulnerable to procedural objections because they lacked authorizing acts. The Snyder Act was passed in order to authorize all the activities the BIA was then carrying out. The act’s broad language, however, may be read as authorizing—though not requiring—nearly any Indian program, including health care, for which Congress enacts appropriations.

Transfer Act of 1954 ⁸²

The act transferred the responsibility for Indian health care from the BIA to the PHS in the newly established Department of Health, Education and Welfare (now HHS). Among other reasons, Congress felt the PHS could do a better job of providing health care services to Indians.

Indian Sanitation Facilities Act of 1959 ⁸³

This act, amending the Transfer Act, authorizes the PHS to construct sanitation facilities for Indian communities and homes.

⁸¹ Act of November 2, 1921, 42 Stat. 208, as amended; 25 U.S.C. 13.

⁸² P.L. 83-568, act of August 5, 1954, 68 Stat. 674, as amended; 42 U.S.C. 2001 et seq.

⁸³ P.L. 86-121, act of July 31, 1959, 73 Stat. 267; 42 U.S.C. 2004a.

Indian Self-Determination and Education Assistance Act (ISDEAA) of 1975 ⁸⁴

ISDEAA, as amended, provides for tribal administration of federal Indian programs, especially BIA and IHS programs. The act allows tribes to assume some control over the management of their health care services by negotiating “self-determination contracts” with IHS for tribal management of specific IHS programs. Under a self-determination contract, IHS transfers to tribal control the funds it would have spent for the contracted program so the tribe might operate the program. Under ISDEAA authority, IHS has also established a tribal consultation policy giving tribes an opportunity to help formulate health priorities in the President’s annual budget request.

Tribal Self-Governance Program

Beginning in 1992, Congress amended ISDEAA to allow tribal governments to consolidate IHS self-determination contracts for multiple IHS programs into a single “self-governance compact.” Under a self-governance compact, the same transfer of IHS funds and operating control takes place as happens with a self-determination contract, but the compacting tribe is authorized to redesign programs and services and to reallocate funds for those programs and services. BIA programs had been authorized for compacting under a demonstration program in 1988,⁸⁵ and similar authority was extended to IHS programs in 1992.⁸⁶ In 2000, the Tribal Self-Governance Amendments⁸⁷ made the IHS self-governance program permanent, as Title V of ISDEAA.

Indian Health Care Improvement Act (IHCIA) of 1976 ⁸⁸

IHCIA authorizes many specific IHS activities, sets out the national policy for health services administered to Indians, and sets health condition goals for the IHS service population in order to “assure the highest possible health status for Indians and urban Indians.”⁸⁹ Most significantly, IHCIA authorizes direct collections from Medicare, Medicaid, and other third party insurers. It also gives IHS authority to grant funding to urban Indian organizations to provide health care services to urban Indians and established substance abuse treatment programs, Indian health professions recruitment programs, and many other programs. The IHCIA was last fully reauthorized by the Indian Health Amendments of 1992,⁹⁰ which extended authorizations of its appropriations through FY2000. The authorizations for all IHCIA programs were later extended through FY2001.⁹¹

⁸⁴ P.L. 93-638, act of January 4, 1975, 88 Stat. 2203, as amended; 25 U.S.C. 450 et seq.

⁸⁵ Title II of P.L. 100-472, act of October 5, 1988, 102 Stat. 2285, 2296.

⁸⁶ §814 of P.L. 102-573, act of October 29, 1992, 106 Stat. 4526, 4590.

⁸⁷ P.L. 106-260, act of August 18, 2000, 114 Stat. 711; 25 U.S.C. 458aaa et seq.

⁸⁸ P.L. 94-437, act of September 30, 1976, 90 Stat. 1400, as amended; 25 U.S.C. 1601 et seq., and 42 U.S.C. 1395qq, 1396j (and amending other sections).

⁸⁹ IHCIA, §3(a); 25 U.S.C. 1602(a).

⁹⁰ P.L. 102-573, act of October 29, 1992, 106 Stat. 4526. Previous reauthorizations occurred in 1980 (P.L. 96-537) and 1988 (P.L. 100-713), and substantial amendments were made in 1990 (P.L. 101-630, Title V).

⁹¹ Omnibus Indian Advancement Act, P.L. 106-568, §815, act of December 27, 2000, 114 Stat. 2868, 2918.

Alaska Native and American Indian Direct Reimbursement Act of 2000

⁹² This act amended IHCA to make permanent a demonstration program for direct billing of Medicare, Medicaid, and other third-party payors by Indian tribes and health organizations with self-determination contracts or self-governance compacts. The demonstration program, involving four tribally operated IHS-owned hospitals and clinics, had increased collections, reduced the turn-around time between billing and receipt of payment, eased tracking of billings and collections, and reduced administrative costs.

Congressional Committee Jurisdiction

Currently a number of committees hold jurisdiction over legislation affecting the Indian Health Service. In general, legislation amending an existing statute is likely to be referred to the committees that held jurisdiction over the original legislation.

House Jurisdiction

Major jurisdiction over Native American issues, Indian health care legislation, and self-governance is held by the Natural Resources Committee. In matters of public health care and health facilities legislation and for programs such as Medicaid, Medicare Part B,⁹³ and the State Children's Health Insurance Program (SCHIP), the Energy and Commerce Committee has jurisdiction. However, the Energy and Commerce Committee shares jurisdiction with the Committee on Ways and Means for legislation dealing with Medicare Part B. The Committee on Ways and Means has exclusive jurisdiction over Medicare Part A. Bills to reauthorize IHCA have been referred to the Committee on Natural Resources, and, in addition, to the Committees on Energy and Commerce and on Ways and Means for consideration of provisions that come under their jurisdiction. Recent IHCA reauthorization bills also contain a provision to elevate the IHS director to the level of an assistant secretary within HHS; a reauthorization bill with this provision in the 107th Congress (H.R. 1662) was referred to the Committee on Government Reform (now the Committee on Oversight and Government Reform), but bills with the same provision were not so referred in the 108th-110th Congresses.

Senate Jurisdiction

In general, the Committee on Indian Affairs holds jurisdiction over all Senate legislation relating to Indians. The Senate Health, Education, Labor and Pensions Committee has jurisdiction over matters of public health. The Senate Finance Committee has jurisdiction over Medicare, Medicaid, and SCHIP. Recent Senate IHCA reauthorization bills have been referred to the Indian Affairs Committee alone, but in the 109th and 110th Congresses several bills relating to provisions in the Social Security Act added by IHCA, regarding Medicaid and Medicare, originated in or were referred only to the Finance Committee.

⁹² P.L. 106-417, act of November 1, 2000, 114 Stat.1812; 25 U.S.C. 1645 and 1601 note, and 42 U.S.C. 1395qq(e), 1396j(d).

⁹³ Medicare Part B covers supplementary medical benefits such as physicians' and laboratory services; Medicare Part A covers inpatient hospital and certain related services. For more detail, see CRS Report RL33202, *Medicaid: A Primer*, by (name redacted).

Appropriations Jurisdiction

Although IHS is part of the Public Health Service of HHS, its annual appropriation is under the jurisdiction of the Interior and Environment subcommittees of the Appropriation Committees, in both houses.

Current Legislative Issues

There are a number of Indian health issues that have been or likely will be debated in the 110th Congress. Foremost is the reauthorization of the IHCA (and related amendments to the Social Security Act (SSA)).

Reauthorization of the Indian Health Care Improvement Act

Although many, if not all, IHS programs may be considered permanently authorized by the Snyder Act's authorization of expenditures for "conservation of health,"⁹⁴ the IHCA authorized a number of specific new programs and inserted Indian provisions in the SSA. IHCA's specific authorizations of appropriations expired at the end of FY2001. Congress has continued to appropriate funds for its programs.⁹⁵

IHCA reauthorization has been under consideration since 1999.⁹⁶ Negotiations among Indian health proponents, HHS agencies, other departments, the Administration, and congressional committees and offices have led to numerous changes in the bills from one Congress to the next. Extensive hearings have been held on most bills, but only in the 108th-110th Congresses have bills been reported from committee.

In the 110th Congress, the Senate's IHCA reauthorization bill, S. 1200, was introduced on April 24, 2007, and reported, with amendments, by the Senate Indian Affairs Committee on October 16, 2007 (S.Rept. 110-197). The House IHCA reauthorization bill in the 110th Congress, H.R. 1328, which was very similar to S. 1200, was introduced March 6, 2007, and referred to the Natural Resources Committee, as well as to the Energy and Commerce Committee and the Ways and Means Committee for provisions within their jurisdictions. The Natural Resources Committee ordered H.R. 1328 reported, with amendments, on April 25, 2007; the printed report was published April 4, 2008 (H.Rept. 110-564, part 1). The House Subcommittee on Health of the Energy and Commerce Committee held hearings on H.R. 1328 on June 7, 2007, and marked up the bill and forwarded it, amended, to the full committee on November 7, 2007. Another Senate bill, which addressed only IHCA-related amendments to the SSA, was ordered reported by the Senate Finance Committee on September 12, 2007; this bill was introduced January 8, 2008, as S. 2532 and was reported the same day (S.Rept. 110-255). S. 2532's provisions had already been

⁹⁴ 25 U.S.C. 13.

⁹⁵ For a discussion of the relationship between appropriations and authorizations, see CRS Report RS20371, *Overview of the Authorization-Appropriations Process*, by (name redacted)

⁹⁶ Reauthorization bills were introduced in the 106th (H.R. 3397 and S. 2526), 107th (S. 212 and H.R. 1662), 108th (S. 556 and H.R. 2440), and 109th (H.R. 5312, S. 1057, S. 3524, and S. 4122) Congresses.

incorporated into S. 1200 as reported and into H.R. 1328 as ordered reported by the House Natural Resources Committee.⁹⁷

S. 1200 was passed, amended, in the Senate on February 28, 2008, and referred in the House to the same committees as H.R. 1328. H.R. 1328 was discharged from the Energy and Commerce Committee and the Ways and Means Committee on June 6, 2008, and the Natural Resources-reported bill was placed on the House calendar. Neither S. 1200 nor H.R. 1328 came to a vote on the House floor before the end of the 110th Congress.

No IHCIA reauthorization bill has been introduced in the 111th Congress as of the date of this report, although Medicaid-related provisions concerning cost-sharing, property exclusions, and consultation have been included in current draft economic-stimulus legislation. The discussion below examines the IHCIA bills from the 110th Congress.

S. 1200 and H.R. 1328 have two health-related titles. *Title I* of each bill contains three sections, one subsection of which (§101(a)) reauthorizes all of IHCIA's eight titles. The other subsections of Section 101 make technical amendments elsewhere in federal law. Section 102 of Title I concerns sanitation facilities for the Soboba Band of Luiseno Indians, and Section 103 amends the ISDEAA to create a new Native American health and wellness foundation. The Senate added to Title I of S. 1200 four more sections, two related to Indian health and two to other matters. *Title II* of each bill contains amendments to the SSA, including SSA provisions previously added or amended by the IHCIA. The Senate added to Title II of S. 1200 six additional sections, two on Indian matters and four on non-Indian Medicare and Medicaid issues. The Senate also added a *Title III* to S. 1200, apologizing to Native American peoples for U.S. Indian policy.

S. 1200, as passed by the Senate, and H.R. 1328, as reported, would make numerous significant changes to current law. They would expand the roles of tribes, tribal organizations (TOs), and urban Indian organizations (UIOs) in management and decision-making; organize behavioral health services (alcohol and substance abuse, social services, and mental health programs) into a "comprehensive continuum" of prevention and treatment programs; create a construction priority system for IHS-funded health facilities; authorize long-term and hospice care; exempt Indians from Medicaid and SCHIP premiums and copayments; allow urban Indian health programs (UIHPs) to get reimbursements from Medicare and other third parties; and establish a commission on how to improve Indian health care delivery. While retaining the same general structure of the current IHCIA, the bills would rearrange many existing IHCIA sections so that provisions dealing with similar topics, such as mental health or third-party reimbursements, are in the same title. The bills would also centralize separate appropriations authorizations, now scattered within each of IHCIA's titles, into a single general authorization of appropriations for each title and extend authorizations of appropriations through FY2017.

Issues and provisions are discussed below in their general order of occurrence in the bills—S. 1200 as passed by the Senate and H.R. 1328 as reported. Changes are also noted that were made in H.R. 1328 by the House Health Subcommittee of the Energy and Commerce Committee, in the version it forwarded to the full committee in November 2007.⁹⁸ The bills are compared with

⁹⁷ See U.S. Congressional Budget Office, "Cost Estimate: Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2007, As Ordered Reported by the Senate Committee on Finance on September 12, 2007," October 10, 2007, p. 5.

⁹⁸ See Manager's amendments offered to H.R. 1328 in House Energy and Commerce Committee's Health Subcommittee, November 6, 2007, available at http://energycommerce.house.gov/cmte_mtgs/HESub110707MU/ (continued...)

current law and sometimes with bills from previous Congresses. During the Senate's consideration of S. 1200, the Administration issued a "Statement of Administration Policy" (SAP) on S. 1200.⁹⁹ The SAP objected to about a dozen and a half items in S. 1200 and threatened a veto over a provision involving the "Davis-Bacon Act Application" (see below). Some of the new concerns raised by the SAP are noted in the discussions below.

Definitions

The bills add or amend many of the definitions used in the act, set in IHCA Section 4. Some of the changes may have program or policy implications, discussed below.

Expansion of Services Definitions

The bills greatly expand the definitions of *health promotion* and *disease prevention*, which increases the range of services that Indians may demand of IHS, since the terms occur frequently in IHCA. For instance, IHCA Section 203(b) of the bills would require that the HHS Secretary "shall provide health promotion and disease prevention services to Indians." The term *health promotion* would be expanded from seven items to 34 and would include general activities, such as "improving the physical, economic, cultural, psychological, and social environment," as well as many more specific programs, such as abuse prevention, community health, and safe work environments (§4(11)). The definition of *disease prevention* would be expanded to include limitation and prevention of disease in general, not just of specific conditions (§4(9)). IHS fears it may not have the funding or ability to provide all such expanded services (e.g., *safe housing* or a *safe work environment*).¹⁰⁰

Entities

The bills would add several new terms for Indian health services managed by various entities: "Tribal Health Program" and "Indian Health Program." The term Tribal Health Program (THP) is defined as a tribe or TO that operates a health program or facility funded partly or wholly by the IHS under an ISDEAA funding agreement (§4(24)). An Indian Health Program (IHP) is defined as any Indian health program administered directly by the IHS, by a THP, or by a tribe or TO with HHS funding under the Buy Indian Act¹⁰¹ (§4(13)). Many references to tribes and TOs in current law are changed to THPs in the bills; similarly, references to the IHS, tribes, and TOs in current law are changed to IHPs. Current law already authorizes TOs or tribes to operate some IHS-funded programs, but in the bills the new terms often expand the types of entities eligible to receive funding or administer programs.

(...continued)

Manager's%20amendment.pdf, last accessed June 10, 2008.

⁹⁹ U.S. Executive Office of the President, Office of Management and Budget, "Statement of Administration Policy: S. 1200—Indian Health Care Improvement Act Amendments of 2008," January 22, 2008; available at <http://www.whitehouse.gov/omb/legislative/sap/110-2/saps1200-s.pdf>.

¹⁰⁰ Telephone conversation with an IHS spokesman, November 4, 2

¹⁰¹ Act of April 30, 1908, Chap. 153 (60th Cong.), 35 Stat. 70, 71; §23 of the act of June 25, 1910, Chap. 431 (61st Cong.), 36 Stat. 855, 861, as amended; 25 U.S.C. 47.

Traditional Health Care

The bills in several sections authorize or direct IHS to fund traditional Indian health care practices, training, and practitioners. Some earlier IHCA reauthorization bills defined “traditional health care practices” as “the application by Native healing practitioners of the Native healing sciences” as opposed to western medicine (e.g., S. 1057, 109th Congress, §4(23)), but the current bills contain no definition of traditional health care practices. The SAP objected to IHS-connected use of traditional health care practices without language protecting the U.S. government from possible liability and litigation.

Indian Health Professional and Human Resources

As in current law, Title I of both bills covers personnel recruitment, scholarships, and other educational programs. The purpose of this title is to increase the number, and enhance the skills, of Indian and non-Indian health professionals and other health personnel in the IHS. To do this, the act authorizes scholarships for preparatory and professional schools. The bills add UIO programs and employees, where possible, to be eligible for involvement with training. They also expand the right to a “retention bonus” to all health professionals employed in or assigned to IHP or UIO programs. They eliminate nursing school clinics and restrict the existing community-college health training programs to accredited community colleges on or near reservations.

Community Health

Title I of the bills also reauthorizes two programs, the Community Health Representative Program and the Community Health Aide/Practitioner (CHAP) program in Alaska. These two programs not only recruit and train health representatives and aides, but also authorize them to provide health care, health promotion, and disease prevention services (including some dental services) to Indian communities, especially rural communities that have difficulty accessing health services. A new provision in the CHAP authorization in the bills authorizes a national CHAP program, although excluding certain community dental health services.

Community Dental Health Services

The Alaska CHAP program recently started a new Alaska Dental Health Aide Therapist Program.¹⁰² The program seeks to provide access to dental care for residents of remote Alaskan villages which cannot support full-time dentists. It expands an existing CHAP program, which trains aides in dental education, dental assistance, and preventive dental services, to allow the aides to be trained as dental health aide *therapists*, who can perform more complicated dental work. Although support exists for this expansion of responsibilities for dental health aide therapists, including among dental hygienists and the American Public Health Association, the American Dental Association (ADA) is opposed, because of concerns that dental health aide therapists could be performing dental work in Alaska that would not be up to the standards of care offered to everyone else, and concerns that a CHAP dental health aide therapist program may be extended to the lower 48 states. The ADA argues that because of severe oral disease in the Alaskan Native population, highly skilled and trained dentists are needed to solve these dental

¹⁰² Eugene Sekiguchi, Albert H. Guay, L. Jackson Brown, and Thomas J. Spangler, Jr., “Improving the Oral Health of Alaska Natives,” *American Journal of Public Health*, vol. 95, no. 5, May 2005, pp. 769-772.

challenges. Supporters of the dental health aide therapist program, on the other hand, claim that the need is so great that specially trained dental therapists could assist and solve many of the dental problems faced by remote villages. Currently, Alaska CHAP dental health aide therapists receive training outside the United States, because there are no U.S. programs training such dental health aide therapists.

Both bills would allow the CHAP dental health aide therapist program in Alaska to continue, but would prohibit any CHAP dental health aide therapists outside Alaska, and would prohibit most oral surgery by therapists and limit their ability to perform simple tooth extractions and pulpal therapy to situations certified as medical emergencies by licensed dentists. Both bills would also require a study of the Alaska CHAP dental health aide therapist program, to be conducted by a neutral panel of “clinicians, economists, community practitioners, oral epidemiologists, and Alaska Natives” (§121(c)(1)(B)), who would make several determinations on the quality and adequacy of dental health aide therapist services and on safer and cheaper alternatives, and report to Congress and the HHS Secretary.

Health Services

In current law, the health services title (Title II) authorizes a number of specific health programs. In the bills Title II authorizes specific physical, but not mental, health programs. Programs are moved in from other titles, new programs are created, and a number of programs are moved to other titles; for instance, most of the mental health provisions of this title in current law are moved to the bills’ “behavioral health” title (Title VII), and provisions on third-party reimbursements and managed care are moved to Title IV, which covers Medicare, Medicaid, and other programs (see discussions below).

The provisions that remain in the health services title broaden the range of health care services that the IHCA authorizes IHS to provide. They add to the purposes of the Indian Health Care Improvement Fund the elimination of funding inequities for health care programs. They set out the requirements for the Catastrophic Health Emergency Fund, including a new single-value threshold cost (\$19,000) for treatment of victims. They broaden the provisions on diabetes prevention, treatment, and control; create an IHS Office of Indian Men’s Health; and add oral health and youth programs to Indian school health education programs. They enlarge and combine the contract health service delivery areas (CHSDAs) in North and South Dakota to become one CHSDA covering both states. Both bills include the current requirement that the IHS establish an epidemiological center in every IHS service area (§209).

Health-Care-Related Services

The current IHCA authorizes an IHS feasibility study of hospice care for terminally ill Indians and demonstration projects for home- and community-based care for functionally disabled Indians. IHCA Section 213 in both S. 1200 and H.R. 1328 would substitute a general authorization to fund, via IHS, tribes, and TOs, other health-care-related services and programs, specifically including hospice care, home- and community-based services, assisted living, and long-term care. The House Health Subcommittee’s version of H.R. 1328 would require that funding to flow only through the IHS. Concerns have been raised about the standards under which these types of care would be provided, the specific services that might be included, and the persons eligible for such care. H.R. 1328 but not S. 1200 requires conformance with the “accepted and appropriate standards” for the type of care provided and requires that the relevant

state's standards apply to the care provided (unless the HHS Secretary establishes standards by regulation, which may be no more stringent than state standards). S. 1200 only requires that assisted living and home- and community-based services meet "applicable standards." Both bills define the services included through definitions; both bills define hospice care and home- and community-based services by reference to the SSA (and, for hospice care, other services that a tribe or TO determines necessary). S. 1200 but not H.R. 1328 defines assisted living services and long-term care services by references to other laws. While silent on services to ineligible persons, both bills specify that individuals eligible for long-term care must meet certain disability criteria, or be determined eligible by an IHP, and do not require IHS eligibility. The Administration's SAP, however, objects to the possibility that currently ineligible persons may become eligible for IHS-funded services, and also objects to the expansion to new services.

S. 1200, but not H.R. 1328, authorizes funding for IHP "convenient care services" programs, which are defined elsewhere in the bill as primary health care services (such as urgent care, and "non-emergent" care, prevention, and screening) that are provided outside regular operating hours or at alternative settings (IHCIA §§213(d) and 306(c)(2) in S. 1200).

Diabetes

IHCIA Section 204 of S. 1200 (as passed by the Senate) and H.R. 1328 (as reported) replaces the existing diabetes provision with new language that would require that IHS screen each eligible Indian for diabetes, determine the prevalence of and the types of complications of this disease, and take steps to reduce the incidence of diabetes. These bills would also require the Secretary to continue funding all IHS diabetes programs in existence on the date of enactment or established thereafter, a provision to which the Administration objects. The House Health Subcommittee version of H.R. 1328 limits the funding requirement to model diabetes prevention programs in existence on the date of enactment, and adds an end date of FY2017. The bills would authorize the establishment of dialysis programs, including purchasing equipment and providing necessary staffing. In addition, if funding is available, the Secretary is required to consult with THPs in each IHS area to establish a registry of diabetics in order to track the incidence and complications of diabetes in the area and further to ensure that the data are disseminated among all other area offices. The IHS could also establish a diabetes control officer in each IHS area office. The bills would also authorize IHS to establish criteria under which urban Indian organizations could receive grant funding for the prevention, treatment, and control of diabetes.

Licensing of Health Professionals

Under current IHS rules, health professionals employed directly by IHS are required to have a state license, certificate, or registration for their professional field,¹⁰³ but the rules do not require state licensure from each state in which an IHS health professional may practice. Hence an IHS-employed health professional, if licensed by any one state, may provide services in an IHS facility in the same or any other state.¹⁰⁴ Both bills (§222 of H.R. 1328 as reported, and §221 of S. 1200 and the House Health Subcommittee version of H.R. 1328) would extend this licensing exemption to THP-employed health professionals, to provide services under the THP's ISDEAA

¹⁰³ U.S. Dept. of Health and Human Services, Indian Health Service, Indian Health Manual, Part 3, Chap. 1, Section 3-1.3(B)(5); available at <http://www.ihs.gov/publicinfo/publications/ihsmanual/Part3/Pt3Chpt1/pt3chpt1.htm>.

¹⁰⁴ IHS, personal communication, November 19, 2007.

contract or compact in any state served by that THP. Concerns have been expressed that this provision of the bills may reduce the quality of health care to Indians. The House Health Subcommittee version of H.R. 1328 limits the exemption to licensed health professionals and to the services provided in the THP's facilities.

Health and Sanitation Facilities

In current law, health and sanitation facilities are covered in Title III. In the bills, several programs are transferred into Title III from other titles and new programs are created. Among the new provisions in the bills are a requirement (instead of a discretionary authorization) that the Secretary provide financial and technical assistance to tribes, TOs, and Indian communities to establish utility organizations to operate and maintain sanitation facilities; an authorization for short-term, emergency IHS assistance to tribes in the operation of sanitation facilities; a requirement for a feasibility study for a new health-facility construction loan fund for tribes and TOs; authority for THPs to set rents on staff quarters; and authority for IHS to accept funding for health care facility construction from federal, state, and non-governmental sources. The current IHCA prohibits closure of all or part of an IHS-operated health care facility unless an impact report has been submitted to Congress at least one year in advance, but, to prevent facility closures based on reports done many years previously, the bills add a requirement that the impact report be submitted no more than two years in advance (S. 1200 applies these strictures to reductions in service hours as well as closures).

Allocation of Funds

Another new provision is a requirement that the Secretary develop a priority system for health-care facility construction, instead of just reporting on the priority system now in use (§301(c)). The bills, however, retain current priority levels for the top 10 projects in four categories of facilities (inpatient, outpatient, staff quarters, and youth treatment centers), to avoid penalizing projects that have been slowly rising up the current priority ladder. This retention, or “grandfathering,” of certain projects’ current priority levels concerns tribes whose projects might be delayed even if, under a new system, they were to be assigned higher priority levels than current top-10 projects. Both bills require the Secretary to consult with tribes, TOs, and UIOs in developing innovative approaches to meeting unmet facility needs, but S. 1200 specifies that this may include an “area distribution fund,” composed of part of health facilities funding, under which each IHS area would receive at least some health facilities funding (which is not the case under the current priority system).

Small Ambulatory Care Facilities

Section 305 of S. 1200 and H.R. 1328 (as reported) amends a current provision, which authorizes grants to tribes and TOs to construct or modernize small ambulatory care facilities, to reduce the minimum service-population size for the grants and change the minimum user-population size to a minimum number of visits. It also expands an exemption from these minimum-size requirements, from (under current law) tribes or TOs on islands, to tribal or TO facilities that are either on islands or on road systems that do not give direct access to inpatient hospitals. The bills also expand the allowable uses of the grants to include the reduction of tribal or TO debt incurred to construct or modernize such ambulatory facilities. The House Health Subcommittee’s version of H.R. 1328 restores current language regarding minimum population sizes and deletes the use for debt reduction, but adds a set-aside for grants to Indian communities below a minimum size.

Convenient Care Facilities

S. 1200, but not H.R. 1328, authorizes demonstration grants for convenient care services at IHS-funded facilities. S. 1200 defines convenient care services as primary health care services, including urgent and nonemergent care, prevention services, screenings, and health promotion and disease prevention services that are “provided outside the regular hours of operation of a health care facility; or offered at an alternative setting” (IHCIA §306(c)(2)(A)).

Sanitation Facility Loans

Section 302(c) of H.R. 1328 adds new authority to use appropriations for IHS sanitation-facilities construction to fund tribes’ loans for sanitation facility construction and to meet other programs’ matching or cost-participation requirements. Section 302(c) of S. 1200 changes this to an authorization for the Secretary to guarantee loans made to tribes to construct sanitation facilities, in accordance with Section 302(c) and certain sections of the Public Health Service Act, and to the extent appropriations are specifically provided and appropriations for IHS sanitation-facilities construction are not reduced. The House Health Subcommittee version of H.R. 1328 deletes the authorization to fund tribal loans from sanitation-facilities appropriations.

HUD Housing Sanitation

Both bills prohibit the use of IHS sanitation-facilities funding to provide sanitation facilities for new homes funded by the Department of Housing and Urban Development (HUD) (§302(c)(3)). Congress has included a similar prohibition in annual IHS appropriations acts since FY2003. The goal of this provision is for HUD to fund sanitation facilities for HUD-financed new homes, so that IHS funds can be used to provide sanitation upgrades or initial sanitation services to existing Indian homes and to homes built or improved by tribes, the BIA, individuals, or other non-HUD public or private programs.

Davis-Bacon Act Application

The Davis-Bacon Act¹⁰⁵ requires the payment of “prevailing wages” in construction and renovation contracts to which the federal government is a party and authorizes the Secretary of Labor to determine the prevailing wages for a project. The current IHCIA applies the Davis-Bacon Act to facility construction or renovation funded in whole or part by funds authorized under Title III. Provisions in the ISDEAA exempt tribes and TOs from Davis-Bacon if they both perform the construction under a self-determination contract or self-governance compact and use their own employees.¹⁰⁶ Critics of Davis-Bacon argue that the act’s effect is to increase construction costs and reduce the volume of construction, while proponents of Davis-Bacon argue that it prevents unfair competition and improves craftsmanship and efficiency.¹⁰⁷ Both bills retain

¹⁰⁵ P.L. 71-798, act of March 3, 1931, 46 Stat. 1494, as amended; 40 U.S.C., Chap. 31, subchap. IV.

¹⁰⁶ 25 U.S.C. 450e(a) and 25 U.S.C. 458aaa-8(g). For regulations on the application of Davis-Bacon to IHS construction under the ISDEAA, see 25 CFR 900.125(c)(4) and 42 CFR 137.379; for regulations on Davis-Bacon application to non-ISDEAA construction, see 42 CFR 136.110(b)(3).

¹⁰⁷ For more complete discussion of these issues, see CRS Report 94-408, *The Davis-Bacon Act: Institutional Evolution and Public Policy*, by (name redacted), and CRS Report 94-908, *Davis-Bacon: The Act and the Literature*, by (name redacted).

the current application of Davis-Bacon. The Senate-reported version of S. 1200, however, had added exemptions from Davis-Bacon if a tribe or TO either carried out the project with its own employees (whether under ISDEAA or not) or else contracted for the work with ISDEAA (or other federal) funds and made its own determination of prevailing wages. The January 2008 Statement of Administration Policy had objected to S. 1200's Davis-Bacon provision as an expansion of Davis-Bacon requirements, and the Senate replaced the reported language with current law.

Negotiated Rulemaking for Facilities

Title III of some earlier versions of IHCA reauthorization, such as S. 1057 (109th Congress), greatly expanded the application of negotiated rulemaking for IHS facilities.¹⁰⁸ Negotiated rulemaking would have been required in establishing construction standards, sanitation facility needs, criteria for participating in IHS-tribal joint ventures, and the priority systems for facilities construction and for IHS funding to operate tribally constructed facilities, as well as in applying Indian preference in construction or renovation of IHS facilities and approving applications for Indian health care delivery demonstration projects. The Administration objected, arguing that requiring negotiated rulemaking was resource-intensive and unnecessary. S. 1200 and H.R. 1328 drop almost all the requirements for negotiated rulemaking, except in the setting of the maximum renovation cost threshold for a health care facility above which a tribe may use maintenance and improvement funds to replace the facility, where the bills require that the threshold be determined through negotiated rulemaking (§313(c)). The House Health Subcommittee version of H.R. 1328 drops this remaining requirement for negotiated rulemaking.

Access to Federal Health Services and Reimbursements

Authority for IHS health-care facilities to receive reimbursements from SSA's Medicare and Medicaid programs, contained in IHCA's Title IV in current law, was a major component of the original IHCA. The current bills consolidate provisions covering reimbursements from third parties, whether from SSA programs or private parties, into both Title II of the bills and IHCA's Title IV as rewritten in Section 101(a) of the bills. Several programs are moved in from other titles of current law, especially from the health services and miscellaneous provisions titles (IHCA Titles II and VIII, respectively), and new provisions are added.

Jurisdiction over Medicare, Medicaid, and SCHIP in the Senate is assigned to the Finance Committee, which reported bills in the 109th (S. 3524) and 110th (S. 2532) Congresses that moved all IHCA provisions (whether in current law or proposed) that amend the SSA out of the IHCA proper and placed them in a distinct part of the reauthorization bills.¹⁰⁹ In the 109th Congress,

¹⁰⁸ Negotiated rulemaking is a process for making federal regulations in which the federal agency and representatives of interested groups (e.g., the group or industry to be regulated, community and public interest groups, or state or local governments) meet as a committee to reach consensus on a proposed regulation, before the proposal is published in the Federal Register (Negotiated Rulemaking Act of 1990, P.L. 101-648, act of November 29, 1990, 104 Stat. 4970; 5 U.S.C., Chap. 5, Subchap. III). For a discussion of issues related to this method of creating regulations, see CRS Report RL32452, *Negotiated Rulemaking*, by (name redacted).

¹⁰⁹ U.S. Congress, Senate Committee on Finance, Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2006, report to accompany S. 3524, 109th Cong., 2nd sess., S.Rept. 109-278 (Washington: GPO, 2006); and U.S. Congress, Senate Committee on Finance, Medicare, Medicaid, and SCHIP Indian Health Care Improvement Act of 2007, report to accompany S. 2532, 110th Cong., 2nd sess., S.Rept. 110-255 (Washington: GPO, 2008).

several of the IHCIA reauthorization bills (H.R. 5312 as reported and S. 4122 as introduced) later incorporated much of the Finance Committee proposals as Title II of each bill. S. 1200 and H.R. 1328 in the 110th Congress followed suit, retaining in IHCIA's Title IV only those provisions related to Medicare, Medicaid, and SCHIP that do *not* amend the SSA, and placing amendments to the SSA in Title II of each bill.¹¹⁰

To reduce confusion, this section of the report (as well as the section below titled “Amendments to the Social Security Act”) distinguishes between “Title II of the bills,” where the bills place SSA amendments, and “IHCIA Title IV,” which is amended in Title I of the bills. This section discusses only provisions in IHCIA's Title IV.

Several of the revised IHCIA provisions would change the status of tribes and TOs with regard to recovering funds under federal health care programs, in particular Medicare, Medicaid, and SCHIP. (These programs are administered in HHS's Centers for Medicare and Medicaid Services, or CMS, and so are called CMS programs.) For example, IHCIA Section 401(a) in S. 1200 and H.R. 1328 adds UIOs and SCHIP to existing IHCIA Title IV language excluding Medicare or Medicaid reimbursements from being considered when determining annual Indian health appropriations. Additional changes to IHCIA's Title IV are discussed below.

Special Fund for Reimbursements

IHCIA Section 401(c) in S. 1200 and H.R. 1328 (as reported) continues the authority for a special fund (administered by the HHS Secretary) into which must be paid Medicaid reimbursements for services provided by IHS facilities, but expands the special fund's reach to include not only Medicaid payments but also payments from any SSA program. Payments from the special fund go to IHS service units, and Section 401(c) of the bills increases from 80% to 100% the proportion of any reimbursement that must go to the service unit that provided the health services. Section 401(c) also broadens the allowable uses of the reimbursement funds to authorize expenditures to reduce health resource deficiencies in the tribe(s) served, once expenditures sufficient for compliance with Medicare and Medicaid requirements have been made. The House Health Subcommittee version of H.R. 1328 limits the SSA programs that pay reimbursements into the special fund to Medicare and Medicaid, and limits the allowable uses (after compliance expenditures) to increasing the capacity, quality, and accessibility of the facility's services.

Direct Reimbursement

The Alaska Native and American Indian Direct Reimbursement Act of 2000 (see “Statutory Authority” above) amended the IHCIA to require HHS to establish a program under which THPs might directly bill and receive reimbursements from Medicare, Medicaid, and other third-party payors, for prescribed services provided to eligible participants.¹¹¹ Under current IHCIA law, reimbursements for THPs choosing direct billing go directly to the THP, not into the special fund. HHS must approve THPs' applications to participate and must monitor participating health facilities' performance. Participating health facilities must report annually to HHS and must

¹¹⁰ In current IHCIA law, several sections in Title IV amend the SSA. S. 1200 and H.R. 1328 remove SSA amendments from IHCIA Title IV and change the sections so they simply cross-reference the relevant SSA provision in Title II of each bill.

¹¹¹ See 25 U.S.C. 1645.

expend reimbursements first to achieve or maintain compliance with Medicare and Medicaid requirements, and may expend the funds to improve the tribe's health resources deficiency level only if there are funds left over.

In the bills, IHCA Section 401(d) provides THPs with direct authority to do direct billing and deletes current requirements for HHS approval, monitoring, and reports. It expands the allowable uses of the reimbursements to include not only complying with CMS programs' requirements but also providing additional health care services, improving health care facilities and programs, achieving any of the IHCA objectives listed in IHCA Section 3, or carrying out "any health care related purpose." It also subjects reimbursements to all applicable auditing requirements. HHS has objected to expanding the allowable uses beyond the original purpose of meeting CMS program requirements; specifically it objects to the inclusion of any IHCA Section 3 objective and "any health care related purpose" as allowable uses. The House Health Subcommittee version of H.R. 1328 expands the programs covered to include SCHIP and limits the allowable uses to the same ones as the special fund (compliance expenditures and increasing the capacity, quality, and accessibility of the services).

Outreach Grants

IHCA Section 402 of the bills expands the current program of grants to TOs for outreach—intended to encourage Indian enrollment in Medicare and Medicaid, including by paying premiums and processing applications—to cover SCHIP enrollment and to include grants to UIOs. H.R. 1328 (as reported) requires that HHS facilitate cooperation with and agreements between the states and IHS, tribes, TOs, and UIOs (a parallel provision is contained in Section 202 of Title II of the bills). S. 1200 and the House Health Subcommittee version of H.R. 1328 change the requirement to facilitate cooperation to a requirement to develop and disseminate best practices for facilitating agreements (the Health Subcommittee version further requires the Secretary, acting through CMS, to consult with states, IHS, tribes, TOs, and UIOs on this activity). The application processing provision in current law is moved to Title II of the bills.

Rights to Reimbursements from Third Parties

Current IHCA law gives the United States, tribes, and TOs the right to recover the "reasonable expenses incurred" in providing health services to individuals, including through civil actions in court (except the United States may not recover against a tribal or TO self-insurance plan). IHCA Section 403 in the bills expands the right to recover to UIOs, changes the right to recover to "reasonable charges billed," and grants tribes and TOs the same rights of recovery from any persons with liability (or their insurers) under the Federal Medical Care Recovery Act¹¹² as the United States would have. HHS is concerned that the change from "expenses incurred" to "charges billed" may—because IHPs do not bill for services to IHS-eligible persons—allow responsible third parties to argue that they are not liable because no charges have been billed. The House Health Subcommittee version of H.R. 1328 allows recovery of the highest amount the third party would pay for care by nongovernmental providers (even if higher than reasonable charges billed).

¹¹² P.L. 87-693, act of September 25, 1962, 76 Stat. 593, as amended; 42 U.S.C. 2651 et seq.

Purchase of Health Coverage with Federal Funds

A new provision in the bills, IHCIA Section 405, allows tribes, TOs, and UIOs to use federal health services funds and reimbursements to purchase health benefits coverage, such as through a tribal health care plan, a health insurance provider or managed care plan, or a self-insurance plan. Tribes, TOs, and UIOs are allowed to base the purchase of health care coverage on beneficiaries' financial need. S. 1200 allows purchase of coverage through high deductible or health savings account plans, while the House Health Subcommittee version of H.R. 1328 excludes purchase of coverage through high-deductible health plans (or through health flexible spending arrangements). The House Health Subcommittee version of H.R. 1328 adds a requirement that the coverage must qualify as "creditable coverage" as defined in the Public Health Service Act.¹¹³

Sharing Arrangements with Veterans Affairs and Defense Departments

Another new provision in the bills, IHCIA Section 406, authorizes HHS to enter agreements for IHS, tribes, and TOs to share medical facilities and services with the VA and the Defense Department. This provision also creates a new requirement that the VA and the Defense Department reimburse IHS, tribes, or TOs for services provided to beneficiaries eligible for services from either the VA or Defense. The House Health Subcommittee version of H.R. 1328 deletes this requirement for VA and Defense reimbursements. The Administration's SAP objected to the reimbursement provision as a change to the allocation of costs for Indian veterans' health care costs between IHS and the VA under current law.

S. 1200 adds a new Section 407 that reaffirms the goals of a 2003 memorandum of understanding between IHS and VA's Veterans Health Administration regarding VA treatment of eligible Indian veterans at IHS facilities. New Section 407 requires the HHS Secretary to provide for payment for such treatment and to establish guidelines for such payments to the VA, and prohibits use of funds appropriated for IHS facilities, CHS, or contract support costs to make such payments. The section also authorizes local memoranda of understanding, requires consultation with affected tribes in negotiating such local memoranda, and defines "eligible Indian veteran." H.R. 1328 has no similar provision.

Payor of Last Resort

If an Indian is eligible for health care services under any other federal or state program, the IHS may assist that Indian to enroll in the program and collect for that Indian's health services provided through the IHS. After all other sources of payment are applied (including Medicaid, Medicare, SCHIP, any state program, or any private insurance), the IHS pays for services or costs not covered by those programs. Under a regulation in the current *Code of Federal Regulations*, the IHS is designated as the payor of last resort, although only for contract health services.¹¹⁴ New IHCIA Section 408 in S. 1200 and Section 407 in H.R. 1328 broaden the "payor of last resort" designation to cover all services provided to eligible persons and extend the designation from the IHS to THPs and UIO health care programs. The House Health Subcommittee version of H.R. 1328 adds an exception, specifying that IHPs and UIOs are not payors of last resort for services to individuals eligible for VA or Defense health services.

¹¹³ 42 U.S.C. 300gg(c)(1).

¹¹⁴ See 42 C.F.R. 136.61.

Exemption of Entities from State or Local Licensing

IHS-operated entities are exempt from state licensure requirements because of their federal status.¹¹⁵ Facilities funded by IHS but operated by tribes, TOs, or UIOs are not so exempt. New IHCA Section 408 in H.R. 1328 and Section 409 in S. 1200 exempt entities operated by the IHS, tribes, TOs, and UIOs from having to be licensed or recognized under state or local laws as a condition for eligibility for reimbursement from any federal health care program. Instead, such an entity shall be deemed to have met such state or local licensing requirements if it is determined that the entity “meets all applicable standards for such licensure.” If any staff member of the entity lacks a state or local license required for its location, that fact may not be taken into account if the staff member has a valid license from another state. The bills prohibit payments by federal health care programs to entities or individuals who have been excluded from participation in any federal health care program or whose license is under suspension by the state. A parallel amendment to the SSA is in Section 205 of Title II of the bills.

HHS opposes exemption of tribal, TO, and UIO entities from state licensure, arguing that it would not be consistent with maintaining quality of care. The bills do not state who determines that an entity meets all the applicable standards, and place no limits on the number or proportion of entity staffers who may not have state or local licenses. The House Health Subcommittee version of H.R. 1328 deletes both this section and Section 205 in Title II of the bills.

Feasibility Study of Treating the Navajo Nation as a State under Medicaid

Both bills require the Secretary to study the feasibility of allowing the Navajo Nation—a tribe with significant reservation land and population in three states (Arizona, New Mexico, and Utah)—to be treated as a state for the purposes of Medicaid services for all Indians within its boundaries. The study would assess whether an entity should be established to which, like a state Medicaid agency, the Secretary could pay all Medicaid and related administrative expenditures that would ordinarily go to the states of Arizona, New Mexico, and Utah for Indians living within Navajo boundaries.

Urban Indian Health Services

In current law, IHS funding for urban Indian health programs is authorized in IHCA Title V. The same title in the bills contains new and more inclusive programs for urban Indians and establishes a Division of Urban Indian Health in IHS. It also adds several new programs and greatly revises others. The bills authorize a UIO to provide health care services in any urban center, instead of just in the urban center where the UIO is located, and also authorize HHS funding for the construction and operation of at least two (in S. 1200, one) residential treatment centers in each state, for urban Indian youth who need culturally competent alcohol and substance abuse treatment services. Besides the annual onsite evaluations of UIHPs required in current law, the bills add as an alternative the option of accepting evidence of the UIO’s accreditation by a recognized Medicare review entity (the House Health Subcommittee version of H.R. 1328 deletes this alternative option). Grants to UIOs are authorized for diabetes prevention, treatment, and control, similar to existing diabetes grants to tribes and TOs under IHCA Title II. UIOs are given access to the Community Health Representatives program (see IHCA Title I). Both bills

¹¹⁵ IHS, personal communication, November 19, 2007. See also 42 CFR 431.110(b).

authorize HHS to study the feasibility of federal direct or guaranteed loans for UIO facilities construction, and require that IHS consult (or, in S. 1200, confer) with UIOs “to the greatest extent practicable.” The bills make all changes effective immediately upon enactment, whether any implementing regulations have been promulgated or not.

Some previous bills reauthorizing the IHCA would have extended to UIOs the protections of the Federal Tort Claims Act (FTCA),¹¹⁶ given UIOs access to federal vendors and suppliers on the same basis as federal executive agencies, and expanded the current authorization for UIOs to use HHS federal facilities to include equipment and other personal property in the facilities. None of these proposals are included in S. 1200 or H.R. 1328.

Constitutionality of Urban Indian Health Program

IHCA extends eligibility for its urban Indian health program not only to members of federally recognized tribes but also to persons who are not members of such tribes, including members of state recognized tribes, members of tribes whose federal recognition was terminated after 1940, non-member descendants of tribes, and individuals who are Alaska Native or are considered to be Indian by the Secretary of the Interior or the HHS Secretary.¹¹⁷ Federally recognized Indian tribes are considered political entities by the federal government, so federal assistance to such tribes and their members is not based on race. The U.S. Department of Justice has questioned whether the urban Indian eligibility standards, insofar as they go beyond federally recognized tribes, are racially based, and thus whether the current urban Indian health program meets Constitutional equal protection standards.¹¹⁸ Proponents of the urban Indian health program argue that state-recognized tribes are also political entities and that the IHCA’s definition of urban Indians meets the necessary legal tests.¹¹⁹ In the years since the urban Indian health program was authorized in the original IHCA in 1976, there have been no challenges to the constitutionality of the urban Indian health program, so there are no federal court decisions on the questions raised by the Justice Department.

IHS Organizational Changes

The bills make no change in IHS’s organizational status as a part of the PHS within HHS, but H.R. 1328 establishes a new position of Assistant Secretary of Indian Health. The bills also authorize contracts and agreements with federal and state agencies and private and nonprofit

¹¹⁶ Act of August 2, 1946, Chap. 753 (79th Cong.), Title IV, 60 Stat. 842, as amended; 28 U.S.C., Chap. 171. IHS employees, as federal employees, are covered by the FTCA. Tribes and tribal organizations with ISDEAA contracts or compacts, and their employees, are also covered by the FTCA (25 U.S.C. 450f(d), 25 U.S.C. 450f note). See GAO, Federal Tort Claims Act: Issues Affecting Coverage for Tribal Self-Determination Contracts (GAO/RCED-00-169, July 2000), available at <http://www.gao.gov/archive/2000/rc00169.pdf>. UIOs with contracts under IHCA Title V are not covered.

¹¹⁷ 25 U.S.C. 1603(c), (f).

¹¹⁸ “Prepared Statement of C. Frederick Beckner III, Deputy Assistant Attorney General, Civil Division, Department of Justice,” in U.S. Congress, Senate Committee on Indian Affairs, Indian Health Care Improvement, hearings, 110th Cong., 1st sess., March 8, 2007, S.Hrg. 110-53 (Washington: GPO, 2007), pp. 41-42. See also “Department of Justice White Paper,” available at http://www.nihb.org/docs/ihcia_doj_2006-10_opposition_paper.pdf, pp. 2-3; the unofficial release of this unofficial Justice Department paper was discussed in the March 8, 2007, hearings (S.Hrg. 110-53, pp. 16-18).

¹¹⁹ “Statement of Edward P. Lazarus, Partner, Akin Gump Strauss Hauer & Feld, LLP,” in U.S. Congress, Senate Committee on Indian Affairs, Indian Health Care Improvement, S.Hrg. 110-53, pp. 81-100.

organizations for enhancing information technology and add requirements that the automated management information system include a training component and an interface mechanism for the patient billing and accounts receivable system.

Elevation of the Director

Section 601 of H.R. 1328, in all versions, elevates the Director of IHS to the new position of Assistant Secretary of Indian Health under the Secretary of Health and Human Services. The new assistant secretary would be responsible for reporting to the Secretary on all policy and budget matters relating to Indian health, coordinating department activities on Indian health matters, advising on all Indian health matters, and representing Indian issues to the heads of other HHS agencies and programs. S. 1200 as passed by the Senate dropped this provision.

Behavioral Health Programs

Current law has a title (IHCIA Title VII) covering alcohol and substance abuse programs. The bills expand the existing title to cover all mental and behavioral health programs, not just alcohol and substance abuse. The aim is to create a “comprehensive behavioral health prevention and treatment program” (see Sections 701 and 703 in the bills). Title VII in the bills brings together all the mental and behavioral health programs that are in other titles of current law, generally substitutes the term “behavioral health” for the terms “mental health” and “alcohol and substance abuse,” expands eligibility and additional practices, and adds mandates to consult with tribes and TOs on policy decisions.

The bills require HHS to provide a “comprehensive continuum of behavioral health care ” (within feasibility and appropriations limitations) that includes nine specified sets of services, including outpatient and residential treatment, acute hospitalization, detoxification, emergency shelter, transitional living, and community-based prevention, intervention, and aftercare (§701). The section also requires various specific behavioral health services for Indian children, adults, families, and elders. Section 703 expands the current requirement for a comprehensive alcohol and substance abuse prevention and treatment program to a comprehensive behavioral health, prevention, treatment, and aftercare program. Section 703 in S. 1200 and H.R. 1328 (as reported, but not the House Health Subcommittee version) adds tribes and TOs to the current authorization for IHS to use CHS for treatment services. Section 709 of the bills authorizes HHS to provide one inpatient mental health care facility in each IHS service area (with California being divided into two areas). Section 708 creates a youth telemental health demonstration project targeting Indian youth suicide. In addition, Title VII of the bills expands the alcohol and substance abuse programs for women and youth to cover all behavioral health problems and adds a set-aside for UIOs in the women’s program (§§706-707). Title VII also expands the program for community education and involvement to all behavioral health issues and allows (in S. 1200 and H.R. 1328 as reported but not in the House Health Subcommittee version) implementation by tribes and TOs (§710); changes the fetal alcohol disorder (FAD) program to add diagnostic clinics, early intervention projects, and FAD housing (§712); requires (current law authorizes) establishment in every IHS service area of treatment programs for both child sexual abuse victims and (in H.R. 1328 but not S. 1200) child sexual abuse perpetrators (§713); and changes the behavioral health research program by making tribes, TOs, and UIOs, instead of the IHS, the contractors with research institutions (§714 in H.R. 1328 and §716 in S. 1200).

Other Issues

In current law, a number of separate provisions covering reports, regulations, and a variety of other topics are included in a “Miscellaneous” title (IHCIA Title VIII). The bills retain this title, but add a number of new programs and move many provisions of current law to other titles.

Reports

Many titles of the current IHCIA contain requirements for annual or one-time reports to Congress, and current IHCIA Title VIII requires additional reports and directs that most of the reports be transmitted to Congress with the President’s annual submission of the U.S. government budget (§801). S. 1200 and H.R. 1328 retain this pattern, but they require the reports to be transmitted directly to Congress; expand the required report on the impact of new national health-care programs to cover HHS consultation with TOs and UIOs; add SCHIP to the accounting on reimbursements from other CMS programs (Medicaid and Medicare); and add a report on Indian use of contract health services. The bills drop a provision of earlier versions (e.g., H.R. 5312 and S. 1057 in the 109th Congress) requiring a comparison of actual Indian health appropriations with the amounts needed to achieve Indian parity with the general population in health status and services. The House Health Subcommittee version of H.R. 1328 adds a report on compliance by IHS, tribal, TO, and UIO facilities with IHS credentialing and state licensure requirements. It also moves to the CMS accounting report (from Title II, Section 209, of the bills) requirements for information on Indians who use CMS programs, their use of IHS, and their health status. The Statement of Administration Policy objects to requirements for new reports, arguing that they restrict HHS flexibility to deliver health care services.

Negotiated Rulemaking for Regulations

S. 1200 and H.R. 1328 increase the number of instances where IHS must conduct negotiated rulemaking¹²⁰ to create programs’ regulations. Under the current IHCIA (§802), the requirements for regulations are that IHS must first consult with tribes and TOs and must publish final regulations in the *Federal Register* at least 60 days prior to their effective date. The new IHCIA Section 802 in the bills requires negotiated rulemaking for regulations relating to health services (Title II), behavioral health (Title VII), and Section 313(c) (see “Health and Sanitation Facilities” above) and Section 807 (regarding health services for IHS-ineligible persons), and allows discretionary rulemaking under the Administrative Procedure Act¹²¹ for human resources (Title I), facilities (Title III), reimbursements (Title IV), and urban Indian health (Title V). Earlier versions of IHCIA reauthorization (e.g., S. 1057 in the 109th Congress) required negotiated rulemaking in many more programs, including most of human resources (Title I) and facilities (Title III), and also prohibited rulemaking on IHS organization (Title VI) and for the miscellaneous-provisions title (Title VIII). Section 802 in the bills also sets a deadline for publication of all proposed regulations of two years after enactment, requires a minimum time length for comment periods, and sets a deadline for publication of all final regulations of three years after enactment. A provision in earlier bills, setting a deadline after which HHS authority to make IHCIA regulations would expire, is not included in H.R. 1328 or S. 1200.

¹²⁰ 5 U.S.C., Chap. 5, Subchap. III. See “Negotiated Rulemaking for Facilities,” above.

¹²¹ Act of June 11, 1946, Chap. 324 (79th Cong.), 60 Stat. 237, as amended; 5 U.S.C., Chap. 5.

As noted above, the Administration opposed many negotiated rulemaking requirements, arguing that negotiated rulemaking was more resource-intensive and was not necessary.

Abortion

Under current IHCA law, funds appropriated for the IHS must follow whatever limitations on funding for abortions there are in the HHS appropriations act for the same time period.¹²² This restriction, added in its current form to the IHCA in 1988, applies to any IHS funds expended by IHPs and UIHPs. Such limitations on federal funding for abortion are usually known as “Hyde Amendments.” The Hyde Amendment in the current HHS appropriations act forbids funding for abortion—or for health benefits coverage (defined as the package of services provided by a managed care organization) that includes coverage of abortion—except in cases of rape or incest or when the mother has a physical condition that would endanger her life unless an abortion were performed.¹²³

S. 1200 was amended on the Senate floor to add a provision (Sec. 805(a)-(b)) that replaces the current law with language similar but not identical to the current Hyde Amendment. The provision differs from the Hyde Amendment in two respects: the incest exception is applied only to incest against a minor, and the term “health benefits coverage” is redefined to include services under a contract, compact, grant, or other agreement. Proponents of the provision argued that, because the Hyde Amendment in HHS appropriations acts must be voted on every year, it is subject to change every year, while the provision would make the Hyde Amendment permanent in its application to the IHS. An opponent of the provision, the private nonprofit National Indian Health Board, argued that the IHS already complies with the Hyde Amendment and should not be held to different standards from other HHS programs, and that the amendment is unnecessary and duplicative insofar as it is the same as the Hyde Amendment.

H.R. 1328, in both the introduced and House Health Subcommittee versions, retains the abortion provision in current law.

Eligibility for Services

Section 811 of H.R. 1328 (but not S. 1200) adds to IHCA a provision postponing the application of a 1987 IHS regulation on health services eligibility until IHS submits to the House and Senate Appropriations Committees a budget proposal that reflects any increased costs associated with the proposed changes in eligibility, and the budget proposal has been enacted into law. Application of the 1987 regulation has been continually postponed in annual appropriations acts. (See “Eligible Population,” above.)

Labor Law Exemption

Section 811 of S. 1200, as passed by the Senate, extends to tribes and TOs carrying out self-determination contracts or self-governance compacts the same exemptions from the National

¹²² IHCA §806; 25 U.S.C. 1676.

¹²³ Consolidated Appropriations Act, 2007, P.L. 110-161, Div. G, Title V, §§507-508, 121 Stat. 1844, 2208-2209. For fuller discussion of the Hyde Amendments, see CRS Report RL33467, *Abortion: Legislative Response*, by (name redacted).

Labor Relations Act¹²⁴ that federal, state, and local governments enjoy. H.R. 1328 has no similar provision, in any of its versions, nor does current IHCIA law. Section 811 of S. 1200 does not limit the application of this exemption to ISDEAA contracts or compacts with IHS or HHS, so the exemption may apply to ISDEAA contracts and compacts with all federal agencies.

Entitlement or Non-Entitlement

¹²⁵ IHCIA Section 813 of S. 1200 and H.R. 1328 as reported (Section 812 of the House Health Subcommittee version of H.R. 1328) would establish a national bi-partisan commission on the delivery of Indian health care. Earlier versions of IHCIA reauthorization, introduced in the 108th and preceding Congresses, would have created a commission focused entirely on Indian health care entitlement, with directions to recommend whether health services could be provided to Indians under an entitlement program.

The IHS health care delivery program is not an entitlement under federal law. IHS cannot commit funding for services if that funding has not been appropriated. Consequently, IHS health services depend each year on the annual appropriation. An entitlement program, on the other hand, such as Medicaid and Medicare, statutorily obligates the federal government to make payments to any person who meets the legal criteria for eligibility. An entitlement program may be funded through either permanent or annual appropriations, but the program's law requires that Congress appropriate whatever funds are needed. One of the major issues addressed in the IHCIA reauthorization bills before Congress is the tension between (1) the choices that must be made under the constraints of a finite annual appropriation and (2) the view of many Indians that their health care services are (or should be) an entitlement and, as such, are the sole responsibility of the federal government under trust or treaty obligations.

To its proponents, the advantage of an entitlement program for Indians would be that federal spending on eligible Indians' health care would not be limited to a specific appropriated amount. Spending controls on entitlement programs are done either by reducing benefits, limiting the conditions covered, changing the eligibility requirements for beneficiaries, or generating new revenues, so among the issues to be considered would be whether and how to limit the entitlement's level of spending. Entitlement proponents argue that Indians' loss of land and resources justifies making Indian health care an entitlement program, despite the cost. Some advocates are concerned about how a "beneficiary" would be defined, and whether Congress would require "means testing" as part of the eligibility criteria. These supporters argue that if Congress imposed means testing, those Indians not meeting the means test would have their treaty rights abrogated. Some opponents argue that federal Indian treaties and agreements did not promise unlimited health care services to all Indians, or else that Indians have already been compensated for lost lands and resources. Other opponents question whether an entitlement's "benefit package" would cover the non-clinical services (e.g., sanitation facilities) provided now through IHS. If non-clinical services were not provided, some believe that the quality of care would diminish under an entitlement program.

¹²⁴ Act of July 5, 1935, Chap. 372 (74th Cong.), 49 Stat. 450, as amended; 29 U.S.C., Chap. 7, subchap. II

¹²⁵ See the discussions at Jo Ann Kauffman, *Reauthorization of the Indian Health Care Improvement Act: Background and Issues* (Henry J. Kaiser Family Foundation, October 1999), pp. 32-36; available at <http://www.kff.org/minorityhealth/upload/Reauthorization-of-the-Indian-Health-Care-Improvement-Act-Background-and-Issues-Report.pdf>; and U.S. Commission on Civil Rights, *Broken Promises*, pp. 107-108

The commission authorized under S. 1200 and H.R. 1328 would make recommendations on Indian health care delivery and related issues, including “the optimal manner”—such as entitlement—in which to provide Indian health care. The Administration’s SAP objected to the commission, arguing it was unnecessary because HHS and IHS continually try to improve health care services delivery to Indians.

Charges for Health Care Services (Cost-Sharing)

Currently the IHS is forbidden to charge eligible Indians for services, nor can it require tribes and TOs with ISDEAA arrangements to charge them.¹²⁶ IHS policy since at least 1967 had been that it was not required to charge Indians for services.¹²⁷ Congress added annual prohibitions against IHS charging for services in the annual appropriations acts for IHS for FY1985-FY1995, before making the prohibition permanent in 1996.¹²⁸ Four years later Congress also forbade IHS from billing under ISDEAA and from requiring tribes or TOs to do so.¹²⁹

IHS had assumed that the statutory prohibitions against its charging for services also covered tribes and TOs with ISDEAA arrangements, as had been confirmed in a 1996 ruling by the HHS Departmental Appeals Board.¹³⁰ In January 2008, however, in a case involving a California tribe negotiating an ISDEAA self-governance compact with IHS, a federal district court rejected that argument, finding that IHS could not deny the tribe’s compact merely because the tribe planned to charge Indians for services for which IHS could not charge.¹³¹ IHS did not appeal this ruling.

The Senate amended S. 1200 to add a new provision, Sec. 816, that specifies that nothing in the IHCA limits the ability of a THP operating an IHS-funded program through an ISDEAA self-governance compact to charge an Indian for services it provides. (Section 816 also adds that nothing in the IHCA authorizes IHS either to charge an Indian for services or to require a THP to charge an Indian for services.) The provision does not address whether THPs operating programs under an ISDEAA self-determination contract may charge Indians for services, and leaves to compacting THPs the decisions on the amounts to charge, the criteria for charging, or the programs for which to charge. The Senate passed S. 1200 with this amendment. H.R. 1328 has no similar provision, in either the reported version or the House Health Subcommittee’s version.

Cherokee Freedmen

A membership dispute within the Cherokee Nation of Oklahoma (CNO) may lead to the addition of a provision to an IHCA reauthorization bill that would restrict CNO access to IHS funding and services.¹³² The Cherokee Nation, one of the two largest federally recognized tribes, voted in

¹²⁶ 25 U.S.C. 1681 and 25 U.S.C. 458aaa-14(c).

¹²⁷ U.S. Department of Health and Human Services, Indian Health Service, Indian Health Manual, Part 2, Chap. 2, “Payment for Services,” last updated November 2, 1967; available at <http://www.ihs.gov/publicinfo/publications/ihsmanual/Part2/pt2chapt2/pt2chpt2.htm>, last accessed April 11, 2008.

¹²⁸ 25 U.S.C. 1681 notes.

¹²⁹ 25 U.S.C. 458aaa-14(c).

¹³⁰ *Nizhoni Smiles, Inc. v. Indian Health Services*, DAB CR450 (1996); available at <http://www.hhs.gov/dab/decisions/cr-450.htm>.

¹³¹ *Susanville Indian Rancheria v. Leavitt et al.*, 2008 U.S. Dist. LEXIS 365 (E.D. Cal., January 3, 2008, No. 2:07-cv-259-GEB-DAD).

¹³² “Cherokee Freedmen Issue Affects Debate on Hill,” *Indianz.com*, April 14, 2008, available at (continued...)

March 2007 to amend the membership criteria in its tribal constitution so as to limit membership to descendants of only one of the CNO “Dawes Rolls” (compiled by the federal government in the early 20th century), namely the so-called “blood roll.” The effect of the amendment is to drop from tribal membership all those descended solely from another Dawes Roll, the so-called “Freedmen roll.” The previous tribal constitution approved in 1976 included descendants of either roll as members. The Cherokee Freedmen oppose the 2007 amendment, arguing that it is discriminatory¹³³ and violates an 1866 treaty between the United States and the Cherokee Nation.¹³⁴ The CNO argues that a tribe should be able to determine its own membership and that the amendment simply limits CNO membership to persons with Cherokee ancestry.¹³⁵ Both CNO courts and federal courts are considering cases related to Cherokee Freedmen membership in the CNO. A May 2007 CNO court injunction reinstated the Cherokee Freedmen’s tribal membership until the court decided whether the 2007 amendment was legal.¹³⁶

Legislation already introduced (H.R. 2824, 110th Cong.) would sever the CNO’s government-to-government relationship with the federal government (making the CNO ineligible for federal Indian programs), and suspend the CNO’s right to conduct gaming under the Indian Gaming Regulatory Act,¹³⁷ until the CNO is in compliance with the 1866 treaty and the Cherokee Freedmen’s tribal membership is restored. Amendments to House bills concerning Indian housing (H.R. 2786) and economic development (H.R. 3002) programs would also make the CNO ineligible for these programs pending CNO compliance with the 1866 treaty and restoration of Cherokee Freedmen membership (although H.R. 2786 would suspend CNO ineligibility while the CNO court injunction against the 2007 amendment is in force). It is likely that a Cherokee Freedmen provision, were it offered as an amendment to an IHCA reauthorization bill, would place restrictions on IHS and other federal health funding for the CNO similar to those in these three bills.

Amendments to the Social Security Act

Separate from the reauthorization of the IHCA, S. 1200 and H.R. 1328 amend several sections of titles XVIII (Medicare), XIX (Medicaid), XXI (SCHIP), and XI (general provisions) of the Social Security Act. As noted above (“Access to Federal Health Services and Reimbursements”), amendments to SSA were removed from the IHCA proper and incorporated into a Title II of the bills in the 109th Congress. SSA amendments remain in Title II in both S. 1200 and H.R. 1328 in the 110th Congress. As in the above section, this section of the report distinguishes between “Title

(...continued)

<http://www.indianz.com/News/2008/008164.asp>]; and “House Committees Given Extension on IHCA,” *Indianz.com*, April 28, 2008, available at [<http://www.indianz.com/News/2008/008424.asp>].

¹³³ See *Descendants Of Freedmen Of The Five Civilized Tribes*, “Why,” available at <http://www.freedmen5tribes.com/Why.htm>, last accessed April 30, 2008.

¹³⁴ Treaty with the Cherokee, July 19, 1866, 14 Stat. 799. In Article 9 of the treaty the Cherokee Nation agreed that all freedmen (liberated slaves and “free colored persons”) who met certain conditions, and their descendants, “shall have all the rights of native Cherokees...” (14 Stat. 801).

¹³⁵ See Cherokee Nation, “Citizenship Status of Non-Indians,” available at <http://freedmen.cherokee.org/>, last accessed April 30, 2008.

¹³⁶ For more detailed discussion, see CRS Report RL34321, *The Cherokee Freedmen Dispute: Legal Background, Analysis, and Proposed Legislation*, by Yule Kim.

¹³⁷ P.L. 100-497, act of October 17, 1988, 102 Stat. 2467, as amended; 25 U.S.C., Chap. 29, and 18 U.S.C. 1166-1168.

II of the bills,” where the bills place SSA amendments, and “IHCIA’s Title IV,” which is amended in Title I of the bills. This section discusses provisions in Title II of the bills.

Medicaid

Under current law, Section 1911 of the SSA¹³⁸—added to the SSA by the 1976 IHCIA—makes IHS health facilities, whether operated by IHS, a tribe, or a TO, eligible for reimbursement from Medicaid for coverable services, and authorizes HHS to make agreements to reimburse states for Medicaid-eligible services provided by IHS, tribal, and TO facilities.¹³⁹

Title II, Section 201(a), of the bills amends SSA Section 1911 to extend Medicaid eligibility to UIOs. It also changes the eligible entities from IHS *facilities* to IHS, tribes, TOs, and UIOs as *organizations*, whether or not the organizations are IHPs (i.e., provide health services under ISDEAA or the Buy Indian Act—see “Definitions” above). This change may broaden the range of eligible health services, facilities, and entities. HHS objects to the addition of UIOs, arguing that eligible UIOs can already get Medicaid reimbursements through states. It also objects to the extension of eligibility beyond IHPs, to organizations. The House Health Subcommittee version of H.R. 1328 drops the addition of UIOs and limits eligibility for Medicaid reimbursement to IHPs.

Other amendments by Section 201(a) of Title II of the bills to SSA Section 1911 require reimbursements for benefits covered under a state Medicaid waiver as well as under a state plan, and specify that health services may be covered whether the delivery of the services is direct, through referral, or under contract or other arrangements. HHS considers the new service delivery language confusing, and the House Health Subcommittee version of H.R. 1328 deletes this language.

Section 201(a) of the bills also renews a long-dormant provision in Section 1911, which gave facilities up to 18 months from IHCIA’s 1976 enactment to meet Medicaid requirements, by bringing the provision up to date, adding tribes, TOs, and UIOs, and adding to the original requirement for a plan to meet Medicaid conditions a further requirement that a facility make improvements in accordance with the plan. HHS opposes this renewal, arguing that current IHS and tribal facilities have long been in compliance with Medicaid requirements and that IHS and CMS processes are sufficient to resolve any compliance problems. The House Health Subcommittee version of H.R. 1328 drops the renewal, deleting the provision altogether.

Section 201(a) also adds definitions of “Indian tribe,” “Indian Health Program,” “Tribal Health Program,” and other terms to Section 1911 by referral to definitions in IHCIA Section 4. The House Health Subcommittee version of H.R. 1328 moves the definitions to the general SSA definitions section in Title XI of the SSA.

¹³⁸ 42 U.S.C. 1396j.

¹³⁹ Section 1905(b) of the SSA sets the federal reimbursement rate to states for such IHS-funded facilities at 100% (42 U.S.C. 1396d(b)).

Medicare

Under current law, Section 1880 of the SSA¹⁴⁰—added to the SSA by the 1976 IHCA—makes IHS health facilities, whether operated by IHS, a tribe, or a TO, eligible for reimbursement from Medicare for coverable services, as long as they meet applicable Medicare requirements. The 1976 IHCA amendment was necessary because the SSA prohibits payment to a federal agency for Medicare-covered services (with exceptions for VA hospitals and certain hospital emergency services).¹⁴¹ Section 201(b) of Title II of the bills makes amendments to current Medicare law that parallel many of the amendments made by Section 201(a) to the Medicaid section.

Section 201(b) of Title II of the bills amends Section 1880 to add facilities operated by UIOs as eligible for Medicare reimbursements, and to cover all Medicare-covered items and services provided by IHS or a tribe, TO, or UIO, without reference to a health facility. HHS opposes inclusion of UIOs under Section 1880 because they are eligible under general Medicare law. HHS also argues that the language covering IHS, tribes, and TOs is too broad, suggesting IHPs as a narrower term. As with Medicaid, the House Health Subcommittee version of H.R. 1328 drops the addition of UIOs and limits eligibility for Medicare reimbursement to IHPs.

Section 201(b) of the bills also renews a dormant provision in Section 1880, similar to that in the Medicaid section, giving facilities 18 months from IHCA's 1976 enactment to meet Medicare requirements and makes the same amendments as in the Medicaid section. HHS has the same objections to this renewal as to the Medicaid renewal, and the House Health Subcommittee version of H.R. 1328 drops the provision.

Title II of the bills also adds the same definitions as for Medicaid, which the House Health Subcommittee version of H.R. 1328 moves to the general SSA definitions section.

SCHIP

Currently, Section 2105 of the SSA¹⁴² exempts an IHS-operated or IHS-funded insurance program from the SCHIP prohibition on federal reimbursements to states for child health services where another federal health insurance program has paid or is expected to make the payment. Section 203(c) of Title II of the bills adds tribes, TOs, and UIOs to SSA Section 2105 and changes the type of program for which reimbursements are allowed from insurance to health care. Section 201(c) of Title II of the bills amends SSA Section 2107, which lists SSA sections that apply to SCHIP in the same way as they do to the Medicaid program, to add most of the amended SSA Section 1911's Medicaid provisions to the provisions that apply to SCHIP. This includes such provisions as eligibility (thus extending eligibility from IHS alone to tribes, TOs, and UIOs), HHS agreements with states for reimbursement to Indian entities, direct billing by Indian entities, and definitions of Indian entities. The provision regarding payment of reimbursements into the special fund would not apply to SCHIP. The House Health Subcommittee version of H.R. 1328, by changing the bills' amendments to SSA Section 1911, drops UIOs from SSA Section 2107.

¹⁴⁰ 42 U.S.C. 1395qq.

¹⁴¹ 42 U.S.C. 1395f(c).

¹⁴² 42 U.S.C. 1397ee(c)(6)(B).

Increasing Indian Enrollment in Medicaid and SCHIP

Title II of the bills amends the SSA, including replacing current SSA Section 1139, to add a number of new provisions intended to improve outreach to and enrollment of Indians in Medicaid and SCHIP. Section 202 of Title II of the bills amends a provision in IHCA Title IV of current law—which allows HHS agreements with tribes, TOs, and UIOs for receipt and processing of applications for Medicare and Medicaid at IHS-funded facilities—to require HHS to encourage states to provide for Medicaid and SCHIP enrollment on or near Indian reservations, including state agreements with IHS, tribes, TOs, and UIOs for the Indian entities to provide outreach services including enrollment. Existing arrangements between states and IHS, tribes, TOs, and UIOs regarding such administrative activities are not to be affected. Section 202 of the bills also requires the HHS Secretary, through CMS, to “take such steps as are necessary to facilitate cooperation with, and agreements between” states and the IHS, tribes, TOs, and UIOs regarding provision of health care under the CMS programs (similar language is included in IHCA Section 402 of the bills).¹⁴³ HHS objects to the mandate that HHS take whatever steps are necessary to facilitate cooperation and agreements, arguing that the provision invites litigation over whether HHS has taken sufficient steps to meet the mandate. The House Health Subcommittee version of H.R. 1328 changes the requirement to facilitate cooperation to a requirement that HHS consult with states, IHS, tribes, TOs, and UIOs in the development and dissemination of best practices for facilitating agreements.

The SSA currently sets a cap on expenditures for outreach and other specified purposes at 10% of federal payments to a state for SCHIP benefits.¹⁴⁴ Section 203(a) of Title II of the bills excludes from the 10% cap expenditures for outreach activities to families of Indian children likely to be eligible for SCHIP or Medicaid, including outreach under agreements under Section 202 of Title II of the bills.¹⁴⁵ HHS opposes the exclusion from the 10% cap, arguing that it would permit unlimited expenditures from a state’s federal SCHIP allotment for outreach to Indian families, and further that such unlimited expenditures might be used for Medicaid outreach, which might expand the federal reimbursements for Medicaid beyond normal expenditures.

Documentation of U.S. Citizenship for Medicaid

The SSA requires that states, to receive federal reimbursement for Medicaid services, must obtain satisfactory documentary evidence of citizenship and identity for all Medicaid applicants who have declared they are U.S. citizens or nationals. SSA specifies certain documents as satisfying this requirement to demonstrate citizenship and identity, including U.S. passports, certain DHS naturalization and citizenship certificates, state driver’s licenses for those states that require either proof of U.S. citizenship or a verified social security number, or other documentation to be established by HHS regulations.¹⁴⁶ Many Indian citizens, especially older ones, because of their

¹⁴³ Nearly identical language to §202 of Title II of the bills was included in §202(a) of H.R. 3963 (110th Cong.), the Children’s Health Insurance Program Reauthorization Act of 2007, which was vetoed on December 12, 2007. For more information on H.R. 3963, see CRS Report RL30473, *State Children’s Health Insurance Program (SCHIP): A Brief Overview*, by (name redacted), (name redacted), and (name redacted), and CRS Report R40130, *The Children’s Health Insurance Program Reauthorization Act of 2009*, by (name redacted) et al.

¹⁴⁴ 42 U.S.C. 1397ee(c)(2).

¹⁴⁵ Nearly identical language to §203(a), Title II, of the bills was included in §202(b) of H.R. 3963 (110th Cong.), the Children’s Health Insurance Program Reauthorization Act of 2007. See note 144, above.

¹⁴⁶ SSA, §1903(x), as added by the Deficit Reduction Act of 2005, P.L. 109-171, §6036, act of February 8, 2006, 120 Stat. 4, 80, as amended; 42 U.S.C. 1396b(x). For more information, see CRS Report RS22629, *Medicaid Citizenship* (continued...)

current and past remote locations and poverty, lack such standard documents as birth certificates, Social Security cards, driver's licenses, or passports. Moreover, some Indian groups were divided by U.S. international borders, and their descendant tribes may have members who are not U.S. citizens.

Section 203(d) of Title II of the bills amends SSA's list of satisfactory documentation, at SSA Section 1903(x), to add documents from a federally recognized Indian tribe evidencing membership or enrollment in, or affiliation with, that tribe. Under this amendment, for Medicaid citizenship and identity purposes, such tribal membership documents would be treated as equivalent to U.S. passports, the DHS certificates, and driver's licenses from states that require proof of U.S. citizenship or a verified social security number. For tribes that both are in states with international borders and have members who are not U.S. citizens, Section 203(d) requires HHS to issue regulations authorizing use of other documentation of U.S. citizenship (including, if appropriate, tribal documents); until the regulations are issued, members of such border tribes could use the same tribal documents as other tribes.

HHS opposes Section 203(d), arguing that the language is unworkable and that the HHS regulations¹⁴⁷ implementing SSA Section 1903(x) took tribal members' situation into account and included satisfactory tribal documentation of U.S. citizenship. Some opponents question whether tribal membership documents provide reliable proof of citizenship and identity and also resist counterfeiting. The HHS regulations make tribal documents acceptable for purposes of identity (but not citizenship) if they carry a photograph or other personal identifying information (e.g., weight, height, race, age, sex).¹⁴⁸ For a similar function—proving citizenship and identity for border-crossing purposes—the Department of Homeland Security (DHS) makes tribal documents acceptable for citizenship and identity if the documents are designated by DHS as meeting DHS document security standards; DHS promises to work with tribes to develop, test, and produce tribal documents compliant with its standards.¹⁴⁹

Both S. 1200 and the House Health Subcommittee version of H.R. 1328 add examples of tribal documentation to Section 203(d),¹⁵⁰ but S. 1200, for border tribes with non-citizen members, adds a requirement for interim final HHS regulations within 90 days and also requires that, during the period before these regulations are issued, tribal documents be accompanied by a signed attestation of U.S. citizenship and a tribal certificate that the member was born in the United States.

(...continued)

Documentation, by (name redacted).

¹⁴⁷ 42 CFR 435.407.

¹⁴⁸ 42 CFR 435.407(e)(1)(vi).

¹⁴⁹ 73 FR 18384-18418, April 3, 2008, esp. pp. 18397-18399, 18406, 18417-18418.

¹⁵⁰ The House Health Subcommittee version of H.R. 1328 also adds a prohibition on execution of §203(d) if the Children's Health Insurance Program Reauthorization Act of 2007—currently H.R. 3963—is enacted first. H.R. 3963, at §211(b), amends SSA Section 1903(x) using language identical to §203(d) of the House Health Subcommittee version of H.R. 1328. See also note 141, above.

Exemptions from Medicaid Cost-Sharing Charges and Payments

Section 204(a) of Title II of the bills amends SSA Section 1916¹⁵¹ to exempt Indians from deductibles, co-payments, coinsurance payments, premiums, enrollment fees, or other cost-sharing charges under Medicaid for items and services provided by (or on a CHS referral by) IHS, a tribe, TO, or UIO. No means test is required. S. 1200, but not H.R. 1328, excludes from this exemption Indians who would only be eligible for such programs and services under IHCIA Sections 102 and 103 (Indian health professions recruitment and undergraduate scholarships) or IHCIA Title V (urban Indian health programs); this would exclude those members of terminated, state-recognized, or other non-federally-recognized tribes (or their children and grandchildren), as well as Alaska Natives and persons considered Indian by HHS or DOI, who are not otherwise eligible for IHS-funded health care services. Section 204(a) prohibits Medicaid reimbursements to IHS, a tribe, TO, UIO, or CHS provider from being reduced by the amount of any cost-sharing otherwise due. S. 1200 and H.R. 1328 as reported include definitions of Indian entities and contract health services, but the House Health Subcommittee version of H.R. 1328 does not. Further, S. 1200, but neither version of H.R. 1328, specifies that Section 204(a) takes effect October 1, 2009. Earlier versions of this provision (e.g., in S. 1057 as reported in the 109th Congress) included SCHIP as well as Medicaid and did not limit the exemption to services and items provided by or through IHS, a tribe, TO, or UIO.

In the 111th Congress, a draft economic stimulus bill being considered by the House Energy and Commerce Committee¹⁵² contains a provision that is very similar to Sec. 204(a) of the House Health Subcommittee version of H.R. 1328. The draft provision exempts Indians from Medicaid cost-sharing but, unlike S. 1200 and H.R. 1328 as reported, does not include definitions of Indian entities and contract health services. The Energy and Commerce Committee began marking up the draft stimulus bill with this provision on January 22, 2009.

Under current Medicaid law, most cost-sharing is nominal or prohibited for many categories of beneficiaries.¹⁵³ The most recent estimate by the Congressional Budget Office (CBO) for S. 1200 is that the cost-sharing exemption in Section 204(a) would increase federal Medicaid spending by \$5 million in FY2008 and \$74 million over FY2008-FY2017.¹⁵⁴ (For the broader exemption in S. 1057, 109th Congress, CBO estimated its cost would have increased Medicaid and SCHIP spending by \$26 million in FY2007 and by \$357 million over the period FY2007-FY2016.¹⁵⁵)

¹⁵¹ 42 U.S.C. 1396o.

¹⁵² See §5005(a) in “Health Title V” on the Committee’s website at http://energycommerce.house.gov/index.php?option=com_content&task=view&id=1471&Itemid=1, last accessed January 21, 2009.

¹⁵³ For discussion of cost-sharing under Medicaid, see CRS Report RS22578, *Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)*, by (name redacted), and CRS Report RL33202, *Medicaid: A Primer*, by (name redacted).

¹⁵⁴ U.S. Congressional Budget Office, “Cost Estimate: S. 1200, Indian Health Care Improvement Act Amendments of 2007, As Ordered Reported by the Senate Committee on Indian Affairs on May 10, 2007,” revised September 11, 2007, pp. 5-6. Earlier, CBO estimated the FY2008 cost as \$6 million and the FY2008-FY2017 cost as \$82 million; see U.S. Congressional Budget Office, “Cost Estimate: H.R. 1328, Indian Health Care Improvement Act Amendments of 2007, As Ordered Reported by the House Committee on Natural Resources on April 25, 2007,” June 8, 2007 (pp. 5-6); and U.S. Congressional Budget Office, “Cost Estimate: S. 1200, Indian Health Care Improvement Act Amendments of 2007, As Ordered Reported by the Senate Committee on Indian Affairs on May 10, 2007,” June 8, 2007 (pp. 5-6).

¹⁵⁵ U.S. Congressional Budget Office, “Cost Estimate: S. 1057, Indian Health Care Improvement Act Amendments of 2005, As Reported by the Senate Committee on Indian Affairs on March 16, 2006,” April 26, 2006, pp.

Exclusion of Property from Medicaid and SCHIP Eligibility Determinations

Section 204(b) of Title II of the bills amends SSA Section 1902 to exclude certain Indian property from being considered in determining Medicaid or SCHIP eligibility. Property to be excluded, or “disregarded,” in determining eligibility would include all real property and improvements, in trust or restricted status,¹⁵⁶ located within current Indian reservations, former reservations in Oklahoma (which may cover almost all of the state except the Panhandle and perhaps certain lands in southwestern Oklahoma), Alaska Native regions established under the Alaska Native Claims Settlement Act¹⁵⁷ (which cover all of Alaska), and BIA-approved Indian allotments on or near reservations. For members of a federally recognized tribe that is not covered by the preceding sentence, *any* property, whether in trust or restricted status or not, located within the most recent boundaries of a prior federal reservation is excluded. Also excluded are ownership interests in income from natural-resource properties when the income results from exercising federally protected rights, and interests or use rights in property that is of “unique religious, spiritual, traditional, or cultural significance” or that is used for subsistence or to support traditional lifestyles, according to tribal law or custom. The House Health Subcommittee version of Sec. 204(b) specifies that the property is excluded from resources (as opposed to income) in determining eligibility. Section 204(b) contains a definition of “Indian” (by reference to the ISDEAA definition) that is deleted in the House Health Subcommittee version of H.R. 1328.

In the 111th Congress, an economic stimulus bill being considered by the House Energy and Commerce Committee¹⁵⁸ contains a provision that is nearly identical to Sec. 204(b) of the House Health Subcommittee version of H.R. 1328. The provision excludes the same Indian property from being considered in Medicaid and SCHIP eligibility determinations. The Energy and Commerce Committee began marking up the draft stimulus bill with this provision on January 22, 2009.

Current Medicaid law provides numerous eligibility categories, for some of which states are required to apply asset or property tests, and for some of which such tests are optional for states. For many of the asset tests, states may choose different guidelines in counting or disregarding assets.¹⁵⁹ One guideline frequently used by states, that for Supplemental Security Income,¹⁶⁰ excludes trust property of Indians in (or descended from) federally recognized tribes¹⁶¹ and Alaska Natives’ stock in Native regional or village corporations.¹⁶² To some extent, then, Indian

¹⁵⁶ “Trust property” means property owned by the federal government in trust for an Indian tribe or individual. “Restricted property” means property owned by an Indian tribe or individual subject to federal restrictions on sale or mortgage or other encumbrance. See 25 CFR 151.2(d),(e).

¹⁵⁷ P.L. 92-203, act of December 18, 1971, 85 Stat. 688, as amended; 43 U.S.C., Chap. 33. The act created regional, village, and other Native corporations in which member Alaska Natives owned stock. Together, the regions assigned by the act to each of the 12 regional corporations cover the entire state. Native corporation stock is inalienable unless the Native corporation’s stockholders vote otherwise.

¹⁵⁸ See §5005(b) in “Health Title V” on the Committee’s website at http://energycommerce.house.gov/index.php?option=com_content&task=view&id=1471&Itemid=1, last accessed January 21, 2009.

¹⁵⁹ For further discussion of Medicaid eligibility asset tests, see archived CRS Report RL33019, *Medicaid Eligibility for Adults and Children*, and CRS Report RL33593, *Medicaid Coverage for Long-Term Care: Eligibility, Asset Transfers, and Estate Recovery*.

¹⁶⁰ Social Security Act, Title XVI; 42 U.S.C., Chap. 7, Subch. XVI, §§1381 et seq.

¹⁶¹ 20 CFR 416.123.

¹⁶² 42 U.S.C. 1382b(a)(5). These are the two major types corporations established under the Alaska Native Claims Settlement Act.

trust property and similar Alaska Native property may already be excluded in defining Medicaid eligibility, at least in some states. Section 204(b)'s provision would expand the types of property excluded from Medicaid eligibility tests and require all states to exclude such property. CBO's cost estimates have not addressed any costs connected to the exclusions.

Exemption of Entities from State or Local Licensing

Section 205 of Title II of the bills—exempting IHS, tribal, TO, and UIO entities from state or local licensing to be eligible for reimbursement from federal health programs—is nearly identical to IHCA Title IV, Section 408. See the discussion in “Exemption of Entities from State or Local Licensing” above. The House Health Subcommittee version of H.R. 1328 deletes both this section and IHCA Section 408.

Required Medicaid Consultations

Section 206 of Title II of the bills (Section 205 in the Health Subcommittee version of H.R. 1328) requires the Secretary to maintain an existing national Tribal Technical Advisory Group within CMS, in accordance with a charter dated September 30, 2003, with IHS and UIO as well as tribal and TO representatives. No other state or entity has such access given by statute. Section 206 also authorizes a state receiving Medicaid or SCHIP payments to establish a consultation process with IHPs and UIOs that provide health care for which Medicaid assistance is available within that state. The state should consult regularly with these federal and Indian entities, especially before it submits any Medicaid plan amendments, waiver requests, or proposals for demonstration projects that are likely to have a direct effect on IHPs or UIOs. S. 1200, but neither version of H.R. 1328, specifies that Section 206 takes effect October 1, 2009.

In the 111th Congress, an economic stimulus bill being considered by the House Energy and Commerce Committee¹⁶³ contains a provision regarding consultation that is nearly identical to Sec. 205 of the House Health Subcommittee version of H.R. 1328. The Energy and Commerce Committee began marking up the draft stimulus bill with this provision on January 22, 2009.

Safe Harbors from Criminal Prohibition of Remunerations

Current SSA, Title XI, has an anti-kickback provision that authorizes criminal penalties for soliciting or receiving remuneration in return for either referrals for services or purchases, leases, or orders for goods, facilities, services, or items, when the payment for the services, items, etc., may be made under a federal health care program.¹⁶⁴ The provision allows for a number of exceptions,¹⁶⁵ and the HHS Secretary must annually solicit proposals for additions or amendments to such “safe harbors” (i.e., payments not considered kickbacks).¹⁶⁶

Section 207(b) of Title II of S. 1200 and H.R. 1328 (as reported) amends the SSA anti-kickback provision to add safe harbors from criminal prosecution for certain transactions (1) among IHPs,

¹⁶³ See §5006 in “Health Title V” on the Committee’s website at http://energycommerce.house.gov/index.php?option=com_content&task=view&id=1471&Itemid=1, last accessed January 21, 2009.

¹⁶⁴ 42 U.S.C. 1320a-7b.

¹⁶⁵ See 42 U.S.C. 1320a-7b(b)(3) and 42 CFR 1001.952.

¹⁶⁶ 42 U.S.C. 1320a-7d.

tribes, TOs, and UIOs (covered are transfers of inventory or supplies, staff, waiver of premiums or cost sharing, and the collection, transport, analysis, or interpretation of diagnostic specimens or test data); (2) among patients and IHPs, tribes, TOs, and UIOs (covered are transfers for expenditures for patient transportation, patient or family housing, escorts, or payment of cost sharing); (3) between an IHP, tribe, TO, or UIO under a contract, or between IHS and an outside health care provider under a CHS contract (covered are transfers of anything of value, provided the transfer is not tied to referrals or other business and is limited to fair market value); and (4) any other transfer of anything of value involving an IHP, tribe, TO, UIO, or patient that the HHS Secretary, in consultation with the U.S. Attorney General, determines is appropriate.

According to its supporters, the intent of the safe harbor provision is “to eliminate any ambiguity about whether tribal health programs can continue to share resources after assuming the programs from IHS. Such interactions are an integral part of the Indian health system funded by IHS and are essential to maintaining continuity of care for patients and efficient, cost effective operations.”¹⁶⁷ HHS opposes this safe harbor provision, stating that it does not know what problems the provision is supposed to address, that statutory exceptions may undermine the criminal prohibition, that lack of a statutory safe harbor may not make a particular transaction or arrangement illegal, and that current law authorizes the HHS Secretary to create safe harbors through regulations. The House Health Subcommittee version of H.R. 1328 deletes the language in this section of Title II of the bills, substituting instead (as Section 206 of the Health Subcommittee version) a requirement that the HHS Secretary, through the HHS Inspector General, solicit a proposal for safe harbors related to IHP and UIO health care items and services.

Indians and Medicaid and SCHIP Managed Care Organizations

The SSA, Title XIX, authorizes states to elect to provide Medicaid services through Medicaid managed care organizations or entities (MCEs), in which Medicaid beneficiaries enroll to receive Medicaid services.¹⁶⁸ Section 208 of Title II of the bills (Section 207 of the House Health Subcommittee version of H.R. 1328) makes two sets of changes regarding Indian health entities and Medicaid managed care.

First, Section 208 adds Medicaid and SCHIP rules applying to all Medicaid MCEs. The rules require non-Indian Medicaid MCEs to allow IHS-eligible Indian enrollees to choose an “Indian health care provider” (defined as an IHP or UIO) as their primary care provider. The rules also place additional requirements on an MCE with a “significant percentage” of enrollees who are Indian; the additional requirements concern such issues as the number of Indian health care providers in the MCE’s network, rates and promptness of payments to Indian health care providers (whether participating in the MCE network or not), exemption of Indian health care providers from compliance with an MCE requirement if it conflicted with a statute or regulation, satisfaction of Indian enrollees’ claim-submission requirements by submission of claims by Indian health care providers, and use of FTCA coverage to allow an Indian health care provider to meet requirements for medical malpractice insurance. The House Health Subcommittee version of H.R. 1328 drops the Medicaid compliance exemption, claims submission, and malpractice

¹⁶⁷ Testimony of Myra M. Munson, in U.S. Congress, Senate Committee on Indian Affairs, Reauthorization of the Indian Health Care Improvement Act, hearing on S. 556, 108th Cong., 1st sess., July 23, 2003, S.Hrg. 108-204 (Washington: GPO, 2003), p. 388.

¹⁶⁸ For a discussion of Medicaid managed care, see CRS Report RL33711, *Medicaid Managed Care: An Overview and Key Issues for Congress*, by (name redacted).

coverage provisions, and also drops the requirement that MCEs subject to the remaining rules have a significant percentage of Indian enrollees.

Second, Section 208 adds rules regarding Indian Medicaid MCEs. It requires that a state offer to make agreements to allow an Indian Medicaid MCE (as defined in the section) to serve as the Medicaid or SCHIP MCE for eligible Indians, if (1) the state has elected to provide Medicaid services through MCEs and (2) an Indian health care provider (funded wholly or partly by IHS) or a consortium of IHPs or UIOs has established an Indian Medicaid MCE that meets the relevant required quality standards. Section 208 establishes special rules for these Indian Medicaid MCEs, covering such areas as enrollment restrictions by Indian Medicaid MCEs or states, default enrollment of Indians in Indian Medicaid MCEs, application of Medicaid solvency standards by HHS instead of the state, status of the Indian Medicaid MCE as a “public entity” under Medicaid law (hence exemption from certain state solvency standards and risk-related licensing requirements), waiver of certain requirements for patients’ advance directives, and modification of MCE marketing and information rules to allow culturally appropriate and understandable materials. The House Health Subcommittee version of H.R. 1328 deletes the requirement for states to offer to make agreements with Indian Medicaid MCEs, and drops all the special rules for Indian Medicaid MCEs except the rule regarding enrollment restrictions.

S. 1200, but not H.R. 1328, specifies that Section 208 takes effect October 1, 2009.

HHS worked with Indian health care proponents on many of Section 208’s provisions, but opposes requiring states to take the actions envisioned in Section 208 and has other, more specific objections.

Annual Report on Indian SSA Health Program Beneficiaries

Section 209 of Title II of S. 1200 and H.R. 1328 (as reported) amends SSA to require the HHS Secretary, acting through CMS and IHS, to report annually to Congress on the enrollment and health status of Indians receiving items or services under SSA health benefits programs during the previous year. Among the subjects to be covered would be the number of Indians receiving benefits under each SSA health program, the health status of such Indians (disaggregated by specific diseases or conditions), the number of Indians who receive benefits from both IHS and SSA health programs, and the status of IHP and UIO facilities’ compliance with CMS conditions and requirements. HHS opposes this provision, stating that neither CMS nor IHS has the data and arguing that collecting the data would be burdensome. The House Health Subcommittee version of H.R. 1328 (in Section 208 of this version) drops the report on facilities’ compliance with CMS requirements; moves to IHCA Title VIII the requirement for information on Indians who use CMS programs, their use of IHS, and their health status; and adds a requirement that CMS and IHS collect data on provision of CMS services to Indians in a way that provides for the Title VIII report.

Other Legislative Issues

Congress has also considered other legislative initiatives that have a direct impact on Indian health.

Contract Support Costs

Under the ISDEAA, IHS pays annual contract support costs to a tribe to cover the tribe's expenses for administering IHS programs under a self-determination contract (ISDEAA Title I) or a self-governance compact (ISDEAA Title V). Contract support costs are separate from direct program operating costs. They include pre-award costs (such as planning), one-time start-up costs (such as office-equipment purchases), direct costs (such as unemployment taxes on program salaries or training required for program personnel certification), and indirect costs (overhead costs shared with other programs, such as financial management, data processing, utilities, and janitorial services).¹⁶⁹ The amount of each tribe's contract support costs for IHS programs is negotiated between the tribe and IHS. The ISDEAA, however, makes the funding of contract support costs dependent on "the availability of appropriations."¹⁷⁰

Funding has been insufficient to cover tribal contract support costs. While appropriations for IHS contract support costs have risen over time (see **Table 4** above), they have seldom covered 100% of the total contract support costs negotiated with tribes.¹⁷¹ Moreover, the expenses that contract support costs are to pay have also gone up, because more tribes are electing to operate health delivery services, the total amount of program dollars contracted by the tribes has increased, and administrative costs have risen.¹⁷²

When tribes' contract support costs are not fully funded through appropriations, the tribes must either use program funds to make up the difference or forego the administrative support. Contracting and compacting tribes argue that usage of program funds for contract support costs means less health treatment can be offered at IHS-funded facilities. They have argued further that federal failure to pay contract support costs is a breach of federal contract law. The Cherokee Nation of Oklahoma and the Duck Valley Shoshone-Paiute Tribes of Nevada filed suits against the United States in the late 1990s over IHS failure to fully fund the tribe's contract support costs, and eventually won their case before the U.S. Supreme Court.¹⁷³

The tribes' victory in court does not appear, however, to fix the problem of the underfunding of contract support costs. The Supreme Court noted that the entire IHS appropriation from which contract support costs are drawn is available to pay the costs, but only if the appropriations act does not cap the amount appropriated for contract support costs.¹⁷⁴ Even before the Court decision, however, from FY1998 on, Congress began including language in appropriation acts that explicitly limited amounts for IHS contract support costs.

The main proposals for fully funding contract support costs—besides increasing the appropriations—involve making them an entitlement. Proponents of entitlement argue that contracting and compacting tribes are operating federal programs and carrying out federal

¹⁶⁹ U.S. General Accounting Office, *Indian Self-Determination Act: Shortfalls in Indian Contract Support Costs Need to Be Addressed*, Report to Congressional Requestors, GAO/RCED-99-150, June 1999, Washington, 1999. See Table 1.1, p. 18.

¹⁷⁰ ISDEAA, § 106(b); 25 U.S.C. 450j-1(b).

¹⁷¹ GAO, *Indian Self-Determination Act: Shortfalls in Indian Contract Support Costs*, pp. 33-35..

¹⁷² *Ibid.*, p. 3..

¹⁷³ *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, WL464860 (March 1, 2005). For further analysis of this case, see archived CRS Report RL32681, *Indian Self-Determination and Education Assistance Act Contracts and Cherokee Nation of Oklahoma v. Leavitt: Agency Discretion to Fund Contract Support Costs*.

¹⁷⁴ *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, WL464860 (2005) (slip opinion at 4).

responsibilities and that tribes should not have to use tribal financial resources to subsidize federal contract support costs.¹⁷⁵ Critics warn the proposal would be extremely expensive and argue that making an entitlement for one IHS funding source would jeopardize funding for other programs. Bills introduced in the 106th and 108th Congresses (H.R. 4148 and S. 2172, respectively) would have made these costs an entitlement for IHS and BIA contracts and compacts, but neither bill was enacted.

Substance Abuse and Mental Health Program Consolidation

Indian communities are plagued by mental health problems and alcohol and substance abuse, at rates generally far greater than those of the general population. Alcohol continues to be an important risk factor associated with the top three killers of AI/AN youth—accidents, suicide, and homicide.¹⁷⁶ In fact, in 2002, alcohol was the primary abuse substance over illicit drugs among all AI/AN.¹⁷⁷ Compared to the average American, AI/AN are 6.5 times more likely to die from alcoholism-related diseases or accidents (see **Table 3** above). According to a 2003 Senate Committee on Indian Affairs report, mental health and social problems are associated with more than one-third of the demands made on Indian health facilities for services.¹⁷⁸ An HHS report states that, although little evidence is available, the existing data suggest that AI/AN youth and adults suffer a disproportionate burden of mental health problems when compared with other ethnic and racial groups in the United States.¹⁷⁹

Recognizing that there is significant co-morbidity of mental and substance abuse disorders, particularly alcohol abuse, the federal government offers several disparate mental health and substance abuse prevention and treatment programs for which Indian tribes and tribal health organizations are eligible to receive funding. According to the 2003 Senate Committee on Indian Affairs report, however, the funding available for the operation of these programs is generally very small.¹⁸⁰ According to the Senate Committee report, when Indian tribes and tribal organizations are able to access program funding from several different sources, the amounts are generally so meager, and the auditing and reporting requirements so onerous, that it is simply not cost effective to attempt to operate a program which combines multiple sources of available funding. The Senate Committee report also stated that an HHS study identified those department

¹⁷⁵ U.S. Congress, House Committee on Resources, Tribal Contract Support Cost Technical Amendments of 2000, report to accompany H.R. 4148, 106th Cong., 2nd sess., H.Rept. 106-837 (Washington: GPO, 2000), p. 4.

¹⁷⁶ U.S. Congress, Senate Committee on Indian Affairs, *To Authorize the Integration and Consolidation of Alcohol and Substance Abuse Programs and Services Provided by Indian Tribal Governments, and for Other Purposes*, a report to accompany S. 285, 108th Cong., 1st sess., S.Rept. 108-75 (Washington: GPO, 2003), p. 2 (hereafter cited as Senate Committee on Indian Affairs, *Alcohol and Substance Abuse Programs*).

¹⁷⁷ “Substance Abuse Treatment Admissions among American Indians and Alaska Natives: 2002,” *The DASIS Report* [Drug and Alcohol Services Information System] (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, February 11, 2005), pp. 1-2; available at <http://www.oas.samhsa.gov/2k5/IndianTX/IndianTX.cfm>.

¹⁷⁸ Senate Committee on Indian Affairs, *Alcohol and Substance Abuse Programs*, p. 2.

¹⁷⁹ U.S. Department of Health and Human Services, *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001), p. 96; available at [<http://www.surgeongeneral.gov/library>]

¹⁸⁰ Senate Committee on Indian Affairs, *Alcohol and Substance Abuse Programs*, p. 2.

programs that could be consolidated by tribes into a self-governance compact, or that would be useful to a self-governance compact, but could not be consolidated due to statutory restrictions.¹⁸¹

Legislation was introduced in the 106th (S. 1507), 107th (S. 210), and 108th (S. 285) Congresses to allow Indian tribes or TOs operating federal substance abuse and mental health programs to consolidate them into a single program for administrative purposes. IHCA Title VII in S. 1200 and H.R. 1328 (110th Congress) emphasized coordination of behavioral health care, but did not authorize consolidation of federal program funding. New legislation may be introduced to authorize tribal consolidation of federal substance abuse and mental health funding.

¹⁸¹ Ibid.

Appendix. Brief History of Federal Indian Health Services

From 1789 to 1849, the Department of War was charged by Congress with handling Indian affairs (1 Stat. 49), so early federal health services to Indians were most likely to be provided by military doctors and were probably chiefly to prevent the spread of infectious diseases. Congressional appropriations for the War Department in this period did not mention Indian health care. In addition to whatever the War Department spent, some of the funds the federal government provided to missionaries for educating Indians may have been used for medical care of Indian students.

The earliest statutory authorization (and appropriation) explicitly for federal Indian health care was the act of May 5, 1832 (4 Stat. 514), which authorized Indian agents to employ local or U.S. Army doctors to provide smallpox vaccinations to Indians, and appropriated \$12,000 for the purpose. Additional appropriations for smallpox vaccinations were made in 1839 (5 Stat. 328), 1853 (10 Stat. 226), and annually from 1860 to 1915.

The earliest Indian treaty providing for health services was signed on September 15, 1832 (7 Stat. 370), with the Winnebago of Wisconsin; it included funding for two physicians for 27 years as part of the compensation for a land cession. Of the approximately 210 treaties made with Indian tribes after this 1832 treaty until 1871 (when Congress ended Indian treaty-making), about 44 treaties committed the federal government to provide the signatory tribe(s) a physician, a hospital, medicines, or vaccine, or some combination of these, usually for a delimited period of time.

After 1849, when Indian affairs were transferred from the War Department to the new Department of the Interior (9 Stat. 395), federal executive activities regarding Indian health care fell under civilian rather than military authority. As the placement of Indian tribes on reservations accelerated in the second half of the 19th century, the federal government gradually became aware of the need for medical care on reservations. As noted, Congress made annual appropriations for Indian vaccination against smallpox from 1860 to 1915. By the 1860s Congress was also making appropriations for doctors and medicine for some agencies, and the BIA was appointing physicians, although only at some agencies. The number of medical employees in BIA agencies and schools increased from at least 12 in 1865 to 86 in 1897, and by 1888 there were four BIA hospitals. By 1884 the BIA published regulations specifying physicians' responsibilities. Except for 1873-1877, however, BIA had no organized medical division. It was not until 1908 that the Commissioner of Indian Affairs first appointed a chief medical supervisor.

Critics and studies inside and outside the BIA pointed out the severity of health problems, especially tuberculosis, in Indian schools and reservations. Between 1900 and 1911, the number of BIA hospitals and sanatoria jumped from five to 50.

In 1910 Congress enacted its first appropriation for *general* Indian medical needs (36 Stat. 271), as opposed to appropriations for specific reservations or diseases, for \$40,000. By 1920 Congress had increased this overall Indian health appropriation to \$375,000, and had also added appropriations specifically for hospital construction and operation and for general medical treatment of Indians (and, for a few years, "correction of sanitary defects in Indian homes").

In 1921, Congress passed the Snyder Act (P.L. 67-85), a general authorization of appropriations for Indian health services, without time or dollar limitations (see "Statutory Authority," above).

Despite these actions and further appropriations increases, criticism of BIA health services continued, including suggestions to transfer BIA medical services to the Public Health Service (PHS). In 1926 a PHS surgeon was assigned to supervise the BIA medical division. In 1929 Congress authorized the Secretary of the Interior to permit state agents to inspect AI/AN health and education conditions and to enforce sanitation and quarantine regulations (P.L. 70-760), and in 1934, through the Johnson-O'Malley Act (P.L. 73-167), Congress gave the BIA authority to contract for medical services from states, local governments, and private organizations.

Indian health problems were still severe, however. In 1955, under authority of the Transfer Act of 1954 (P.L. 83-568), the BIA's Indian health programs were transferred to the PHS in the then-new Department of Health, Education and Welfare, now HHS (see "Statutory Authority," above). Indian Health Service appropriations increased markedly after the transfer,¹⁸² and Indians' health status improved greatly in the next 20 years. It still lagged behind that of the American population, however, and in 1976 Congress enacted the Indian Health Care Improvement Act (P.L. 94-437), authorizing new programs and IHS access to Medicaid and Medicare funds (see "Statutory Authority"). A year earlier, Congress had enacted the Indian Self-Determination and Education Assistance Act (P.L. 93-638), whose authorization of self-determination contracts and, through amendments, self-governance compacts has led to tribal operation of a majority of IHS facilities.

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¹⁸² IHS's transfer to HEW became effective at the beginning of FY1956. Jurisdiction over IHS appropriations was transferred from the Interior appropriations subcommittees to the Labor-HEW subcommittees for FY1956-FY1961, but for FY1962 was transferred back to the Interior appropriations subcommittees and has remained there ever since. See U.S. Congress, House Committee on Appropriations, *Department of the Interior and Related Agencies Appropriations Bill, 1962*, 87th Cong., 1st sess., H.Rept. 87-233 (Washington: GPO, 1961), p. 20.

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