Indian Health Care and Reauthorization of the Indian Health Care Improvement Act:

Still Underfunded and Not Reauthorized

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The National Congress of American Indians [NCAI] held its Executive Council Winter Session February 28- March 2, 2005, in Washington D.C. The meeting's focus was on anticipated legislative issues that would be debated by members of the 109th Congress, and included a specific briefing on the reauthorization of the Indian Health Care Improvement Act [IHCIA]. This paper will explore the historical and federal legislative background of Indian health care, including the importance of the IHCIA, health care issues for tribes today, the significance of the current version of the IHCIA, the NCAI and the involvement of tribal leaders in current attempts to reauthorize the IHCIA.

Background

Today's Indian[1] health care system issues and related federal legislative activities, such as the attempts to reauthorize the Indian Health Care Improvement Act [IHCIA], are rooted in the long history of a special government-to-government [G2G] relationship between Indian Nations and the United States Government. This G2G relationship was established in 1787, based on Article I, Section 8 of the U.S. Constitution. [2] The Federal government assuming responsibility for Indian health care has been well established in numerous legislative and judicial actions, Executive Orders and treaties between the United States Government and several Indian Nations. A local example is Washington State's Stevens Treaties.[3] They include reference to doctors that would be provided to the tribes signing the treaties as part of the reimbursement for the huge amount of land being ceded by the Indian Nations.

The conquering colonists brought with them many diseases previously unknown to the indigenous people. The Native Americans had not developed natural immunities

and experienced a high incidence of new infectious diseases among them and the colonizers' developed a fear of infection from Indians. The main purpose of doctors treating Indians in the early 1800's was to provide immunization services to Indians near military bases to protect the soldiers and colonists with whom they had close contact. The focus was on protecting the health of the colonists, not enhancing and protecting the health of Indians.

Federal policy later forced many Indian Nations to move to reservations. Often there were accompanying orders forbidding Indians to have access to their traditional medicines, and access to their traditional practices. This generally resulted in no health care for Indians causing widespread degradation of Indians' health and devastating losses of life. The results of federal policy led Tribes, when negotiating with the Federal government, to insist on health care as a key component in exchange for their withdrawal from ancestral lands. During the late 1800's doctors and hospitals were added to reservations.[4]

> According to the Task Force on Indian Health (Task Force Six) in the Final Report to the American Indian Policy Review Commission[5] (Final Report), `[t]he health care which Indians actually received in the first 100 years was delivered in a piecemeal, inconsistent fashion and the few appropriations made were never large enough to meet the overwhelming need.' [6]

The Federal responsibility for Indian health care was frequently moved from one Department or Administration to another. In 1803 it was initially housed in the War Department [a placement speaking volumes about the Federal relationship to Indians], then moved in 1849 to the Interior Department, and finally shifted to the Department of Health, Education and Welfare (DHEW).[7] Originally named the Division of Indian Health, the name was later changed to the name we know today, the Indian Health Service [IHS]. IHS is the federal program responsible for providing federal health

services to American Indians/Alaska Natives. In the 1950's, the IHS also received the responsibility for building and maintaining sanitation facilities in Indian communities, as the lack of sanitation was seen as a prime cause of many Indian health problems.

Statutes Authorizing Indian Health Care

There are two federal statutes providing the legislative foundation for the provision of Indian health care by the federal government. The first is the Snyder Act, 25 U.S.C. 13, passed in 1921. It provided permanent appropriations authority for Indian Health programs and services[8], but didn't include meaningful standards to assess Indian health care status or measure improvements in service provision. "It authorized funds 'for the relief of distress and conservation of health…[and]…for the employment of …physicians…for Indian tribes throughout the United States.' "[9]

The Indian Policy Review Commission was created by an act of Congress on January 2, 1975, and charged with reviewing federal policy toward Indians and making recommendations to Congress. One of its task forces reviewed health care policy and determined "there [was] no clear overall direction or policy for implementation of the various [Indian Health Care] programs. As a result, [IHS] operates primarily an emergency and crisis oriented service…This has resulted in increased prevalence of certain health deficiencies which are virtually unknown in the general population."[10] Congress attempted to correct their failings in 1976 with passage of the Indian Health Care Improvement Act [IHCIA]. It is the second federal statute authorizing Indian health care and it provides the statutory framework for the provision of Indian health care.

The general guiding concepts in the Snyder Act reflect values of minimal maintenance and crisis response. There is a significant shift from the values in the Snyder Act. The contemporary 'purpose' language such as in the November 16, 2004 IHCIA reauthorization amendment attempt of the 108th Congress states,

> The reauthorization is intended to raise the health status of AI/ANs to the highest possible level in accordance with Health People 2010. [Healthy People 2010 is the prevention agenda for the Nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats.—U.S. Dept. of Health and Human Services.][11]

The 109th Congress' May 17, 2005 introduction of the IHCIA Amendments of 2005, to revise and extend the Act[12] reflects a similar sense of purpose. In subsection (3) and subsection (5) of Sec. 3 *Declaration of National Indian Health Policy*, it says,

> Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians…to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs.[13]
>
> Congress declares it is the policy of this Nation…to require meaningful consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to implement this Act and the national policy of Indian self-determination…[14]

The IHCIA significantly raises the expectations for the health care Indians will receive and assumes a higher level of health for Indians will follow from this care lessening the significant health disparities noted in the findings of the American Indian Policy Review Commission.

<u>Inadequate Funding, Huge Health Disparities, and Inequitable Health Care</u>

Inadequate federal funding for American Indian/Alaskan Native health care has resulted in a tribal health crisis. The Indian Health Service [IHS], an agency within the federal Department of Health and Human Services,

> Operates a comprehensive health service delivery system for approximately 1.6 million of the nation's 2.6 million American Indians and Alaska Natives… Members of federally recognized Indian tribes and their descendents (approximately 2.4 Million people) are eligible for services provided by IHS. There are more than 560 federally recognized tribes in the United States. Their members live mainly on reservations and in rural communities in 35 states, mostly in the western United States and Alaska…Less than 60 percent of the health care needs of these people can be met by the current IHS funding level.[15]

The Northwest Portland Area Indian Health Board [NPAIHB] in its 2005 Legislative Plan, prepared for the 109th Congress, dated February 15, 2005, states "Over 93,000 Indian people in Oregon, Washington, and Idaho receive primary health care from Indian health programs. Nationally, over 1.9 million American Indian/Alaska Natives receive care from Indian health programs…" The two sources differ slightly in total estimates, but provide a current picture of Indian health care in the U.S.

The federal government has been sorely lacking in an equitable fulfillment of its treaty obligations in the area of health care. For example,

> Compared to the rest of the population in the U.S., American Indians have some of the highest rates of illnesses and diseases, most of which are preventable with proper medical care, including diagnosis, treatment, medication and education. [Notable statistics include:] 425 percent greater rate of tuberculosis; 579 percent greater rate of alcoholism and 250 percent greater rate of diabetes.[16]

It is possible to understand the consequences of the lack of health care equity for American Indians [AI] and tribes by reviewing a few of the death rates for American Indians compared with the rest of the U.S. population. IHS collated the data.

> American Indians die:
> - of tuberculosis at a rate 500 percent greater than the rest of the U.S. population,
> - of diabetes at a rate of 390 percent greater than the rest of the U.S. population, and
> - of alcoholism at a rate of 740 percent greater than the rest of the U.S. population.
>
> Infant mortality is 21 percent higher for American Indians than the rest of the U.S. population.[17]

The lack of adequate health care is devastating to individuals, families and entire tribal communities, especially when most tribes are very small in total population. Every person is precious, and each tribal member's diminished health or demise reduces the tribe's literal life. Many Indian health leaders point to comparisons with other federal health program spending. "Not only does IHS funding fall short in comparison to other mainstream health plans, but also when compared to other federal programs. According

to the National Indian Health Board, in 1997, IHS spends approximately $1,221 per person annually. That compares with $3,047 for Medicaid, $4,662 for veterans and $2,980 for the health of prisoners."[18]

Increased Tribal Authority

Tribes have advocated for an increase in tribal governmental authority to respond to tribal health needs. The 1975 passage of PL 93-638, the Indian Self-Determination and Education Assistance Act, enabled tribes to contract with the federal government to run programs, including health care. Theoretically this returned "decision-making and funds to local Tribal governments…"[19] would help support a revitalization of Tribal Governments and improve services.

The Self-Determination law allows tribes, with funds contracted from the federal government, to run their own health programs as long as they follow the guidelines for IHS programs. This allows tribes to directly hire health care staff, who are responsible to the specific tribal government as opposed to IHS staff employed by and responsible to the Federal government. This implemented a governmental trend toward local control.

While PL 93-638 did return more power to Tribal Governments, it didn't go as far as Tribes had originally envisioned. Tribes had expected contracting to be a simple process, with a simple document. "By the mid-1980's, Self-Determination contracts, originally conceived as simple documents, had evolved to literally hundreds of pages—with every variety of oversight requirements, reports, and forms; a true bureaucratic nightmare."[20] Another problem for the operation of health programs under PL 93-638 has been the requirement to follow IHS definitions and program structures. This has allowed less flexibility than tribes found they needed to utilize insufficient resources to maximum benefit for their members.

Several tribes advocated for a Self-Governance Demonstration Project by the federal government to reduce the bureaucratic oversight and complexity. NCAI's and

tribal advocacy effectively created Title III of PL 100-472, allowing compacts between ten tribes and the federal government. Compacts were envisioned as simple funding transfers to replace contracts. The compacts allowed tribes greater latitude in using the available money. The Self-Governance Demonstration Project was a success leading to almost half of the tribes today compacting with the federal government.[21]

Both the Self-Determination Act and the Self-Governance Act were tribal initiatives and proposals that both required and facilitated changes in tribal organization and structure. The ability to "run" programs, rather than just be recipients of services, led to significant increases in tribal governments' programs with the accompanying needs to hire staff and create more complex bureaucracies. Tribes worked to maximize billing of third party revenue sources including Medicaid. This was a skillful maneuver to increase the needed health revenues that were not being provided by the federal government. Ed Fox, Executive Director of the NPAIHB, stated at both a recent NPAIHB meeting and the May 2005 Affiliated Tribes of Northwest Indians' [ATNI] Health Committee that increases in Medicaid have been what has kept tribal health programs 'above water' when the federal government has continued its underfunding.

Tribal Health Care in Crisis

The current reductions in federal and state Medicaid spending, related to budget shortfalls and changes in political will, combined with skyrocketing medication and staffing costs, and federal funding for Indian health services not keeping up with inflation and increased medical costs has led to the tribal health crisis being reported today.

The Lummi Nation and Swinomish Tribe have been local leaders in publicizing this health crisis, with multiple newspaper articles from the *Skagit Valley Herald* and *Bellingham Herald* to the *New York Times*. The April 3, 2005 edition of the *Skagit Valley Herald* ran an article "Money Woes threatening tribal health programs." It publicized the fact that most Northwest tribes have,

> to limit the medical services for which they'll pay off-reservation providers. Most tribes now only pay off-reservation providers for "Priority 1" procedures—emergency room treatment, kidney dialysis, life-saving surgery—said Leon John, office coordinator of the Swinomish Tribal health clinic. The payment restriction stops many tribal members from going to their regular physician or seeking preventative treatment, John said.
>
> 'It's been a big change,' he said. 'It makes is impossible to do preventative care outside the clinic.'
>
> Indian health advocates fear the shortage of funds could jeopardize three decades of progress in improving Native American health. Even U.S. Sen. John McCain of Arizona, the Republican chairman of the Senate Co. on Indian Affairs, has argued the funding shortfalls are harming Native Americans.[22]

The May 2005 issue of the American Journal of Public Health, Vol. 95, No. 5 focused on American Indian/Alaska Native Health Policy.[23] Andy Schneider, JD states, "Chronic underfunding of American Indian and Alaska Native [AI/AN] health care by the federal government has weakened the capacity of the Indian Health Service, tribal governments, and the urban Indian health delivery system to meet the health care needs of the AI/AN population."[24] The health crisis continues for tribes and tribal members regardless of the format of their health care services.

There are three governmental structures or formats used by tribes to provide health care services to their members. One is being a direct service tribe. This means they receive their health care directly from the federal government by federal employees of IHS working on their reservations. The second form is the tribe contracting with the federal government to provide health services themselves to their members, often called "638" programs. The third form is a tribe compacting as a self-governance tribe, allowing more self-control and less paperwork, to provide health services directly to their members.

There is a non-tribal, fourth method, of Indian health care focused on Urban Indians. Some health services are provided in urban centers through Urban Indian Health Clinics, usually funded as Federally Qualified Health Centers [FQHC's]. The

profound lack of funding for Indian health care has finally defeated all attempts, to date, to alleviate the tribal health crisis and bring tribal health closer to that of the rest of the U.S. population.

"Rationed" Health Care

Another twist in the federal policy driven health care crisis is penalizing tribes for being small, as are many Washington tribes. A part of the IHS budget concerned with facility building, the facilities construction rules and priorities, penalizes small tribes with low user counts, making it very difficult for them to even get on the list of tribes waiting for facilities to be built with federal funds. Many tribes at best have small clinics with limited staff. When tribes have small clinics, they must rely on referrals to specialists and services off-reservation. Referrals for services not provided by the on-site clinicians also keep user counts low and are paid for with contract health dollars. There are not enough contract health dollars to meet the need. This is where the tribal health care crisis comes into sharp focus. The off-reservation services are regulated [rationed]. The Swinomish/Upper Skagit by a process called "Priority One" authorizes Contract Health Services provided the following information on what being in 'priority one' means.

> Because of funding shortfalls from the federal government to Contract Health Services, most Northwest Indian tribes can only pay for "Priority 1" health care authorizations for medical services performed by off-reservation providers. Tribal members can still attain any treatments available through tribal clinics.
>
> While "Priority 1" rules are in place, Contract Health Services money can only cover the following procedures:
> -Emergency care for life-threatening ailments or acute trauma
> -Dialysis for acute and chronic conditions
> -Emergency psychiatric care
> -Care necessary for the evaluation of potentially life-threatening ailments.
> -Obstetrical deliveries and acute prenatal care.
> -Neonatal care.[25]

At a spring 2005 Health Committee meeting of the Affiliated Tribes of Northwest Indians [ATNI], there were numerous anecdotal examples of what this means in practical terms. One participant stated, "We ask who we will be burying today." Another shared the example of a youngster for whom parents attempted to receive authorization for care. They were told their child wasn't sick enough. The adolescent died two days later. The parents took their child back to the clinic and asked, "Are they sick enough yet? They're dead."

Tribal members with serious chronic illnesses often do not receive authorization for needed care until after their health has already dangerously declined. There are many examples, such as dialysis being prescribed, but by the time it is finally authorized it can not prolong life because the patient's health status is too compromised.

There have been several articles in the *Bellingham Herald* about the health crisis the Lummi Nation is experiencing. "Lummi Nation will no longer pay for health care outside its clinic for patients who aren't connected to the tribes. As of May 1, only members of Lummi Nation or members of other tribes living on the Lummi reservation will be eligible for Lummi federal funds to pay for health care outside the clinic." The Lummi Nation serves approximately 4,000 members. One social services worker for the tribe provided an example, "We can't afford to buy glasses for our kids."[26] The *Bellingham Herald* article goes on to report:

> "Folks that go to the emergency room and receive care…that is not for life or limb, they might have to pay for those services," said Darrell Hillaire, chairman of the Lummi Indian Business Council.
>
> Lummi health care is provided by the reservation's clinic, which is not open evenings or weekends…. Indian Health Services defines [Priority 1] care as necessary to prevent death or serious injury.[27]

The reductions in health care services to Indians are caused by federal underfunding of Indian health care, regardless if the services are provided as direct services, contracted services or compacted services. Most Indians receive their health

care from the Indian health system, not private insurers or low-income public health clinics. Tribal leaders describe Indian health care as “universal, but rationed”.

> In 1999, the IHS and tribes developed a methodology to identify the resource shortfall for IHS-wide and each Indian health program. The methodology is based on a defined benefit package for a federal mainstream health plan and used standard actuarial methods…The study found that $2,980 per person is needed to assure annual benefits equivalent to those in a mainstream health plan. …[Specific program costs were adjusted for the number of active users, and current prices and health status of the local mainstream communities.] Based on this methodology, a “level of need” was determined.
>
> The 29 federally recognized tribes in Washington including both IHS- and tribal-managed health programs, were funded at 53% of “level of need.”[28]

Th 1999 cost per person does not reflect the inflation in health care costs of the past six years. During this time there has been a skyrocketing of prescription medication use and costs, plus the increased costs of staff salaries and benefits. The 2005 Legislative Plan, prepared for the 109th Congress, of the Northwest Portland Area Indian Health Board [NPAIHB], states

> Medical inflation in the Northwest exceeds 7%. Providing services to over 1.9 Million patients residing in primarily rural areas, Indian health programs do not realize the same level of cost savings that managed care achieves in urban areas and costs continue to rise for Tribal health programs. Prescription drugs alone have accounted for an increase of 36% since 1997.[29] It is unfair to hold the IHS budget to 2%, while allowing inflation and population adjustments for other federal health programs such as Medicaid and Medicare. This year, the Congressional Budget Office estimates that Medicaid expenditures grew by 8.5% in FY 2005 and are anticipated to continue to grow at that amount. Likewise, Medicare expenditures will expand by 9% and are anticipated to grow even more with the implementation of Part D in 2006. Meanwhile the IHS health care program increases never cover the true costs of inflation…[30]

Almost 30 years after the passage of the original IHCIA Indians continue to experience significantly marked health disparities when compared with the general population or other sub-groups of the general population. Continued underfunding of Indian health services fuels these health disparities.

Legislative Origins, Content, and Significance of the IHCIA

Congress has taken many legislative approaches concerning Indian health care policy and Indian Nations. When it passed the 1975 Indian Self-Determination and Education Assistance Act [Public Law 93-638] it "provide[d] tribes the option of either assuming from the IHS the administration and operation of health services and programs in their communities, or …remain[ing] within the IHS administered direct health system."[31]

The initial passage of the 1976 Indian Health Care Improvement Act [Public Law 94-437] was a health specific law that bolstered the options of PL 93-638. Its initial goal was "to provide the quantity and quality of health services necessary to elevate the health status of AI/ANs to the highest possible level and to encourage the maximum participation of tribes in the planning and management of those services."[32]

The IHCIA was last reauthorized in 1992. In 1999, when tribal leaders realized the IHCIA could not win reauthorization, they pushed for funding specific health initiatives of particular concern to Indians that could continue to work toward the highest possible health for Indians. They included diabetes, cancer, obesity, and tobacco cessation. This was a strategic interim step by tribal leaders to receive some new money for specific health care programs in a political climate resistant to reauthorizing the IHCIA.

The National Congress of American Indians [NCAI] has been actively collaborating with the National Indian Health Board [NIHB] to get the IHCIA reauthorized. The result of those efforts, about six years ago, was the creation of a tribal work group comprised of representatives from direct service tribes, 638 [self-determination] tribes, self-governing tribes, and Urban Indian Health Clinics. The workgroup through much discussion and compromise identified an Indian position on what was needed to reach the lofty purposes of the IHCIA. That work group wrote the IHCA version that was

considered by the 108th Congress and is being considered by the 109th Congress. This is an historic accomplishment and milestone. IHS staff has developed all previous legislation related to Indian health care. To quote a Northwest Indian Health Care Director, "It's a matter of Indian pride. It is the first time tribes got together, wrote and agreed. Now it's an issue of what do you have against Indians [not reauthorizing the IHCIA]? It's an embarrassment."

Senator McCain references this group's work in his May 17, 2005 introduction of the IHCIA Amendments of 2005 [the current attempt to reauthorize the IHCIA] into the Congressional Record.

> Six years ago a steering co. of Tribal leaders, with extensive consultation by the IHS developed a broad consensus in Indian Country about what needs to be done to improve and update health services for Indian people. In the 108th Congress significant progress was made in crafting a bill that was acceptable to all parties but still did not pass the full Senate. In the legislation introduced today, I have tried to address concerns raised last year, but understand that there may still be some differences. I look forward to continuing discussions on these differences, but am introducing the bill to get the process moving because we want to get this legislation enacted.
>
> The IHCIA is the statutory framework for the Indian health system and covers just about every aspect of health care. It provides grants and scholarships to recruit Indians into health professions serving native communities and funds to expand the health care infrastructure. It lifted the prohibition against Medicare and Medicaid reimbursement for health services provide by the IHS or the Indian tribes, and established health services for Indians in urban areas.

The bill is comprehensive. Indian health leaders involved in its development worked to identify all areas of health care service provision and financing that were barriers and/or unmet needs in their communities. The 2005 bill has eight titles. The first title provides extensive support for a full array of health care workforce development, retention, and funding. The second title defines health services. Some sections identify certain areas [California, North and South Dakota, Trenton, and Arizona] as contract health service delivery areas. It includes sections on diabetes prevention, treatment and

control; epidemiology centers; patient travel costs; Indian women's health care; environmental and nuclear health hazards, and licensing. The third title on facilities provides much needed revamping of policy to allow more flexibility in facility construction that will aid Washington's smaller tribes with small IHS user counts.

The fourth title deals with access to health services, billing and financing details, content related to Medicaid, Medicare, State Children's Health Insurance Program [SCHIP], and how Indians and Indian health services are to be treated under Medicaid managed care. The fifth title concerns services, facilities, grants and regulations for health services for Urban Indians. The sixth title deals with organizational improvements, establishing IHS as an agency of the Public Health Service rather than a program and establishing an automated management information system for the service, for both financial management and patient records.

The seventh title deals with behavioral health programs. It encourages more comprehensive prevention and treatment, the combining of substance abuse and mental health services, specific licensing requirements, unique programs for Indian women, Indian youth, fetal alcohol disorder funding, child sexual abuse and prevention treatment programs, and inpatient and community-based mental health facilities design, construction and staffing.

The Congressional Record reflects some contradiction with reference to the bill's eighth title. The listing of sections before the bill's content [S5329- S5330] identifies title eight as a miscellaneous section of the bill that includes many items. Some sections [S5361-S5364] are: eligibility of California Indians; health services for ineligible people; provision of services in Montana; and most important to some, the establishment of a National Bipartisan Commission on Indian Health Care [Sec.814] that will study and recommend the best means of providing Indian health care. The body of the bill in the Congressional Record [S 5364 – S5365] also identifies the eighth title as the creation of

a Native American Health and Wellness Foundation. All but title six, federal organizational improvements, includes a section authorizing appropriations.

Senator Dorgan, the ranking Minority Leader on the Senate Committee on Indian Affairs, concludes the May 17,2005 introduction of the bill. He reminds his colleagues that

> Getting the [IHCIA] reauthorized this year is the Indian Affairs Committee's top priority. This legislation was last reauthorized in 1992. Since 1999, the director of the Indian Health Service and his staff have worked with a national steering committee of tribal leaders and representatives of Indian health organizations…on reauthorization of and amendments to the IHCIA…[33]

Both Senator McCain and Senator Dorgan reference work that has occurred since 1999, with Senator McCain referencing the failed reauthorization attempts in the last, 108th Congress.

NCAI Briefing

The Winter 2005 NCAI briefing, I was privileged to attend, provided important information and background to the official recordings and statements concerning reauthorization attempts. Tribal leaders had been involved in writing the current IHCIA legislation. This NCAI briefing was occurring after the failed reauthorization attempts in the "last hours" of the 108th Congress in the hopes that NCAI could mobilize its forces at the beginning of the new 109th Congress to achieve reauthorization.

Buford Roland, a member of the National Indian Health Board provided the briefing at NCAI. There was almost a hushed tone to the event. Much of the briefing reviewed events to date. Mr. Roland recapped that tribal leaders had high hopes they could accomplish reauthorization during the lame duck session at the end of the 108th Congress. Many tribal leaders, members of area health boards, staff and advocates came to Washington D.C. the last week of November 2004 to visit their congressional representatives and urge bill passage. The Senate Co. on Indian Affairs reported the bill

[S. 556] out of committee on November 16, 2004 and it was placed on the Senate's Legislative Calendar. The House Resources Co. reported out their comparable bill [H.R. 2440] on November 19, 2004 and it was referred to the Energy and Commerce Co. until Monday November 22, 2004. But neither house of Congress moved the reauthorization forward as a stand-alone bill.

Congress was focused on passing an omnibus appropriations bill. So tribal leaders thought the reauthorization might get passed if it was attached to the larger bill. Senator Ben Nighthorse Campbell, Chair of the Senate Co. on Indian Affairs, and Senator Ted Stevens, Chair of the Senate Appropriations Co. worked to achieve this idea.[34] At the last minute, unidentified people from the President's administration brought up issue after issue with which they weren't satisfied. Tribal leaders, Senators, and their staffs worked with the White House to resolve issues. The President's staff stopped the reauthorization.

At the NCAI briefing, Mr. Roland spent a long time sharing the story almost as if it was a rendition of a spy thriller. Some unnamed people had identified some as yet unspecified six or seven, seven or eight items that the Administration thought needed work before the Administration could support the reauthorization. These last minute objections came after there had been previous agreement by the Administration to reauthorization.

At the time of the briefing, repeated attempts by members of the NIHB, NCAI, and key staff had been unsuccessful in their attempts to receive a list of the specific "sticking points" for the administration. Briefing participants repeatedly asked for examples or an idea of what those items were. Mr. Roland repeatedly said he wasn't sure, didn't want to 'jinx' it, and wasn't at liberty to share details. He reported he was expecting a phone call to hopefully pursue details. He mentioned several other people who were working communication channels, and stated he hoped it would soon be

possible to share information more broadly. He mentioned an upcoming April NIHB meeting, and shared that the Health Board hoped to have the information before that time and planned to set up a meeting of the National Steering Committee for the Reauthorization of the IHCIA in conjunction with the Health Board meeting. The NIHB website does indicate the national steering co. meeting took place April 28th in Albuquerque. In less than a month the 2005 version of the reauthorization was entered into the Congressional Record.

Personal Observations

I was impressed with the dedication of tribal leaders I met at the NCAI meeting, and specifically at the IHCIA Reauthorization Briefing. I came away from both the briefing and the larger meeting with a deepened appreciation for the work of NCAI, its membership and a "front seat" view of the "dance of legislation" applied to the IHCIA. I better understand the necessity of having a national presence in D.C. to provide expert legislative lobbying and leadership. I developed a sense of the level of expertise required and individual commitment of the tribal representatives. It was repeatedly evident that tribal leaders put in long hard work for years to realize improved health conditions for the people. It was inspiring to witness this dedication. Participating in the NCAI meeting placed the small role I play in my job in an important and much broader context. I also found encouragement to continue on for the long haul, in my education, employment and work for our people.

To date, a bill titled the "Indian Health Care Improvement Act Amendments of 2005" was formally reported out of the Senate Committee on Indian Affairs and officially registered in the *Congressional Record* on May 17, 2005. It awaits further discussion and action. No comparable bill has yet been formally offered to the House of Representatives for consideration. To date, the IHCIA is not yet reauthorized. The long told story goes on and on and on…

[1]The term "Indian" as used in this paper will be assumed to include Alaska Natives.

[2] IHS website: **http://www.IHS.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp**

[3] Generally boilerplate treaties with similar content all signed over an approximate ten month period beginning with the first treaty council signing in December 26, 1854 of what is known today as the "Medicine Creek Treaty".

[4] Senate Committee on Indian Affairs report on the reauthorization of the IHCIA, Calendar No. 802, 108th Congress, 2nd session, 108-411, November 16, 2004.

[5] The American Indian Policy Review Commission was created by an act of Congress on January 2, 1975, and charged with reviewing federal policy toward Indians and making recommendations "by Indians for Indians" to Congress.

http://college.hmco.com/history/readerscomp/naind/html/na_001700_americanind3.htm

[6] Ibid.

[7] DHEW was the predecessor of the present day Department of Health and Human Services [DHHS].

[8] Ibid., Senate Co.on Indian Affairs Report, Nov. 16, 2004

[9] IHS website, Ibid.

[10] Ibid.

[11] Ibid., Senate Co. on Indian Affairs Report, 11/16/04 and **www.healthypeople.gov**. (last reviewed July 15, 2004)

[12] Congressional Record, May 17, 2005, S5329.

[13] Ibid., S5330.

[14] Ibid.

[15] *"Healthcare for American Indians Questions and Answers"* link on the California Rural Indian Health Board's "Action for Indian Health Campaign, **http://www.crihb.org/campaign.htm**

[16] *"Fact Sheet: The Appalling Health Status of American Indians"* link at **http://www.crihb.org/campaign.htm**

[17] Ibid.

[18] *"Healthcare…Q and A",* Ibid.

[19] "Testimony of Henry Cagey Chairman, The Lummi Indian Nation Before the Resources Committee of the U.S. House of Representatives, March 17, 1998."

[20] Cagey, Ibid., p. 2.

[21] **http://resourcescommittee.house.gov/archives/108/testimony/lylemarshall.htm**

[22] **http://www.skagitvalleyherald.com/articles/2005/04/03/news/news02.txt**

[23] Published ahead of print on April 15, 2005, as 10.2105/AJPH.2004.053769.

[24] *Am J Public Health.* 2005:95:766-768. Doi:10.2105/AJPH. 2004.061317.

[25] *Skagit Valley Herald*, Ibid., p. 2.

[26] Comments made during a recent Washington State DSHS Department-level Tribal Billing Instructions Workgroup.

[27] **http://news.bellinghamherald.com/stories/20050426/LocalState/242025.shtml**

[28] Washington State Tribal Medicaid Administrative Match [MAM] Cost Allocation Plan [CAP], Draft Three, August 18, 2005, p. 7.

[29] U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index, Series Catalog I.D. CUUR0000SEMA, "Prescription Drugs and Medial Supplies", extracted February 15, 2005.

[30] NPAIHB 2005 Legislative Report, pg. 3-4.

[31] IHS website, Ibid.

[32] Ibid.

[33] *Congressional Record*, May 17, 2005, S5365.

[34] Recap of public version on NIHB website, Ibid., under Congressional Information link.