The original documents are located in Box 2, folder "Health Care Legislation - S. 522 (1)" of the Bradley H. Patterson Files at the Gerald R. Ford Presidential Library.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET

DATE: 4/9/74

TO: Mr. Patterson

FROM: Jim Stimpson (X 3736)

Per your request, I am sending a copy of the HEW testimony on S. 2938 as revised and approved by our program divisions.

Leaving until (Wed afternoon) several questions.

OMB FORM 38
REV AUG 73

Mr. Chairman, I am pleased to have this opportunity to appear before you today to discuss S. 2938, the Indian Health Care Improvement Act. This bill provides specific authorizations for Indian Health manpower, Health Services, Health Facilities construction and renovation, Access to Health Services for reservation Indians, Access to Health Services for Urban Indians and a requirement for the Secretary to report to the President and the Congress on progress made in effecting the purposes of the Act.

This Administration is committed to a program of Indian ~~Self-~~Determination, to expanded efforts to train Indians for health careers, and to a strengthened Federal effort to advance the health of these first Americans. These commitments were related to the Congress in the President's Special Indian Message of July 8, 1970.

This Department has ~~the central~~ an important part of the responsibility ~~of~~ for translating this policy into programs particularly in the area of health. We are seeking to advance the health status of these Americans in a variety of ways.

Health Care Options

First, Indian people and Alaska Natives, as American citizens, may participate in the health programs administered by the Department on the same basis as any other citizen. We are attempting to assure that they are aware of the broad health benefits offered through these programs, particularly the benefits under Medicaid and Medicare. These programs represent a significant health resource for the Indian people and we are attempting to ensure that the Indian population take advantage of these benefits to the extent possible.

Two months ago, the Administration sent to Congress the Comprehensive Health Insurance Act (CHIP). CHIP will make catastrophic comprehensive health insurance available to Indians and Alaska Natives without in any way diminishing or affecting the health care now being provided Indian people through the Indian Health Service (IHS). Thus this proposal should be considered as a supplement to presently available health services.

As with any other American, the status of Indians and Alaska Natives under CHIP will be determined by the choice or circumstance of the individual. Those who are full-time employees will have the choice of enrolling under the Employee Health Insurance Plan (EHIP), or if it is economically advantageous, in the Assisted Health Insurance Plan (AHIP), which will require less in cost sharing charges. Of course, those who are 65 or older eligible to receive Medicare will have the option of enrolling in the Medicare plan which also will have reduced cost sharing charges.

We recognize that because of the geographical isolation of many Alaska Natives and Indians and the cost sharing charges under CHIP, their choice will in fact often be limited to the IHS facilities in their vicinity. However, for those within commuting distance of private facilities and practitioners, the EHIP, AHIP and Medicare plans under CHIP will provide an alternative to the IHS facilities.

Indians and Alaska Natives who elect to enroll in any of the three plans under CHIP will receive a healthcard which will be honored for services at virtually all non-Federal health facilities and by virtually all private practitioners. They will also be subject to the same cost sharing and premiums as all other enrollees under the plans.

In addition to these other health resources being available to Indians and Alaska Natives, the Indian Health Service budget to provide health care services has grown from ~~$84.9~~ #107 million in 1968 to ~~$200.0~~ 209 million in 1974. The President's budget for 1975 requests a further increase to ~~$226.0~~ #281 million.

These increases are significant because they bring real benefits in terms of people served. They will help us meet the rapidly growing demand for health services on the part of the Indian people--a demand that is growing because of their increasing confidence in modern health practices, based on positive experiences.

For example, Indian Health Service facilities expect to receive an additional 100,000 outpatient visits in 1974, and another 100,000 in 1975, over and above the 2.3 million visits experienced in 1973. ~~[Also, this expected increase of funds will enable us to cut into the huge backlog of unmet needs for surgery and other kinds of care which built up in past decades.]~~

Good health facilities are crucial to the delivery of high-quality health services to Indians. The fiscal year 1974 and 1975 Indian Health Service budgets recognize this and provide for further orderly and realistic progress in the necessarily long-range effort to replace or remodel outmoded Indian Health Service hospitals and other facilities, and to upgrade others.

The FY 1974 construction program contained funds for replacing the old and obsolete health facilities at Zuni, New Mexico; Owyhee, Nevada and Choctaw, Mississippi. A replacement hospital at Tuba City, Arizona will be completed in fiscal year 1975. Funds are also available to plan a replacement

Dunlap Camp BIA is trying to place one this school. A new health facility will keep pressure on to keeping it open.

health facility at Bethel, Alaska, and planning funds for the [new Chemawa,] Oregon School Health Center are also contained in FY 1974's construction program. The FY 1975 President's budget would provide construction funds for the replacement health facility at Claremore, Oklahoma, and to replace the school health center at Riverside, California. Funds to construct a small addition to the existing health center at Tohatchi, New Mexico and to construct 207 units of housing at Tuba City, Arizona are also contained in the FY 1975 program.

The fiscal years 1974 and 1975 budgets also will provide for meaningful inroads against the problems inherent in the rigorous environment which characterize Indian country, and which contribute to disease, suffering and premature death. Fiscal year 1974 funds of $36.2 million will enable us to provide sanitation facilities construction, including water and waste disposal systems, for an additional 8,500 new and improved homes, and approximately 3,500 existing homes during that year. An additional 8,000 new and improved homes, and an additional 4,900 existing homes will be so served through the fiscal year 1975 budget of $40.5 million. These budgets and numbers of homes served stand out in sharp contrast to the fiscal year 1968 when the budget was $10.5 million and the number of homes served was only 7,350.

In addition to the health care provided by the Indian Health Service in its own facilities and through contract health care, other Public Health Service agencies are contributing more than $11 million in 1975 for a broad range of services.

I believe the FY 1975 budget demonstrates our commitment to better Indian health care and represents real progress toward our mutual goal.

Measures of Success of Present Programs

The true measure of our Indian health efforts is found in the health status of the Indian people. The ~~Impact~~ improvement has been both profound and enduring. It can be illustrated by the dramatic reduction of Indian death rates between 1955 and 1972. The infant death rate has declined 67 percent; the tuberculosis rate is down 85 percent; the gastritis and related diseases rate has dropped 81 percent; and the rate for influenza and pneumonia is down 58 percent.

These figures represent firm evidence that the Administration's decision to place high priority on investing in health services for Indian people has been a wise one, and that the methods it has employed to deliver services have been effective.

~~Backlog of Health Services~~

As this committee is aware, we find ourselves in the situation of having a significant unmet need which has developed over past decades. We have begun to make inroads into the present backlog of unmet needs and believe that we will be making further substantial progress in reducing this backlog especially in view of our increased budgetary requests. For example, in fiscal year 1974 a supplemental budget request of $6.6 million has been made of which $3.4 million is specifically for the purpose of reducing unmet needs. The President's budget for fiscal year 1974 represents an increase of approximately $26 million dollars primarily for medical services. These added funds, if appropriated, will be used to continue the 1974 program, to help overcome unmet medical needs of children and adults

and to provide for mandatory cost increase such as staffing for the Tuba City (Arizona) hospital, currently under construction. This we believe is an orderly and realistic approach to the problem consistent with available Federal and community resources.

S. 2938 proposes to accelerate the process of eliminating the backlog of health service and health facilities needs of the Indian people. This Department is firmly committed to the principle of providing fully adequate health care to these Americans in facilities which permit the delivery of quality health services and the right of self-determination of Indians and therefore support the intent of this bill. While we endorse the principles of the bill, we are unable to recommend enactment of several provisions and ~~would recommend modifications in other sections.~~ I would now like to comment specifically on the provisions of S. 2938 by title.

Title I - Indian Health Manpower

Title I of the bill would establish a scholarship program for training qualified Indians in the fields of medicine, optometry, osteopathy, dentistry, pharmacy, podiatry, public health, nursing and allied health professions. We support ~~the need for special scholarship provisions to enable~~ the objective of increasing Indians to enter these health fields. ~~and as a means of ultimately securing the necessary medical manpower to furnish the Indian people with adequate health care.~~ ~~The unique relationship of Indians to the Federal Government as expressed in the Constitution, treaties and statutes, the goal of self-determination and the lessons of the last two hundred years, mandate~~ doesn't mandate, but this is like scholarship

As the President stated in his July 1970 Indian Message there is a need "...to expand our efforts to train Indians for health careers". The Bureau of Indian Affairs in the Department of Interior already conducts a scholarship program that meets the objectives of S. 2938 in this regard. Moreover, the Indian Health Service provides training to health workers such as community health aides and other paraprofessionals. In addition, the Administration has already proposed broad scholarship authority for the health professions in the proposed National Health Service Corps Scholarship Amendments (S. 3290) which would provide scholarships in return for service. We intend to use that authority fully, giving special preference to students from disadvantaged background including Indian students.

Part C of title I would provide continuing Education allowances for Indian Health Service physicians to leave their duty stations annually for the purpose of professional consultation and attendance at refresher training courses. The Public Health Service Act already provides ample authority for paying the expenses for physician consultations and training. In addition, the authority of the PHS Act permits the paying of expenses for refresher training and consultations of allied profession health employees of the Service. Accordingly, part C of Title I, is unnecessary and duplicative. We, therefore, oppose the enactment of this part.

Title II - Health Services and Title III - Health Facilities

Titles II and III provide authorization levels for health services and health facilities construction.

As you know, Mr. Chairman, the Indian Health Service currently does not have any specific authorization levels with respect to its activities. Moreover, in comparison to the levels in the Presidents' budget the proposed authorization levels for these activities are excessive and beyond those determined by the Department to meet the essential health needs of Federally recognized Indians in a responsible and orderly manner.

We have taken major steps to expand the health services and facilities for Indians and Alaska Natives over the last several years. We cannot, however, support excessive and unnecessary authorization levels such as provided in these two titles. The planned incremental increased support for expanding Indian health services initiated in the FY 1974 and FY 1975 budgets will increase the participation of these first Americans in their health programs. We firmly resolve to pursue this course of action because we believe it represents the best possible path to the objective we both seek; Indian self-determination.

Title IV - Access to Health Services

As I have indicated, Indians and Alaskan Natives are already entitled to participate in Medicare and Medicaid and would be entitled to benefit from CHIP on the same basis as other citizens. The Department is taking the necessary steps to assure that this right to participate is in all cases fully recognized and honored.

Because of the isolated areas in which they live and other reasons, many Indians and Alaskan Natives only have access to IHS health care facilities. Presently, however, IHS facilities are not eligible to participate under Medicare and Medicaid. The Administration has proposed that free-standing clinics generally be eligible for Medicare and Medicaid reimbursement. Title IV would, provide for Medicare and Medicaid reimbursements for

health services provided in IHS facilities. We believe that Indian participation in these health resources is a key consideration in the achievement of the self-determination policy. This policy holds to the principle that Indians will eventually assume total responsibility for the planning and operation of their health care delivery system. As this occurs there should be a proven system in place for obtaining reimbursement for the delivery of health services to persons who have established eligibility for such services under the several National and State-operated health resource programs. Since time will be required to prove such a system, we should begin now to work towards this end because some Indian groups have already expressed a desire to assume control of their health delivery system. Consequently, we support Title IV of S. 2938 requiring Medicare and Medicaid reimbursements for services provided to eligible beneficiaries in IHS facilities. We oppose, however, the provision contained in Title IV that would attempt to prohibit consideration of reimbursements in determining appropriation levels. We believe--particularly with the advent of comprehensive health insurance--that the Appropriations Committees of the Congress should be able to consider receipts available to the IHS facilities in determining overall funding requirements. It should be stressed, however, that this provision will in no way interfere with or diminish the health services now provided by IHS.

Title V - Access to Health Care for Urban Indians

Title V would establish outreach programs in urban areas to make available health services more accessible to the urban Indian population.

We oppose a statutory enlargement of Indian Health Service responsibilities to include urban Indians. While the Department has supported such activities on a limited basis through the Native Affairs Program and through the Indian Health Service, we believe that primary reliance for social services for urban Indians, including health services, should be on the existing State and local social services agencies which the Federal Government already supports.

Therefore, we oppose the concept of a categorical program to fund Indian organizations in urban areas to develop Indian programs to interface with health services in place in these areas. Instead, we intend to work with existing social service agencies to assure that urban Indians are an important outreach target as part of the ongoing activities of those agencies.

Title VI - Miscellaneous

Title VI, the last title of the bill would establish a report requirement for the Secretary of this Department. We view such a requirement as unnecessary. Our experience has been that appropriations and oversight hearings by the Congress during its regular deliberations on substantive legislation and on appropriation requests are much more effective and informative than lengthy reports.

General

Titles I, II, III and V of the bill provides for specific appropriation authorizations, adding $1 billion over a five-year period to existing program levels and commitments. We cannot support the excessive authorizations in S. 2938. We favor retaining the open ended appropriation authorization contained in the Snyder Act (25 U.S.C. 13) and Public Law 568 of the 83rd Congress, as amended, the so called Indian Health Service Transfer Act.

Conclusion

In conclusion, Mr. Chairman, I would like to stress that we share a common objective of better health care for Indians and wish to assure the Committee that the Department will continue its pursuit of this goal. Just recently, I had the opportunity to visit a number of IHS facilities in Arizona and New Mexico. That trip reinforced my personal conviction that the Indian people do indeed present both a tremendous challenge and a real achievement with respect to our National capacity to provide high quality health services when and where they are needed. I think we can meet this challenge.

Nevertheless, we believe that the Department can accomplish that common objective without legislation such as S. 2938 for the reasons I have stated.

Mr. Chairman, that concludes my statement. My colleagues and I would be pleased to try to answer any questions you or members of the Committee may have.

REVISED

Mr. Chairman, I am pleased to have this opportunity to appear before you today to discuss S. 2938, the Indian Health Care Improvement Act. This bill provides specific authorizations for Indian Health manpower, Health Services, Health Facilities construction and renovation, Access to Health Services for reservation Indians, Access to Health Services for Urban Indians and a requirement for the Secretary to report to the President and the Congress on progress made in effecting the purposes of the Act.

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This Department has the central responsibility of translating this policy into programs particularly in the area of health. We are seeking to advance the health status of these Americans in a variety of ways.

Health Care Options

First, Indian people and Alaska Natives, as American citizens, may participate in the health programs administered by the Department on the same basis as any other citizen. We are attempting to assure that they are aware of the broad health benefits offered through these programs, particularly the benefits under Medicaid and Medicare. These programs represent a significant health resource for the Indian people and we are attempting to ensure that the Indian population take advantage of these benefits to the extent possible.

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We recognize that because of the geographical isolation of many Alaska Natives and Indians and the cost sharing charges under CHIP, their choice will in fact often be limited to the IHS facilities in their vicinity. However, for those within commuting distance of private facilities and practitioners, the EHIP, AHIP and Medicare plans under CHIP will provide an alternative to the IHS facilities.

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These increases are significant because they bring real benefits in terms of people served. They will help us meet the rapidly growing demand for health services on the part of the Indian people--a demand that is growing because of their increasing confidence in modern health practices, based on positive experiences.

For example, Indian Health Service facilities expect to receive an additional 100,000 outpatient visits in 1974, and another 100,000 in 1975, over and above the 2.3 million visits experienced in 1973. Also, this expected increase of funds will enable us to cut into the huge backlog of unmet needs--for surgery and other kinds of care--which built up in past decades.

Good health facilities are crucial to the delivery of high-quality health services to Indians. The fiscal year 1974 and 1975 Indian Health Service budgets recognize this and provide for further orderly and realistic progress in the necessarily long-range effort to replace or remodel outmoded Indian Health Service hospitals and other facilities, and to upgrade others.

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health facility at Bethel, Alaska, and planning funds for the new Chemawa, Oregon School Health Center are also contained in FY 1974's construction program. The FY 1975 President's budget would provide construction funds for the replacement health facility at Claremore, Oklahoma, and to replace the school health center at Riverside, California. Funds to construct a small addition to the existing health center at Tohatchi, New Mexico and to construct 207 units of housing at Tuba City, Arizona are also contained in the FY 1975 program.

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In addition to the health care provided by the Indian Health Service in its own facilities and through contract health care, other Public Health Service agencies are contributing more than $11 million in 1975 for a broad range of services.

I believe the FY 1975 budget demonstrates our commitment to better Indian health care and represents real progress toward our mutual goal.

Measures of Success of Present Programs

The true measure of our Indian health efforts is found in the health status of the Indian people. The impact has been both profound and enduring. It can be illustrated by the dramatic reduction of Indian death rates between 1955 and 1972. The infant death rate has declined 67 percent; the tuberculosis rate is down 85 percent; the gastritis and related diseases rate has dropped 81 percent; and the rate for influenza and pneumonia is down 58 percent.

These figures represent firm evidence that the Administration's decision to place high priority on investing in health services for Indian people has been a wise one, and that the methods it has employed to deliver services have been effective.

Backlog of Health Service

As this committee is aware, we find ourselves in the situation of having a significant unmet need which has developed over past decades. We have begun to make inroads into the present backlog of unmet needs and believe that we will be making further substantial progress in reducing this backlog especially in view of our increased budgetary requests. For example, in fiscal year 1974 a supplemental budget request of $6.6 million has been made of which $3.4 million is specifically for the purpose of reducing unmet needs. The President's budget for fiscal year 1974 represents an increase of approximately $26 million dollars primarily for medical services. These added funds, if appropriated, will be used to continue the 1974 program, to help overcome unmet medical needs of children and adults

and to provide for mandatory cost increase such as staffing for the Tuba City (Arizona) hospital, currently under construction. This we believe is an orderly and realistic approach to the problem consistent with available Federal and community resources.

S. 2938 proposes to accelerate the process of eliminating the backlog of health service and health facilities needs of the Indian people. This Department is firmly committed to the principle of providing fully adequate health care to these Americans in facilities which permit the delivery of quality health services and the right of self-determination of Indians and therefore support the intent of this bill. While we endorse the principles of the bill, we are unable to recommend enactment of several provisions and would recommend modifications in other sections. I would now like to comment specifically on the provisions of S. 2938 by title.

Title I - Indian Health Manpower

Title I of the bill would establish a scholarship program for training qualified Indians in the fields of medicine, optometry, osteopathy, dentistry, pharmacy, podiatry, public health, nursing and allied health professions. We support the need for special scholarship provisions to enable Indians to enter these health fields and as a means of ultimately securing the necessary medical manpower to furnish the Indian people with adequate health care. The unique relationship of Indians to the Federal Government as expressed in the Constitution, treaties and statutes, the goal of self-determination and the lessons of the last two hundred years, mandate

particularized legislation in this regard. As the President stated in his July 1970 Indian Message there is a need ". . . to expand our efforts to train Indians for health careers". We therefore support this aspect of the legislation in principle. We do, however, wish to point out that the Administration is now in the final stages of developing an overall health manpower program. In this regard, we believe that the legislation under consideration today should be consistent with our forthcoming manpower legislation and would like to work with the committee toward achieving compatibility between this bill and the Administration proposal.

Because the Administration's program will give sufficient priority to providing service to the Indian populations, we therefor believe it is unnecessary under this bill to provide for scholarships for persons other than Indians and Alaskan Natives. We also would recommend that the penalty provision for default on an obligation be significantly strengthened in order for the bill to be more effective in achieving the goal of service to Indians by Indians.

Further we would recommend that the preparatory scholarships be recast as preadmission scholarships to more accurately reflect what we believe is the intent of this provision. This section should be available to those Indians and Alaskan Natives who have demonstrated that they have the aptitude to successfully gain admission for graduate study in schools of medicine, dentistry and osteopathy. The scholarship provision should thus be specifically directed toward assistance in gaining this type of graduate level training.

Part C of title I addresses the need for physicians to leave their duty stations annually for the purpose of professional consultation and attendance at refresher training courses. The rapid expansion of knowledge brought about by new discoveries in the health sciences makes such consultation and training mandatory if this knowledge is to be used for the benefit of patients. The Public Health Service Act, one of the legislative authorities under which the Indian Health Service operates, contains ample authority for paying the expenses for physician consultations and training. In addition, the authority of the PHS Act permits the paying of expenses for refresher training and consultations of allied profession health employees of the Service. Accordingly, we feel that part C of Title I is directed more toward the solving of a budget and management problem than the provision of new authority. We, therefore, oppose the enactment of this part.

Title II - Health Services and Title III - Health Facilities

Titles II and III set out a program with respect to Health Services and Health Facilities. These two titles address the budgetary need to eliminate the backlog of health services, the need for modern facilities for health care and the need for safe domestic water supplies and sanitary waste treatment facilities for Indian homes and communities. Authorizations are provided each section and part of these proposed titles.

Neither of these titles provide additional authority to eliminate the backlogs of need for services and facilities. If appropriations are not made consistent with the proposed funding authorizations, the result would be a raising of expectations of the Indian people beyond that which would be realized.

As you know, Mr. Chairman, our Nation is confronted with a great number of critical priority needs. We in the Administration and you in the Congress must address each of these crucial needs with reasoned, responsible actions. While we agree that the health service and facility needs of the Indian people are of great importance, I think that you would also agree that other needs of our Nation may be of equal or greater significance. While we are committed to strengthened Federal effort to expand the health services for Indians and Alaska Natives, we cannot support an accelerated program such as provided in these two titles. The planned incremental increased support for expanding Indian health services initiated in the FY 1974 and FY 1975 budgets will increase the participation of these first Americans in their health programs. We firmly resolve to pursue this course of action because we believe it represents the best possible path to the objective we both seek; Indian self-determination.

Title IV - Access to Health Services

As I have indicated, Indians and Alaskan Natives are entitled to participate in Medicare and Medicaid on the same basis as other citizens. And the Department is taking the necessary steps to assure that this right to participate is in all cases fully recognized and honored.

Because of the isolated areas in which they live and other reasons, many Indians and Alaskan Natives only have access to IHS health care facilities. Presently, however, IHS facilities are not eligible to participate under Medicare and Medicaid. This title, however, provides for the direct participation of Medicare and Medicaid in meeting the health care needs of those people who only have access to IHS facilities. We believe that Indian participation in

these health resources is a key consideration in the achievement of the Self-determination Policy. This policy holds to the principle that Indians will eventually assume total responsibility for the planning and operation of their health care delivery system. As this occurs there should be a proven system in place for obtaining reimbursement for the delivery of health services to persons who have established eligibility for such services under the several National and State-operated health resource programs. Since time will be required to prove such a system, we should begin now to work towards this end because some Indian groups have already expressed a desire to assume control of their health delivery system. Consequently, we endorse the concept embodied in this title. It should be stressed, however, that this provision will in no way interfere with or diminish the health services now provided by IHS.

Title V - Access to Health Care for Urban Indians

This title proposes to establish outreach programs in urban areas to make available health services more accessible to the urban Indian population. The statutes under which we now operate provide ample authority for IHS to assist in the development of outreach programs for Indians in urban areas. In fact, we have to date provided developmental funds to Indian organizations in four urban areas for this purpose. This effort will be expanded this year so that we will be providing this assistance in a total of 9 or 10 urban centers.

Therefore, we strongly support the concept of aiding Indian organizations in urban areas to develop Indian programs to interface with health services in place in these areas. Title V, however, would simply duplicate existing authority and is therefore unnecessary.

Title VI - Miscellaneous

Title VI, the last title of the bill would establish a report requirement for the Secretary of this Department. We view such a requirement as appropriate and one which could be valuable to the Congress during its deliberations on substantive legislation as well as on appropriation requests.

General

Titles I, II, III and V of the bill provide for specific appropriation authorizations. The authorizations provided in S. 2938 would limit the existing authorities both in terms of amounts and time. Therefore, we would recommend amending the bill to delete the authorizations in favor of clearly retaining the open ended appropriation authorization contained in the Snyder Act (25 U.S.C. 13) and Public Law 568 of the 83rd Congress, as amended, the so called Indian Health Service Transfer Act.

Conclusion

In conclusion, Mr. Chairman, I would like to stress that we share a common objective of better health care for Indians and wish to assure the Committee that the Department will continue its pursuit of this goal. Just recently, I had the opportunity to visit a number of IHS facilities in Arizona and New Mexico. That trip reinforced my personal conviction that the Indian people do indeed present a tremendous challenge to our National capacity to provide high quality health service when and where they are needed. I think we can meet this challenge.

I know of this Committee's similar convictions and I would like to emphasize that I stand ready to work as closely as possible with the Committee in improving health care for Indian people. Although the Department does not totally support S. 2938, I wholeheartedly endorse the objective sought by the bill and applaud the motivation behind it. I certainly look forward to working with this Committee on this very urgent matter.

Mr. Chairman, that concludes my statement. My colleagues and I would be pleased to try to answer any questions you or members of the Committee may have.

93D CONGRESS
2D SESSION

S. 2938

IN THE SENATE OF THE UNITED STATES

FEBRUARY 1, 1974

Mr. JACKSON (for himself, Mr. BARTLETT, Mr. FANNIN, Mr. HASKELL, and Mr. METCALF) introduced the following bill; which was read twice and referred to the Committee on Interior and Insular Affairs

A BILL

To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Health Care Improvement Act".

FINDINGS

SEC. 2. The Congress finds that—

(a) Federal Indian health services to maintain and improve the health of the Indians are consonant with and re-

quired by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the America Indian people.

(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

(c) Federal health services to Indians have resulted in a reduced prevalence and incidence of preventable illnesses and unnecessary and premature deaths among Indians.

(d) Despite such services, the unmet health needs of the American Indian people are severe and the health status of Indians is far below that of the general population of the United States. Illustratively, for Indians compared to all Americans in 1971, the tuberculosis death rate was over four and one-half times greater, the influenza and pneumonia death rate over one and one-half times greater, and the infant death rate about 20 per centum greater.

(e) All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.

(f) Further improvement in Indian health is imperiled by—

(1) inadequate, outdated, inefficient, and undermanned facilities. For example, only twenty-one of fifty-one Indian Health Service hospitals are accredited; only twelve meet national fire and safety codes; and fifty-seven areas with Indian populations have been identified as requiring either new or replacement health centers and stations, or clinics remodeled for improved or additional service;

(2) shortage of personnel. For example, about two-thirds of the Service hospitals, four-fifths of Service hospital outpatient clinics, and one-half of the Service health clinics meet only 80 per centum of staffing standards for their respective services;

(3) insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and mental health services, and services available through contracts with private physicians, clinics, and agencies. For example, about 82 per centum of the surgical operations needed for otitis medai are unperformed, over 57 per centum of required dental services have not been provided, and about 98 per centum of the need for hearing aids is unmet;

(4) related support factors. For example, over seven hundred housing units are needed for staff at remote Service facilities;

(5) lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climatic conditions; and

(6) lack of safe water and sanitary waste disposal services. For example, over forty thousand existing, and sixty-two thousand planned replacement and renovated, Indian housing units need new or upgraded water and sanitation facilities.

(g) The Indian people's growing confidence in Federal Indian health services is revealed by their increasingly heavy use of such services. Progress toward the goal of better Indian health is dependent on this continued growth of confidence. Both such progress and such confidence are dependent on improved Federal Indian health services.

DECLARATION OF POLICY

SEC. 3. The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation 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.

DEFINITIONS

SEC. 4. For purposes of this Act—

(a) "Indian", unless otherwise designated, means a person who is a member of an Indian tribe.

(b) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native community as defined in the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(c) "Secretary", unless otherwise designated, means the Secretary of Health, Education, and Welfare.

(d) "Service", unless otherwise designated, means the Indian Health Service.

TITLE I—INDIAN HEALTH MANPOWER

SEC. 101. The purpose of this title is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the Service and private practice among Indians.

PART A—HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

SEC. 102. (a) The Secretary shall, in accordance with the provisions of this title, make scholarship grants to individuals (i) who are enrolled in medical schools; schools of optometry, osteopathy, dentistry, pharmacy, podiatry, pub-

lic health, or nursing; or schools licensed by a State to train persons in the allied health professions and (ii) who agree to provide their professional services to Indians after completion of their professional training.

(b) (1) The Secretary shall, in awarding scholarship grants under this part, accord priority to applicants as follows—

(A) first, to any qualified applicant who is a member of an Indian tribe and resides on an Indian reservation;

(B) second, to any qualified applicant who is a member of an Indian tribe and resides in a place other than an Indian reservation;

(C) third, to any other qualified applicant.

(2) Scholarship grants under this title shall be made with respect to academic years.

(c) (1) Any scholarship grant awarded to any individual under this title shall be awarded under the condition that such individual will, after the completion of his professional training, provide his professional services to Indians.

(2) The Secretary shall prescribe by regulations—

(A) the criteria for determining when an individual is providing professional services to Indians in fulfill-

ment of the condition for scholarship assistance provided in paragraph 1, and

(B) the reasonable period of time said condition must be complied with by such individual.

(3) If any individual to whom the condition referred to in paragraph (1) is applicable fails, within the period prescribed pursuant to regulations under paragraph (2), to comply with such condition for the full period, the United States shall be entitled to recover from such individual an amount equal to the amount produced by multiplying—

(A) the aggregate of (i) the amounts of the scholarship grant or grants (as the case may be) made to such individual under this part, and (ii) the sums of the interest which would be payable on each such scholarship grant if, at the time such grant was made, such grant were a loan bearing interest at a rate fixed by the Secretary of the Treasury, after taking into consideration private consumer rates of interest prevailing at the time such grant was made, and if the interest on each such grant had been compounded annually, by

(B) a fraction the numerator of which is the number obtained by subtracting from the number of months to which such condition is applicable a number equal to one-half of the number of months with respect to

which compliance by such individual with such condition was made, and the denominator of which is a number equal to the number of months with respect to which such condition is applicable.

Any amount which the United States is entitled to recover under this paragraph shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount, be paid to the United States. Until any amount due the United States under this paragraph on account of any grant under this part is paid, there shall accrue to the United States interest on such amount at the same rate as that fixed by the Secretary of the Treasury pursuant to clause (A) with respect to the grant on account of which such amount is due the United States.

(4) (A) Any obligation of any individual to comply with the condition applicable to him under the preceding provisions of this subsection shall be canceled upon the death of such individual.

(B) The Secretary shall by regulations provide for the waiver or suspension of any such obligation applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.

SEC. 103. The Secretary may enter into agreements with any schools referred to in section 102 (a), hospitals, or appropriate public or private agencies under which such schools, hospitals, or other agencies will, as agents of the Secretary, perform such functions in the administration of this part, as the Secretary may specify. Any such agreement with any such school, hospital, or agency may provide for payment by the Secretary of amounts equal to the expenses actually and necessarily incurred by such school, hospital, or agency in carrying out such agreement.

SEC. 104. There are authorized to be appropriated for the purpose of this part $8,000,000 for fiscal year 1975, $16,000,000 for fiscal year 1976, $22,000,000 for fiscal year 1977, $30,000,000 for fiscal year 1978, and $34,000,000 for fiscal year 1979, and, for each succeeding fiscal year, such sums as may be necessary to continue to make such grants to individuals who (prior to July 1, 1979) have received such grants and who are eligible for such grants under this part during such succeeding fiscal year.

PART B—HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM

SEC. 105. (a) The Secretary shall, in accordance with the provisions of this part, make scholarship grants to Indians who—

(1) have successfully completed their high school education; and

(2) have demonstrated an aptitude for being capable of successfully completing a premedical, predental, or preosteopathy course of study.

(b) A scholarship grant made under this part shall be for a period not to exceed two academic years.

(c) A scholarship grant made under this part may cover costs of tuition, books, transportation, board, and other necessary related expenses.

(d) There are authorized to be appropriated for the purpose of this part $1,000,000 for fiscal year 1975; $2,000,000 for fiscal year 1976; $3,000,000 for fiscal year 1977; $3,000,000 for fiscal year 1978; and $3,000,000 for fiscal year 1979.

PART C—CONTINUING EDUCATION ALLOWANCES

SEC. 106. (a) In order to encourage professionals to join the Service and to provide their services in the rural and remote areas where a significant portion of the American Indian people reside, the Secretary may provide allowances to Service physicians to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

(b) There are authorized to be appropriated for the

purpose of this section $350,000 for fiscal year 1975, $350,000 for fiscal year 1976, $375,000 for fiscal year 1977, $390,000 for fiscal year 1978, and $410,000 for fiscal year 1979.

TITLE II—HEALTH SERVICES

SEC. 201. (a) For the purpose of eliminating backlogs in Indian health care services and to supply known, unmet medical, surgical, dental, and other Indian health needs, the Secretary is authorized to expend, through the Service, $123,500,000 over a five-fiscal-year period in accordance with the schedule provided in subsection (c). As such funds which are appropriated pursuant to this Act are to eliminate health services backlogs, they shall not be used to offset or limit the appropriations required by the Service to continue to serve the health needs of Indian people during and subsequent to such five-fiscal-year period but shall be in addition to the annual appropriations required to continue the health service program to the Indian people.

(b) The Secretary is also authorized to employ persons to implement the provisions of this section during the five-fiscal-year period in accordance with the schedule provided in subsection (c). Such persons shall be in addition to, and shall not reduce the number of, the employees required to conduct ongoing activities of the Service during and subsequent to such period.

(c) The following amounts and positions are authorized, by fiscal year, for the specific purposes noted:

(1) Patient care (direct and indirect): for fiscal year 1975, $11,000,000 and two hundred and forty positions; for fiscal year 1976, $17,000,000 and five hundred and forty positions; for fiscal year 1977, $14,000,000 and four hundred and ten positions; for fiscal year 1978, $9,000,000 and five hundred positions; and for fiscal year 1979, $7,000,000 and four hundred and ninety positions;

(2) Field health, excluding dental care (direct and indirect): for fiscal year 1975, $12,000,000 and three hundred positions; for fiscal year 1976, $10,000,000 and two hundred twenty-five positions; for fiscal year 1977, $7,000,000 and two hundred positions; for fiscal year 1978, $7,000,000 and two hundred positions; and for fiscal year 1979, $5,000,000 and one hundred positions;

(3) Dental care (direct and indirect): for fiscal year 1975, $900,000 and sixty positions; for fiscal year 1976, $700,000 and seventy-five positions; for fiscal year 1977, $700,000 and seventy-five positions; for fiscal year 1978, $600,000 and seventy-five positions; and for fiscal year 1979, $600,000 and sixty positions; and

(4) Maintenance and repair (direct and indirect): for fiscal year 1975, $6,000,000 and thirty positions; for fiscal year 1976, $4,000,000 and thirty positions; for fiscal year 1977, $4,000,000 and thirty positions; for fiscal year 1978, $4,000,000 and thirty positions; and for fiscal year 1979, $3,000,000 and thirty positions.

TITLE III—HEALTH FACILITIES

PART A—CONSTRUCTION AND RENOVATION OF SERVICE FACILITIES

SEC. 301. For the purpose of eliminating inadequate, outdated, and otherwise unsatisfactory Service hospitals, health centers, health stations, and other Service facilities, the Secretary is authorized to expend $400,000,000 over a five-fiscal-year period in accordance with the following schedule:

(a) Hospitals: for fiscal year 1975, $40,000,000; for fiscal year 1976, $76,000,000; for fiscal year 1977, $65,000,000; for fiscal year 1978, $55,000,000; and for fiscal year 1979, $80,000,000.

(b) Health centers and health stations: for fiscal year 1975, $4,000,000; for fiscal year 1976, $6,000,000; for fiscal year 1977, $2,000,000; for fiscal year 1978, $2,000,000; and for fiscal year 1979, $11,000,000.

(c) Staff housing: for fiscal year 1975, $13,-

000,000; for fiscal year 1976, $21,000,000; for fiscal year 1977, $16,000,000; for fiscal year 1978, $5,000,000; and for fiscal year 1979, $4,000,000.

SEC. 302. The Secretary is authorized to equip and staff such Service facilities at levels commensurate with their operation at optimum levels of effectiveness.

SEC. 303. For the purpose of implementing the provisions of this part, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or carried out in whole or in part by funds made available pursuant to this part are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1921 (46 Stat. 1491), as amended.

PART B—CONSTRUCTION OF SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 304. (a) For the purpose of reducing health hazards, the Secretary is authorized to expend, pursuant to Public Law 86–121, $470,000,000 within a five-fiscal-year period following the enactment of this Act, in accordance with the schedule provided in subsection (b), to supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.

(b) The following amounts are authorized, by fiscal year, for the purpose prescribed in subsection (a): $90,-

000,000 in fiscal year 1975; $95,000,000 in fiscal year 1976; $95,000,000 in fiscal year 1977; $95,000,000 in fiscal year 1978; and $95,000,000 in fiscal year 1979.

(c) The Secretary is authorized and directed to develop a plan, together with the Secretaries of Housing and Urban Development and the Interior, to assure that the schedule provided for in subsection (b) will be met. Such plan shall be submitted to the Congress no later than ninety days from the date of enactment of this Act.

TITLE IV—ACCESS TO HEALTH SERVICES

SEC. 401. (a) Notwithstanding any other provision of law, for the purpose of title XVIII of the Social Security Act, as amended, the Service facilities used to provide health care and services to Indians are hereby deemed to be accredited facilities, the services so provided shall be deemed to be provided by licensed practitioners in their respective fields, and the facilities may receive payment for such services on the same basis as other providers of service.

(b) The Secretary shall undertake to improve and maintain such Service facilities such that they will, at a minimum, meet the accreditation standards imposed on other providers of service.

(c) Any payments received for services provided to beneficiaries hereunder shall be credited to the appropriation charged for the actual provision of care and services and shall

not be considered in determining appropriations for health care and services to Indians.

(d) Nothing herein authorizes the Secretary to provide services to an Indian beneficiary with coverage under title XVIII of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

SEC. 402. (a) Notwithstanding any other provision of law, for the purpose of title XIX of the Social Security Act, as amended, the Service facilities used to provide health care and services to Indians are hereby deemed to be accredited facilities and the services so provided in these facilities are deemed to be provided by licensed practitioners in their respective fields.

(b) The Secretary is authorized to enter into agreements with the appropriate State agency for the purpose of receiving reimbursement for health care and services provided to Indians who are beneficiaries under title XIX of the Social Security Act, as amended.

(c) The Secretary shall undertake to improve such facilities such that they will meet or exceed any applicable accredited standard.

(d) Any payments received for services provided beneficiaries hereunder shall be credited to the appropriation charged for the actual provision of care and services, which amount shall not be considered in determining appropriations for the provision of health care and services to Indians.

(e) Nothing in this section shall authorize the Secretary to provide services to an Indian beneficiary with coverage under title XIX of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

TITLE V—ACCESS TO HEALTH SERVICES FOR URBAN INDIANS

SEC. 501. The purpose of this title is to encourage the establishment of outreach programs in urban areas to make health services more accessible to the urban Indian population.

SEC. 502. For the purpose of this title—

(a) "Urban Indian" means any individual who resides in an urban center and who is (i) an Indian as defined in section 4(a) of this Act or (ii) a person of Indian descent who is considered ineligible for the special programs and services of the Service and the Bureau of Indian Affairs and who, in accordance with regulations promulgated by the Secretary which take into consideration such person's health needs, lack of access to health services, and other relevant factors, is identified as an appropriate recipient of assistance from an urban Indian organization in accordance with the provisions of this title.

(b) An "urban Indian organization" is a nonprofit corporate body situated in an urban center, composed of

urban Indians, and providing the maximum participation of all interested Indian groups, which body is capable of legally cooperating with other bodies, Federal, State, and local, for the purpose of performing the activities described in section 503 (c).

(c) An "urban center" is any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under this title, as determined by the Secretary.

SEC. 503. (a) The Secretary shall enter into contracts with urban Indian organizations to provide Federal assistance to such organizations for the purpose of establishing and administering outreach programs to make urban Indians in the urban centers in which such organizations are situated knowledgeable of the health service resources available within such centers and the means of gaining access to those resources.

(b) Urban Indian organizations shall make use of Federal assistance provided by contracts pursuant to this title not to provide health services to urban Indians but to render advice and consultation to such Indians concerning the availability and means of access to all public and private health services.

(c) The Secretary shall place such conditions as he deems necessary in any contract which he makes with any

urban Indian organization pursuant to this title. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake the following tasks:

(1) determine, in accordance with the regulations promulgated pursuant to section 502 (a), the population of urban Indians which are or could be recipients of such services;

(2) identify all public and private health service resources within the urban center in which the organization is situated which are or may be available to urban Indians;

(3) assist such resources in providing service to such urban Indians;

(4) assist such urban Indians in becoming familiar with and utilizing such resources;

(5) provide basic health education to such urban Indians;

(6) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs; and

(7) make recommendations to the Secretary and Federal, State, local, and other resource agencies on methods of improving health service programs to meet the needs of urban Indians.

(d) The Secretary shall by regulation prescribe the

criteria for selecting urban Indian organizations with which to contract pursuant to this title. Such criteria shall, among other factors, take into consideration—

(1) the extent of the unmet health care needs of the urban Indian in the urban center in question;

(2) the size of the urban Indian population which is to receive assistance;

(3) the relative accessibility which such population has to health care services in such urban center;

(4) the extent, if any, that the project would duplicate any previous or current public or private project funded by another source in such urban center;

(5) the appropriateness and likely effectiveness of a project assisted pursuant to this title in such urban center;

(6) the existence of an urban Indian organization capable of performing the activities set forth in subsection (c) and of entering into a contract with the Secretary pursuant to this title; and

(7) the extent of existing or likely future participation of appropriate health and health-related State, local, and other resource agencies.

SEC. 504. (a) Contracts with urban Indian organizations pursuant to this title shall be in accordance with all Federal

contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform with the provisions of the Act of August 24, 1935 (49 Stat. 793), as amended.

(b) Payments under any contracts pursuant to this Act may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract made by him with such organization pursuant to this title as necessary to carry out the purposes of this title: *Provided, however,* That whenever an urban Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.

(d) In connection with any contract made pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing

facilities owned by the Federal Government within his jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

(e) The contracts authorized under this title may include provisions for the performance of personal services which would otherwise be performed by Federal employees: *Provided,* That the Secretary shall not make any contract which would impair his ability to discharge his trust responsibilities to any Indian tribe or individuals.

(f) Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision by such organizations of services and assistance to Indians in the conduct and administration of programs or activities under such contracts.

SEC. 505. For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, the organization which requested such contract or grant shall submit to the Secretary a report including information gathered pursuant to 503 (c) (6) and (7), information on activities conducted by the organization pursuant to the contract, an accounting of the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of the urban Indian organization with

respect to such contract or grant shall be subject to audit by the Secretary and the Comptroller General of the United States.

SEC. 506. There are authorized to be appropriated for the purpose of this title $3,000,000 for the fiscal year 1975; $4,000,000 for the fiscal year 1976; and $5,000,000 for the fiscal year 1977.

SEC. 507. Within six months after the end of fiscal year 1976, the Secretary shall review the program established under this title and shall submit to the Congress his assessment thereof and recommendations for any further legislative efforts he deems necessary to meet the purposes of this title.

TITLE VI—MISCELLANEOUS

SEC. 601. The Secretary shall report annually to the President and the Congress on progress made in effecting the purposes of this Act. Within three months after the end of fiscal year 1978, the Secretary shall review the programs established or assisted under this Act and shall submit to the Congress his assessment thereof and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and insure a health status for Indians, which is at a parity with the health services available to, and the health status of, the general population.

SEC. 602. The Secretary may prescribe such regulations as he deems necessary to carry out the purposes of this Act. Such regulations shall provide the opportunity for maximum participation of Indians in the planning and implementation of Indian health programs.

SEC. 603. The funds appropriated pursuant to this Act shall remain available until expended.

93D CONGRESS
2D SESSION

S. 2938

A BILL

To implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes.

By Mr. JACKSON, Mr. BARTLETT, Mr. FANNIN, Mr. HASKELL, and Mr. METCALF

FEBRUARY 1, 1974

Read twice and referred to the Committee on Interior and Insular Affairs

United States of America

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Senate

By Mr. JACKSON (for himself, Mr. METCALF, Mr. HASKELL, Mr. FANNIN, and Mr. BARTLETT):

S. 2938. A bill to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes. Referred to the Committee on Interior and Insular Affairs.

INDIAN HEALTH LEGISLATION

Mr. JACKSON. Mr. President, I am introducing for appropriate reference, legislation which addresses one of the most deplorable situations in the United States, that of the provision of basic health services to Indians.

Earlier this Congress, the Senate passed the Indian Financing Act, to provide economic assistance to enable the Indian people to design and build their own future. By unanimous vote on January 28 of this year, the Indian Self-Determination and Educational Reform Act was ordered reported to the Senate by the Committee on Interior and Insular Affairs. Both of these measures reaffirm the policy of this body that it is the Indian people who must decide their own future and they provide the educational and economic tools to shape that future.

The most basic human right must be the right to enjoy decent health. Certainly, any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians. Without a proper health status, the Indian people will be unable to fully avail themselves of the many economic, educational, and social programs already available to them or which this Congress will provide them.

The purpose of the legislation I introduce today is to augment and expand upon presently established health programs and services for Indian citizens. It is designed to eliminate enormous backlogs of essential patient care, to construct and renovate hospitals and other health facilities which at the present time are either nonexistent or in a state of general deterioration, and to provide financial and organizational support for the development and growth of urban Indian health projects.

In the early history of this country, Federal health services provided to Indians were confined to those military physicians assigned to frontier forts and reservations. Primarily the attention of these physicians focused on preventing the spread of smallpox and other contagious diseases; diseases, I may point out, which were virtually unknown to Indians before their contact with the white man.

In 1849, with the transfer of the Bureau of Indian Affairs to the Department of the Interior, Indian health policy shifted from military to civilian administration. Although some limited progress occurred under this new administrative arrangement, by 1875 there were still only about half as many doctors as there were Indian agencies, and by 1900 the physicians serving Indians numbered only 83. During this time Indian health services were financed out of miscellaneous funds of the Bureau of Indian Affairs. It was not until 1911 that general Indian health appropriations began.

In the mid-1920's a more concerted effort was made to assist the health needs of Indian communities, facilitated by the assignment of commissioned officers of the Public Health Service to Indian health programs. Considerable improvement in Indian health can be said to have resulted from the contributions of these officers. While these highly trained medical and public health officers strengthened the overall direction of the Federal Indian health program, they were unable to overcome the serious health problems of Indians due to other shortcomings in the Indian health program. Outdated and inadequate Federal health facilities and delivery systems were incapable of sustaining the demands for service found on Indian reservations. Finally, in an effort to consolidate and expand the diverse and disjointed programs of Indian health care and to accommodate Indian health needs which had grown to crisis proportions, Congress, in 1955, transferred all authority for Indian health from the Department of the Interior to the Public Health Service.

Presently, the responsibility for providing adequate health and medical services for Indian people resides with the Indian Health Service, a special branch of the Public Health Service within the Department of Health, Education, and Welfare. Of the approximately 827,000 Indians in the United States representing some 260 tribes and 215 Alaskan Native villages, more than half a million Native Americans depend almost entirely upon the Indian Health Service for medical and hospital care. To meet the needs of these citizens, the Service operates 51 hospitals in 13 States offering a total of 2,700 beds with an additional 1,000 beds provided through contract facilities with local private and public hospitals. The total manpower of these services constitutes more than 7,000 professional and staff personnel, including some 450 physicians and 170 dentists in the Commissioned Officers Corps of the Public Health Service. Contracts with some 300 private and community hospitals and 500 physicians provide additional personnel and facilities.

Although the Indian Health Service has begun at long last to achieve a limited

progress in improving the health status of Indian people, health statistics reveal that in spite of this progress the vast majority of Indians live in an environment characterized by inadequate and understaffed health facilities, improper or nonexistent waste and water systems, and continuing dangers of deadly or disabling diseases. These circumstances have produced a situation in which the health of Indians ranges far below that of other Americans. Health concerns which most of our communities have forgotten as long as 25 years ago continue to plague Indian communities. For every Indian health need treated by existing services, another need will go unmet, only to arise at a later date, inhibiting the lives and pursuits of native citizens and strangling their development as free, self-determined people.

Illustrative of this situation are the following facts: the incidence of tuberculosis for Indians and Alaska Natives is 6.4 times higher than the rate for all citizens of the United States; the Indian and Alaska Natives rate for diabetes is almost twice that of all races of the United States; and while respiratory and gall bladder illnesses are not reported in the general population, Indian Health Service officials state emphatically that the rates for these diseases among Indians and Alaska Natives are significantly higher than the general population. Otitis media, an infection of the inner ear, affecting most commonly children under the age of 2 years, continues to be a leading cause fo disability in American Indians and Alaska Natives.

Although surgical treatment is possible which can generally prevent the long-term and serious disabilities of deafness and learning deficiencies, only a fraction of this essential surgery is now being provided. The infant mortality rate among Indians is almost 1½ times the national average while the Indian birth rate soars at a ratio twice that of other Americans. The frequency with which these events occur and the prevalence of disease in Indian communities cannot help but have a significant impact on the social and cultural fiber of Indian societies, contributing to their general disintegration and attendant problems of mental illness, alcoholism, accidents, homicide and suicide. For example, suicide within Indian communities is approximately twice as high as in the total U.S. population. The real life facts of Indian health in this Nation add up to the simple yet deplorable conclusion that while every other American can expect to live to the age of at least 70.4 years, the Indian and Alaska Native can expect to live only to age 64.9.

All efforts to alter these conditions are met with an initial and fundamental impediment of outdated or inadequate health facilities. Of existing facilities, some 38 hospitals, 66 health centers and 240 other health stations are at least 20 years old.

Many of them are old one-story Army-style buildings with inadequate electricity, ventilation, insulation, and fire protection systems, and of such insufficient size to jeopardize the health and safety of their occupants. To meet the needs of some 530,000 Indians, Service and contract facilities provide some 3,700 hospital beds. Compared with a national average of 1 hospital bed per 125 persons Indian facilities provide 1 bed per 132 persons, a shortage of more than 200 beds under existing standards of service and demand. A special committee of the American Medical Association has investigated the condition of Indian health services. It is their conclusion that only 21 of the 51 existing Indian Health Service hospitals meet their standards of accreditation (either because of insufficient staffing or poor physical plants), that two-thirds of the hospitals are obsolete, and that 22 need complete replacement.

In order to overcome the gross deficiencies in the quantity and quality of existing facilities, more money must be allocated. Per capita expenditures for Indian health purposes are 30 to 40 percent below expenditures for the average American community. The greater incidence of disease among Indians renders this deficiency all the more acute. It is further compounded by the fact that many of our more modern national health programs, designed to assist the general population, are difficult or impossible to apply to Indians. Meidcare, medicaid, and social security programs afford little relief because, given their unique social situation, few Indians either know they are eligible for medicare or have not worked long enough for social security eligibility.

At the center of this tragic set of circumstances is probably the most pressing and serious problem facing Indian Health Service, the manpower shortage among physicians and related health personnel. At present there are 450 physicians in the Indian Health Service. Simply translated this represents a ratio of one physician for 1,080 Indians as against a national average of slightly over 600 persons per physician. These shortages are complicated by the highly dispersed and remote nature of Indian tribes, vast distances between settled areas on reservations, and the lack of adequate roads and minimum emergency transportation systems

Unfortunately, the Indian people cannot look to their own tribal members for relief in this vital health manpower shortage category. There are only 50 known physicians of Indian descent engaged in the practice of medicine today, and all but 2 or 3 are serving non-Indian patients. My proposed legislation holds promise for opening new opportunities for young Indian men and women to enter medicine and other health professions for service to their own people.

I find particularly disturbing the projection that severe manpower shortages are likely to become even more acute in the coming years due in large part to the decline in recruitment for the Public Health Service Commissioned Officers Corps. In past years the main source of the Service's physicians enlisting in the Public Health Service has greatly declined. An absence of adequate housing facilities and the remoteness and cultural isolation of assignments have added to the problem of recruiting professional manpower. Leading medical officials have given truly dire warnings that any further decline in manpower could have critical implications for the health of Indians.

By and large the problems I have described for you are with respect to those Indians who live on or near reservations and are members of federally recognized tribes or Indians. However, a substantial segment of the Indian population—300,000 to 400,000—resides away from the reservation, mostly in large urban centers.

My bill contains a provision aimed specifically at assisting urban Indians to develop health leadership among their own members and to establish the kind of resource identification which will help to meet the most pressing health needs of these deserving people. An integral aspect of this effort will involve an outreach program to seek out individuals and faimlies who require health care and refer them to services at the earliest possible date.

While current Indian policy prohibits the extension of the special Indian Health Service hospital and medical care program to the urban centers, I am convinced that my proposal in this area of concern will do much to alleviate a serious health situation among the Indian people concentrated in a number of major cities throughout the United States. I want to underscore the fact that the funds designated for these programs will in no way reduce the level of funding I have proposed to meet the serious health and medical needs for thousands of Indian people residing on federally recognized reservations and in Indian communities. I want both the members of federally recognized tribes and the urban Indians to understand that my bill in no way sets up a "tug of war" over limited financial resources and services but rather the measure addresses itself to the needs of both groups.

Title I of my bill is designed to augment the inadequate number of health professionals serving the Indian community. Part A provides scholarship grants to individuals who are enrolled in medical schools: schools of optometry, osteopathy, dentistry, pharmacy, podiatry, public health or nursing; or schools licensed by a State to train persons in the allied health professions. These grants contain the condition that the individuals who receive them must serve the Indian community after completion of their professional training. Part B provides scholarship grants to Indians who have finished high school and demonstrate a capability of successfully completing a premedical, predental or preosteopathy course of study.

Part C addresses the problem of maintaining the physicians, once trained, in the rural and remote areas where a significant portion of the Indian people reside. The difficulties associated with meeting physician needs in rural America are well known. These difficulties are based on several critical factors among which are lack of sufficient monetary reward, few social amenities available in rural communities, inadequate housing and the inability to have frequent asso-

ciation with professional colleagues. While it is difficult to say with certainty that any one of these factors is overriding when a young physician is preparing to initiate his career, the ability to frequently associate with professional colleagues can be an important consideration in determining where he will practice. Part C attempts to offset the negative impact of the lack of such associational opportunities in rural areas by providing allowances to Service physicians to enable them to leave their duty station for prescribed periods of time for professional consultation and refresher training courses.

Title II provides added appropriations over a 5-year period to alleviate the tremendous backlog in basic patient care, field health care and dental care. In addition, funds are provided for basic maintenance and repair of existing hospitals and related facilities. Also provided are such additional health personnel and administrators necessary to implement this massive effort to reduce the patient backlog.

Title III, part A, attacks the problem of inadequate or outdated Service hospitals, health centers and health stations by authorizing $400 million over 5 years for construction of new facilities. This title, if enacted, would constitute a major effort at eliminating some of the more archaic health installations and at the same time providing some new facilities in geographic areas where they are critically needed. The Secretary of Health, Education, and Welfare is also authorized to equip and staff these facilities at levels commensurate with their operation at optimum levels of effectiveness.

Part B authorizes $470 million over a 5-year period to supply vitally needed safe water and sanitary waste disposal facilities in both existing and new Indian homes and communities. It requires the Secretary of Health, Education, and Welfare, together with the Secretaries of Interior and Housing and Urban Development, to come forth within 3 months with a plan to provide the essential water and sanitation facilities in accordance with the 5-year expenditure schedule.

Title IV is designed to give Indians greater access to and benefits from the present social welfare programs presently available to all Americans. To accomplish this the bill will provide for direct medicare and medicaid payments to Indian health hospitals instead of to the general Treasury.

Title V encourages the establishment of "outreach programs" in urban areas to make health services more accessible to the urban Indian population. A few urban Indian organizations have already established referral services to assist their members in securing the fullest possible access to adequate medical services and facilities. This bill gives recognition to the modest success of these organizations in the urban Indian community. To encourage additional efforts, the Secretary of Health, Education, and Welfare is authorized to enter into contracts with urban Indian organizations to provide them with financial assistance. These contracts are conditioned upon the urban Indian organizations identifying the available health resources within the urban centers in which they are situated, determining the Indian population which are or could be recipients of health services; and assisting urban Indians in utilizing these available resources.

Title VI provides for an evaluation system whereby the Secretary of Health, Education, and Welfare is required within 3 months of the end of fiscal year 1978 to submit a report containing a review and assessment of the programs provided under this bill including recommendations of additional programs and assistance designed to bring Indians to a health status equal to that of the general population.

Mr. President, in conclusion I want to state emphatically that unless our Government is willing to take affirmative action to improve the health status of Indian people, I am convinced that many of our efforts to improve the social and economic progress of Indians will stand as mere hollow promises. I ask my colleagues how individual Indians and their tribes whose health status is at least a generation behind that of the general population can aggressively pursue complex community, social and economic development plans when they are faced with such serious health constraints?

Mr. President, I stand on the principle that every Indian man, woman and child in this Nation has the God given right to enjoy sound physical and mental health. The members of this great body can help Indian people to achieve that right. In fact we owe them that right due to the Indians' unique historic and legal relationship with the Federal Government which has its basis in the Constitution itself. But to do so we must be prepared to provide them with appropriate tools—financial resources, facilities, manpower training and flexible authorities—to develop a health delivery system capable of achieving this highly desirable goal.

Mr. President, that concludes my formal remarks. I ask that the bill be printed in the RECORD along with several tables which demonstrate all too clearly the deplorable health conditions presently existing among Indians.

There being no objection, the bill and tables were ordered to be printed in the RECORD, as follows:

S. 2938

A bill to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Indian Health Care Improvement Act."

FINDINGS

SEC. 2. The Congress finds that—

(a) Federal Indian health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, the resulting responsibility to, the American Indian people.

(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

(c) Federal health services to Indians have resulted in a reduced prevalence and incidence of preventable illnesses and unnecessary and premature deaths among Indians.

(d) Despite such services, the unmet health needs of the American Indian people are severe and the health status of Indian is far below that of the general population of the United States. Illustratively, for Indians compared to all Americans in 1971, the tuberculosis death rate was over four and one-half times greater, the influenza and pneumonia death rate over one and one-half times greater, and the infant death rate about 20 percent greater.

(e) All other Federal services and programs in fulfillment of the Federal responsibility to Indians are jeopardized by the low health status of the American Indian people.

(f) Further improvement in Indian health is imperilled by—

(1) inadequate, outdated, inefficient and undermanned facilities. For example, only 21 of 51 Indian Health Service hospitals are accredited; only 12 meet national fire and safety codes; and 57 areas with Indian populations have been identified as requiring either new or replacement health centers and stations, or clinics remodeled for improved or additional service;

(2) shortage of personnel. For example, about two-thirds of the service hospitals, four-fifths of service hospital outpatient clinics, and one-half of the service health clinics meet only 80 percent of staffing standards for their respective services;

(3) insufficient services in such areas as laboratory, hospital inpatient and outpatient, eye care and mental health services and services available through contracts with private physicians, clinics, and agencies. For example, about 82 percent of the surgical operations needed for otitis media are unperformed, over 57 percent of required dental services have not been provided, and about 98 percent of the need for hearing aids is unmet;

(4) related support factors. For example, over 700 housing units are needed for staff at remote service facilities;

(5) lack of access of Indians to health services due to remote residences, undeveloped or underdeveloped communication and transportation systems, and difficult, sometimes severe, climatic conditions; and

(6) lack of safe water and sanitary waste disposal services. For example, over 40,000 existing, and 62,000 planned replacement and renovated, Indian housing units need new or upgraded water and sanitation facilities.

(g) The Indian people's growing confidence in Federal Indian health services is revealed by their increasingly heavy use of such services. Progress toward the goal of better Indian health is dependent on this continued growth of confidence. Both such progress and such confidence are dependent on improved Federal Indian health services.

DECLARATION OF POLICY

SEC. 3. The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation 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.

DEFINITIONS

SEC. 4. For purposes of this Act—

(a) "Indian", unless otherwise designated, means a person who is a member of an Indian tribe.

(b) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native

community as defined in the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(c) "Secretary", unless otherwise designated, means the Secretary of Health, Education, and Welfare.

(d) "Service", unless otherwise designated, means the Indian Health Service.

TITLE I—INDIAN HEALTH MANPOWER

SEC. 101. The purpose of this title is to augment the inadequate number of health professionals serving Indians and remove the multiple barriers to the entrance of health professionals into the Service and private practice among Indians.

PART A—HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

SEC. 102 (a). The Secretary shall, in accordance with the provisions of this title, make scholarship grants to individuals (i) who are enrolled in medical schools; schools of optometry, osteopathy, dentistry, pharmacy, podiatry, public health, or nursing; or schools licensed by a State to train persons in the allied health professions and (ii) who agree to provide their professional services to Indians after completion of their professional training.

(b)(1) The Secretary shall, in awarding scholarship grants under this part, accord priority to applicants as follows—

(A) first, to any qualified applicant who is a member of an Indian tribe and resides on an Indian reservation;

(B) second, to any qualified applicant who is a member of an Indian tribe and resides in a place other than an Indian reservation;

(C) third, to any other qualified applicant.

(2) Scholarship grants under this title shall be made with respect to academic years.

(c)(1) Any scholarship grant awarded to any individual under this title shall be awarded under the condition that such individual will, after the completion of his professional training, provide his professional services to Indians.

(2) The Secretary shall prescribe by regulations—

(A) the criteria for determining when an individual is providing professional services to Indians in fulfillment of the condition for scholarship assistance provided in paragraph 1, and

(B) the reasonable period of time said condition must be complied with by such individual.

(3) If any individual to whom the condition referred to in paragraph (1) is applicable fails, within the period prescribed pursuant to regulations under paragraph (2), to comply with such condition for the full period, the United States shall be entitled to recover from such individual an amount equal to the amount produced by multiplying—

(A) the aggregate of (i) the amounts of the scholarship grant or grants (as the case may be) made to such individual under this part, and (ii) the sums of the interest which would be payable on each such scholarship grant if, at the time such grant was made, such grant were a loan bearing interest at a rate fixed by the Secretary of the Treasury, after taking into consideration private consumer rates of interest prevailing at the time such grant was made, and if the interest on each such grant had been compounded annually, by

(B) a fraction the numerator of which is the number obtained by subtracting from the number of months to which such condition is applicable a number equal to one-half of the number of months with respect to which compliance by such individual with such condition was made, and the denominator of which is a number equal to the number of months with respect to which such condition is applicable.

Any amount which the United States is entitled to recover under this paragraph shall, within the three-year period beginning on the date the United States becomes entitled to recover such amount, be paid to the United States. Until any amount due the United States under this paragraph on account of any grant under this part is paid, there shall accrue to the United States interest on such amount at the same rate as that fixed by the Secretary of the Treasury pursuant to clause (A) with respect to the grant on account of which such amount is due the United States.

(4)(A) Any obligation of any individual to comply with the condition applicable to him under the preceding provisions of this subsection shall be canceled upon the death of such individual.

(B) The Secretary shall by regulations provide for the waiver or suspension of any such obligation applicable to any individual whenever compliance by such individual is impossible or would involve extreme hardship to such individual and if enforcement of such obligation with respect to any individual would be against equity and good conscience.

SEC. 103. The Secretary may enter into agreements with any schools referred to in section 102(a), hospitals, or appropriate public or private agencies under which such schools, hospitals, or other agencies will, as agents of the Secretary, perform such functions in the administration of this part, as the Secretary may specify. Any such agreement with any such school, hospital, or agency may provide for payment by the Secretary of amounts equal to the expenses actually and necessarily incurred by such school, hospital, or agency in carrying out such agreement.

SEC. 104. There are authorized to be appropriated for the purpose of this part $8,000,000 for fiscal year 1975, $16,000,000 for fiscal year 1976, $22,000,000 for fiscal year 1977, $30,000,000 for fiscal year 1978, and $34,000,000 for fiscal 1979, and, for each succeeding fiscal year, such sums as may be necessary to continue to make such grants to individuals who (prior to July 1, 1979) have received such grants and who are eligible for such grants under this part during such succeeding fiscal year.

PART B—HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM

SEC. 105. (a) The Secretary shall, in accordance with the provisions of this part, make scholarship grants to Indians who—

(1) have successfully completed their high school education; and

(2) have demonstrated an aptitude for being capable of successfully completing a pre-medical, pre-dental, or pre-osteopathy course of study.

(b) A scholarship grant made under this part shall be for a period not to exceed two academic years.

(c) A scholarship grant made under this part may cover costs of tuition, books, transportation, board, and other necessary related expenses.

(d) There are authorized to be appropriated for the purpose of this part $1,000,000 for fiscal year 1975; $2,000,000 for fiscal year 1976; $3,000,000 for fiscal year 1977; $3,000,000 for fiscal year 1978; and $3,000,000 for fiscal year 1979.

PART C—CONTINUING EDUCATION ALLOWANCES

SEC. 106. (a) In order to encourage professionals to join the Service and to provide their services in the rural and remote areas where a significant portion of the American Indian people reside, the Secretary may provide allowances to Service physicians to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty stations for professional consultation and refresher training courses.

(b) There are authorized to be appropriated for the purpose of this section $350,000 for fiscal year 1975, $350,000 for fiscal year 1976, $375,000 for fiscal year 1977, $390,000 for fiscal year 1978, and $410,000 for fiscal year 1979.

TITLE II—HEALTH SERVICES

SEC. 201. (a) For the purpose of eliminating backlogs in Indian health care services and to supply known, unmet medical, surgical, dental and other Indian health needs, the Secretary is authorized to expend, through the Service, $123,500,000 over a five fiscal year period in accordance with the schedule provided in subsection (c). As such funds which are appropriated pursuant to this Act are to eliminate health services backlogs, they shall not be used to offset or limit the appropriations required by the Service to continue to serve the health needs of Indian people during and subsequent to such five fiscal year period but shall be in addition to the annual appropriations required to continue the health service program to the Indian people.

(b) The Secretary is also authorized to employ persons to implement the provisions of this section during the five fiscal year period in accordance with the schedule provided in subsection (c). Such persons shall be in addition to, and shall not reduce the number of, the employees required to conduct ongoing activities of the Service during and subsequent to such period.

(c) The following amounts and positions are authorized, by fiscal year, for the specific purposes noted:

(1) patient care (direct and indirect): for fiscal year 1975, $11,000,000 and 240 positions; for fiscal year 1976, $17,000,000 and 540 positions; for fiscal year 1977, $14,000,000 and 410 positions: for fiscal year 1978, $9,000,000 and 500 positions; and for fiscal year 1979, $7,000,000 and 490 positions;

(2) field health, excluding dental care (direct and indirect): for fiscal year, 1975, $12,000,000 and 300 positions; for fiscal year 1976, $10,000,000 and 225 positions; for fiscal year 1977, $7,000,000 and 200 positions; for fiscal year 1978, $7,000,000 and 200 positions; and for fiscal year 1979, $5,000,000 and 100 positions;

(3) dental care (direct and indirect): for fiscal year 1975, $900,000 and 60 positions; for fiscal year 1976, $700,000 and 75 positions; for fiscal year 1977, $700,000 and 75 positions; for fiscal year 1978, $600,000 and 75 positions; and for fiscal year 1979, $600,000 and 60 positions; and

(4) maintenance and repair (direct and indirect): for fiscal year 1975, $6,000,000 and 30 positions; for fiscal year 1976, $4,000,000 and 30 positions; for fiscal year 1977, $4,000,000 and 30 positions; for fiscal year 1978, $4,000,000 and 30 positions; and for fiscal year 1979, $3,000,000 and 30 positions.

TITLE III—HEALTH FACILITIES

PART A—CONSTRUCTION AND RENOVATION OF SERVICE FACILITIES

SEC. 301. For the purpose of eliminating inadequate, outdated and otherwise unsatisfactory Service hospitals, health centers, health stations and other Service facilities, the Secretary is authorized to expend $400,000,000 over a five fiscal year period in accordance with the following schedule:

(a) hospitals: for fiscal year 1975, $40,000,000; for fiscal year 1976, $76,000,000; for fiscal year 1977, $65,000,000; for fiscal year 1978, $55,000,000; and for fiscal year 1979, $80,000,000.

(b) health centers and health stations: for fiscal year 1975, $4,000,000; for fiscal year 1976, $6,000,000; for fiscal year 1977, $2,000,000; for fiscal year 1978, $2,000,000; and for fiscal year 1979, $11,000,000.

(c) staff housing: for fiscal year 1975, $13,000,000; for fiscal year 1976, $21,000,000; for

fiscal year 1977, $16,000,000; for fiscal year 1978, $5,000,000; and for fiscal year 1979, $4,000,000.

SEC. 302. The Secretary is authorized to equip and staff such Service facilities at levels commensurate with their operation at optimum levels of effectiveness.

SEC. 303. For the purpose of implementing the provisions of this part, the Secretary shall assure that the rates of pay for personnel engaged in the construction of renovation of facilities constructed or carried out in whole or in part by funds made available pursuant to this part are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1921 (48 Stat. 1491), as amended.

PART B—CONSTRUCTION OF SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 304. (a) For the purpose of reducing health hazards, the Secretary is authorized to expend, pursuant to Public Law 86–121, $470,000,000 within a five fiscal year period following the enactment of this Act, in accordance with the schedule provided in subsection (b), to supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.

(b) The following amounts are authorized, by fiscal year, for the purpose prescribed in subsection (a): $90,000,000 in fiscal year 1975; $95,000,000 in fiscal year 1976; $95,000,000 in fiscal year 1977; $95,000,000 in fiscal year 1978; and $95,000,000 in fiscal year 1979.

(c) The Secretary is authorized and directed to develop a plan, together with the Secretaries of Housing and Urban Development and the Interior, to assure that the schedule provided for in subsection (b) will be met. Such plan shall be submitted to the Congress no later than ninety days from the date of enactment of this Act.

TITLE IV—ACCESS TO HEALTH SERVICES

SEC. 401. (a) Notwithstanding any other provision of law, for the purpose of Title XVIII of the Social Security Act, as amended, the Service facilities used to provide health care and services to Indians are hereby deemed to be accredited facilities, the services so provided shall be deemed to be provided by licensed practitioners in their respective fields, and the facilities may receive payment for such services on the same basis as other providers of service.

(b) The Secretary shall undertake to improve and maintain such service facilities such that they will, at a minimum, meet the accreditation standards imposed on other providers of service.

(c) Any payments received for services provided to beneficiaries hereunder shall be credited to the appropriation charged for the actual provision of care and services and shall not be considered in determining appropriations for health care and services to Indians.

(d) Nothing herein authorizes the Secretary to provide services to an Indian beneficiary with coverage under Title XVIII of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

SEC. 402. (a) Notwithstanding any other provision of law, for the purpose of Title XIX of the Social Security Act, as amended, the Service facilities used to provide health care and services to Indians are hereby deemed to be accredited facilities and the services so provided in these facilities are deemed to be provided by licensed practitioners in their respective fields.

(b) The Secretary is authorized to enter into agreements with the appropriate State agency for the purpose of receiving reimbursement for health care and services provided to Indians who are beneficiaries under Title XIX of the Social Security Act, as amended.

(c) The Secretary shall undertake to improve such facilities such that they will meet or exceed any applicable accredited standard.

(d) Any payments received for services provided beneficiaries hereunder shall be credited to the appropriation charged for the actual provision of care and services, which amount shall not be considered in determining appropriations for the provision of health care and services to Indians.

(e) Nothing in this section shall authorize the Secretary to provide services to an Indian beneficiary with coverage under Title XIX of the Social Security Act, as amended, in preference to an Indian beneficiary without such coverage.

TITLE V—ACCESS TO HEALTH SERVICES FOR URBAN INDIANS

SEC. 501. The purpose of this title is to encourage the establishment of outreach programs in urban areas to make health services more accessible to the urban Indian population.

SEC. 502. For the purpose of this title—

(a) "Urban Indian" means any individual who resides in an urban center and who is (i) an Indian as defined in section 4(a) of this Act or (ii) a person of Indian descent who is considered ineligible for the special programs and services of the Service and the Bureau of Indian Affairs and who, in accordance with regulations promulgated by the Secretary which take into consideration such person's health needs, lack of access to health services, and other relevant factors, is identified as an appropriate recipient of assistance from an urban Indian organization in accordance with the provisions of this title.

(b) An "urban Indian organization" is a non-profit corporate body situated in an urban center, composed of urban Indians, and providing the maximum participation of all interested Indian groups, which body is capable of legally cooperating with other bodies, Federal, State and local, for the purpose of performing the activities described in section 503(c).

(c) An "urban center" is any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under this title, as determined by the Secretary.

SEC. 503(a). The Secretary shall enter into contracts with urban Indian organizations to provide Federal assistance to such organizations for the purpose of establishing and administering outreach programs to make urban Indians in the urban centers in which such organizations are situated knowledgeable of the health service resources available within such centers and the means of gaining access to those resources.

(b) Urban Indian organizations shall make use of Federal assistance provided by contracts pursuant to this title not to provide health services to urban Indians but to render advice and consultation to such Indians concerning the availability and means of access to all public and private health services.

(c) The Secretary shall place such conditions as he deems necessary in any contract which he makes with any urban Indian organization pursuant to this title. Such conditions shall include, but are not limited to, requirements that the organization successfully undertake the following tasks:

(1) determine, in accordance with the regulations promulgated pursuant to section 502(a), the population of urban Indians which are or could be recipients of such services;

(2) identify all public and private health service resources within the urban center in which the organization is situated which are or may be available to urban Indians;

(3) assist such resources in providing service to such urban Indians;

(4) assist such urban Indians in becoming familiar with and utilizing such resources;

(5) provide basic health educaton to such urban Indians;

(6) identify gaps between unmet health needs of urban Indians and the resources available to meet such needs; and

(7) make recommendations to the Secretary and Federal, State, local and other resource agencies on methods of improving health service programs to meet the needs of urban Indians.

(d) The Secretary shall by regulation prescribe the criteria for selecting urban Indian organizations with which to contract pursuant to this title. Such criteria shall, among other factors, take into consideration—

(1) the extent of the unmet health care needs of the urban Indian in the urban center in question;

(2) the size of the urban Indian population which is to receive assistance;

(3) the relative accessibility which such population has to health care services in such urban center;

(4) the extent, if any, that the project would duplicate any previous or current public or private project funded by another source in such urban center;

(5) the appropriateness and likely effectiveness of a project assisted pursuant to this title in such urban center;

(6) the existence of an urban Indian organization capable of performing the activities set forth in subsection (c) and of entering into a contract with the Secretary pursuant to this title; and

(7) the extent of existing or likely future participation of appropriate health and health-related State, local, and other resource agencies.

SEC. 504 (a) Contracts with urban Indian organizations pursuant to this title shall be in accordance with all Federal contracting laws and regulations except that, in the discretion of the Secretary, such contracts may be negotiated without advertising and need not conform with the provisions of the Act of August 24, 1935 (49 Stat. 793), as amended.

(b) Payments under any contracts pursuant to this Act may be made in advance or by way of reimbursement and in such installments and on such conditions as the Secretary deems necessary to carry out the purposes of this title.

(c) Notwithstanding any provision of law to the contrary, the Secretary may, at the request or consent of an urban Indian organization, revise or amend any contract made by him with such organization pursuant to this title as necessary to carry out the purposes of this title: *Provided, however,* That whenever an urban Indian organization requests retrocession of the Secretary for any contract entered into pursuant to this title, such retrocession shall become effective upon a date specified by the Secretary not more than one hundred and twenty days from the date of the request by the organization or at such later date as may be mutually agreed to by the Secretary and the organization.

(d) In connection with any contract made pursuant to this title, the Secretary may permit an urban Indian organization to utilize, in carrying out such contract, existing facilities owned by the Federal Government within his jurisdiction under such terms and conditions as may be agreed upon for their use and maintenance.

(e) The contracts authorized under this title may include provisions for the performance of personal services which would otherwise be performed by Federal employees: *Provided,* That the Secretary shall not make any contract which would impair his ability to discharge his trust responsibilities to any Indian tribe or individuals.

(f) Contracts with urban Indian organizations and regulations adopted pursuant to

this title shall include provisions to assure the fair and uniform provision by such organizations of services and assistance to Indians in the conduct and administration of programs or activities under such contracts.

SEC. 505. For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, the organization which requested such contract or grant shall submit to the Secretary a report including information gathered pursuant to 503(c) (6) and (7), information on activities conducted by the organization pursuant to the contract, an accounting of the amounts and purposes for which Federal funds were expended, and such other information as the Secretary may request. The reports and records of the urban Indian organization with respect to such contract or grant shall be subject to audit by the Secretary and the Comptroller General of the United States.

SEC. 506. There are authorized to be appropriated for the purpose of this title $3,000,000 for the fiscal year 1975; $4,000,000 for the fiscal year 1976; and $5,000,000 for the fiscal year 1977.

SEC. 507. Within six months after the end of fiscal year 1976, the Secretary shall review the program established under this title and shall submit to the Congress his assessment thereof and recommendations for any further legislative efforts he deems necessary to meet the purposes of this title.

TITLE VI—MISCELLANEOUS

SEC. 601. The Secretary shall report annually to the President and the Congress on progress made in effecting the purposes of this Act. Within three months after the end of fiscal year 1978, the Secretary shall review the programs established or assisted under this Act and shall submit to the Congress his assessment thereof and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services to Indians, and ensure a health status for Indians, which is at a parity with the health services available to, and the health status of, the general population.

SEC. 602. The Secretary may prescribe such regulations as he deems necessary to carry out the purposes of this Act. Such regulations shall provide the opportunity for maximum participation of Indians in the planning and implementation of Indian health programs.

SEC. 603. The funds appropriated pursuant to this Act shall remain available until expended.

HEALTH MANPOWER STATISTICS

The number of Indian Health Service physicians and registered nurses per 100,000 persons served by the Indian Health Service has continually lagged behind the rate for the United States.

A degree of success has been shown in closing the gap between the physician rates for the Indian Health Service and the United States all races. The number of physicians per 100,000 population in 1971 in the Indian Health Service was 58 percent of the U.S. rate. In 1960 the IHS rate was less than 40 percent of the U.S. rate.

The rate for registered nurses within the IHS has remained almost constant since 1967. The range during this period was from a low of 213 registered nurses per 100,000 population in 1967 to a high of 230 in 1956. The rate for the United States has experienced a continual increase from 1956 through 1971.

NUMBER OF REGISTERED NURSES AND PHYSICIANS - INDIAN HEALTH SERVICES AND UNITED STATES, ALL RACES

Year	Registered nurses			Physicians		
	Number IHS staff	Rate per 100,000 IHS	Rate per 100,000 United States [1]	Number IHS staff	Rate per 100,000 IHS	Rate per 100,000 United States [2]
1971	1,073	228	356	458	98	[3] 170
1970	1,007	219	347	449	93	[3] 166
1969	981	217	338	425	94	[3] 163
1968	984	222	331	392	88	[3] 161
1967	930	213	325	357	82	158
1966	909	212	319	335	78	156
1964	913	222	306	299	73	151
1962	875	221	298	256	65	NA
1960	809	213	282	216	57	148
1958	828	229	268	209	58	NA
1956	790	230	259	195	57	NA

[1] Facts about Nursing.
[2] Health Resources Statistics, 1971.
[3] Estimated.
NA—Not available.

INFANT DEATH RATES BY AGE

The 1971 Indian and Alaska native infant death rate is 24 percent higher than the provisional U.S. all races rate for 1971. The Indian and Alaska native infant death rate was 65 percent higher than the U.S. all races rate in 1966. Thus, we have seen considerable improvement in the Indian and Alaskan native infant death rate just since 1966.

The neonatal death rate for the Indian and Alaska native is below that of the U.S. However, the postneonatal rate is over 2.3 times the U.S. rate. This ratio, however, is improving. In 1966 the Indian and Alaska native rate was 3.3 times the U.S. rate.

INFANT DEATH RATES BY AGE AT DEATH INDIANS AND ALASKA NATIVES AND UNITED STATES, ALL RACES

[Rates per 1,000 live births]

	Infant death rate	Neonatal			Postneonatal, 28 days to 11 mo.
		Total	Under 1 day	1 to 6 days	7 to 27 days	
Indians and Alaska Natives:						
1971	23.8	12.5	7.4	3.4	1.7	11.4
1970	NA	NA	NA	NA	NA	NA
1969	NA	NA	NA	NA	NA	NA
1968	30.9	14.4	7.9	4.1	2.4	16.5
1967	32.2	15.3	8.4	5.1	1.8	16.9
1966	39.0	17.3	9.6	5.6	2.7	21.7
United States, all races:						
1971 [1]	19.2	14.3	NA	NA	NA	4.9
1970 [1]	19.8	14.9	NA	NA	NA	5.0
1969 [1]	20.7	15.4	NA	NA	NA	5.4
1968	21.8	16.1	9.5	5.1	1.5	5.7
1967	22.4	16.5	9.6	5.3	1.6	5.9
1966	23.7	17.2	10.0	5.6	1.6	6.5

[1] Provisional, Monthly Vital Statistics Report, NCHS, vol. 20, No. 11.
NA—Not available.

MEDICAL CARE COST

The consumer price index for medical care shows a continuous upward trend. Physician fees, hospital daily charges, and drugs and prescriptions costs increased; physician fees were 32 percent above the base year 1967, hospital daily charges 66 percent, and drugs and prescriptions 6 percent.

CONSUMER PRICE INDEX FOR URBAN WAGE EARNERS AND CLERICAL WORKERS, U.S. CITY AVERAGE

[1967=100 [1]]

Year	Medical care				Physicians' fees				Hospital daily services charges				Drugs and prescriptions			
	March	June	September	December	March	June	September	December	March	June	September	December	March	June	September	December
1961	80.8	81.4	81.9	82.3	78.3	78.9	79.4	80.2	58.9	60.8	61.8	62.7	103.4	103.7	103.1	102.7
1962	83.1	83.7	83.9	84.3	80.8	81.3	81.7	82.2	64.3	64.7	65.5	66.1	102.3	102.1	101.0	100.0
1963	84.9	85.7	86.0	86.2	82.9	83.1	83.4	83.8	68.1	68.9	69.8	70.4	100.8	100.8	100.8	100.0
1964	86.8	87.3	87.6	88.0		85.0		86.3	71.7	72.3	73.0	73.7		100.7		100.2
1965	88.8	89.4	89.8	90.5		88.0	88.7	89.6	75.4	76.2	77.4	78.5		100.2	100.0	100.2
1966	91.7	92.9	94.7	96.5	91.2	93.0	95.1	96.6	80.4	82.1	86.3	91.5	100.5	100.7	100.6	100.4
1967	98.5	99.7	101.3	102.7	98.5	99.8	101.3	102.5	97.1	100.0	102.0	105.6	100.1	99.8	100.0	100.2
1968	104.5	105.6	107.1	109.1	104.1	105.3	106.5	108.4	109.9	112.2	115.8	119.6	100.3	100.1	100.1	100.0
1969	111.6	113.5	115.3	115.7	110.9	113.0	114.8	116.3	124.5	126.8	130.9	133.9	100.9	101.4	101.4	101.7
1970	118.2	120.5	122.6	124.2	119.0	121.6	123.3	125.7	139.4	142.1	147.5	152.0	102.5	103.8	104.3	104.2
1971	126.8	128.6	130.4	130.1	128.0	129.9	131.5	132.2	157.1	160.5	164.4	165.5	104.9	105.7	105.7	105.0
1972	131.4	132.4	133.1	134.4	132.9	133.9	134.4	135.4	NA	NA	NA	NA	105.7	105.8	105.7	105.6

DENTAL SERVICES PROVIDED BY AGE

In fiscal year 1972, 72 percent of the required services in the age group 5–14 were provided. This age group has historically seen the highest percentage of required services provided. The percentage decreased with each successive age group.

Estimated services required for the Indian and Alaska native population in fiscal year 1972 was over 2 million. The percentage of required services provided was 40.3.

It is estimated that a total dental program should provide comprehensive dental services to 70–80 percent of the population 3–19 years and 46 percent of the population over age 20. The IHS dental program provided less than 60.2 percent of the needed services for Indian children less than 20 years of age and only 18.9 percent of the services needed for the Indian population age 20 and over.

PERCENT OF ESTIMATED REQUIRED DENTAL SERVICES PROVIDED, FISCAL YEAR 1972

Age group (in years)	Services required per person examined	Indian health service population	Estimated services required in population	Services provided direct and contract	Percent of required services provided
All ages	8.06	469,632	2,098,215	844,724	40.3
Under 5	6.66	61,287	102,042	41,596	40.8
5 to 9	6.45	70,698	364,801	268,554	73.6
10 to 14	5.72	66,800	305,676	214,057	70.0
15 to 19	7.03	63,172	261,659	119,883	45.8
20 to 24	9.80	33,057	161,979	49,615	30.6
25 to 34	10.72	52,148	279,513	63,727	22.8
35 to 44	11.29	43,192	243,818	39,387	16.2
45 to 54	11.57	33,997	177,005	24,927	15.1
55 to 64	11.19	27,135	121,456	14,267	11.7
65 to 74	10.91	18,086	59,195	6,603	11.2
75 and over	10.47	10,060	21,065	2,108	10.0

INFANT DEATHS

The infant death rate among Indians and Alaska Natives declined 61.9 percent between 1955 and 1971. The 1955 rate of 62.5 had been reduced to 23.8 deaths per 1,000 live births by 1971. Concurrently, the U.S. general population experienced a drop of 27.3 percent. The 1955 Indian and Alaska Native infant death rate was 2.37 times the U.S. All Races rate. By 1971 the Indian rate had been reduced to 1.24 times the U.S. rate. The Alaska Native rate has consistently exceeded the Indian rate. In 1971 the Alaska Native rate was 17 percent higher than the Indian rate.

INFANT DEATHS AND DEATH RATES—INDIAN AND ALASKA NATIVES IN 24 RESERVATION STATES AND UNITED STATES, ALL RACES, CALENDAR YEARS 1955–71

[Rates per 1,000 live births]

Year	Indian and Alaska Native		Indian		Alaska Native		United States all races	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate
1971	560	23.8	513	23.5	47	27.4	NA	[2] 19.2
1970	[1] 570	NA	[1] 523	NA	[1] 47	NA	NA	[2] 19.8
1969	579	NA	533	NA	46	NA	75,073	21.5
1968	668	30.9	606	30.2	62	40.4	76,263	21.8
1967	666	32.2	571	30.1	95	55.6	79,028	22.4
1966	822	39.0	722	37.7	100	51.4	85,516	23.7
1965	872	39.0	740	36.4	132	65.4	92,866	24.7
1964	856	37.6	747	35.9	109	54.8	99,783	24.8
1963	972	43.6	864	42.9	108	53.7	103,390	25.2
1962	967	44.2	827	41.8	140	66.8	105,479	25.3
1961	961	44.4	827	42.3	134	64.0	107,956	25.3
1960	1,064	50.3	914	47.6	150	76.3	110,873	26.0
1959	1,016	49.5	870	46.7	146	76.7	112,008	26.4
1958	1,123	58.0	989	56.7	134	69.0	113,789	26.1
1957	1,136	60.4	989	58.2	147	80.2	112,094	26.3
1956	1,066	59.4	900	56.1	166	87.0	108,183	26.0
1955	1,065	62.5	936	61.2	129	74.8	106,903	26.4

[1] Estimated.

[2] Provisional, Monthly Vital Statistics Report, NCHS, vol. 20, No. 12.

TUBERCULOSIS DEATHS AND DEATH RATES

Tuberculosis death rates for Indians and Alaska Natives, combined, declined about 86 percent from 1955 to 1971. In 1971 the Indian rate was about 1/6 what it was in the 1954–1956 period, and the Alaska Native rate was only 1/16 as high as it had been in the 1954–1956 period. Concurrently, there was a decline in the U.S. All Races rate from 9.1 deaths per 100,000 population in 1955 to a provisional figure of 2.1 in 1971. As a result, the combined Indian and Alaska Native rate, which was 6.1 times the U.S. rate in 1955, was still 3.7 times as high in 1971.

TUBERCULOSIS MORTALITY—INDIANS AND ALASKA NATIVES IN 24 RESERVATION STATES AND UNITED STATES, ALL RACES CALENDAR YEARS 1955 TO 1971, RATES PER 100,000 POPULATION [1]

Year	Indian and Alaska Native		Indian		Alaska Native		United States, all races		Ratio Indian and Alaska Native to United States, all races
	Number of deaths	Rate	Number of deaths	Rate	Number of deaths	Rate	Number of deaths	Rate	
1971	56	7.8	51	7.6	5	9.7	[2] 4,380	[2] 2.1	3.7
1970	NA	NA	NA	NA	NA	NA	[2] 5,560	[2] 2.7	NA
1969	86	12.6	82	13.0	4	8.0	5,567	2.8	4.5
1968	78	12.8	71	12.8	7	12.9	6,292	3.1	4.1
1967	90	13.5	82	13.4	8	14.3	6,901	3.5	3.9
1966	91	15.3	85	15.4	6	15.3	7,625	3.9	3.9
1965	104	19.0	96	19.3	8	16.0	7,934	4.1	4.6
1964	111	21.8	103	21.6	8	24.0	8,303	4.3	5.1
1963	130	25.1	114	24.8	16	28.5	9,311	4.9	5.1
1962	150	26.0	137	25.3	13	34.0	9,506	5.1	5.1
1961	120	25.4	105	24.5	15	34.8	9,938	5.4	4.7
1960	115	26.6	98	25.1	17	43.1	10,866	6.1	4.3
1959	163	29.0	140	27.9	23	41.8	11,456	6.5	4.5
1958	150	34.3	138	31.5	12	65.1	12,361	7.1	4.8
1957	186	38.2	134	34.2	43	83.3	13,324	7.8	4.9
1956	212	46.2	171	40.2	41	116.8	14,054	8.4	5.5
1955	253	55.1	208	47.3	45	157.5	14,940	9.1	6.1

[1] Indian and Alaska Native rates are 3-year averages through 1968. All other rates are based on single year data.

[2] Provisional figures—Monthly Vital Statistics Report.

NA Not available.

INDIAN AND ALASKA NATIVE ADMISSIONS

Admissions to IHS and contract hospitals have experienced an upward trend since 1955. Admissions for fiscal year 1972 are more than double the admissions reported in 1955. Admissions to contract hospitals have increased more rapidly than for IHS facilities. The rate of increase for IHS hospitals has been 77.9 percent as contrasted to a 257.9 percent increase in contract hospital admissions.

NUMBER OF ADMISSIONS TO PHS INDIAN AND CONTRACT HOSPITALS, FISCAL YEARS 1955–72

Fiscal year	Total	PHS Indian hospitals	Contract hospitals
1972	102,472	76,054	26,418
1971	94,945	70,729	24,216
1970	92,710	67,877	24,833
1969	94,490	69,560	24,930
1968	92,186	68,086	24,100
1967	89,556	65,456	24,100
1966	91,799	67,049	24,750
1965	91,744	67,744	24,000
1964	89,934	65,934	24,000
1963	87,549	64,749	22,800
1962	81,476	59,976	21,500
1961	74,313	54,313	20,000
1960	76,754	56,874	19,880
1959	73,268	54,568	18,700
1958	71,859	55,649	16,210
1957	66,455	53,160	13,295
1956	57,975	46,218	11,757
1955	50,143	42,762	7,381

OUTPATIENT VISITS

Outpatient visits to IHS Hospitals, Health Centers, and Field Stations have increased each year since fiscal year 1955. Total outpatient visits in fiscal year 1972 was 2,235,881. This is five times as many visits as reported in 1955. Outpatient visits to field clinics have increased almost tenfold during the period 1955–1972.

NUMBER OF OUTPATIENT MEDICAL VISITS [1] TO PHS INDIAN HOSPITALS AND FIELD HEALTH CLINICS, FISCAL YEARS 1955–72

Fiscal year	Total	Hospitals	Field clinics
1972	2,235,881	1,275,726	[3] 960,155
1971	2,195,240	1,202,030	993,210
1970	1,786,920	1,068,820	718,100
1969	1,661,500	982,300	679,200
1968	1,575,440	926,640	648,800
1967	1,494,600	849,800	644,800
1966	1,367,000	788,500	578,500
1965	1,325,400	757,700	567,700
1964	1,295,000	742,400	552,600
1963	1,271,400	721,700	549,700
1962	1,142,300	673,200	469,100
1961	1,022,600	628,700	393,900

Fiscal year	Total	Hospitals	Field clinics
1960	989,500	585,100	404,400
1959	957,900	546,900	411,000
1958	900,000	533,440	366,500
1957	650,000	510,000	140,000
1956 [2]	540,860	415,860	125,000
1955 [3]	455,000	355,000	100,000

[1] Excludes visits for dental services.
[2] Estimate.
[3] Decreased because of underreporting of grouped services.

TUBERCULOSIS MORBIDITY

The incidence rate for tuberculosis for the Indian and Alaska Native has declined 79 percent since 1955. The U.S. All Races rate has declined 72 percent during the same period. The Indian and Alaska Native rate in 1971 was 9.3 times the U.S. All Races rate. The 1955 ratio was 12.6.

The rates shown prior to 1962 include some newly reported inactive cases while the later years are for newly reported active cases only. However, the trends mentioned are not affected.

TUBERCULOSOS MORBIDITY

[Rates per 100,000 population]

Calendar year	Indian and Alaska Natives	Indian	Alaska Native	United States all races
1971	157.4	152.0	200.3	[1] 17.0
1970	154.1	154.1	154.0	18.3
1969	140.8	141.6	134.3	19.1
1968	133.8	128.0	179.1	21.3
1967	155.8	152.7	179.8	23.0
1966	141.7	127.8	247.8	24.4
1965	201.5	160.5	507.8	25.3
1964	237.8	184.1	630.2	26.6
1963	234.0	192.3	534.9	28.7
1962	257.7	209.4	604.7	28.9
1961	318.8	284.8	562.8	37.0
1960	322.4	292.3	547.5	39.4
1959	418.0	338.2	1,048.0	42.6
1958	485.0	421.8	978.7	47.5
1957	565.2	426.9	1,649.7	51.0
1956	680.6	474.3	2,283.8	54.1
1955	758.1	563.2	2,225.7	60.1

[1] Provisional.

Mr. FANNIN. Mr. President, I am pleased to join with my distinguished colleagues, Senator JACKSON and Senator BARTLETT, in introducing this vital piece of legislation. The health of our Indian citizens has long been of concern to me and this legislation will, I believe, mark a new beginning in our Indian health programs. It also represents a renewal of our long-standing commitment to the Indian people to provide a program of quality health services.

This legislation is significant because its objective is to redraw the legislative authority of the Indian Health Service so that it can meet the contemporary needs of the Indian people. It has become increasingly clear that the existing authority of the Indian Health Service is no longer capable of meeting the ever pressing health problems of its clients and clearly needs new tools, resources, and innovative programs to meet those needs. That is the basic purpose of this bill.

In addition, this legislation seeks to meet the objective of Indian self-determination by developing a program which will serve to increase the number of Indian health personnel. Earlier this week the Senate Interior and Insular Affairs Committee ordered reported S. 1017, The Indian Self-Determination and Educational Reform Act, which provides authority to the Secretary of the Department of Health, Education, and Welfare to contract the services and programs of the Indian Health Service to tribal organizations. But if we are to realize, to the fullest, the opportunity which exists under the contracting provisions of S. 1017, we must develop Indian personnel who can manage such programs and individuals who can serve those who are in need of health services.

President Nixon, in his Indian message of July 8, 1970, reminded us of the problem facing Indian control of health programs and facilities when he noted:

These and other Indian health programs will be most effective if more Indians are involved in running them. Yet—almost unbelievably—we are presently able to identify in this country only 30 physicians and fewer than 400 nurses of Indian descent.

It is my personal hope that through this legislation we will reverse such depressing statistics and report by the end of the decade a substantial increase in the number of Indian doctors, nurses, administrators, and other allied health personnel serving our Indian people.

Yet beyond the long range effort to develop Indian health personnel there is the immediate need to ease the shortage in doctors and other trained personnel. When the military draft was in existence, the Indian Health Service found itself with a number of young health professionals wanting to serve reservation health facilities. In 1969, for example, over 3,000 medical students sought Public Health Service jobs with many indicating that they would serve in the Indian Health Service program. In 1973, however, with the elimination of the draft, the number of applications had dropped to 500 with 525 slots available in the Indian Health Service facilities. What makes the situation even worse is that many of the current professionals will be ending their 2-year commitment in 1974, thus causing even further shortages. This problem is a critical one, especially when one considers that there were 2.2 million outpatient visits in 1972 alone. Without replacements valuable health services may need to be cut. Thus, this legislation has an immediate problem to solve; one that will not be easily resolved, but which cannot be ignored.

Another basic objective of this legislation is to provide increased resources to meet the backlog in construction of health facilities. While the Federal Government has made a major effort to meet the physical plant needs of the Indian Health Service, there are still many facilities which need substantial renovation and expansion. There is also a need for new facilities, not only hospitals, but outpatient clinics as well. The need for quality facilities is becoming increasingly critical as the Joint Committee on Accreditation of Hospitals has reported that of the 51 IHS facilities, only 22 percent are accredited. Clearly there is need to correct such a deficiency and it is the objective of this bill that such deficiencies be removed.

Since the organization of the Indian Health Service in 1955 a number of serious health problems have been resolved. According to Dr. Emery Johnson, the Director of the Indian Health Service:

The decline in deaths from tuberculosis, diseases of infancy, influenza, pneumonia and gastro-intestinal illnesses has been dramatic. Strides also have been made in correcting environmental deficiencies such as inadequate housing and water and sewage disposal facilities, that give rise to a high incidence of disease and premature deaths.

But Dr. Johnson also notes that:

Although the gap has narrowed between the Indian and Alaska Native state of health and that of the rest of the Nation, it is still far below national standards. Infant death rates are 1.4 times higher than the U.S. all races rate, gastroenteric death rate is 4 times higher, and the incidence of tuberculosis is 8 times as high.

There are obviously still many challenges confronting the Indian Health Service. There is a need to combat a wide range of serious diseases such as otitis media, alcoholism, mental illness, and nutritional problems. In addition, there is also a need for expanded sanitation programs and other endeavors to build a lasting preventive health care program so that our Indian citizens can be relieved of the afflictions of disease and illness.

It is in this context that the IHS appears as the chief instrument through which a whole range of health services can be delivered. Yet, the time has come to redesign that instrument to give it the strength to meet the continuing challenges of providing an environment and a system which will promote better health and better health care.

I am pleased to join in this major legislative endeavor, and our goal must be the goal that Dr. Johnson set out during his testimony on the 1974 IHS appropriations request when he stated that:

The future of the Indian Health Service lies in expanded Indian community development, increased meaningful involvement of Indian people, and a responsive high quality comprehensive health care system.

Our commitment is to identify and mobilize all available Federal, State and private resources, and through effective management processes to develop those resources to maximum potential. As we continue to evolve in this direction, we look forward to a significantly improved health status for Indian and Alaska Native people.

OFFICE OF MANAGEMENT AND BUDGET

ROUTE SLIP

TO Mr. Patterson

Room 182 - EOB

Take necessary action	☐
Approval or signature	☐
Comment	☐
Prepare reply	☐
Discuss with me	☐
For your information	☐
See remarks below	☐

FROM Jim Stimpson (3736)

DATE Apr. 8, 1974

REMARKS

Attached for your review is a copy of proposed HEW testimony on S. 2938, the Indian Health Care Improvement Act, scheduled for delivery on Thursday, April 11.

I would appreciate receiving your comments as early as possible. (Please call me or Naomi Sweeney x 3881)

SPECIAL SERVICE

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UNTIL 12:00 PM, EDT

February 6, 1974

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE CONGRESS OF THE UNITED STATES:

One of the most cherished goals of our democracy is to assure every American an equal opportunity to lead a full and productive life.

In the last quarter century, we have made remarkable progress toward that goal, opening the doors to millions of our fellow countrymen who were seeking equal opportunities in education, jobs and voting.

Now it is time that we move forward again in still another critical area: health care.

Without adequate health care, no one can make full use of his or her talents and opportunities. It is thus just as important that economic, racial and social barriers not stand in the way of good health care as it is to eliminate those barriers to a good education and a good job.

Three years ago, I proposed a major health insurance program to the Congress, seeking to guarantee adequate financing of health care on a nationwide basis. That proposal generated widespread discussion and useful debate. But no legislation reached my desk.

Today the need is even more pressing because of the higher costs of medical care. Efforts to control medical costs under the New Economic Policy have been met with encouraging success, sharply reducing the rate of inflation for health care. Nevertheless, the overall cost of health care has still risen by more than 20 percent in the last two and one-half years, so that more and more Americans face staggering bills when they receive medical help today:

-- Across the Nation, the average cost of a day of hospital care now exceeds $110.

-- The average cost of delivering a baby and providing postnatal care approaches $1,000.

-- The average cost of health care for terminal cancer now exceeds $20,000.

For the average family, it is clear that without adequate insurance, even normal care can be a financial burden while a catastrophic illness can mean catastrophic debt.

Beyond the question of the prices of health care, our present system of health care insurance suffers from two major flaws:

First, even though more Americans carry health insurance than ever before, the 25 million Americans who remain uninsured often need it the most and are most unlikely to obtain it. They include many who work in seasonal or transient occupations, high-risk cases, and those who are ineligible for Medicaid despite low incomes.

Second, those Americans who do carry health insurance often lack coverage which is balanced, comprehensive and fully protective:

-- Forty percent of those who are insured are not covered for visits to physicians on an out-patient basis, a gap that creates powerful incentives toward high-cost care in hospitals;

-- Few people have the option of selecting care through prepaid arrangements offered by Health Maintenance Organizations so the system at large does not benefit from the free choice and creative competition this would offer;

-- Very few private policies cover preventive services;

-- Most health plans do not contain built-in incentives to reduce waste and inefficiency. The extra costs of wasteful practices are passed on, of course, to consumers; and

-- Fewer than half of our citizens under 65 -- and almost none over 65 -- have major medical coverage which pays for the cost of catastrophic illness.

These gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills -- or worse. Delays in treatment can end in death or lifelong disability.

Comprehensive Health Insurance Plan (CHIP)

Early last year, I directed the Secretary of Health, Education, and Welfare to prepare a new and improved plan for comprehensive health insurance. That plan, as I indicated in my State of the Union message, has been developed and I am presenting it to the Congress today. I urge its enactment as soon as possible.

The plan is organized around seven principles:

First, it offers every American an opportunity to obtain a balanced, comprehensive range of health insurance benefits;

Second, it will cost no American more than he can afford to pay;

Third, it builds on the strength and diversity of our existing public and private systems of health financing and harmonizes them into an overall system;

Fourth, it uses public funds only where needed and requires no new Federal taxes;

Fifth, it would maintain freedom of choice by patients and ensure that doctors work for their patient, not for the Federal Government.

Sixth, it encourages more effective use of our health care resources;

And finally, it is organized so that all parties would have a direct stake in making the system work -- consumer, provider, insurer, State governments and the Federal Government.

Broad and Balanced Protection for All Americans

Upon adoption of appropriate Federal and State legislation, the Comprehensive Health Insurance Plan would offer to every American the same broad and balanced health protection through one of three major programs:

-- Employee Health Insurance, covering most Americans and offered at their place of employment, with the cost to be shared by the employer and employee on a basis which would prevent excessive burdens on either;

-- Assisted Health Insurance, covering low-income persons, and persons who would be ineligible for the other two programs, with Federal and State government paying those costs beyond the means of the individual who is insured; and,

-- An improved Medicare Plan, covering those 65 and over and offered through a Medicare system that is modified to include additional, needed benefits.

One of these three plans would be available to every American, but for everyone, participation in the program would be voluntary.

The benefits offered by the three plans would be identical for all Americans, regardless of age or income. Benefits would be provided for:

-- hospital care;

-- physicians' care in and out of the hospital;

-- prescription and life-saving drugs;

-- laboratory tests and X-rays;

-- medical devices;

-- ambulance services; and,

-- other ancillary health care.

There would be no exclusions of coverage based on the nature of the illness. For example, a person with heart disease would qualify for benefits as would a person with kidney disease.

In addition, CHIP would cover treatment for mental illness, alcoholism and drug addiction, whether that treatment were provided in hospitals and physicians' offices or in community-based settings.

Certain nursing home services and other convalescent services would also be covered. For example, home health services would be covered so that long and costly stays in nursing homes could be averted where possible.

The health needs of children would come in for special attention, since many conditions, if detected in childhood, can be prevented from causing lifelong disability and learning handicaps. Included in these services for children would be:

-- preventive care up to age six;

-- eye examinations;

-- hearing examinations; and,

-- regular dental care up to age 13.

Under the Comprehensive Health Insurance Plan, a doctor's decisions could be based on the health care needs of his patients, not on health insurance coverage. This difference is essential for quality care.

Every American participating in the program would be insured for catastrophic illnesses that can eat away savings and plunge individuals and families into hopeless debt for years. No family would ever have annual out-of-pocket expenses for covered health services in excess of $1,500, and low-income families would face substantially smaller expenses.

As part of this program, every American who participates in the program would receive a Healthcard when the plan goes into effect in his State. This card, similar to a credit card, would be honored by hospitals, nursing homes, emergency rooms, doctors, and clinics across the country. This card could also be used to identify information on blood type and sensitivity to particular drugs -- information which might be important in an emergency.

Bills for the services paid for with the Healthcard would be sent to the insurance carrier who would reimburse the provider of the care for covered services, then bill the patient for his share, if any.

The entire program would become effective in 1976, assuming that the plan is promptly enacted by the Congress.

How Employee Health Insurance Would Work

Every employer would be required to offer all full-time employees the Comprehensive Health Insurance Plan. Additional benefits could then be added by mutual agreement. The insurance plan would be jointly financed, with employers paying 65 percent of the premium for the first three years of the plan, and 75 percent thereafter. Employees would pay the balance of the premiums. Temporary Federal subsidies would be used to ease the initial burden on employers who face significant cost increases.

Individuals covered by the plan would pay the first $150 in annual medical expenses. A separate $50 deductible provision would apply for out-patient drugs. There would be a maximum of three medical deductibles per family.

After satisfying this deductible limit, an enrollee would then pay for 25 percent of additional bills. However, $1,500 per year would be the absolute dollar limit on any family's medical expenses for covered services in any one year.

How Assisted Health Insurance Would Work

The program of Assisted Health Insurance is designed to cover everyone not offered coverage under Employee Health Insurance or Medicare, including the unemployed, the disabled, the self-employed, and those with low incomes. In addition, persons with higher incomes could also obtain Assisted Health Insurance if they cannot otherwise get coverage at reasonable rates. Included in this latter group might be persons whose health status or type of work puts them in high-risk insurance categories.

Assisted Health Insurance would thus fill many of the gaps in our present health insurance system and would ensure that for the first time in our Nation's history, all Americans would have financial access to health protection regardless of income or circumstances.

A principal feature of Assisted Health Insurance is that it relates premiums and out-of-pocket expenses to the income of the person or family enrolled. Working families with incomes of up to $5,000, for instance, would pay no premiums at all. Deductibles, co-insurance, and maximum liability would all be pegged to income levels.

Assisted Health Insurance would replace State-run Medicaid for most services. Unlike Medicaid, where benefits vary in each State, this plan would establish uniform benefit and eligibility standards for all low-income persons. It would also eliminate artificial barriers to enrollment or access to health care.

As an interim measure, the Medicaid program would be continued to meet certain needs, primarily long-term institutional care. I do not consider our current approach to long-term care desirable because it can lead to over-emphasis on institutional as opposed to home care. The Secretary of Health, Education, and Welfare has undertaken a thorough study of the appropriate institutional services which should be included in health insurance and other programs and will report his findings to me.

Improving Medicare

The Medicare program now provides medical protection for over 23 million older Americans. Medicare, however, does not cover outpatient drugs, nor does it limit total out-of-pocket costs. It is still possible for an elderly person to be financially devastated by a lengthy illness even with Medicare coverage.

I therefore propose that Medicare's benefits be improved so that Medicare would provide the same benefits offered to other Americans under Employee Health Insurance and Assisted Health Insurance.

Any person 65 or over, eligible to receive Medicare payments, would ordinarily, under my modified Medicare plan, pay the first $100 for care received during a year, and the first $50 toward out-patient drugs. He or she would also pay 20 percent of any bills above the deductible limit. But in no case would any Medicare beneficiary have to pay more than $750 in out-of-pocket costs. The premiums and cost sharing for those with low incomes would be reduced, with public funds making up the difference.

The current program of Medicare for the disabled would be replaced. Those now in the Medicare for the disabled plan would be eligible for Assisted Health Insurance, which would provide better coverage for those with high medical costs and low incomes.

Premiums for most people under the new Medicare program would be roughly equal to that which is now payable under Part B of Medicare -- the Supplementary Medical Insurance program.

Costs of Comprehensive Health Insurance

When fully effective, the total new costs of CHIP to the Federal and State governments would be about $6.9 billion with an additional small amount for transitional assistance for small and low wage employers:

-- The Federal Government would add about $5.9 billion over the cost of continuing existing programs to finance health care for low-income or high risk persons.

-- State governments would add about $1.0 billion over existing Medicaid spending for the same purpose, though these added costs would be largely, if not wholly offset by reduced State and local budgets for direct provision of services.

-- The Federal Government would provide assistance to small and low wage employers which would initially cost about $450 million but be phased out over five years.

For the average American family, what all of these figures reduce to is simply this:

-- The national average family cost for health insurance premiums each year under Employee Health Insurance would be about $150; the employer would pay approximately $450 for each employee who participates in the plan.

-- Additional family costs for medical care would vary according to need and use, but in no case would a family have to pay more than $1,500 in any one year for covered services.

-- No additional taxes would be needed to pay for the cost of CHIP. The Federal funds needed to pay for this plan could all be drawn from revenues that would be generated by the present tax structure. I am opposed to any comprehensive health plan which requires new taxes.

Making the Health Care System Work Better

Any program to finance health care for the Nation must take close account of two critical and related problems -- cost and quality.

When Medicare and Medicaid went into effect, medical prices jumped almost twice as fast as living costs in general in the next five years. These programs increased demand without increasing supply proportionately and higher costs resulted.

This escalation of medical prices must not recur when the Comprehensive Health Insurance Plan goes into effect. One way to prevent an escalation is to increase the supply of physicians, which is now taking place at a rapid rate. Since 1965, the number of first-year enrollments in medical schools has increased 55 percent. By 1980, the Nation should have over 440,000 physicians, or roughly one-third more than today. We are also taking steps to train persons in allied health occupations, who can extend the services of the physician.

With these and other efforts already underway, the Nation's health manpower supply will be able to meet the additional demands that will be placed on it.

Other measures have also been taken to contain medical prices. Under the New Economic Policy, hospital cost increases have been cut almost in half from their post-Medicare highs, and the rate of increase in physician fees has slowed substantially. It is extremely important that these successes be continued as we move toward our goal of comprehensive health insurance protection for all Americans. I will, therefore, recommend to the Congress that the Cost of Living Council's authority to control medical care costs be extended.

To contain medical costs effectively over the long haul, however, basic reforms in the financing and delivery of care are also needed. We need a system with built-in incentives that operates more efficiently and reduces the losses from waste and duplication of effort. Everyone pays for this inefficiency through their health premiums and medical bills.

The measure I am recommending today therefore contains a number of proposals designed to contain costs, improve the efficiency of the system and assure quality health care. These proposals include:

1. Health Maintenance Organizations (HMO's)

On December 29, 1973, I signed into law legislation designed to stimulate, through Federal aid, the establishment of prepaid comprehensive care organizations. HMO's have proved an effective means for delivering health care and the CHIP plan requires that they be offered as an option for the individual and the family as soon as they become available. This would encourage more freedom of choice for both patients and providers, while fostering diversity in our medical care delivery system.

more

(OVER)

2. Professional Standards Review Organizations (PSRO's)

I also contemplate in my proposal a provision that would place health services provided under CHIP under the review of Professional Standards Review Organizations. These PSRO's would be charged with maintaining high standards of care and reducing needless hospitalization. Operated by groups of private physicians, professional review organizations can do much to ensure quality care while helping to bring about significant savings in health costs.

3. More Balanced Growth in Health Facilities

Another provision of this legislation would call on the States to review building plans for hospitals, nursing homes and other health facilities. Existing health insurance has overemphasized the placement of patients in hospitals and nursing homes. Under this artificial stimulus, institutions have felt impelled to keep adding bed space. This has produced a growth of almost 75 percent in the number of hospital beds in the last twenty years, so that now we have a surplus of beds in many places and a poor mix of facilities in others. Under the legislation I am submitting, States can begin remedying this costly imbalance.

4. State Role

Another important provision of this legislation calls on the States to review the operation of health insurance carriers within their jurisdiction. The States would approve specific plans, oversee rates, ensure adequate disclosure, require an annual audit and take other appropriate measures. For health care providers, the States would assure fair reimbursement for physician services, drugs and institutional services, including a prospective reimbursement system for hospitals.

A number of States have shown that an effective job can be done in containing costs. Under my proposal all States would have an incentive to do the same. Only with effective cost control measures can States ensure that the citizens receive the increased health care they need and at rates they can afford. Failure on the part of States to enact the necessary authorities would prevent them from receiving any Federal support of their State-administered health assistance plan.

Maintaining a Private Enterprise Approach

My proposed plan differs sharply with several of the other health insurance plans which have been prominently discussed. The primary difference is that my proposal would rely extensively on private insurers.

Any insurance company which could offer those benefits would be a potential supplier. Because private employers would have to provide certain basic benefits to their employees, they would have an incentive to seek out the best insurance company proposals and insurance companies would have an incentive to offer their plans at the lowest possible prices. If, on the other hand, the Government were to act as the insurer, there would be no competition and little incentive to hold down costs.

There is a huge reservoir of talent and skill in administering and designing health plans within the private sector. That pool of talent should be put to work.

It is also important to understand that the CHIP plan preserves basic freedoms for both the patient and doctor. The patient would continue to have a freedom of choice between doctors. The doctors would continue to work for their patients, not the Federal Government. By contrast, some of the national health plans that have been proposed in the Congress would place the entire health system under the heavy hand of the Federal Government, would add considerably to our tax burdens, and would threaten to destroy the entire system of medical care that has been so carefully built in America.

I firmly believe we should capitalize on the skills and facilities already in place, not replace them and start from scratch with a huge Federal bureaucracy to add to the ones we already have.

Comprehensive Health Insurance Plan -- A Partnership Effort

No program will work unless people want it to work. Everyone must have a stake in the process.

This Comprehensive Health Insurance Plan has been designed so that everyone involved would have both a stake in making it work and a role to play in the process -- consumer, provider, health insurance carrier, the States and the Federal Government. It is a partnership program in every sense.

By sharing costs, consumers would have a direct economic stake in choosing and using their community's health resources wisely and prudently. They would be assisted by requirements that physicians and other providers of care make available to patients full information on fees, hours of operation and other matters affecting the qualifications of providers. But they would not have to go it alone either: doctors, hospitals and other providers of care would also have a direct stake in making the Comprehensive Health Insurance Plan work. This program has been designed to relieve them of much of the red tape, confusion and delays in reimbursement that plague them under the bewildering assortment of public and private financing systems that now exist. Healthcards would relieve them of troublesome bookkeeping. Hospitals could be hospitals, not bill collecting agencies.

Conclusion

Comprehensive health insurance is an idea whose time has come in America.

There has long been a need to assure every American financial access to high quality health care. As medical costs go up, that need grows more pressing.

Now, for the first time, we have not just the need but the will to get this job done. There is widespread support in the Congress and in the Nation for some form of comprehensive health insurance.

Surely if we have the will, 1974 should also be the year that we find the way.

The plan that I am proposing today is, I believe, the very best way. Improvements can be made in it, of course, and the Administration stands ready to work with the Congress, the medical profession, and others in making those changes.

But let us not be led to an extreme program that would place the entire health care system under the dominion of social planners in Washington.

Let us continue to have doctors who work for their patients, not for the Federal Government. Let us build upon the strengths of the medical system we have now, not destroy it.

Indeed, let us act sensibly. And let us act now -- in 1974 -- to assure all Americans financial access to high quality medical care.

RICHARD NIXON

THE WHITE HOUSE,

February 6, 1974.

# # # #

EMBARGOED UNTIL 12:00 NCON, EST
WEDNESDAY, FEBRUARY 6, 1974

February 6, 1974

Office of the White House Press Secretary

THE WHITE HOUSE

FACT SHEET

THE COMPREHENSIVE HEALTH INSURANCE PLAN

MAJOR FEATURES OF THE COMPREHENSIVE HEALTH INSURANCE PLAN

I. STRUCTURE

A. Employee Health Insurance Plan (EHIP)

- All employers would be required to offer the basic insurance plan and Health Maintenance Organization (HMO) coverage to each employee under age 65 who has met the full-time hours of work test. Coverage extends to family members under 65. Employers may self-insure.

- Election of coverage would be voluntary at the option of the employee.

- The basic plan would also be available to self-employed and non-working families, individuals, and non-employer groups (e.g., unions or professional associations), through private carriers.

- Employers would be required to offer coverage meeting the basic plan, and could offer optional plans supplementing the basic plan. Employers could not offer non-approved plans.

- Employers would contribute 65 percent of premium expenses for covered employees. However, if an employer's payroll rises by more than 3 percent due to required contributions to coverage, then the Federal Government would pay a subsidy to the employer for employer premiums in excess of the 3 percent increase in payroll expenses. The subsidy would be 75 percent of such excess in the first year reduced by 15 percentage points each year thereafter.

- The employer contribution toward coverage would begin 90 days after onset of employment and continue for 90 days after termination of full-time employment.

- An individual or family which has been enrolled in an Employee Health Insurance Plan would be allowed to continue coverage under the plan, at the employer's group rate, for 90 days following the period of a required employer contribution (a total of 180 days after termination), by paying the premium in full themselves.

B. Assisted Health Insurance Plan (AHIP)

- States would contract with intermediaries to offer the basic plan to all residents of the State, except those with family incomes of $7,500 or more who are offered the Employee Health Insurance Plan.

- Employers who desire to do so could offer AHIP (at 150% of the average group rate in the State) in fulfillment of the requirement to offer a mandated plan. Members of such employee groups could enroll in AHIP irrespective of income level.

- Persons who would, in fact, enroll in AHIP:

  a. families below $5,000 income ($3,500 for individuals) regardless of work status

  b. non-working families between $5,000 and $7,500 income ($3,500-$5,250 for individuals)

  c. very high risk working families between $5,000 and $7,500 income ($3,500-$5,250 for individuals)

  d. non-working families with unusually high medical risks (disabled and early retirees) regardless of income

  e. unusually high risk employer groups.

- All persons eligible for AHIP would have the option of obtaining coverage through an approved prepaid health care plan.

- The premiums, deductibles, coinsurance, and maximum liability would be related to income.

- Carriers administering AHIP coverage would be reimbursed by the State on the basis of actual benefits paid for covered services, less income derived from the plan, plus a negotiated rate for administration.

- Employers would be required to make a contribution to AHIP for low-income employees who elect that coverage, in the amount they would have contributed for other employees under an Employee Health Insurance Plan.

- For AHIP eligibles who elect coverage through a prepaid health care plan, the State would contribute an amount equal to the cost of providing AHIP coverage.

II. BENEFIT PACKAGE

A. Reimbursable Services

- Hospital services, not subject to a dollar limitation.

- Physician services, not subject to a dollar limitation.

- Prescription drugs, out-of-hospital.

- Mental Health services

  . inpatient - 30 full days or 60 partial days

  . outpatient - 30 visits to a comprehensive community care center or private practitioner (the latter not to exceed 15 visits)

- Special and preventive services for children

  . well child care up to age 6

  . eye examinations, developmental vision care, and eyeglasses up to age 13

  . ear examinations and hearing aids up to age 13

  . routine dental services up to age 13

- Other preventive services

  . prenatal and maternity services

  . family planning

- Home Health Services - 100 visits per year

- Post-hospital extended care - 100 days per year

- Blood and blood products

- Other medical services, as in Medicare (prosthetic devices, dialysis equipment and supplies, x-rays, laboratory, ambulance, etc.).

B. Premiums and Cost-Sharing (EHIP and AHIP)

Employer Plan

- Premiums for employer groups of 51 or more employees and other families and groups being offered EHIP would be negotiated between employer and other groups and the insurance carrier.

- Expenses for an insured individual which exceed $10,000 in a year cannot be attributed to the experience rating of the employee group through which the individual has obtained coverage.

- Each insurance company would be required to offer the same rate to all employees in firms with 1 to 50 employees (subject to the single/family rate differential).

- Rates for coverage under the plan cannot differ on the basis of family size and composition, except that there must be separate rate determinations for singles and families with the single rate being 40 percent of the family rate.

- The benefit package as presently constituted would result in an approximate average group family premium of about $600. (The single person could expect to pay a premium of $240.) The average premium required by this coverage per full-time employee is $415.

- The employer would eventually pay 75% of premium costs and employees the remaining 25%.

- EHIP would not reimburse for services until the insured unit has met a deductible of $150 per person (maximum of three deductibles per family), with a separate $50 per person deductible on reimbursement for outpatient drugs.

- After satisfying the deductible, the enrollee pays a coinsurance of 25 percent, with a maximum liability for cost-sharing (deductible plus coinsurance) of $1,500 in a year.

  There would be no per year or lifetime limitation on benefits paid by the Plan.

Assisted Health Insurance Plan (AHIP)

- Premiums, deductibles, coinsurance, and maximum liability would be all income-related under the AHIP. The following schedule has been used in making cost estimates for the Comprehensive Health Insurance Act of 1974.

SINGLE

	Annual Income	Contribution*	Per Person Deductible		Coinsurance	Maximum Liability
			Drugs	Other		
I	$ 0-1,749	$ 0	$ 0	$ 0	10%	6% of income
II	1,750-3,499	0	25	50	15	9% of income
III	3,500-5,249	120	50	100	20	12% of income
IV	5,250-6,999	240	50	150	25	15% of income
V	7,000 +	360	50	150	25	$1,050

* Based on 50 percent of average group single rate in Group III, 100 percent in Group IV, and 150 percent in Group V. Expected average group single premium rate equals $240.

FAMILY

	Annual Income	Contribution**	Per Person Deductible		Coinsurance	Maximum Liability
			Drugs	Other		
I	$ 0-2,499	$ 0	$ 0	$ 0	10%	6% of income
II	2,500-4,999	0	25	50	15	9% of income
III	5,000-7,499	300	50	100	20	12% of income
IV	7,500-9,999	600	50	150	25	15% of income
V	10,000 +	900	50	150	25	$1,500

** Contributions based on 50 percent of average group family premium rate in the State for Group III, 100 percent for Group IV, and 150 percent for Group V. Expected average group family premium rate equals $600.

III. FEDERAL PROGRAMS

A. Medicare

- Medicare for the Aged would be retained, with the benefits changed to conform with the mandated health plan.

- Medicare would continue to be administered directly by the Social Security Administration through its own system of fiscal intermediaries.

- The benefit package would include the full range of services as in EHIP and AHIP. As a result, outpatient drugs and mental health services would be covered, and the aged would have far superior protection against catastrophic expenses -- complete hospitalization and maximum financial liability. (Medicare now covers 90 days of hospitalization per episode plus a lifetime reserve of 60 days.)

- A Medicare beneficiary would face an annual per person deductible of $100 on all services except outpatient drugs. The deductible for outpatient drugs would be $50. Beneficiaries would pay 20 percent coinsurance on expenses above the deductible up to a maximum annual liability of $750.

- Medicare for the Aged would be financed from the current 1.8 percent payroll tax plus a small premium contribution by the enrollee (about $90 per person annually, roughly equal to the current Part B premium).

- Federal, State, and local government employers and employees would participate in the Medicare system and be subject to the Medicare payroll tax.

- Medicare beneficiaries who are low-income would be eligible for reduced premium payments and cost-sharing. The income testing and income definitions would be tied to SSI.

- Dependents of Medicare beneficiaries below age 65 would be eligible to enroll in AHIP.

- Medicare for the Disabled (including the kidney disease provisions) would cease as a separate program. The disabled would be eligible for AHIP coverage. Most current Medicare disabled beneficiaries would have better protection because of the catastrophic provisions and because a high proportion would qualify for reduced cost sharing because they are low-income but have Social Security cash payments which place them beyond Medicaid eligibility.

- Reimbursement for Medicare services in a State would be based on the same system as used in that State for EHIP/ AHIP services.

B. Medicaid

- Medicaid would be terminated except for certain services not covered by the Comprehensive Health Insurance Act. These include (1) services in a skilled nursing facility or intermediate care facility; (2) care in mental institutions for persons under age 21 or over 65; and (3) home health services.

C. Indian Health

- The Indian Health Service would continue to provide health care to eligible Indians.

- Indians may also participate in State AHIP programs.

D. Veterans Administration

- The VA would continue to operate a separate health care system for those eligible for VA benefits.

- The VA system would be reimbursed for services not related to a disability incurred while in the military.

IV. REIMBURSEMENT POLICY

A. Healthcard

- All persons (including Medicare enrollees) would receive an identification card which would be evidence of financial protection for all covered services.

- Participating providers of service would be required to accept the card as evidence of coverage and would bill the indicated carrier for covered services.

- The carrier would reimburse the provider and would bill the enrollee for the applicable cost-sharing.

B. Classification of Providers

- Full-Participating Providers - would agree to accept reimbursement through the Healthcard as payment in full for all patients (EHIP, AHIP, and Medicare). To these providers the Healthcard would reimburse the full amount of the applicable reimbursement rates (the insured amount as well as the patient's cost-sharing). All institutions would be required to be full-participating providers.

- Associate-Participating Providers - would agree to accept reimbursement through the Healthcard as payment in full for all AHIP and Medicare patients, and as payment of the insured amount of an Employee Health Insurance Plan enrollee's bills. To collect the remainder of his fee for the patient, the physician would bill the patient directly.

- Non-Participating Providers - would not be reimbursed from any approved plan for services provided.

V. Regulation and Administration

A. State Regulation and Administration -- States must enact appropriate legislation fulfilling each of the following responsibilities to be eligible for Federal financial participation in the plan. This regulation must extend to prepaid health care plans as well as to all private carriers and self-insured employers.

- Carriers and self-insured employers providing the basic plan would file their plans with the States, keeping the State advised of the employers and employees to whom the plan is provided. States would be required to provide for prompt review of the plan and determination as to whether it meets the requirements of the law.

- Premium rates and rating structures would be reviewed for reasonableness (file and use procedure) for all private health insurance.

- Enrollees would be guaranteed against noncoverage or nonpayment of claims related to the basic plan resulting from carrier insolvency.

- An annual CPA audit would be required for all insurance carriers offering coverage under the plan.

- Carriers would be required to disclose information with regard to services covered, rates, and the relation between premiums and benefits paid. This requirement must extend to all private health insurance sold.

- All capital investment over $100,000 would be approved by a State-designated planning agency to receive reimbursement through the plan.

- Medical services would be subject to Professional Standards Review Organization.

- Physician reimbursement for covered services under the insurance plans would be based on amounts determined after consultation with providers and other interested parties. Physicians would be free to bill additional charges to those covered under the Employee Health Insurance Plan provided the patient is notified beforehand of such additional charges.

- States would establish prospective reimbursement systems for hospitals.

- Providers would make available to patients information regarding charges for most commonly given services, hours of operation and other matters affecting access to services, and extent of certification, accreditation, and licensure.

- In addition to administration and participation in financing of the AHIP, States would be responsible for certifying health care providers as eligible for participation in the Comprehensive Health Insurance Plan.

B. Federal Regulation and Administration -- The Federal Government would:

- Establish standards for eligibility.

- Define the services to be reimbursed by the plan.

- Operate an expanded program of benefits for the aged.

VI. COSTS

- Added Federal/State expenditures to finance the Assisted Health Insurance Plan would approximate $6.9 billion

- Added State spending under the Government Plan would equal about $1.0 billion. Much of this would be offset by reductions in other State health programs

- Added Federal spending would equal about $5.9 billion

- The Federal subsidy to assist low-income employees and their employers would equal about $0.45 billion

- The additional cost of increased benefits for the aged would be $1.8 billion

VII. FINANCING

A. Employee Health Insurance Plan (EHIP)

- Would be financed jointly by employers and employees.

- Employers would be required to make a contribution to the EHIP for those employees who qualify and enroll.

B. Assisted Health Insurance Plan (AHIP)

- Costs of AHIP above the income derived from enrollees would be shared by State and Federal governments. The States share would be related to current levels of State expenditures, ability to pay, and anticipated future expenditures under The Comprehensive Health Insurance Plan in that State. The total State share would be about 25%.

C. Medicare

- The Medicare Trust Fund (plus a small premium contribution (about $90 per year))would pay for all services provided under the basic Medicare plan. The cost above the basic income aged would be borne by General Revenues and State contributions.

D. Medicaid

- A residual Medicaid program for long term care services would continue with the current Federal/State Medicaid matching formula.

VIII. SPECIAL PROVISIONS TO ASSIST SMALL EMPLOYERS

The following provisions have been incorporated, which would particularly assist small employers, since they have a higher proportion of low wage workers and pay higher premiums than large employers:

- Where two members of the same family are eligible for Employee Health Insurance Plan coverage, only one could accept. This provision would benefit small business, which hire a disproportionate number of secondary workers.

- Each insurance company would be required to offer coverage at the same premium rate to all employees in firms with up to 50 employees. This provision would reduce the costs associated with carriers individually rating small groups. It also would minimize the adverse labor market effects against hiring high medical risk individuals.

- The Federal government will subsidize the employer whose payroll costs increase by more than three percent as a result of The Health Insurance Plan. The excess over three percent will be subsidized by 75% the first year and reduced 15 percentage points each year thereafter.

# # # # #

THE WHITE HOUSE

WASHINGTON

March 7, 1975

MEMORANDUM FOR: JACK MARSH

FROM: TED MARRS

Jack:

I will appreciate your personally reviewing this one and supporting my views on it.

Any comments will be appreciated.

Attachment

THE WHITE HOUSE

WASHINGTON

March 7, 1975

MEMORANDUM FOR: JIM LYNN

FROM: TED MARRS Jim

SUBJECT: S. 522, Indian Health Care Improvement Act

This bill:

- deserves more than an ivory tower automatic negative.
- strikes at the most flagrant medical inequity existing in this country today.
- does not start a new program.
- can be adjusted to be responsible and realistic.

Attachment

cc: Mr. Buchen
Mr. Marsh ✓
Mr. Rumsfeld
Mr. Cannon

S. 522 was introduced into the Senate on February 3, 1975. This bill is identical with S. 2938 (93rd Congress) that passed the Senate on November 25, 1974. Bills similar to S. 522 have also been introduced into the House and assigned numbers H.R. 2525 and H.R. 2526. Co-sponsorship of these bills and the passage of S. 2938 by the Senate in the 93rd Congress indicates there is strong bipartisan Congressional support for passage.

The indicated position of the Administration on this proposed legislation is to generally oppose enactment. I believe that such a position, if taken, needs re-evaluation.

First, a number of studies have been made of the Indian health program. All of these studies have documented the unmet needs of the Indian health services program at essentially the same levels as identified in the proposed legislation. These studies have been made by the Department of Health, Education, and Welfare, by Congressional committees and by outside groups, such as the American Academy of Pediatrics.

Second, to categorically oppose the legislation without an alternative proposal would appear to the Congress and the Indian people that the Administration is either unsympathetic to the health needs of Indians or is unwilling to commit itself to meeting those needs within any reasonable time.

Third, when the President signed the Indian Self-Determination and Education Assistance Act (P.L. 93-638) on January 4, 1975, he stated that the "act gives permanence and stature of law to the objective of my Administration of allowing....indeed encouraging...Indian tribes to operate programs serving them under contract to the Federal Government." He also "pledged the support of this Administration" to the fullest possible use of the authorities provided in the Act (P.L. 93-638).

Several provisions of the bills now pending before the Congress would contribute to the achievement of the policy on Indian self-determination. If these are not singled out for support or a reasonable alternative proposed, the sincerity of the Administration's January 4 pledge to support the fullest use of the authorities contained in P.L. 93-638 would certainly be subjected to question.

To avoid these implications of denial of documented needs, unsympathetic attitude, and insincerity, I would suggest the following alternative to general opposition to enactment of the pending bills entitled "Indian Health Care Improvement Act."

First, the Administration would express its concurrence with the intent of the bills, i.e., unmet needs exist and they must be met. To meet these needs over a five year period is not feasible with the current economic condition of the Nation. Since forecasts are for an improved economic situation, the Administration should agree to initiate measures now to reduce the unmet needs and propose a seven or a ten year plan to eliminate them.

Second, those provisions in the bills that are considered to contribute most to Indian self-determination should be supported. In this connection, I believe that two titles and one section of another title would make the greatest contributions. These are Title I, Indian Health Manpower; Title IV, Access to Health Services; and section 603 of Title VI.

Title I would contribute to self-determin tion and the Indian operation of the health services programs by capacity building in the Indian population. Currently, the number of Indian persons trained in the health professions and paraprofessions is grossly inadequate to enable them to man and manage their health services programs under contract to the Government. This health manpower pool must be substantially increased if such contracts are to be made. The fact that this situation exists demonstrates the inability or failure of existing health manpower programs to fill this need. Title I of S. 522 would be more appropriate if it would provide authority to train only persons of Indian descent. The authorization to train non-Indians should be opposed because this can be accomplished through existing health scholarship authorities for the general population.

Title IV, Access to Health Services, would permit the Indian health service program while still operated by the Government to develop and test a system for collecting third party payment for health care provided at the Indian health facilities. This would contribute to the policy of self-determination by capacity building and, in the future, permit Indian medicare and medicaid eligibles to be treated at their own facility with assurances that reimbursement could be made. This Title would also waive applicable facility standards

providing there is a plan to bring the facility into full compliance with the standards within two years. I'll discuss this further when consideration is given to Title III of the bills.

The last section of the bills which should be supported is Section 603 of Title VI. This section would permit the Secretary to enter into long-term leasing agreements (up to twenty years) with the tribes. Under this authority, Indian tribes could build whatever facility might be needed to operate or manage the health program and the Secretary could lease it from them. Such leases would assist tribes in obtaining financing for construction and it would build the capacity of tribes to construct, operate and maintain major physical facilities. It would also assist the Government in overcoming the need for replacement facilities without, at the same time, making large cash outlays.

Title II, Health Services; Title III, Health Facilities; and Title V, Health Services for Urban Indians and sections 601 and 602 of Title VI, Miscellaneous, are essentially unnecessary authorities or appropriation authorizations. The appropriation authorizations are in effect limiting in Titles II, III and V because the current authorizing law (25 U.S.C. 13, the so called Snyder Act) is open ended.

Titles II and III propose to eliminate the health services and facilities unmet needs during the next five fiscal years. Since these needs are well documented, I would recommend that the Administration's position on these titles endorse the concept of meeting the needs within a specific time frame. The time frame proposed in the bills may, however, not be consistent

with the state of the economy and related budget constraints. It would appear that a seven or possibly ten year time period might be more appropriate than five. A mutually agreed upon plan could be developed through Congressional and Administration participation. The commitment to a plan for facilities would also be consistent with the provision of Title IV which would initially waive compliance with facility standards.

Title V proposes a three year trial program to assist urban Indians in meeting their health needs. A review of the program would be required as would a report to the Congress assessing the program and recommending any further legislative efforts. There is authority to initiate such programs subject only to appropriations. Since the late 1960's, Congress has, through the appropriations process, requested the establishment of several urban Indian projects. These special projects should be continued in the future within the appropriations made by Congress. Since adequate authority already exists for a Federal urban Indian effort, it would seem that the continuation and/or expansion of such an effort should be decided through discussions with Congressional and Administration personnel and not by legislation. Consequently, this matter would be appropriate to discuss during the development of a plan for health services and facilities construction.

BRIEF EXPLANATION OF H.R. 2525, AS REPORTED BY THE COMMITTEE ON INTERIOR, COMMITTEE ON WAYS AND MEANS, AND COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

Section 1 gives the title of the Act.

Section 2 are congressional findings outlining the necessity for the legislation.

Section 3 is a declaration of policy.

Section 4 contains definitions.

TITLE I - INDIAN HEALTH MANPOWER

Section 101 gives the purpose of this title, which is to increase the number of health professionals serving Indians and to increase the number of Indians in those health professions.

Section 102 is a health recruitment program designed to identify those eligible Indians and to publicize existing sources of financial aid. $4.2 million is authorized over 3 fiscal years.

Section 103, the health professions preparatory scholarship program, allows a student to receive scholarship grants, for up to two years, for compensatory preprofessional education. $3.1 million is authorized over three fiscal years.

Section 104, the health professions scholarship program, authorizes an "Indian" program within the National Health Service Corps scholarship program. Such scholarships will be designated Indian Health Scholarships and will extend to physicians, dentists, nurses, optometrists, podiatrists, pharmacists, public health personnel, and allied health personnel $18.95 million is authorized over three fiscal years.

Section 105 allows the Indian Health Service to hire a scholarship grantee as an intern for a period of up to 120 days to work in the nonacademic period of the year. $2.4 million is authorized for three fiscal years.

Section 106, the continuing education allowance provision, authorized .55 million over three fiscal years so that physicians and other professionals can leave their duty stations for professional consultation and refresher training courses.

TITLE II -- HEALTH SERVICES

Section 201 (a) directs that the funds authorized under this title shall be in addition to the level of appropratiions provided in the preceding fiscal year.

Subsection (b) directs that the personnel authorized under this title shall be in addition to the number authorized in the preceding fiscal year.

Subsection (c) gives the following breakdown for funds and positions over three fiscal years:

(1) Patient Care: $24.7 million & 525 positions
(2) Field Health: $8.9 million & 198 positions
(3) Dental Care: $3 million & 130 positions
(4) Mental Health:
   (A) Community mental health: $3.3 million & 60 positions
   (B) Inpatient mental health: $1 million & 30 positions
   (C) Model dormitory: $3.125 million & 100 positions
   (D) Therapeutic & residential treatment centers: $.7 million & 15 positions
   (E) Training of Indian traditional practitioners: $13 million
(5) Treatment of Alcoholism: $13 million
(6) Maintenance & Repair: $7 million & 50 positions

Subsection (d) directs that not less than 1% of the funds appropriated shall be used for research.

Subsection (c) authorizes that not more than $5 million shall be expended in Fiscal Year 1977.

TITLE III - HEALTH FACILITIES

Service Facilities

Section 301 authorizes the Secretary to use these funds for construction and renovation of hospitals, health centers, stations, or other facilities of the Indian Health Service.

Subsection (b) authorizes the following amounts for the following facilities:

(1) Hospitals: $190 million over three fiscal years.
(2) Health centers & stations: $16.906 million over 3 fiscal years
(3) Staff housing: $27.083 million over 3 years

Subsection (c) directs that the Secretary shall consult with any Indian tribe which will be significantly affected by expenditure of these funds; and directs that the facilities constructed shall meet JCAH standards within one year of construction.

Safe Water & Sanitary Waste Disposal Facilities

Section 302. (a) authorizes these funds to be used to provide water and sanitation facilities in new and existing Indian homes.

Subsection (b) authorizes $103 million for this construction in existing homes over three fiscal years. Such sums as may be necessary are authorized for these facilities in new Indian homes.

Subsection (c) directs that former and currently federally recognized Indian tribes in New York State shall be eligible for assistance under this title.

Preference to Indians & Indian Firms

Section 303 (a) directs the Secretary to give preference to Indians and Indian owned firms for construction under this title.

Subsection (b) provides that the Davis-Bacon requirements for federal contracting shall apply.

Soboba Sanitation Facilities

Section 304 directs that the Soboba Band of Mission Indians in California is eligible for IHS sanitation services.

TITLE IV - ACCESS TO HEALTH SERVICES

Medicare

Section 401 makes an amendment to the Medicare Act.

Section 402 further amends the Medicare Act to provide that the IHS can be reimbursed for the care of a medicare eligible patient in an IHS facility. The section allows all facilities to be declared accredited for medicare purposes for a period of 18 months. The funds which are collected by the IHS are to be used exclusively for the purpose of bringing that facility into compliance,

Section 402 amends the Medicaid Act to provide that the IHS can be reimbursed for the care of a medicare eligible patient in an IHS facility. The section allows all facilities to be declared accredited for medicaid purposes for a period of 18 months. The funds which are collected by the IHS are to be used exclusively for the purpose of bringing that facility into compliance.

Section 403 requires the Secretary to make annual reports on the disposition of funds collected by IHS under this title.

TITLE V - URBAN INDIAN TITLE

Section 501 declares the purpose.

Section 502 authorizes the Secretary to enter into contracts with urban Indian groups for provision of health care to urban Indians.

Section 503 establishes the criteria for contract eligibility of an urban group.

Section 503 (a) exempts these contracts from Federal contracting laws.

Subsection (b) declares that payments may be made in advance to an urban group.

Subsection (c) authorizes the revision, amendment, or retrocession of any contract.

Subsection (d) permits an urban Indian group to use existing HEW facilities.

Subsection (e) is designed to assure fair and uniform provision of services to urban Indians under contracts.

Section 506 authorizes $30 million for this program over three fiscal years.

Section 507 authorizes the Secretary to review the contracts at the end of FY 78 and submit an assessment to the Congress. At that time, the Secretary is also asked to recommended further legislative change.

Section 508 authorizes not less than 1% of these funds to be spent on pilot projects in rural communities near Indian reservations.

TITLE VI - American Indian School of Medicine

Section 601 authorizes a one year feasibility study on the establishment of an American Indian School of Medicine.

TITLE VII - MISCELLANEOUS

Section 701 establishes a schedule for secretarial review of this act. Recommendations are to be made to the Congress on additional funds needed.

Section 702 directs the Secretary to actively consult with the Indian community before rules are promulgated, and establishes a schedule for promulgation of the rules. The same Indian consultation is required if the rules are revised.

Section 703 directs the Secretary to prepare, within 240 days after enactment of this Act, a plan for implementation of this Act. This is to include a schedule for appropriations requests.

Section 704 authorizes 20 year leases with Indian tribes.

Section 705 declares that the funds appropriated under this Act shall remain available until expended.