From the Desk of
MELANNE VERVEER

file under
NDtaste
Indians -
ref for HRC's
Speech

From the Desk of
MELANNE VERVEER

The bottom line!
only way to really
fund Indian
health adequately
is thru health
care reform.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

April 28, 1994

NOTE TO: Melanne Verveer
The White House

As discussed last evening, attached are two pieces that may be helpful:

One is a briefing note on issues of concern to tribal leaders that have come out in our regional meetings. As noted, the budget issues have been partially addressed by restoring $125 million for health services and sanitation facilities. Issues on FTEs remain. Many of the tribes have become more active in preparing for health care reform. There is general support for the Health Security Act, although there are specific technical concerns which we are working through with the Indian Health Service and tribal leaders.

Major concern is that budget cuts and FTE reductions for FY95 are contradictory to preparing the IHS and tribal programs to deliver the benefits package under the Health Security Act. In fact, the Veterans Administration will receive $3.3 billion over 3 years to prepare for reform, while the IHS is guaranteed only $40 million in 1995 under a pay go provision and $200 million/year over the next four years, but only if appropriated.

As you know, there will be a final summit meeting in Washington, May 24-25. The First Lady and Secretary Shalala have been invited to join the tribal leaders during that time to hear their concerns first hand and to receive their recommendations on how the HSA can be modified to meet the needs of Indian country.

There is great respect for and continued hope that this Administration will finally mobilize the resources needed to address the health and broad concerns of Indian people.

It would be important if the First Lady could attend the summit because in a sense it is the summing up of an effort that she started with me and Congressman Pat Williams over a year ago in Montana when she suggested that these series of regional meetings be held to establish a dialogue with Indian people.

I hope this is helpful.

Thank you.

Philip R. Lee, M.D.
Assistant Secretary for Health

POSSIBLE ISSUES
for
Tribal Leaders Meeting

- Tribal leaders expect an "equal partner" role in the Federal decisionmaking process. Tribes base their relationship with the Federal Government on a sovereign nation to sovereign nation model.

- There is a perception that the U.S. Government is not committing adequate resources to meet the Government's obligations to Indians as outlined in treaties, legislation, and court decisions. Health care is an area of great concern to the Tribes.

- Assistant Secretary for Health, Philip R. Lee, M.D. and his principal deputy, Jo Ivey Boufford, M.D., are reaching out to Indian Country by conducting 3 regional and 1 national forum(s) with Tribal leaders. The three regional meetings were held in Albuquerque, New Mexico; Portland, Oregon; and Billings, Montana. The national meeting will be held in Washington, D.C. and is scheduled for May 24-26.

- Tribal leaders expect to actively participate in any planning to streamline or restructure the IHS. Furthermore, the Tribes expect any savings that may result to be redirected for services and transferred to tribally operated programs.

Health Related Activities -- Indian Health Service

Budget and FTEs

- The FY 1995 Budget submitted in February proposes a $247 million net reduction in budget authority (BA) composed of a + $29 million for health services; - $172 million in new construction; and $104 million shift in revenue sources from BA to insurance collections. Given the President's current goal to reduce overall federal staffing, HHS believes this would result in a reduction of 1,114 FTEs at IHS by 1995. Tribal leaders view these proposals as a significant threat to health services.

- Many members of Congress (Senators Domenici, Reid, Inouye, Stevens, McCain and Hatfield; and Representative Yates) have expressed serious concerns with the FY 1995 budget and the possible negative impacts if enacted as proposed. These concerns include:

    -- estimated growth in insurance collections (a 400% increase in private insurance in one year) will not materialize causing either a drop in services or force Congress to increase the appropriation.

-- no new staff to fully utilize new larger facilities that are opening in FY 1994 and FY 1995. The new facilities Belcourt, ND; Crow, MT; Tohatchi, NM; Stilwell, OK; Shiprock, NM; and Kotzebue, AK

-- basic deficiencies in the Indian communities (e.g., the number of homes without adequate sanitation due to the elimination of new construction funding in FY 1995).

-- self-determination and self-governance are tribally driven and tribal programs retain federal employees; the time frame of the proposed FTE reductions is faster than interested Tribes believe they can manage the transition.

o Secretary Shalala has asked OMB Director Panetta to reconsider staffing reductions and instead hold IHS staffing constant through FY 95 at the FY 93 level of 15,441, to allow time to negotiate a longer term strategy with Tribes. (Director Panetta has not yet acted on this.)

o On April 22, the President submitted to Congress a FY 1995 budget amendment to provide **an additional $125 million** for the Indian Health Service. As a result of this amendment, total funding for IHS is now $1.8 billion. This amendment would guarantee that IHS continues to be funded at the FY 1994 level for critical health service activities and restore sanitation construction projects. It also lowers previously unrealistically high revenue targets from third party payers (Medicare, Medicaid and private insurance) and any funds earned over the target can be used to finance programs locally.

Self Governance

o Some tribal leaders believe that reducing FTEs is part of a strategy to force them into self-determination contracting or self-governance compacting. Tribes have always believed that any transfer of health services would take place at roughly the same level of resources -- not at a reduced level, if and when a Tribe decides to assume new responsibilities.

o A proposed rule which describes the guidelines for self-determination contracting (638 provisions) was published on January 20. This rule continues to ensure the integrity of IHS administered and delivered programs while assisting interested Tribes transition into managing their own health services. HHS and the Department of Interior have already held regional meetings to maximize Indian participation during the comment period. A national meeting is planned

for May 2-4 in Albuquerque, New Mexico. The comment period ends May 12.

- Senator Inouye, at the urging of the Tribes, has introduced a bill which will legislate such controversial issues as what services and staff support are contractible. The Administration has not yet taken a position on this bill.

- Senator McCain has introduced a bill, "The Indian Self Determination Contract Reform Act of 1994" which would prohibit HHS and DOI from promulgating self determination contracting rules. Essentially, this legislation would require the two Departments to enter into contracts with Indians at their request for whatever services they are willing to provide. The Administration has not yet taken a position on this bill.

- The Self-Governance Demonstration Project permits Tribes to use federal funds to redesign and administer local health services programs. Legislation has been introduced to make Self-Governance a permanent program for the Department of the Interior and we expect similar action for IHS programs.

- Tribes not participating in self-contracting or compacting arrangements expect IHS to ensure that resources are not reduced for IHS administered and/or delivered services.

Health Care Reform

- Although tribal leaders generally endorse the President's Health Security Act (HSA), they have expressed the following concerns:

  -- Budget and FTE cuts now proposed will result in Indian health programs being less able than they currently are to deliver the HSAs universal benefits package.

  -- Funding may not be available to IHS and the Tribes at the time states will be implementing the benefits package, thereby disadvantaging Indian health programs.

  -- The role of states in regulating alliances and plans, and in mental health and long term care planning, is seen as threatening the government to government relationship that Tribes enjoy with the federal Government.

Other Departmental Activities -- Administration for Children and Families (ACF)

- The Administration for Native Americans (ANA), part of ACF, issued a program announcement on March 25 requesting competitive applications to ensure the survival and continuing vitality of Native American languages.

Approximately, $1 million will be awarded under this grant program in FY 1994.

- Secretary Shalala has approved the establishment of the Intra-Departmental Council on Native American Affairs in ACF. The Council will be a visible focal point for Indian concerns within the Department.

- The Administration for Native Americans and the Council are represented on a recently established Welfare Reform Work Group addressing tribal concerns. The goal of this group is to examine tribal welfare programs to identify ways for improving services. Many Indian Tribes are concerned by reports of a proposed gambling tax to finance part of the Welfare Reform package.

- Efforts to improve Head Start have been bolstered by increased appropriations for the program, including a $14.6 million increase for Indian Head Start programs in FY 1994, the largest dollar increase ever for Indian Head Start.

SECRETARY DONNA E. SHALALA
BEFORE
THE HOUSE INTERIOR APPROPRIATIONS SUBCOMMITTEE
APRIL 26, 1994

Good morning Mr. Chairman, thank you for inviting me to testify before your Subcommittee on the President's FY 1995 Budget and its impact on the health of Native Americans and Alaska Natives. As I have said before, the President's FY 1995 Budget is one of the toughest in memory. We were forced to make some very difficult decisions in order to meet the deficit reduction goals set in last year's economic plan. The overall hard freeze on spending limited discretionary growth in this Department to just 3%. Operating under those budgetary constraints, we were determined to meet the challenges of continuing the President's investments begun last year and making a contribution to necessary deficit reduction. These well-placed investments will lead to future service improvements, cost savings, and, ultimately, to citizens who are more independent. However, real budget and deficit control over the long term will come only through changes in our entitlement programs -- primarily health care reform.

Health and Human Services (HHS) is the Department most concerned with people, and most involved in human concerns -- from mailing out Social Security checks, to operating the most successful biomedical research enterprise in the world, to providing the most vulnerable members of our society with basic financial assistance, health care, and supportive services needed to achieve a better life. Through our efforts, we touch the lives of virtually every American, from infancy through retirement.

Our budget for FY 1995 provides sizable expansions for critical HHS investments with proven rates of success. We have worked hard to sustain commitments and accomplishments that emerged from the budget constraints we faced last year. Areas where we are continuing to invest are Head Start, Childhood Immunizations, Child Care for low income families, the National Institutes of Health (NIH), AIDS, Substance Abuse Treatment and Prevention, and improvements to the Social Security disability claims processing. Within this buildup, I would note specific and direct benefits for Indian People -- Head Start will provide $108 million directly to Indian programs, a 21% increase in one year; the Child Care Block Grant reserves for Indian Tribes will increase by 22%; and within the NIH there are over 60 research programs aimed specifically at advancing our understanding of health and illness unique to American Indians and Alaska Natives.

Beyond these investments which will have a direct and immediate benefit for Indian People, HHS recognizes its special relationship and obligation to the Indian tribes. Springing from the United States Constitution, that responsibility has been the foundation for the Indian Health Service and grounds our work to improve and then maintain the well being of Indian People. This obligation is one I take very seriously and is a moral responsibility that my colleagues and I are committed to fulfilling.

But I want to emphasize that our investment increases did not come without a price. We made difficult choices by looking critically at our base and finding a reasonable path for those programs. This meant determining ways to reduce costs and eliminate duplication. We put forth program consolidations, we froze the funding in many programs, and seven major programs are cut by over $1 billion, including a $754 million decrease in the Low Income Home Energy Assistance Program. I realize that a budget which sets priorities and finances those with a reduction in other programs will be painful to adopt.

I am not here to say that our discretionary budget will result in significant improvements in the health of Native Americans. As you, Mr. Chairman, and I have discussed, the twin constraints of discretionary budget caps and statutory FTE ceilings will make it more difficult to achieve this most important goal. The answer here, in the long term, is health care reform. The President's Health Security Act offers Indian People new benefits -- a guarantee of universal coverage and comprehensive services. While I am only one year into my tenure as Secretary of HHS, I want to give my full assurance that I too am absolutely committed to continued improvements in the health of Native Americans.

We have seen substantial improvements, over the last 25 years, in the health of Indian People. For example, a 40% reduction in their age-adjusted mortality rate, a 50% reduction in the number of years of productive life lost, a 50% decrease in the infant mortality rate, and a 74% decrease in tuberculosis mortality. However, there is still much catching up to do. Overall mortality rates for Native Americans are still 11% higher than for all Americans, years of productive life lost are 37% higher, and the mortality rate from accidents is 2.7 times higher. In terms of per capita spending, IHS spends about $1,500 annually which is one-half of what is spent on all other Americans. While this gap is large, it is important to note that a quarter of IHS users have private health insurance and obtain part of their health care services elsewhere. You,

Mr. Chairman, have played a major part in the improvements, but we both know there are serious unmet needs that must be addressed.

Turning now to the budget of the Indian Health Service, I am pleased that we were able to provide recently an amendment to the President's Budget which includes an additional $125 million above what was proposed back in February. As a result of this amendment, total funding for the IHS is $1.8 billion. This amendment guarantees that we will be level-funding the critical health services activities of the IHS. We heard the concerns expressed, and we acted. But not without cutbacks in salaries and expenses, as well as in programs. For example our offsets include, $39 million in primary care services and training of the Health Resources and Services Administration, $29 million in activities of the Centers for Disease Control and Prevention, $23 million from prevention and demonstrations in the Substance Abuse and Mental Health Services Administration, and $11 million from the Health Care Financing Administration which manages the Medicare and Medicaid programs.

In the Indian Facilities program, in recognition of IHS' important disease prevention mission in Indian Country, our recent budget amendment restores $42.5 million for construction of sanitation facilities. At this level of funding, IHS will be able to assure that resources are available to provide access to waste disposal and safe drinking water to new homes being built and to those being rehabilitated -- approximately 3,200. Throughout the Federal Budget, the tight discretionary spending cap has resulted in a "pause" of new construction projects in FY 1995. We see this same situation occurring for medical facilities construction in the Department of Veterans Affairs, school construction in the Bureau of Indian Affairs and some HUD housing programs. As budget plans for the coming years are developed, we must work together to ensure that the health facility needs of Native Americans continue to be met.

A special initiative throughout the Government is to increase treatment services to hard core substance abusers. We have included, in the IHS budget request, an increase of $10.4 million for treatment capacity expansion as well as increasing certification rates for substance abuse counselors. The IHS will be addressing both substance and alcohol abuse, a leading cause of death among Native Americans.

I know of the concerns expressed about the feasibility of attaining significant increases in insurance reimbursements that were assumed in our initial budget. With this budget amendment, we have reduced our private insurance collections

target to $28 million for FY 1995, with expected growth in future years. Any increases in reimbursements received -- Medicaid, Medicare, and private -- will increase the total resources available for the hospitals and clinics. As you and the Committee are fully aware, IHS has made significant progress in recent years to enhance collection of both public and private insurance. Indeed, its record is impressive -- 50% increases in public insurance collections between FY 1991 and FY 1993 and a 106% increase in private insurance collections over the same period. We also know that 25% of Native Americans living in IHS service areas have private health insurance which is a large part of the eligible population. However, our present collection of private insurance only represents 1% of health services revenues. It makes sense that health insurance collections should be used to pay for the care of those Native Americans who are insured. This use of insurance is fundamental to the way in which Native American health care will be funded under the Health Security Act.

On the subject of IHS staffing, I want to assure you I am continuing to work with Director Panetta to try to develop adequate and sensible staffing plans for the IHS. I agree that we should be providing staff to more fully utilize the new facilities that have opened this year and those that will be ready to open next year. However, I also understand that, at the same time, the Federal Work Force Restructuring Act of 1994 mandates reductions to the Federal work force of 272,900 Full Time Equivalents (FTE) by 1999. These are real reductions, and they have real implications. They require us to seek out novel ways to meet staffing needs in critical health care areas, as well as to reduce administrative layers, consolidate operations across government, and seek outside support where it is reasonable to do so. In addition, our IHS amendment provides an increase of $7.5 million to fully fund the Indian Self Determination Fund so that there are resources available to Tribes who seek to begin or expand their management of health service programs.

I would like to reiterate the importance of health care reform and the benefits which Indian people can expect under the President's plan. Unlike <u>any</u> of the other main health care plans before the Congress, the President's Health Security Act reaffirms the unique Federal role and responsibility for health care to Indian people by specifically addressing their health care needs, and by explicitly retaining other Federal statutes related to the provision of health care to Indians. The President's health care plan was also written, and will be implemented, with the extensive involvement of American Indians and Alaska Natives. Leaders of the Indian Health Service have discussed health care reform at every consultation they have had with tribes since last summer. My

Assistant Secretary for Health also hosted four health care reform consultations with Indian People. We will continue to fully discuss the implementation of Health Care Reform with Native Americans and push to ensure that their views are included and incorporated into the most fundamental piece of domestic legislation we will adopt this century.

The Health Security Act offers significant new benefits to Indian people, as it does for all Americans. Under the Act, Native American families and individuals will receive the same guaranteed universal coverage for comprehensive benefit services as other Americans, either through the IHS, Tribal/Urban programs, or through a regional health alliance. Native Americans who choose to remain in the IHS, Tribal, and Urban Indian programs will receive this care without charge. However, cost sharing provisions in the Act -- including discounts -- will apply to Native Americans who choose to enroll in an alliance health plan in the same way that they apply to other Americans. The Indian Health Service will also continue to provide various public health activities, such as public health nursing, community health representatives, and sanitation construction to eligible beneficiaries. The Health Security Act assures that Tribal control over the provision of local health services, for those Tribes who seek it, will continue to be encouraged under the Indian Self Determination and Education Assistance Act.

Mr. Chairman, another important aspect of the Health Security Act is the extension of services to urban Indians. As you well know, the population of Indians living in urban areas has consistently lacked adequate health care. While most of these Indians are eligible for services when provided in an IHS facility, they are unable to access them because of distance. A further problem is the loss of contract care coverage or eligibility once an Indian have left the reservation for 180 days. With universal coverage, this population will gain access to the health care they need. The Act extends full coverage to Indians living in urban areas in which Urban Indian programs are offered. Indians residing in a geographic area in which a health program of the IHS is not offered will enroll in an alliance plan to receive the comprehensive benefits package.

Revenues to fund the comprehensive benefit package will consist of a blend of non-tribal employer premiums paid to the IHS, cost sharing discounts equivalents for low-income non-employed Indians, premiums paid by non-Indian family members, and Federal appropriations. The Health Security Act authorizes additional appropriations of $1 billion, specifically for IHS, over the

next five years for enabling services such as transportation, outreach, and new construction. The Act also authorizes a new loan program to finance capital improvements and other infrastructure development. This will enable the Federal Government to assist Tribes and Tribal organizations in obtaining the necessary capital to expand and improve local health care facilities. There is also $40 million authorized for IHS for FY 1995 and included in the Health Care Reform section of the President's Budget as a PAYGO item. In addition, Indian programs will also be eligible for funding under Title III programs in the Health Security Act.

Mr. Chairman, we have a real challenge - how to improve the health of Native Americans and Alaska Natives in a time of severe budget and staffing constraints. I believe the President's Health Security Act is the best way to significantly expand services to Indian people. I look forward to working with you in the future to ensure that the health of Native Americans continues to improve. I would be happy to answer any questions that you might have.

Talking Points

Donna E. Shalala

U.S. Secretary of Health and Human Services

at

The Tribal Leaders Meeting

April 29, 1994

The White House

- Thank you.

- Talk about your Peace Corps training at Many Farms in Arizona. Your recent trip to North Dakota.

- Historic meeting -- first time a Secretary of HHS has met with all the tribal leaders.

- HHS recognizes special relationship and obligation to the Indian tribes.

  - o This "nation to nation relationship" must be the foundation for the Indian Health Service's work with Tribal leaders to improve and maintain the health and well-being of Indian people.

- This obligation is one I take very seriously and is a moral responsibility that my colleagues and I are committed to fulfilling.

- Tough budget year. We had to: reduce costs, eliminate duplication, consolidate programs all across the government.

- Only a few increases, but increases in programs that are important for Native Americans.

  - o Head Start will provide $108 million directly to Indian programs -- that's a 21% increase in one year.

  - o The Child Care Block Grant reserves for Indian Tribes will increase by 22%.

  - o Within NIH, there are over 60 research programs aimed specifically at advancing our understanding of health and illness unique to American Indians and Alaska Natives.

  - o [level] $17 million in Administration on Aging grants for aging Indian people.

  - o [level] $3.5 million for HIV/AIDS related services.

- Recent amendment to President's Budget includes an additional $125 million for IHS over what was proposed back in January.

  - o Total funding for IHS, now $1.8 billion.

  - o This means we're level-funding the critical health services of IHS.

- We heard your concerns and acted. That meant <u>reductions in other programs</u> across the department to fund the new amendment.

- Amendment restores $42.5 million for construction of sanitation facilities: means waste disposal and safe drinking water to more than 3,000 homes under construction.

- IHS budget request includes an increase of $10.4 million for treatment capacity expansion as well as increasing certification rates for substance abuse counselors.

- IHS amendment provides $7.5 million increase to fully fund the Indian Self Determination Fund so that there are resources available to tribes who seek to begin or expand their management of health service programs.

- Insurance reimbursements: With this amendment, we have reduced our private insurance collections target to $28 million for FY 1995, with expected growth in future years.

  - Any reimbursements above the target levels in Medicaid, Medicare, and private insurance will increase resources available to hospitals and clinics.

  - It makes sense that health insurance collections should be used to pay for the care of those native Americans who are insured. This use of insurance is fundamental to the way in which Native American health care will be funded under the Health Security Act.

- Finally, staffing: Would like to provide staff to fully utilize new facilities. We are working with Mr. Panetta to seek solutions to the overall limitations, but the reality is that FTE ceilings require us to seek out novel ways to meet staffing needs, reduce administrative layers, and consolidate our operations.

- The key to any major infusion of resources in IHS and tribal programs is health care reform.

- President's health reform plan is the only plan before Congress that reaffirms the unique Federal role and responsibility for health care to Indian people.

  - o Addresses health needs.

  - o Explicitly retains other Federal statutes that provide health care to Indians.

- President's plan was written, and will be implemented, with extensive involvement of American Indians and Alaska natives.

  - o IHS leaders have discussed health care reforms at every consultation they have had with tribes since last summer.

  - o Assistant Secretary Phil Lee also hosted four health care reform consultations with Indian leaders throughout the country.

- Health Security Act

  - o Native Americans will receive health care that can never be taken away.

- o Same comprehensive benefits package guaranteed to all Americans.

- o Individual choice:

1. Remain in IHS, Tribal, or Urban Indian programs -- no charge.

2. Enroll in alliance -- cost sharing.

- IHS will continue to provide public health nursing, community health representatives, and sanitation construction to eligible beneficiaries.

- HSA assures Tribal control over the provision of local health services, for those who seek it. Will continue to be encouraged under the Indian Self Determination and Education Assistance Act.

- HSA authorizes additional $1 billion for IHS over the next five years for transportation, outreach, and new construction.

  - o Also authorizes new loan program for capital improvements and infrastructure.

- o $40 million is authorized for IHS for FY 1995 and included in the Health Care Reform section of the President's budget with a guaranteed funding stream.

- o Indian programs will be eligible for funding under all the Public Health Service programs in the Health Security Act.

- Our challenge is:

  - o To work with you to provide services in a way that meets each tribe's needs,

  - o to improve the IHS,

  - o and to provide health security through reform.

- We understand the enormous diversity of our American Indian population -- and we are committed to working with all of you to promote health security and opportunity for all individuals and all tribes.

- Thank you.

SECRETARY DONNA E. SHALALA
BEFORE
THE HOUSE INTERIOR APPROPRIATIONS SUBCOMMITTEE
APRIL 26, 1994

Good morning Mr. Chairman, thank you for inviting me to testify before your Subcommittee on the President's FY 1995 Budget and its impact on the health of Native Americans and Alaska Natives. As I have said before, the President's FY 1995 Budget is one of the toughest in memory. We were forced to make some very difficult decisions in order to meet the deficit reduction goals set in last year's economic plan. The overall hard freeze on spending limited discretionary growth in this Department to just 3%. Operating under those budgetary constraints, we were determined to meet the challenges of continuing the President's investments begun last year and making a contribution to necessary deficit reduction. These well-placed investments will lead to future service improvements, cost savings, and, ultimately, to citizens who are more independent. However, real budget and deficit control over the long term will come only through changes in our entitlement programs -- primarily health care reform.

Health and Human Services (HHS) is the Department most concerned with people, and most involved in human concerns -- from mailing out Social Security checks, to operating the most successful biomedical research enterprise in the world, to providing the most vulnerable members of our society with basic financial assistance, health care, and supportive services needed to achieve a better life. Through our efforts, we touch the lives of virtually every American, from infancy through retirement.

Our budget for FY 1995 provides sizable expansions for critical HHS investments with proven rates of success. We have worked hard to sustain commitments and accomplishments that emerged from the budget constraints we faced last year. Areas where we are continuing to invest are Head Start, Childhood Immunizations, Child Care for low income families, the National Institutes of Health (NIH), AIDS, Substance Abuse Treatment and Prevention, and improvements to the Social Security disability claims processing. Within this buildup, I would note specific and direct benefits for Indian People -- Head Start will provide $108 million directly to Indian programs, a 21% increase in one year; the Child Care Block Grant reserves for Indian Tribes will increase by 22%; and within the NIH there are over 60 research programs aimed specifically at advancing our understanding of health and illness unique to American Indians and Alaska Natives.

Beyond these investments which will have a direct and immediate benefit for Indian People, HHS recognizes its special relationship and obligation to the Indian tribes. Springing from the United States Constitution, that responsibility has been the foundation for the Indian Health Service and grounds our work to improve and then maintain the well being of Indian People. This obligation is one I take very seriously and is a moral responsibility that my colleagues and I are committed to fulfilling.

But I want to emphasize that our investment increases did not come without a price. We made difficult choices by looking critically at our base and finding a reasonable path for those programs. This meant determining ways to reduce costs and eliminate duplication. We put forth program consolidations, we froze the funding in many programs, and seven major programs are cut by over $1 billion, including a $754 million decrease in the Low Income Home Energy Assistance Program. I realize that a budget which sets priorities and finances those with a reduction in other programs will be painful to adopt.

I am not here to say that our discretionary budget will result in significant improvements in the health of Native Americans. As you, Mr. Chairman, and I have discussed, the twin constraints of discretionary budget caps and statutory FTE ceilings will make it more difficult to achieve this most important goal. The answer here, in the long term, is health care reform. The President's Health Security Act offers Indian People new benefits -- a guarantee of universal coverage and comprehensive services. While I am only one year into my tenure as Secretary of HHS, I want to give my full assurance that I too am absolutely committed to continued improvements in the health of Native Americans.

We have seen substantial improvements, over the last 25 years, in the health of Indian People. For example, a 40% reduction in their age-adjusted mortality rate, a 50% reduction in the number of years of productive life lost, a 50% decrease in the infant mortality rate, and a 74% decrease in tuberculosis mortality. However, there is still much catching up to do. Overall mortality rates for Native Americans are still 11% higher than for all Americans, years of productive life lost are 37% higher, and the mortality rate from accidents is 2.7 times higher. In terms of per capita spending, IHS spends about $1,500 annually which is one-half of what is spent on all other Americans. While this gap is large, it is important to note that a quarter of IHS users have private health insurance and obtain part of their health care services elsewhere. You,

Mr. Chairman, have played a major part in the improvements, but we both know there are serious unmet needs that must be addressed.

Turning now to the budget of the Indian Health Service, I am pleased that we were able to provide recently an amendment to the President's Budget which includes an additional $125 million above what was proposed back in February. As a result of this amendment, total funding for the IHS is $1.8 billion. This amendment guarantees that we will be level-funding the critical health services activities of the IHS. We heard the concerns expressed, and we acted. But not without cutbacks in salaries and expenses, as well as in programs. For example our offsets include, $39 million in primary care services and training of the Health Resources and Services Administration, $29 million in activities of the Centers for Disease Control and Prevention, $23 million from prevention and demonstrations in the Substance Abuse and Mental Health Services Administration, and $11 million from the Health Care Financing Administration which manages the Medicare and Medicaid programs.

In the Indian Facilities program, in recognition of IHS' important disease prevention mission in Indian Country, our recent budget amendment restores $42.5 million for construction of sanitation facilities. At this level of funding, IHS will be able to assure that resources are available to provide access to waste disposal and safe drinking water to new homes being built and to those being rehabilitated -- approximately 3,200. Throughout the Federal Budget, the tight discretionary spending cap has resulted in a "pause" of new construction projects in FY 1995. We see this same situation occurring for medical facilities construction in the Department of Veterans Affairs, school construction in the Bureau of Indian Affairs and some HUD housing programs. As budget plans for the coming years are developed, we must work together to ensure that the health facility needs of Native Americans continue to be met.

A special initiative throughout the Government is to increase treatment services to hard core substance abusers. We have included, in the IHS budget request, an increase of $10.4 million for treatment capacity expansion as well as increasing certification rates for substance abuse counselors. The IHS will be addressing both substance and alcohol abuse, a leading cause of death among Native Americans.

I know of the concerns expressed about the feasibility of attaining significant increases in insurance reimbursements that were assumed in our initial budget. With this budget amendment, we have reduced our private insurance collections

target to $28 million for FY 1995, with expected growth in future years. Any increases in reimbursements received -- Medicaid, Medicare, and private -- will increase the total resources available for the hospitals and clinics. As you and the Committee are fully aware, IHS has made significant progress in recent years to enhance collection of both public and private insurance. Indeed, its record is impressive -- 50% increases in public insurance collections between FY 1991 and FY 1993 and a 106% increase in private insurance collections over the same period. We also know that 25% of Native Americans living in IHS service areas have private health insurance which is a large part of the eligible population. However, our present collection of private insurance only represents 1% of health services revenues. It makes sense that health insurance collections should be used to pay for the care of those Native Americans who are insured. This use of insurance is fundamental to the way in which Native American health care will be funded under the Health Security Act.

On the subject of IHS staffing, I want to assure you I am continuing to work with Director Panetta to try to develop adequate and sensible staffing plans for the IHS. I agree that we should be providing staff to more fully utilize the new facilities that have opened this year and those that will be ready to open next year. However, I also understand that, at the same time, the Federal Work Force Restructuring Act of 1994 mandates reductions to the Federal work force of 272,900 Full Time Equivalents (FTE) by 1999. These are real reductions, and they have real implications. They require us to seek out novel ways to meet staffing needs in critical health care areas, as well as to reduce administrative layers, consolidate operations across government, and seek outside support where it is reasonable to do so. In addition, our IHS amendment provides an increase of $7.5 million to fully fund the Indian Self Determination Fund so that there are resources available to Tribes who seek to begin or expand their management of health service programs.

I would like to reiterate the importance of health care reform and the benefits which Indian people can expect under the President's plan. Unlike <u>any</u> of the other main health care plans before the Congress, the President's Health Security Act reaffirms the unique Federal role and responsibility for health care to Indian people by specifically addressing their health care needs, and by explicitly retaining other Federal statutes related to the provision of health care to Indians. The President's health care plan was also written, and will be implemented, with the extensive involvement of American Indians and Alaska Natives. Leaders of the Indian Health Service have discussed health care reform at every consultation they have had with tribes since last summer. My

Assistant Secretary for Health also hosted four health care reform consultations with Indian People. We will continue to fully discuss the implementation of Health Care Reform with Native Americans and push to ensure that their views are included and incorporated into the most fundamental piece of domestic legislation we will adopt this century.

The Health Security Act offers significant new benefits to Indian people, as it does for all Americans. Under the Act, Native American families and individuals will receive the same guaranteed universal coverage for comprehensive benefit services as other Americans, either through the IHS, Tribal/Urban programs, or through a regional health alliance. Native Americans who choose to remain in the IHS, Tribal, and Urban Indian programs will receive this care without charge. However, cost sharing provisions in the Act -- including discounts -- will apply to Native Americans who choose to enroll in an alliance health plan in the same way that they apply to other Americans. The Indian Health Service will also continue to provide various public health activities, such as public health nursing, community health representatives, and sanitation construction to eligible beneficiaries. The Health Security Act assures that Tribal control over the provision of local health services, for those Tribes who seek it, will continue to be encouraged under the Indian Self Determination and Education Assistance Act.

Mr. Chairman, another important aspect of the Health Security Act is the extension of services to urban Indians. As you well know, the population of Indians living in urban areas has consistently lacked adequate health care. While most of these Indians are eligible for services when provided in an IHS facility, they are unable to access them because of distance. A further problem is the loss of contract care coverage or eligibility once an Indian have left the reservation for 180 days. With universal coverage, this population will gain access to the health care they need. The Act extends full coverage to Indians living in urban areas in which Urban Indian programs are offered. Indians residing in a geographic area in which a health program of the IHS is not offered will enroll in an alliance plan to receive the comprehensive benefits package.

Revenues to fund the comprehensive benefit package will consist of a blend of non-tribal employer premiums paid to the IHS, cost sharing discounts equivalents for low-income non-employed Indians, premiums paid by non-Indian family members, and Federal appropriations. The Health Security Act authorizes additional appropriations of $1 billion, specifically for IHS, over the

next five years for enabling services such as transportation, outreach, and new construction. The Act also authorizes a new loan program to finance capital improvements and other infrastructure development. This will enable the Federal Government to assist Tribes and Tribal organizations in obtaining the necessary capital to expand and improve local health care facilities. There is also $40 million authorized for IHS for FY 1995 and included in the Health Care Reform section of the President's Budget as a PAYGO item. In addition, Indian programs will also be eligible for funding under Title III programs in the Health Security Act.

Mr. Chairman, we have a real challenge - how to improve the health of Native Americans and Alaska Natives in a time of severe budget and staffing constraints. I believe the President's Health Security Act is the best way to significantly expand services to Indian people. I look forward to working with you in the future to ensure that the health of Native Americans continues to improve. I would be happy to answer any questions that you might have.