The original documents are located in Box 2, folder "Health Care Legislation - S. 522 (3)" of the Bradley H. Patterson Files at the Gerald R. Ford Presidential Library.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE SECRETARY

8-13-76

The attached may be of interest to you.

BRAD:
Per our conversation...

Deputy Assistant Secretary
for Congressional Liaison

Phone: 245-6787
Room 5443, HEW North
330 Independence Ave., SW.
Washington, D.C. 20201

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D. C. 20201

JUN 30 1976

The Honorable John J. Rhodes
Minority Leader
House of Representatives
Washington, D. C. 20515

Dear Mr. Rhodes:

I understand that the House of Representatives will soon consider H.R. 2525, the "Indian Health Care Improvement Act." I am deeply concerned that you and your colleagues understand our position with regard to this legislation.

In summary, we are strongly opposed to this legislation because it would establish additional categorical programs and substantially exceed the budget requests for program activities in the area of Indian health. We believe that the Department and other Federal agencies are accomplishing the major objectives stated in the bill.

The Administration has a long-standing commitment to improving the health status of federally recognized Indians and Alaska natives. The Indian Health Service (IHS) within this Department has the primary responsibility for providing the necessary services; spending for IHS activities has grown from $113 million in FY 1969 to an estimated outlay of $349 million for FY 1977, an increase of 208 percent in eight years.

The special emphasis that our IHS program has received was recently reiterated by the President in a message to the Congress in which he mentioned it among several examples of Federal responsibilities in which efforts would be concentrated. He stated in relation to his 1977 budget proposals: "To provide improved health services to American Indians and Alaskan natives, I am asking for $355 million. Spending by the Indian Health Service alone in 1977 will result in over $685 per beneficiary, or over $2,740 per Indian family of four." Since then, the President has requested $35 million more for implementing authorities in the "Indian Self-Determination and Education Assistance Act." Moreover, these amounts do not include the broad range of services provided to the eligible Indian population from other Federal health programs.

In light of this, I would hope that our record of strong opposition to H.R. 2525 before the Committee on Interior and Insular Affairs and the Committee on Interstate and Foreign Commerce is regarded as a positive effort to see that scarce Federal health dollars are directed to the areas of greatest need, and that the Congress will agree that existing authorities are sufficient to continue addressing the health needs of American Indians and Alaska natives.

Title I of the bill would authorize several different programs to support the training of Indian health manpower, among them a recruitment and counseling program, a preparatory scholarship program, and a professional scholarship program.

The Department shares your concern relating to the need for adequate numbers of Indian health professionals. However, we believe that the objectives of title I can be achieved under existing authorities for recruitment of disadvantaged students (including Indians) and for scholarships to students. We are unable to see a need to establish a multiplicity of duplicative narrow categorical programs for Indians when the Federal government already administers several programs to accomplish similar or identical purposes.

The Department now helps recruit Indian health professions students as part of an overall effort to improve participation by disadvantaged persons in health occupations. Special provisions for minority recruitment are contained in the health manpower legislative authorities of titles VII and VIII of the Public Health Service Act. Among the projects carried out under these authorities have been a number to identify potential Indian health professions students, help them prepare for entrance into health professions schools, and assist them in completing training.

Special consideration is given to Indians in the administration of the service-conditional National Health Service Corps Scholarship program. In the current academic year there are a total of some 75 Indian recipients of National Health Service Corps Scholarships (56 medical and 19 dental students). Most of these individuals will do their obligated service in the Indian Health Service. The Bureau of Indian Affairs in the Department of the Interior also has a scholarship program.

In the Administration's health professions education bill, H.R. 11119, we have proposed a broadened authority for project grants to assist disadvantaged students, including Indian students, to undertake health professions training. We have requested $5 million for such grants for FY 1977. The scholarship program for students who agree to serve in health manpower shortage areas would be modified and expanded, and our 1977 request for this authority is $35 million. We would strongly prefer to continue giving special attention to the needs of Indian students under general health professions education authorities such as these, rather than having to operate within separate program limitations and funding authorities for Indians.

Title II would add to already existing program levels and commitments approximately $70 million for health services over a 3-year period, and would also authorize approximately 1,100 new positions in the IHS. This title is duplicative of existing basic authority in the "Snyder Act" (25 U.S.C. 13) to provide health services and is certainly unnecessary, as the Department is not legally restricted in seeking as many positions as necessary to accomplish its goals in the program.

Title III, which would authorize over $230 million during the 3-year period for construction and renovation of IHS facilities, as well as over $100 million for sanitation facilities in Indian homes and communities, also raises unrealistic expectations in terms of what the Federal government can afford.

Title IV would amend the Social Security Act to provide Medicare and Medicaid reimbursement to IHS facilities for services rendered to beneficiaries of those programs. We support this general concept, but believe it should be accomplished in separate legislation, particularly since we are opposed to other provisions of title IV. Under this title, IHS hospitals that do not meet current fire and safety or other standards would be granted a one-year period to come into compliance with program requirements, during which time they would be required to use all such reimbursements for that purpose. We believe that this provision might be interpreted as tolerating inadequate standards for the Indian population served by these institutions. We believe present Medicare regulations, which permit the participation of selected hospitals in rural or underserved areas if they are making efforts to improve, best achieve the upgrading of health care without requiring the Secretary to accept all institutions under arbitrary time constraints. We also oppose the provision that would prohibit consideration of third party reimbursements in determining appropriation levels for IHS facilities. We believe the Executive Branch and the appropriation committees of the Congress should be able to consider all receipts to IHS facilities in setting funding requirements.

Title IV of H.R. 2525 also contains a provision for 100 percent Medicaid reimbursement for services provided to Indians in IHS facilities. We oppose this provision on the bases of equity and cost: the Federal reimbursement rate for title XIX services is determined by a State's per capita income; at present it ranges from 50 to 83 percent. To the extent that a State has an Indian population, and to the extent that population is poor, the Federal match will be higher. However, to provide a 100 percent match for services to Indians would be inequitable to other poor recipient groups, and to those States with many families and individuals at poverty levels, who happen not to be Indians. Such a policy would have undesirable implications for the financing of other public assistance programs that require matching contributions.

Title V would provide for a program of contracts with Indian organizations in urban areas for the purpose of making health services more accessible to Indians. This would expand upon existing authority in the previously mentioned "Snyder Act" (25 U.S.C. 13) for the Department to assist Indians in meeting their health needs. It seems to us that Indians who choose not to live on reservations should be able to take advantage of the broader programs of the Department which assist States and localities, such as Community Health Centers, as well as our health financing programs, Medicaid and Medicare.

We also intend to work with existing State and local social service agencies to assure that urban Indians are an important outreach target as part of the ongoing activities of those agencies.

Title VII would establish a reporting 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 appropriations requests are much more effective and informative than reports.

We would like to emphasize again that the Department, through the Indian Health Service, is moving as rapidly as we believe feasible toward the goal of raising the health status of Indians to at least a level equal to that of the non-Indian population. We believe the President's budget requests represent a positive commitment to this goal. In addition, through the recent Indian Self-Determination and Education Assistance Act (P.L. 93-638), the Indians themselves are working with the Department in achieving this objective. However, H.R. 2525 does not in our view present desirable program solutions to Indian health needs and its authorizations of appropriations are excessive. It would authorize approximately $465 million over a 3-year period, at a time when both Congress and the President are seeking ways to hold down Federal spending. Such additional expenditures would either increase the size of the Federal deficit or would require more than $465 million in increased taxes or offsetting expenditure reductions. We believe that the Congress is as concerned as the Administration about the necessity to control spending, and in this context we have opposed the overall appropriation levels authorized in H.R. 2525. Thus, because of its unnecessary categorical provisions for Indian health program activities and its excessive authorization levels, we strongly object to H.R. 2525.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report and that enactment of H.R. 2525 would not be consistent with the objectives of the Administration.

Sincerely,

Marjorie Lynch

Under Secretary

THE UNDER SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

AUG 23 1976

Mrs. LaDonna Harris
President
Americans for Indian Opportunity
1816 Jefferson Place, N.W.
Washington, D.C. 20036

Dear Mrs. Harris:

Thank you for your recent letter regarding the current health problems faced by American Indians. We share your view that there is a continuing need for extended Indian health services.

Statistics reveal that Indian Health programs have been effective: for example, since 1955, the Indian and Alaska Native infant death rate has been reduced 70 percent; the death rate from certain diseases of early infancy is down 69 percent, from gastritis and related diseases 83 percent, and from influenza and pneumonia 67 percent. These gains reflect greater survival rates for infants and Indian people of all ages.

In spite of these advances, we agree that much remains to be done. A number of constructive steps are already underway. For instance, the Indian Health Service has received an $11.2 million increase in its fiscal year 1976 program budget. This increase is one indication of the importance placed on this program by the Administration, especially in the face of an emphasis on budget austerity throughout Government.

While it is true that the number of Indian homes to be served by sanitation facilities will be less in fiscal year 1977 than in fiscal year 1976, a review of the overall budget indicates a significant increase in support for Indian health, and this support has been indicated in past years as well.

Public Law 94-303, approved June 1, provides an additional $3 million for Indian health services to cover unforeseen increases in the costs of contract medical care. These funds will help alleviate situations such as you describe in Albuquerque, where only emergency operations could be funded under contract.

I fully believe that our existing legislative authorities can be utilized in finding solutions to the Indian health problems. Please be assured that we intend to explore every possible alternative for using these authorities to assist Indians in alleviating their health problems. It is our belief that many provisions of the Indian Health Care Improvement Act are not necessary and would raise fiscal expectations which are incapable of fulfillment.

As you indicate in your letter, good health care depends, in part, on good health facilities. I am pleased to report that continued progress has been and is being made in upgrading Indian Health Service physical plants. For instance, since 1955, 17 hospitals, 20 health centers and 85 field stations have been constructed.

A new 80-bed hospital at Claremore, Oklahoma, will open in early spring of 1977. Planning is completed for a new hospital at Acoma-Laguna-Canconcito (Acomita), and replacement hospitals at Santa Fe, New Mexico, and Whiteriver, Arizona, with phased construction funds now available for the Acomita and Santa Fe facilities. Planning is completed for expanding and modernizing the hospital at Shiprock, New Mexico. Funds for the second phase planning and installation of pilings were appropriated in 1976 for the Bethel, Alaska, replacement facility. A master planning study has been completed and a modernization project is proposed for the facility at Browning, Montana. Master plan studies recently completed for Rosebud, South Dakota, Sacaton, Arizona, and Red Lake, Minnesota, recommended replacement facilities in lieu of modernization. Planning funds for replacement facilities at Red Lake, Minnesota, and Cherokee, North Carolina, and a new facility at Ada, Oklahoma, are available and construction will start shortly. In fiscal year 1976 planning and first phase construction funds were appropriated for the health center at Lummi, Washington. The Menominee, Wisconsin, Health Center was also funded for planning and construction in fiscal year 1976.

The IHS has regained some hospital accreditations, and is continuing efforts to receive accreditation for all of its hospital facilities. It should be recognized, however, that some hospitals will not meet the accreditation standards because of age or other physical shortcomings. These hospitals will be replaced or modernized as expeditiously as possible.

The President has recently submitted to the Congress a fiscal year 1977 budget amendment expressly for the purpose of implementing P.L. 93-638, the Indian Self-Determination and Education Assistance Act. This Department has a strong commitment to the concepts of this law, and we intend to do everything possible to make its implementation a reality.

Indians have the right to enjoy the highest possible health status which combined private and public efforts can provide. We intend to pursue every reasonable and prudent effort to alleviate the unmet health needs of the Indian people, and we will urge that the highest possible priority be given to programs which will help to elevate the health status of Indians to the level of other Americans.

Sincerely yours,

/s/Marjorie Lynch

Marjorie Lynch
Under Secretary

20

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pro HR 2525

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JR-1

PRESIDENT GERALD FORD
WHITE HOUSE DC 20500

DEAR MR PRESIDENT

ALL MEMBERS OF THE SMALL TRIBES OF THE ORGANIZATION OF WESTERN
WASHINGTON INC,
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COWLITZ
CHINOOK
JAMESTOWN CLALLAM
LOWER ELWHA
MARIETTA BAND OF NOOKSACK
SUQUAMISH
SAUK-SUIATTLE
SAMISH
STEILACOOM
DUWAMISH
SNOQUALMIE
MUCKLESHOOT
NISQUALLY
NOOKSACK
PORT GAMBLE
SQUAXIN ISLAND
STILLAGUAMISH
SKOKOMISH
SNOHOMISH
UPPER SKAGIT
SHOALWATER
SILETZ

S. 522

RESPECTFULLY REQUEST OF YOU TO SIGN INTO LAW HR 2525 THAT HAS RECENTLY
BEEN PASSED BY THE US HOUSE OF REPRESENTATIVES AND THE US SENATE
RESPECTFULLY YOURS

JOSEPH E CLOQUET
HEALTH ADMINISTRATOR
LEO J LACLAIR
EXECUTIVE DIRECTOR
SMALL TRIBES ORGANIZATION OF WESTERN WASHINGTON INC

16:57 EST

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51. MI pro S. 522

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PRESIDENT GERALD FORD
2000 PENNSYLVANIA AVE
WASHINGTON DC 20201

BP

REGARDING S.522-THE INDIAN HEALTH CARE IMPROVEMENT ACT

DEAR PRESIDENT FORD

AS CHAIRMAN FOR THE EIGHT NORTHERN INDIAN PUEBLO COUNCIL OF NORTHERN NEW MEXICO. OUR PUEBLO PEOPLE EARNESTLY FEEL AND STRONGLY URGE SUPPORT PASSAGE OF S.522.

WE FEEL THAT THIS IS ACT IS ONE OF THE MOST IMPORTANT BILLS TO BE ENACTED; WITH YOUR FINAL APPROVAL; BY YOUR ADMINISTRATION.

MAY THE GREAT SPIRIT GIVE YOU WISDOM TO HELP YOUR PEOPLE. THANK YOU IN BEHALF OF MYSELF AND THE EIGHT NORTHERN GOVERNORS. SINCERELY

GOVERNOR WALTER DASHENO
CHAIRMAN OF EIGHT NORTHERN INDIAN PUEBLO COUNCIL

11:13 EST

MGMCOMP MGM

TO REPLY BY MAILGRAM, PHONE WESTERN UNION ANY TIME, DAY OR NIGHT:

FOR YOUR LOCAL NUMBER, SEE THE WHITE PAGES

OF YOUR TELEPHONE DIRECTORY

OR

DIAL (TOLL FREE) 800-257-2241

(EXCEPT IN NEW JERSEY 800-632-2271)

OR DIAL WESTERN UNION'S INFOMASTER SYSTEM DIRECTLY:

FROM TELEX . . . . . 6161 FROM TWX 910 420 1212

gjs — Pro HR 2525

JR-1

The White House
Washington

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7079832981 TDRN COVELO CA 48 09-07 0514P EST
PMS PRESIDENT GERALD FORD
WHITE HOUSE DC
THE STAFF OF THE ROUND VALLEY INDIAN JOB CENTER, INCORPORATED WOULD EARNESTLY ENCOURAGE YOU TO SUPPORT HR 2525, THE INDIAN HEALTH CARE IMPROVEMENT ACT. AFTER TWO CENTURIES, CONDITIONS ON THE RESERVATIONS ARE STILL DESPERATELY CRUCIAL. PLEASE, PLEASE FOR THE HEATLH OF OUR PEOPLE.
SINCERELY
JIM BONO ADMINISTRATED ASSISTANT
NNNN

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JR-1

Pro-S. 522

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PMS GERALD R FORD
WHITE HOUSE DC
THE CABAZON BAND MISSION INDIANSURGE YOU TO SIGN SENATE BILL 522 THE INDIAN HEALTH CARE AND IMPROVEMENT ACT THE CABAZON BAND MISSION INDIANS ARE A PROJECT MEMBER OF THE RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH BOARD WHO RECEIVE HEALTH CARE FROM THE LOCAL PROJECT SO THEREFORE AGAIN WE URGE YOU TO SIGN THIS IMPORTANT BILL SINCERELY

JOSEPH R BENITEZ, CHAIRMAN CABAZON BAND MISSION INDIANS
NNNN

23

Pro - S.522

JR - 1

The White House
Washington

1976 SEP 14 PM 1 42

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7148494761 TDRN BANNING CA 57 09-14 1222P EST
PMS GERALD R FORD
WHITE HOUSE DC
THE RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH URGES YOU TO SIGN SENATE BILL 522 THE INDIAN HEALTH CARE AND IMPROVEMENT ACT THE RIVERSIDE/SAN BERNARDINO COUNTY INDIAN HEALTH IS A PROJECT MEMBER OF THE CALIFORNIA RURAL INDIAN HEALTH BOARD SERVING 40,000 PLUS INDIANS IN CALIFORNIA MEDICAL DENTAL PROGRAMS THEREFORE WE URGE THAT YOU GIVE EVERY CONSIDERATION TO THIS BILL SINCERELY
THE EMMITT ST MARIE CHAIRMAN FOR THE BOARD
NNNN

20 (MI) pro HR 2525

JR-1

The White House
Washington

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WHITE HOUSE MAIL ROOM

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PMS U S PRESIDENT, DLR, DLR
WHITE HOUSE DC
DEAR MR PRESIDENT, UNITED SOUTHEASTERN TRIBES INCORPORATED STRONGLY SUPPORT HOUSING BILL 2525, INDIAN HEALTH CARE EMPLOYMENT ACT. WE STRONGLY URGE YOU TO SIGN THIS BILL AS SOON AS POSSIBLE RESPECTFULLY YOURS
JONATHAN ED TAYLOR, USET PRESIDENT, EASTERN BAND OF CHEROKEE INDIANS PO BOX 455 CHEROKEE NC 28719
NNNN

00081

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JR-1

The White House
Washington

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ICS IPMBNGZ CSP

6052243516 TDBN PIERRE SD 30 09-08 0445P EST

PMS PRESIDENT GERALD FORD

WHITE HOUSE DC

I STRONGLY URGE THAT YOU SIGN INTO LAW THE INDIAN HEALTH CARE IMPROVEMENT ACT BENEFITS TO BE DERIVED BY INDIAN PEOPLE THROUGH THIS ACT ARE DESPARATELY NEEDED

ROCHELLE SMITH COORDINATOR OF INDIAN AFFAIRS OFFICE PIERRE SOUTH DAKOTA

NNNN

5 - - Two - Indian Health Care Improvement Act

The White House
Washington

JR-1

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PMS RELAY 6053485300 TDBN RAPID CITY SD 48 09-08 507P EST

PRESIDENT FORD

WHITEHOUSE DC

RE INDIAN HEALTH CARE IMPROVEMENT ACT. DEAR SIR WE WOULD LIKE TO ENCOURAGE AND SUPPORT YOU IN SIGNING THE INDIAN HEALTH CARE IMPROVEMENT ACT. WHICH IS ON YOUR DESK FOR SIGNATURE. WE INDIAN PEOPLE ARE IN DIRE NEED OF SERVICES THAT THIS BILL WILL GIVE US.

SINCERELY

SOUTH DAKOTA UNITED INDIAN ASSOCIATION

NNNN

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WHITE HOUSE MAIL ROOM

FORM 0805 PRINTED BY THE STANDARD REGISTER COMPANY, U. S. A.

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JR-1

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PMS PRESIDENT GERALD R FORD

WHITE HOUSE DC

AS HEALTH COORDINATOR FOR THE MICCOSUKEE TRIBE OF INDIANS OF FLORIDA AND HEALTH BOARD CHAIRMAN OF THE UNITED SOUTHEAST TRIBES YOUR SIGNATURE ON S-522 THE INDIAN HEALTH CARE AND IMPROVEMENT ACT IS HEREBY ENDORSED AS A MUCH NEEDED AND LONG AWAITED STEP IN THE DIRECTION TO UP-GRADING HEALTH CARE FOR THIS COUNTRIES FIRST AMERICANS

PEGGY BARNETT

NNNN

35

Bill S 522

JR-1

The White House
Washington

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ICS IPMNTZZ CSP
3052238380 TDMT MIAMI FL 36 09-09 1039A EST
PMS PRESIDENT GERALD R FORD
WHITE HOUSE DC
AS ELECTED TRIBAL CHAIRMAN OF THE MICCOSUKEE TRIBE OF INDIAN OF
FLORIDA I URGE YOU TO SIGN S-522 THE INDIAN HEALTH CARE AND
IMPROVEMENT ACT YOUR SUPPORT IS NEEDED TO PASS THIS LONG AWAITED
CRITICAL LEGISLATION
BUFFALO TIGER
NNNN

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Gw S 522

JR-1

WHB009(1120)(2-019158E253)PD 09/09/76 1120

ICS IPMBNGZ CSP

4052754031 TDBN SHAWNEE OK 22 09-09 1120A EST

PMS PRESIDENT GERALD R FORD

WHITE HOUSE DC

MR PRESIDENT WE URGENTLY REQUEST THAT YOU SUPPORT AND SIGN INTO LAW S.522, THE INDIAN HEALTH CARE AND IMPROVEMENT ACT. RESPECTFULLY

DAN LITTLE AX CHAIRMAN ABSENTEE SHAWNEE TRIBE OF OKLAHOMA

NNNN

The White House
Washington

1976 SEP 9 PM 12 57

Re HR 5465

35

JR-1

The White House
Washington

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1976 SEP 9 PM 12 06

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6057472381 POM TDBN ROSEBUD SD 15 09-09 1011A EST

PMS PRESIDENT FORD

WHITE HOUSE DC

THE ROSEBUD SIOUX TRIBE IS IN FULL SUPPORT IN REGARD TO INDIAN HEALTH IMPROVEMENT ACT

ED DRIVING HAWK CHAIRMAN OF THE ROSEBUD SIOUX TRIBE

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Pro HR 2525

17

The White House
Washington

JR-1

WHB016(1931)(1-033A02C244)PD 08/31/76 1928
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PMS PRES GERALD FORD
WHITE HOUSE
WASHDC

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WHITE HOUSE MAIL ROOM

HONORABLE PRESIDENT GERALD FORD,
REPRESENTING THE GREAT SAN CARLOS APACHE TRIBE OF SAN CARLOS AZ
I AM MAKING A SPECIAL REQUEST FOR YOUR POSITIVE
ACKNOWLEDGEMENT OF HOUSEBILL H.R. 2525 DURING THE
200TH YEAR BICENTENNIAL CELEBRATION OF THE UNITED STATES
GOVERMENT IT WOULD ONLY BE PROPER FOR HISTORY TO BE MADE IN
ALLOWING THE INDIAN HEALTH CARE IMPROVEMENT ACT TO BECOME LAW.
HERE ON THE SAN CARLOS APACHE RESERVATION WE ARE IN GRAVE
NEED OF FUNDS TO IMPROVE THE HEALTH CARE AND DELIVERY

SERVICE. EVERY WORD IN THE OBJECTIVE OF THE BILL, AS STATED IN THE DECLARATION OF POLICIES ARE TRUE. MR PRESIDENT, LET IT BECOME LAW, WHICH WILL SHOW THAT YOUR ADMINISTRATION DO SEE THE SPECIAL NEEDS OF THE FIRST AMERICANS.

BUCK KETCHEYAN CHAIRMAN SAN CARLOS APACHE TRIBE

NNNN

The White House
Washington

1976 Aug 18 PM 3 45

WHITE HOUSE MAIL ROOM

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ICS IPMBNGZ CSP
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PMS PRESIDENT GERALD FORD
WHITE HOUSE DC
THE 19 NEW MEXICO PUEBLOS STRONGLY REQUEST YOU SIGN THE INDIAN
HEALTH CARE IMPROVEMENT ACT. A VETO OF THIS IMPORTANT LEGISLATION
WILL MEAN CONTINUED SUFFERING FOR THE NATIVE AMERICANS
DELFIN LOVATO CHAIRMAN ALL INDIAN PUEBLO COUNCIL
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The White House
Washington

1976 AUG 18 PM 3 45
WHITE HOUSE MAIL ROOM

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ICS IPMRNCZ CSP
6026692807 NL TDRN PARKER AZ 100 08-17 0215P MST
PMS PRESIDENT GERALD R. FORD
WHITE HOUSE DC
WE THE COLORADO RIVER INDIAN TRIBE CONSIDER THE INDIAN HEALTH CARE IMPROVEMENT ACT A MOST SIGNIFICANT INDIAN HEALTH MEASURE AND VITAL TO THE NEEDS OF ALL INDIANS TODAY AND WHEREAS WE HAVE DECIDED THAT ALL INDIAN HEALTH PROGRAM ARE MUCH NEEDED ON OUR RESERVATIONS WE HEREBY REQUEST THAT YOU SIGN THIS BILL INTO LAW WHEN IT APPEARS BEFORE YOU FOR APPROVAL. YOUR ADMINISTRATION HAS SUPPORTED THE INDIAN PEOPLE FOR HIGH QUALITY EDUCATIONAL OPPORTUNITIES AND AVAILABLE ECONOMY. WE FURTHER APPEAL TO YOU FOR THE HIGHEST QUALITY OF MEDICAL SERVICES TO OUR PEOPLE. WE EXTEND OUR SINCERE WISHES TO YOUR ADMINISTRATION
ANTHONY DRENNAN SR, CHAIRMAN TRIBAL COUNCIL COLORADO RIVER

INDIAN TRIBES

NNNN

DRAFT SIGNING STATEMENT

I am today signing H.R. 2525, the Indian Health Care Improvement act. I do this because the well-recognized need for improvement in Indian health manpower, services and facilities outweighs the defects in the bill itself.

Over the past twelve years the Government of the United States has made promises to its citizens that it would end or cure some of the nation's egregious social problems. Many of those promises were overstated.

Over the past two hundred years, the Government has made promises to Indian people. Some of those promises were deceptions: they were never kept at all.

In signing this bill I want neither to overstate nor to deceive.

The proper committees of the House and the Senate have studied the Indian health care delivery system during both the 93rd and 94th Congresses. In spite of the fact that our Executive Branch spending for Indian Health Service activities has grown from $113 million in FY 1969 to ~~$354.9~~ 1425.6 million in FY 1977, Indian people still lag behind the American people as a whole in having their health needs met. The careful documentation the Committees have provided is what has persuaded me to sign this bill.

H.R. 2525 itself is but an authorization; it asks the President of 1977 and 1978 and 1979, and it asks the 95th and 96th Congresses

to aim at spending_____, _____, and_____ respectively for Indian health. It insists that the number of federal employees in the Indian Health Service grow from _____ today to_____ by FY 1980.

Indian people and American citizens generally should understand that a Presidential signature on this bill today does not guarantee that Presidential budgets of the years to come will inevitably propose the amounts authorized and does not guarantee at all that future Congresses will appropriate the amounts set forth.

H. R. 2525 is a statement of direction of effort toward meeting a clear need, and as such, it meets with my full approval.

H. R. 2525 is also, however, a bill replete with authorities which which are not needed, with narrow categorical specifications which are inimical to good public administration and with mandated personnel add-ons which diminish flexibility for executive management. Title V of H. R. 2525 risks initiating new and uneeded health programs for urban Indians; I am asking the Secretary of Health, Education and Welfare to administer Section 503 (a) (9) with great caution, since it is preferable that urban Indian people receive health care from existing local facilities than to start up duplicative programs at unnecessary cost.

Since Title VII of this bill provides for reports to the Congress from the Secretary, including a review of progress and an assessment of the bill's programs, I believe the Administration can in this way

bring to the attention of the Congress any changes then needed to improve the provisions of H. R. 2525.

Indian health needs are great; I am signing this bill to helpmeet those needs. But in signing H. R. 2525 I confirm my equal duty to all the taxpayers of the nation to avoid excessive costs in even the most laudatory of assistance programs.

THE WHITE HOUSE

WASHINGTON

September 3, 1976

MEMORANDUM TO: SARAH MASSENGALE

FROM: BRAD PATTERSON

SUBJECT: Draft Signing Statement for the Indian Health Bill

I have tried my hand at a draft, as per our recent conversation.

The dilemma is rather acute here; how to compose a signing statement which is properly cautionary, but which does not put such a wet blanket on the approval that we take all the credit away from ourselves for signing it at all. The easy way out would be just to sign the bill (and maybe have a ceremony) but doing that in this case might undermine the credibility of HEW and OMB which, for good reasons, have taken a clearly negative position on this bill for three years running.

Let's discuss with each other and then with OMB.

Adm. Always agreed to Findings & Conclusions
Needs for Health Manpower ~~see~~ – use some
1970 Message – Hard to do administratively

Title IV – Adm position

Title V – in effect restrictive → of Snyder Act
is ~~cited~~ applied to urban areas

THE WHITE HOUSE

WASHINGTON

September 3, 1976

MEMORANDUM TO: SARAH MASSENGALE

FROM: BRAD PATTERSON

SUBJECT: Draft Signing Statement for the Indian Health Bill

I have tried my hand at a draft, as per our recent conversation.

The dilemma is rather acute here; how to compose a signing statement which is properly cautionary, but which does not put such a wet blanket on the approval that we take all the credit away from ourselves for signing it at all. The easy way out would be just to sign the bill (and maybe have a ceremony) but doing that in this case might undermine the credibility of HEW and OMB which, for good reasons, have taken a clearly negative position on this bill for three years running.

Let's discuss with each other and then with OMB.

OFFICE OF
THE SECRETARY OF THE INTERIOR

9/9/76

TO: BRAD PATTERSON

FROM: Loren Rivard

SUBJ: Indian Health Bill

Enclosed are memos from both Commissioner Thompson and John Powell which should be helpful to you.

United States Department of the Interior

BUREAU OF INDIAN AFFAIRS
WASHINGTON, D.C. 20245

IN REPLY REFER TO:
Legislation
BCCO - #5365

SEP 2 1976

Memorandum

To: Loren Rivard

From: Commissioner of Indian Affairs

Subject: S. 522 (H.R. 2525), Indian Health Care Improvement Act

I recommend that the President sign S. 522 when it becomes enrolled. If it is felt necessary, he could issue a signing statement outlining appropriate objections and concerns with the bill which has been approved by HEW and OMB.

A veto of S. 522 could badly damage the Administration's relations with Indian leaders, Indian people generally, and those who are supportive of the American Indian because of past wrongs done to Indians, and sympathetic to their present situation. Considerable effort and time has been devoted by Indian people to achieving passage of the bill.

It should be noted that there is every indication that a veto of S. 522 would be overridden. (See John Powell's August 25 note to you).

As the result of reductions in the authorizations in the bill by the House Interstate and Foreign Commerce Committee, the bill now authorizes $475 million in appropriations over a 3-year period whereas the Senate passed version would have authorized $1.6 billion over a seven-year period.

The Minority Views in the Interstate and Foreign Commerce Committees Report on the bill includes the following pertinent paragraph:

> "There is a risk that opposition to the approaches taken in H.R. 2525 will be viewed as a lack of concern about Indian health needs and a lack of commitment to their resolution. Our support of the goals of this bill and our Committee amendments belies any such interpretations. Modifications in the bill, in our opinion, simply do not go far enough to insure a realistic building upon the progress that has been made in recent years".

The Interstate and Foreign Commerce Committee voted unanimously to favorably report with amendments which were adopted by the House. The Committee's report includes the following in its Findings and Recommendations:

> "The Committee was impressed with the evidence presented in hearings *** concerning the lack of adequate numbers of health care personnel to serve the Indian population in the Indian Health Service, with the disturbing statistics on the generally poorer health level of the American Indian in comparison with the general population, [and] with the deplorable state of many of the Indian Health Service facilities ***."
>
> "The need for improved health care for Indians is clear to the Committee. They endorse the concept embodied in H.R. 2525 that the Congress and the nation make a commitment to the American Indian to bring the level of Indian health, and the quality of health care facilities and health professions manpower serving Indians, to a level equal to that enjoyed by other Americans".

Enactment of a bill such as the Indian Health Care Improvement Act can be attributed to the lack of adequate concern by the Executive Branch for a number of years. For example, of the 51 IHS hospitals, 26 do not meet the standards for national hospital accreditation and 20 cannot pass fire and safety requirements. The average age of the hospitals is 21 years with the oldest having been built in 1909. Of the 9 IHS hospitals built in the last 10 years, 3 were requested by the Administration and 6 were the result of congressional add-ons. HEW acknowledges that 21 of the hospitals should be replaced.

It is facts like the above which render ineffective further Administration opposition to a legislative initiative to remedy the situation. However, if the President should decide that he must veto the bill, I would strongly urge that the veto message include specific steps which he is taking (including commitments to request additional funding in next January's budget submission to the Congress) to achieve the purposes and goals of the bill.

Morris Thompson

United States Department of the Interior

OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20240

AUG 25 1976

NOTE TO: Loren Rivard

SUBJECT: HR 2525 (S 522)

This responds to your request for comments on Brad Patterson's inquiry concerning the Indian Health Care bill. His note of August 17 raises two questions: 1) Is a veto of HR 2525 sustainable? and 2) What is our view of an Indian reaction to such a veto?

Since HR 2525 (and its companion S 522) passed both Houses by overwhelming margins, (Senate, by unanimous consent without debate; House, 310-9) a veto would be difficult to sustain. Moreover, there was substantial minority support for this legislation in both Houses. Senate sponsers included: Bartlett, Domenici, Fannin, Goldwater, Hatfield, Stevens, and Dole. House sponsers included: Wilson (Cal.), Young (Alaska), Esch, Rhodes, Conlan, Steiger (Ariz.), and Lujan.

The BIA believes that a veto would produce a considerable adverse reaction in the Indian community. In addition, while the Department has supported the Administration position in opposition to this legislation, we have always expressed an appreciation for the need to improve Indian Health Care programs.

John

John M. Powell
Asst. Legislative Counsel

September 10, 1976

MEMORANDUM FOR: SARAH MASSENGALE

FROM: BRAD PATTERSON

SUBJECT: Indian Health Bill - Draft Signing Statement

I would suggest a couple of amendments to the draft which I sent you the other day:

1. At the end of the fourth paragraph (and for the beginning of the fifth) insert the following:

> The Second Session of the 94th Congress has also greatly improved this bill from its earlier form: its cost has been reduced from $1.6 billion to $480 million and the number of years of specifically authorized funding have been cut from seven to three. These improvements, and the bipartisan support which the improved bill enjoys, make S 522 much more acceptable.
>
> S 522 is, of course, but an authorization;

2. Re-identify the bill as S-522 throughout the statement.

(The bill passed the Senate yesterday with a couple of amendments, 78-0).

Let's discuss soon.

THE WHITE HOUSE

WASHINGTON

September 23, 1976

Sarah -

I think we can be a little more positive about the Indian Health Care Improvement Act, and therefore propose an alternative Signing Statement here in draft.

Suggest we discuss with each other and then with OMB.

What do you think about a Signing Ceremony? I have a contingency list of invitees..

Jack

cc: Mrs. Kilberg

DRAFT SIGNING STATEMENT FOR S 522

I am today signing S 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have determined that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill itself.

There has never been any question throughout my Administration about the validity of the Congressional Findings in S 522.

There have been differences with the Congress of course about the best methods for meeting the needs identified in those Findings. Earlier versions of this bill contained many undesirable provisions.

But the Congress, after careful and bipartisan review, has modified S 522 and has in my opinion corrected the features which would have been unacceptable.

The proper Committees of the House and Senate have studied the Indian health care delivery system during both the 93rd and 94th Congresses. In spite of the fact that our Executive Branch spending for Indian Health Service activities has grown from $113 million in FY 1969 to $425.6 million in FY 1977, Indian people still lag behind the American people as a whole in having their health needs met. I am persuaded to sign this bill because of the careful documentation that the Committees have made and because of my own personal conviction that our First Americans must no longer be last in opportunity.

The authorizations in this bill may be beyond what future Presidents or future Congresses may be willing or able to approve; there are unneeded authorities given and narrow program categories mandated. But S 522 is a statement of direction of effort toward meeting a clear need, and as such it meets with my personal approval.

Title V of S 522, however, may risk initiating new and unneeded health programs for urban Indians; I am asking the Secretary of Health, Education and Welfare to administer Section 503(a)(9) with great caution, since it is preferable that urban Indian people receive health care from existing local facilities than to start up duplicative programs at unnecessary cost.

Since Title VII of this bill provides for future reports to the Congress from the Secretary, including a review of progress and as assessment of the bill's progress, I believe the Administration can in this way bring to the attention on the Congress any changes then needed to improve

the provisions of S 522.

I am proud to point out that this new statute is only the latest in a distinguished series of legislative, executive and judicial actions in the past few years which have totally reversed the shameful policies of the past towards American Indian people. The restorations of Blue Lake, of the Yakima lands, of the Menominees, the Alaska Native Claims Settlement Act, the Indian Financing Act and the Indian Self-Determination Act, the government's vigorous defense of Indian natural resources and water rights, the resulting milestone Court decisions such as McClanahan, Washington, Mazurie, Stevens and Bryan, the tripling and quadrupling of agency budgets for Indian programs -- are rectifying the sorry past and are enabling our American Government to hold its head high where our American Indian citizens are concerned.

There is much more to do, but this Act and the chain of statutes and policies of which it is a link have marked a new direction of which I am proud and which I shall continue.

GRF

Allen, Henry, Chairman, Board of Directors, North Central Oklahoma Inter-Tribal Health Council, Inc.

Allen, Jim, President, Inter-Tribal Council of Eight Northeastern Tribes

American Academy of Family Physicians, Carl B. Hall, M.D. - Pres.
Thomas Jacobsen, M.D

American Association of Colleges of Pharmacy, Tom S. Muja - Pres.

* American Medical Association, Richard Palmer - Pres.

* American Dental Association, Robert B. Shira, D.D.S. - Pres.

American Optometric Association, Ronald Fair, O.D. - Pres.

American Psychological Association, Wilbert J. McKeachie, Ph.D.-Pres.

American Speech and Hearing Association, Daniel P. Boone, Ph.D. - Pres. of Board; Kenneth O. Johnson, Exec. Sec.

Banashley, Fred, Sr., Chairman, White Mountain Apache Tribe, Whiteriver, Arizona

* Bartlett, Honorable Dewey T., a U.S. Senator from the state of Oklahoma

Bear Don't Walk, Marjorie, Director, National Institute of Health Grant, Native American Studies, University of Montana

* Belindo, John, Executive Director, National Indian Health Board

Benally, Hauley, Gallup Health Advisory Board Office

Bernal, Paul, vice Chairman, All Indian Pueblo Council

Bia, Emmett, Council Delegate, Many Farms, Arizona

Blueye, Henrietta, Seattle Indian Health Board

Burch, Leonard, Chairman, Southern Ute, Colorado

Cannon, Bob, Executive Director, Comanche County Improvement Foundation, Inc.

* Chino, Wendell, President, National Tribal Chairmen's Association, Chairman, Mescalero Apache

Cottier, Belva, Executive Director, San Francisco Native American Health Service

Cox, Claude, Chief, Creek Nation

Crawford, Earl, Tribal Sanitation Representative of the Cherokee Nation

Dashee, Alvin, Vice Chairman, Hopi Tribal Council

Deegan, Charles, Jr., Acting Chairman, National Off-Reservation Indian Health Programs

* Dole, Honorable Robert, a U. S. Senator from the state of Kansas

Dressler, Effie, Chairman, Western Nevada Indian Health Board, Inc.

* Ducheneaux, Frank, House consultant, Subcommittee on Indian Affairs, Committee on Interior and Insular Affairs

* Fannin, Honorable Paul J., a U. S. Senator from the state of Arizona

* Forrest, Erin, Chairman, National Tribal Chairmen's Association Health Committee

Garcia, Merle, Governor, Pueblo of Acoma

* Gerard, Forrest J., Staff Assistant, Subcommittee on Indian Affairs, Committee on Interior and Insular Affairs

Goodbear, Howard, Chairman, United Tribes of Western Oklahoma and Kansas; Elnita Rank, Chairman, United Sioux Tribes of South Dakota; Robert Hoag, President, Seneca Nation of Indians; Tom Pable, Chairman, Montana Inter-Tribal Policy Board

* Hawkins, George, President, National Indian Board on Alcohol and Drug Abuse OKLA

House, Benjamin A., Crownpoint, New Mexico

* Jackson, Honrable Henry M., a U. S. Senator from the state of Washington

Jackson, May, Creek and Seminole Tribe

* Jennings, Don, Executive Director, Association of American Indian Physicians OKLA

* Johnson, Emery A., M. D., Assistant Surgeon General, Director, Indian Health Service

Keen, Ralph, Former Business Manager of the Cherokee Nation

King, Eloise, Chairperson, Governor's Indian Advisory Council, Tumwater, Washington

White, Ada, Chairman, Billings Area Indian Health Board

* Lavis, Rick, AA to Fannin

Little Axe, Danny, United Indian Tribes of Western Oklahoma and Kansas

Isaac, Calvin J., Chief, Mississippi Band of Choctaw Indians

McKenzie, Dr. Taylor, Navajo Health Authority, Dean/Executive Director

* Muschenheim, Dr. Carl, Chairman, National Committee on Indian Health of the Association of American Indian Affairs

Old Person, Earl, Blackfeet Tribe

Overton, James, Governor, Chickasaw Nation - Oklahoma

Red Eagle, Ed, Sr., Chairman, North Central Oklahoma Inter-Tribal Health Council, Fairfax, Oklahoma

Reyes, Luana, Seattle Indian Health Board

* Rhoades, Dr. Everett R., Past President of the Association of American Indian Physicians OKLA

* Sampson, Melvin, Vice Chairman, National Indian Health Board WASH

Sarracino, Emmett, Director, Health Program, Los Angeles, California

Sekaquaptewa, Abbott, Chairman, Hopi Tribal Council

* Skubitz, Joe, Congressman from the State of Kansas

Smith, Frank, Assistant Deputy Director, Cook Inlet Native Association

Smith, Leonard, Executive Director, California Indian Health Council

Starr, Hickory, Jr., Project Director, Central Oklahoma American Indian Health Council, Inc.

Sundust, Perry, Chairman, Phoenix Area Indian Health Board

Swimmer, Ross, former General Counsel, Cherokee Nation now Principal Chief, Cherokee Nation

Tafoya, Paul, Governor, Santa Clara Pueblo, New Mexico

Tanana Chiefs Health Authority

Tanyan, Ed, Chief, Seminole Tribe, Oklahoma, Chairman, Oklahoma City Area Indian Health Board

Taylor, Jonathan, Vice-Chairman, Cherokee, North Carolina

Tiepelman, Dennis A., Executive Director, Mauneluk Association, Kotzebue, Alaska, to Subcommittee on Indian Affairs

Tinker, Sylvester J.,Principal Chief, Osage Tribe of Indians, Pawhuska, Oklahoma

* Tommie, Howard, Chairman, National Indian Health Board

* Tonasket, Mel, President, National Congress of American Indians

* Trimble, Charles, Executive Director, National Congress of American Indians

Waln, Sonny, Chairman, Rosebud Sioux Tribe Health and Welfare Committee

* Wauneka, Annie

Webb, Gordon S., Member, Nez Perce Tribe of Idaho, San Francisco, California

Williams, Cecil, Chairman, Executive Health Staff

(*) Wood, Rosemary, RN MS, American Indian Nurses' Association, Inc.

* Youpee, William, Executive Director, National Tribal Chairmen's Association

Bergman, Abraham, M.D., Childrens' Hospital, Seattle, Wn.

* Kemberling, Sidney, M.D., Chairman of Indian Health Committee, American Academy of Pediatrics

* Koomen, Jacob, M.D., Association of State and Territorial Health Officials - Chairman

Don Young

Lloyd Meeds

Paul Rogers

IHS draft

DRAFT

The Indian Health Care Improvement Act promises to assist the Administration in providing the Indian people with the authorities and program support necessary to meet their health needs. Further, it is consistent with long-standing positions and statements of the Executive Branch regarding its concern for, and resolve to meet the problems of Indian health.

Title I of this Bill relates to three initiatives undertaken within the Executive Branch, including HEW. First, in 1970, the former President in his Indian message to the Congress expressed keen awareness of need for increased numbers of Indians trained in the health professions. Second, in 1975, former Secretary Weinberger asked the Health Resources Administration to conduct a study on ways in which the needs for Indian health manpower could be met. It was indicated that administrative means for meeting these needs would be most desireable. The study, however, revealed that suitable and feasible administrative means were not available. Thirdly, it was thought that giving preference to Indians within existing national scholarship program budgets would be a good way to increase the Indian health manpower pool. The OGC, however, said there is no legal authority to do this. Thus, the Administration, long interested in increasing the Indian health manpower pool, found that there was no administratively

feasible way of meeting this need within the framework of existing structures and authorities.

Congress, in Title I of this Act, has provided a legal means to do what has been denied to the Administration because of administrative and legal complications. The title provides Indian preference, rather than massive new programs, for professional scholarships, and is, therefore, consistent with the Administration's basic approach to the problems of Indian health manpower.

Titles II and III, respectively, relate to health services for Indian people, and health facilities needed to deliver those services. The titles set forth a phased approach to meeting needs in these areas. The Executive Branch has long held there is a need for such a phased approach for meeting unmet needs for services, and for appropriate health facilities. For example, in 1970, former Assistant Secretary for Planning and Evaluation, Lawrence Lynn, testified that an incremental approach to meeting unmet Indian health needs is desireable and referred to a plan which was to be developed by the Department. For whatever reasons, this plan was not submitted to the Congress. Titles II and III, therefore, confirm and support a longstanding HEW approach to resolving problems of unmet needs for Indian health services and facilities.

It is true that Titles II and III specify with precision the needs, and numbers and dollars to be addressed to these needs. It is noteworthy, however, that the Congress has done so in a way that provides certain flexibilities for the Executive Branch over the seven-year life of the Bill. Congress has given HEW three years to work with these numbers and dollars. At the end of that time the Department, based on its three years of experience, can go back to the Congress with the recommendations for the last four years of the bill's life.

The Administration supports Title IV of the bill. Should the President choose to sign the bill into law, he would, in fact, be reaffirming the Administration's position on this Title.

Title V, basically, is a restrictive title pertaining to urban Indians. The current law governing IHS operations does not preclude full-blown Indian Health Service operations throughout the country including urban areas. S.522 limits this potentially unlimited scope of IHS operations. Further, it assists urban Indians to participate in programs designed to serve all people in need. Both of these features are consistent with the Administration's position that urban Indians should be fully aware of, and full participants in the health programs available to the general public, on the same basis as anyone else who qualifies, rather than establishing a massive, special Federal health services to Indian people.

Title VI would authorize a feasibility study relative to the establishment of an Indian medical school. Several years ago, former Secretary Richardson took the initiative in exploring the need for an Indian medical school. This title does not offer to build these schools as it originally did; rather, it authorizes the aforementioned study. Again, this title is consistent with earlier actions by the Executive Branch.

It is clear from the aforegoing that each of the titles in this bill, rather than being in conflict with, or alien to Executive Branch initiatives, aims positions, and practices, their relative to Indian health needs, and, indeed, parallel in many cases, some pioneering initiatives on the part of the Administration.

There is every reason to believe that the Administration's concern about Indian health needs continues to be at a very high level as it long has been. Illustratively, as recently as July 16, 1976, President Ford, in remarks to a group of Indian leaders, established a higher than ever level of expectations of his Administration among the Indian community. Unquestionably, Indian leadership and community membership throughout the country look with great hope and confidence to the President to meet these expectations and provide relief for their longstanding problems. It is crystal clear that they would find his signing this bill into

law to be completely consistent with previous Executive Branch initiatives and the public positions he has taken. It would be a solid affirmation of his credibility with the First Americans.

THE NAVAJO NATION

WINDOW ROCK, ARIZONA 86515

PETER MacDONALD
CHAIRMAN

SEP 27 1976

Dear President Ford:

BP

It has come to our attention that the INDIAN HEALTH CARE IMPROVEMENT ACT has been approved by both Houses of the United States Congree and the Bill has been forwarded to you for consideration.

On behalf of the Navajo People, as well as that of other Indian People, and the upgrading of the level of their Health, which is at present far below National Norms, and in the spirit of your stated intentions to work with and improve the well-being of these people, I respectfully urge that you carry out your commitment to the Indian People of America by signing immediately into Law the INDIAN HEALTH CARE IMPROVEMENT ACT. The Navajo People, specifically, look and appeal to you to honor the trust America holds for the American Indian People and Treaties made to guarantee this trust.

Peter MacDonald
Navajo Tribal Council

President Gerald R. Ford
United States of America
The White House
Washington, D.C.

Replied by phone
10-1-76

THE WHITE HOUSE

WASHINGTON

September 27, 1976

MEMORANDUM FOR THE PRESIDENT

FROM: BRADLEY H. PATTERSON, JR.

THROUGH: WILLIAM J. BARODY, JR.

SUBJECT: S. 522 -- The Indian Health Care Improvement Act

I respectfully recommend that you sign S. 522 and issue the attached statement (Tab A).

Most of my reasons for this recommendation are not reflected in the Enrolled Bill Memorandum; they are as follows:

1. For seven years there has been an unbroken series of Presidential actions which have reversed and rectified the past decades of neglect for Native Americans. It has been a brilliant executive/legislative accomplishment in which you and a bipartisan Congress fully share. A veto of this bill would be the first turnaround in that seven-year record and, as such, would have symbolic impact greater than the merits of the bill considered by themselves.

2. This symbolic impact could not come at a more inopportune time.

   (a) Our experience with Indian matters from Alcatraz to Wounded Knee has shown us that while the Indian community itself is small, the latent interest in and sympathy for Indian people in the population generally is widespread, is undiscriminating and is a magnet for media exploitation. The symbolic force of a veto here risks galvanizing that latent sympathy into an attention-getting political backlash among

conservative and independent people, as well as among Democrats.

(b) Carter's staff is keeping close track of Indian matters; (he has sent Messages to all the recent Indian meetings.) A veto of this bill will raise the whole area of Indian affairs up into his target sights.

(c) You have just (properly) vetoed a less important bill on early retirement for non-Indian federal employees. The two vetoes together will have a synergistic effect. Three weeks from today the National Congress of American Indians assembles in Salt Lake City; vetoing the Indian Health bill will convert the Conference into a minor political disaster for us in addition to its longer term negative opinion effect among Indian leaders.

3. The bill is only an authorization measure. While it is true that the Indian community and the Indian Health Service will be encouraged by your signature to recommend appropriations for the full amounts, you and OMB can handle any unjustified requests through the budget machinery, and in that discriminating way -- next December -- rather than through the sledgehammer of a veto -- in October, protect the budget from excesses. The draft statement (Tab A) makes it clear that your signing the bill does not constitute overpromising or making a commitment to budget the amounts authorized.

4. Contrary to the impression which may be given at the bottom of page 6 of the Enrolled Bill Memorandum, Republican support for this bill is strong; a veto (unless it is of the "pocket" variety) will be overridden.

(a) Joe Skubitz, ranking on the House Interior Committee, joined in the successful effort to have the earlier version of the bill amended, stating:

> If the amendments are adopted, it is a bill which I personally believe the President can sign in good conscience. . .
>
> I can truthfully say that the Interstate

committee has done its best to report a responsible bill, which in our judgment, should be both fiscally and philosophically acceptable to the administration."

(b) On House passage, the following members of the Minority of the House Interior Committee joined Mr. Skubitz in voting for the bill: Messrs. Bauman, Clausen, Johnson, Lagomarsino, Pettis, Smith and Symmes.

(c) Congressman Rhodes is a co-sponsor of the bill and has written you a special letter urging you to sign it.

(d) Senators Dole, Fannin, Goldwater, Bartlett, Domenici, Stevens and Hatfield are supporters of the amended bill.

5. We are on somewhat slippery grounds in opposing the final, amended bill. In unusual steps, both Ranking Member Skubitz and Ranking Member Fannin went out of their way to castigate HEW generally and Secretary Mathews personally for being unwilling earlier on to sit down with the Committees and staffs to work out an acceptable compromise. 53 weeks ago, Senators Fannin and Bartlett had lunch with Secretary Mathews to start this process, but HEW never followed up. The Skubitz and Fannin statements are attached here as Tab B.

6. The Indian Health facilities lack more than "eight-foot-wide halls". When the House and Senate Committee reports pointed out that 25 out of 51 IHS hospitals failed of accreditation by the Joint Commission on Accreditation of Hospitals, they added:

"Many of them are old one-story, wooden frame buildings with inadequate electricity, ventilation, insulation and fire protection systems and of such insufficient size as to seriously jeopardize the health and safety of patients and staff alike."

7. I share Paul O'Neill's concern about special health programs for urban Indians, but the draft signing statement recommended here includes a special instruction to Secretary Mathews to use the bill's authority to avoid duplication.

DRAFT SIGNING STATEMENT FOR S 522

I am today signing S 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have determined that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill itself.

There has never been any question throughout my Administration about the validity of the Congressional Findings in S 522.

There have been differences with the Congress of course about the best methods for meeting the needs identified in those Findings. Earlier versions of this bill contained many undesirable provisions.

But the Congress, after careful and bipartisan review, has modified S 522 and has in my opinion corrected the features which would have been unacceptable.

The proper Committees of the House and Senate have studied the Indian health care delivery system during both the 93rd and 94th Congresses. In spite of the fact that our Executive Branch spending for Indian Health Service activities has grown from $113 million in FY 1969 to $425.6 million in FY 1977, Indian people still lag behind the American people as a whole in having their health needs met. I am persuaded to sign this bill because of the careful documentation that the Committees have made and because of my own personal conviction that our First Americans must no longer be last in opportunity.

The authorizations in this bill may be beyond what future Presidents or future Congresses may be willing or able to approve; there are unneeded authorities given and narrow program categories mandated. But S 522 is a statement of direction of effort toward meeting a clear need, and as such it meets with my personal approval.

Title V of S 522, however, may risk initiating new and unneeded health programs for urban Indians; I am asking the Secretary of Health, Education and Welfare to administer Section 503(a)(9) with great caution, since it is preferable that urban Indian people receive health care from existing local facilities than to start up duplicative programs at unnecessary cost.

Since Title VII of this bill provides for future reports to the Congress from the Secretary, including a review of progress and as assessment of the bill's progress, I believe the Administration can in this way bring to the attention of the Congress any changes then needed to improve the provisions of S 522.

I am proud to point out that this new statute is only the latest in a distinguished series of legislative, executive and judicial actions in the past few years which have totally reversed the shameful policies of the past towards American Indian people. The restorations of Blue Lake, of the Yakima lands, of the Menominees, the Alaska Native Claims Settlement Act, the Indian Financing Act and

the Indian Self-Determination Act, the government's vigorous defense of Indian natural resources and water rights, the resulting milestone Court decisions such as McClanahan, Washington, Mazurie, Stevens and Bryan, the tripling and quadrupling of agency budgets for Indian programs -- are rectifying the sorry past and are enabling our American Government to hold its head high where our American Indian citizens are concerned.

There is much more to do, but this Act and the chain of statutes and policies of which it is a link have set a new direction of which I am proud and which I shall continue.

Gerald R. Ford

INDIAN HEALTH CARE IMPROVEMENT ACT

Mr. FANNIN. Mr. President, I concur with the distinguishcd chairman of the committee.

For nearly 2½ years, the Congress has been considering legislation to strengthen the quality of Indian health care services. Beginning with hearings in 1973 on the shortages in Indian health manpower, the Congress has, through hearings, investigations, and GAO studies, confronted Indian health care deficiencies and needs. It would serve no useful purpose to remind the Senate once again of these problems, except to say that these problems remain unresolved, awaiting resolution.

In response, the Senate Interior Committee developed the Indian Health Care Improvement Act which the Senate on two occasions approved unanimously. This legislation was designed to expand, under a carefully developed plan, the level of health care services provided to Indian people. In addition, the bill addressed the crisis in manpower facing the IHS and the inadequate and unsafe facilities which the IHS must utilize in treating Indian citizens. The Senate in approving this legislation was confident that its approach, which was comprehensive in scope, addressed in a reasonable way the neglect which limited resources had fostered within the Indian Health Service. In doing so, the Senate committed itself to establishing better health care for Indian citizens as a priority concern of the Federal Government.

In the House, three major authorizing Committees, Interior and Insular Affairs, Interstate and Foreign Commerce and Ways and Means examined this issue in depth and recommended approval of the Senate-passed bill, S. 522, as amended. The House concurred by a vote of 310 to 9. By this vote, the House committed itself to strengthening our Indian health care program and joined with the Senate in making Indian health care a matter of highest importance.

As amended by the House, S. 522 was modified only to the extent of its commitment. As passed by the Senate, S. 522 had authorized the expenditure of $1.6 billion over 7 years. This approach was neither arbitrary, unreasonable or excessive as it had been our policy to limit the impact of these much needed expenditures while assuring a strong commitment to eliminating the deficiencies in manpower, patient care services and facilities. In approving this 7-year program, the Senate had sought to avoid those problems that might occur with a short-term crisis program.

The House, after careful deliberation, determined that it would be unwise to make such a long-term commitment. It amended S. 522 by authorizing the expenditure of approximately $500 million over a 3-year period. It did, however, commit itself to reviewing the balance of the 7-year plan following the initial 3-year authorization period. Nevertheless, the bill, as amended, remains virtually intact in terms of its basic structure. The Senate had designed a bill which contained a series of programs which were interrelated and complementary. This approach, to which the House agreed, is fundamental to successfully overcoming the overall problems in the Indian health care delivery system. Therefore, because the House retained the basic structure developed by the Senate and is committed to reviewing the balance of the 7-year plan following the 3-year authorization period, I can accept S. 522 as amended and urge my Senate colleagues, without reservation, to approve this much needed legislation.

There is one issue, however, in the bill which needs to be discussed so that the record is quite clear as to congressional intent. During its consideration of title I, dealing with manpower, the House Interstate and Foreign Commerce Committee approved an amendment to establish the section 104, health scholarship program within the National Health Service Corps program. This amendment was unacceptable initially to the Senate because it created a situation in which the Indian Health Service would be unable to control the program. It was definitely the intent of the Senate to provide the Indian Health Service with sufficient authority to manage its own manpower programs as developed within title I, so that it would not have to rely on other existing programs which have proven unable to meet IHS needs. The amendment by the House appeared to have weakened that approach causing us great concern. In response, the House agreed to a further amendment which would insure that the Indian Health Service could write the prescription for its manpower needs while allowing the National Health Service Corps to administer the details of the scholarship application and funding process. In view of this clarification, I have no further objection to the House amendment with the understanding that the Indian Health Service will have the authority to determine scholarship recipients and the distribution of scholarships among those health care professions that are either in demand or expected to be in demand within the Indian Health Service.

Mr. President, as we move to conclude the final action on the Indian Health Care Improvement Act, there hangs over this much needed legislation the threat of a veto. This threat deeply concerns me; but let me be very clear that I do not intend to stand idly by in the event of a veto.

This threat has existed since Congress began its consideration of the Indian Health Care Improvement Act. The position of the Department of Health, Education, and Welfare has always been negative. In letter after letter, in statement after statement, the Department has never changed its mind that this legislation was unnecessary, too expensive, excessive in scope, and inconsistent with the objectives of the administration.

The Department has failed to even practice the art of compromise, conciliation, and cooperation in the development of this bill. On two occasions in this and the last Congress, my staff met with departmental officials to discuss agreement on this bill. Their attitude was clearly negative and exhibited an unwillingness to work out an acceptable compromise. Senator BARTLETT and I even met with Secretary Mathews to encourage support and to possibly open communications on resolving the Department's posture of opposition. It was my impression following this meeting that the Department was interested in the problems of the Indian Health Service and in discussing possible approaches to their solution both within nad without the context of the Indian Health Care Improvement Act. Yet, progress toward agreement was conspicuous by its absence. The Department made no effort whatsoever to produce any alternatives and, in fact, I never heard from Secretary Mathews on the subject again. In view of the unbending opposition by the Department, the Congress had no choice but to proceed as best it could in developing legislation that would address the very critical health care problems faced by Indian citizens.

Time and again the Department indicated that this legislation would create undue expectations among the Indian people. Yet, what expectations does the Department provide to Indian people themselves when their own budget requests for IHS contains funds which are inadequate to effectively address patient care needs and the obvious need for better facilities. For example, since fiscal year 1969, through fiscal year 1977, the Department has on its own requested only enough funds to construct two replacement hospitals. Yet, as the Congress knows, the needs of the IHS facilities far exceed the level of that support.

In summary, the Department's position on this legislation is without merit and this troubles me. Despite the Department's opposition to S. 522, its own

statements reflect the concern that the quality of care that IHS is able to provide is inadequate. In a recent letter, for example, to Congressman RHODES, the House minority leader, the Undersecretary of HEW, Marjorie Lynch, acknowledges that fact by stating that the Department, and I quote, "is working toward raising the health status of Indians to at least a level equal to that of the non-Indian population." This admission by the Department itself that Indian health care is inadequate makes their opposition to this legislation somewhat mystifying.

In my opinion, the Department and Congress agree that Indian health care services are inadequate. Where we disagree is the speed with which we should address the problem. Congress is in a mood, however, to move ahead more rapidly than the Department. In view of the needs which have been so completely documented both within Congress and in the Department itself, we are at a loss to understand why the Department feels so compelled to drag its feet in addressing this problem.

Mr. President, this legislation has enjoyed broad bipartisan support within the Congress as well as among virtually every important national health organization. But more importantly, it is supported wholeheartedly by the Indian people themselves as better health is their number one priority. Only the Department stands in lone opposition to this much needed legislation.

Mr. President, it is my hope that President Ford will recognize the importance of this legislation. The Congress has produced a reasonable piece of legislation which will assure a better health care delivery system for our Indian people. In that spirit, I hope the Persident will approve the Indian Health Care Improvement Act as a positive commitment toward securing a better life for our Indian citizens.

Mr. President, I feel very keenly about this legislation. It is legislation that will be of great value to our Indian people. I do not consider there is anything more important to our Indian people than their health care.

Mr. President, I want to commend the outstanding leadership of my chairman, Senator JACKSON, in assisting in the development of this legislation. His leadership and concern for resolving the problems of Indian health care programs will long be remembered.

Mr. President, I urge adoption of the Senate amendment and approval of S. 522 as amended.

I yield to the Senator from Oklahoma.

Mr. BARTLETT. Mr. President, it is with great pleasure that I rise today in support of S. 522, the Indian Health Care Improvement Act, as passed by the House with the clarifying and substantive changes offered in the Fannin/Jackson amendment. I sincerely hope the Senate will, as it has done twice before, act favorably and expeditiously on this measure. I can see no need to debate the issues involved in this bill to any degree here today because they have been thoroughly discussed by the Senate twice before in the Interior Committee, and the same conclusion was reached in both instances—that there clearly exists a very great need for a comprehensive health care plan to meet the unmet health care needs of the Indian people of this country.

The staffs of both Houses of this Congress have worked long and diligently to devise such a plan, and in my opinion have come up with an excellent one. This plan, S. 522, addresses the long-standing and often neglected responsibility of the Federal Government, that is, the responsibility to provide health care services to native Americans in this country. The health care needs of this segment of the population have heretofore been given piecemeal attention, an approach which I feel has contributed considerably to their present day health status. Although the Indian Health Service has in recent years made significant advances in its efforts to provide quality health care to the Indian people, the unmet health needs are still alarmingly high. Their health needs far exceed that of the general population.

Even though the Department of Health, Education, and Welfare is just as much aware of this fact as I, it opposes enactment of this much needed legislation. It would not be difficult for me to understand HEW's position on this bill if the health care status of Indian people were on a par with that of the general population, but recognizing the great unmet need that clearly exists in the quality of health care services delivered to Indian people and recognizing that the responsibility for correcting this grave situation is clearly that of the Federal Government, I find the position of HEW on this bill to be unconscionable.

Both Senator FANNIN and I have met with Secretary Matthews and others in the Department of HEW to point out to them the merits of this bill, but our efforts were to no avail. HEW has still not seen the need to support this legislation and, in fact, has indicated that it will recommend a veto if the bill is presented to the President for approval.

Mr. President, I have been a strong supporter of this bill from its inception, and I will continue to lend my support to it until it is signed into law by the President of the United States. I feel strongly that the Federal Government has failed to provide an adequate Indian health bill. Enactment of S. 522 eliminates many of the existing deficiencies in Indian health care services.

FOR IMMEDIATE RELEASE September 29, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

TO THE HOUSE OF REPRESENTATIVES:

Just before adjourning for the final weeks of the election campaign, the Congress has sent me H.R. 14232, the Departments of Labor, and Health, Education, and Welfare appropriations for fiscal year 1977 which begins October 1. This last and second largest of the major Federal appropriation bills to be considered by this Congress is a perfect example of the triumph of election-year politics over fiscal restraint and responsibility to the hard-pressed American taxpayer.

Contained in this bill are appropriations for numerous essential domestic programs which have worthy purposes. My budget for these purposes totaled $52.5 billion, $700 million more than this year. Since 1970 expenditures for these programs have increased at a rate 75% greater than the rate of growth in the overall Federal Budget. Therefore, my 1977 proposals included substantial reforms in the major areas covered by these appropriations designed to improve their efficiency and reduce the growth of Federal bureaucracy and red tape.

The majority in control of this Congress has ignored my reform proposals and added nearly $4 billion in additional spending onto these programs.

The partisan political purpose of this bill is patently clear. It is to present me with the choice of vetoing these inflationary increases and appearing heedless of the human needs which these Federal programs were intended to meet, or to sign the measure and demonstrate inconsistency with my previous anti-inflationary vetoes on behalf of the American taxpayer.

It is to present me with the dilemma of offending the voting groups who benefit by these government programs, or offending those primarily concerned with certain restrictions embodied in the bill.

I am sympathetic to the purposes of most of these programs. I agree with the restriction on the use of Federal funds for abortion. My objection to this legislation is based purely and simply on the issue of fiscal integrity.

I believe the American people are wiser than the Congress thinks. They know that compassion on the part of the Federal Government involves more than taking additional cash from their paychecks. They know that inflationary spending and larger deficits must be paid for not only by all Federal taxpayers but by every citizen, including the poor, the unemployed, the retired persons on fixed incomes, through the inevitable reduction in the purchasing power of their dollars.

I believe strongly in compassionate concern for those who cannot help themselves, but I have compassion for the taxpayer, too. My sense of compassion also says that we

more

shouldn't ask the taxpayers to spend their money for a tangled mess of programs that the Congress itself has shown all too often to be wasteful and inefficient -- programs which all too often fail to really help those in need.

The Congress says it cares about cutting inflation and controlling Federal spending.

The Congress says it wants to stop fraud and abuse in Federal programs.

The Congress says it wants to end duplication and overlap in Federal activities.

But when you examine this bill carefully you discover that what the Congress says has very little to do with what the Congress does.

If the Congress really cared about cutting inflation and controlling Federal spending, would it send me a bill that is $4 billion over my $52.5 billion request?

If the Congress really wanted to stop fraud and abuse in Federal programs like Medicaid, would it appropriate more money this year than it did last year without any reform?

If the Congress really wanted to end duplication and overlap in Federal activities, would it continue all of these narrow programs this year -- at higher funding levels than last year?

If the Congress really wanted to cut the deficit and ease the burden on the taxpayer, would it ignore serious reform proposals?

The resounding answer to all of these questions is no.

Our longtime ally, Great Britain, has now reached a critical point in its illustrious history. The British people must now make some very painful decisions on government spending. As Prime Minister Callaghan courageously said just yesterday, "Britain for too long has lived on borrowed time, borrowed money and borrowed ideas. We will fail if we think we can buy our way out of our present difficulties by printing confetti money and by paying ourselves more than we earn."

I cannot ask American taxpayers to accept unwarranted spending increases without a commitment to serious reform. I do not believe the people want more bureaucratic business as usual. I believe the people want the reforms I have proposed which would target the dollars on those in real need while reducing Federal interference in our daily lives and returning more decision-making freedom to State and local levels where it belongs.

I therefore return without my approval H.R. 14323, and urge the Congress to enact immediately my budget proposals and to adopt my program reforms.

GERALD R. FORD

THE WHITE HOUSE,

September 29, 1976.

# # #

THE WHITE HOUSE

WASHINGTON

September 30, 1976

MEMORANDUM FOR JUDY JOHNSTON

Subject: Comment on the 9/30 Draft Signing Statement on S 522

I realize that a good deal of the language in my September 27 draft has been dropped out, but I do recommend that a few bits of it be put back, i.e.:

a) The paragraph on urban Indians is, I think, quite important so that this program does not grow out of control. It could lead to many false expectations if it is not included here.

b) I would reinsert the first sentence, at least, of my next-to-last paragraph. Perhaps delete "totally" and "shameful".

c) Then I would close with my original last paragraph. I expect to send this signing statement to many Indian groups and organizations; it sets the right tone at the end.

Bradley H. Patterson, Jr.

S. 522 - Indian Health Care Improvement Act Signing Statement

I am today signing S. 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have determined that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill.

While spending for Indian Health Service activities has grown from $107 million in FY 1969 to an estimated $417 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our First Americans must not be last in opportunity.

Some of the authorizations in this bill are duplicative of existing authorities and there is an unfortunate proliferation of narrow categorical programs. But still, S. 522 is a statement of direction of effort and, as such, it meets with my personal approval.

Title VII of this bill provides for future reports to the Congress from the Secretary of Health, Education and Welfare, including a review of progress under the terms of the new Act. I believe the Administration can in this way bring to the attention of the Congress any changes needed to improve the provisions of S. 522.

On balance, this bill is a positive step and I am pleased to sign it.

SKUBITZ:

death rates, greater disease, and more frequent infant deaths than non-Indians.

It is the Congress which must undertake the necessary initiative here.

It is the Congress which must commit itself to a serious program for Indian health improvement.

But H.R. 2525, unless amended, is not the answer.

The legislation is irresponsible, for it makes firm commitments of staggering amounts of taxpayers' money for up to 7 years, when not even the best of experts is able to estimate with accuracy Indian health needs or medical costs that far in the future.

The legislation is pure puffery, for the committee makes bold promises which it knows no Appropriations Committee could fully endorse and which no administration in its right fiscal mind could tolerate.

For many years the Interior Committee has had nearly exclusive jurisdiction over Indian matters.

Thus, the committee has responsibility to the Indian people to present their case in a wise and defensible manner.

To be taken seriously, the committee should recommend seriously.

Even given the state of Indian health, I still cannot defend a 434-percent increase over the President's budget request for first year funds for construction of Indian health facilities.

I cannot defend $16.8 million for an Indian school of medicine that is not even endorsed by the Indians.

I cannot defend a 7-year package which totals $1.2 billion when this committee has no idea what Indian health needs will be in 1983, when this committee has no idea what medical costs or technology will be in 1983, when this committee has not the slightest notion as to whether this program will solve Indian health problems—in 7 years—or "70 times 7" years.

I cannot defend this committee "washing its hands" of the bill and putting all the heat on the President.

If he vetoes this irresponsible bill he gets the criticism when, in reality, this committee deserves it.

You may call this bill a "commitment to Indian health."

I call it an evasion of legislative responsibility.

Mr. Chairman, I followed this bill through both the Interior and Interstate Committees.

Needless to say, I was very disappointed with the bill as reported by the Interior Committee.

However, the amendments to H.R. 2525 to be presented by the Interstate Committe go a long way toward correcting many of the bill's inadequacies.

Most importantly, the authorization has been reduced from 7 years to 3.

May I emphasize to my colleagues that such a 3-year authorization does not mean that the Indian health program will be abruptly terminated after only 3 years.

Instead, the Congress commits itself to a realistic and rational 3-year program, and then promises to reevaluate the Indian health situation in the light of the program's successes and failures.

The Interstate amendments will reduce the first year construction allocations for medical facilities.

Although I believe that the $67 million provided is still far too much, it is a significant improvement over the Interior Committee's recommendation of $124 million.

Finally, the amendments to be offered will strike the provision which creates an American Indian medical school.

With the adoption of these amendments I feel that H.R. 2525, although not perfect, nevertheless is an acceptable bill and provides a program which will take giant strides toward improving the Indian health situation.

If the amendments are adopted, it is a bill which I personally believe the President can sign in good conscience.

If the amendments are not adopted, Congress will send to the President an irresponsible bill bloated with inefficiency, waste, and duplication.

Approving H.R. 2525 without amending it plays "chicken" with the White House and invites a veto.

We gain nothing by losing an Indian health program to a successful veto.

Even more importantly, the Indian population gains nothing, despite our rhetoric, promises, and intentions.

Let us be realistic, let us agree to commit ourselves to a comprehensive program which will bring the level of Indian health up to the standards of the non-Indian population.

Let us agree on a proposal which both the administration, the Congress, and the American people—Indian or otherwise—will recognize as serious and reasoned legislation.

Mr. Chairman, I will support H.R. 2525 if the House accepts the Interstate amendments.

I hope the administration has adopted a similar position.

I just want to say a few more words on this matter.

It is almost an understatement to say I have been distressed and frustrated in working with the administration on this legislation.

I can accept the fact that often the position adopted by the administration is different from my own.

I recognize that as inevitable, for in the final analysis, we are accountable to two different constitutencies.

But I cannot accept the uncooperative spirit I have encountered in dealing with the Department of Health, Education, and Welfare about this bill.

I would like to state, for the record, the Department's position on this bill, but I honestly do not know what it is.

A number of times I called the Secretary's office to ascertain the administration's opinion but, unfortunately, Mr. Mathews has been either "too busy" or "out of the office" so much that, at present, I have no idea what HEW wants.

Perhaps Mr. Mathews has seen fit to communicate to other Members of this House the administration's position, but he has ignored completely the ranking Republican on the committee with primary jurisdiction over the bill and who also serves on the committee which handles health matters.

I can truthfully state that the Interstate committee has done its best to report a responsible bill, which, in our judgment, should be both fiscally and philosophically acceptable to the administration.

If the President later concludes that this Indian health package is unacceptable or too costly, I respectfully suggest that such a position should have been expressed weeks ago by the Office of the Secretary of Health, Education, and Welfare.

Mr. YOUNG of Alaska. Mr. Chairman, I yield such time as he may consume to the distinguished minority leader, the gentleman from Arizona (Mr. RHODES).

(Mr. RHODES asked and was given permission to revise and extend his remarks.)

Mr. RHODES. Mr. Chairman, the bill we are considering today, H.R. 2525, deserves the support of this Congress. It provides for long unmet health care needs of our American Indian population.

Since the mid-1800's, Indian health care has lagged behind that available to our general population and serious disease has afflicted our Indian people and shortened their lifespan. This bill is similar to H.R. 7852 which I introduced. It simply is an effort to remedy the inadequacies of Indian health care.

Basically the bill outlines a 7-year program to upgrade Indian health care delivery. It provides for new hospitals where none exist, and modernization of obsolete facilities. It would provide safe water supplies and adequate sanitary waste disposal systems.

The bill would encourage Indians to participate more actively in management of health care programs, and to seek help from community health assistance facilities.

It provides for participation in medicare ad medicaid programs through the Indian Health Service. In addition, it would establish an Indian School of Medicine to insure that properly trained Indian physicians and other health personnel will be available in the future.

Mr. Chairman, this is a sound approach to the unmet health care needs of our Indian people. It encourages them to be part of the system, to participate in cooperative Federal and local programs, and to provide health care manpower, now in seriously short supply.

The Indian Health Care Improvement Act has attracted strong bipartisan support in both houses of the Congress. I believe this is a good bill, a practical and constructive move to help deserving people meet a major challenge. I urge that my colleagues support H.R. 2525 so this worthwhile program may begin.

The CHAIRMAN. Does the gentleman from Alaska (Mr. YOUNG) desire to yield further time?

Mr. YOUNG of Alaska. Not at this time, Mr. Chairman.

The CHAIRMAN. Does the gentleman from Florida (Mr. ROGERS) desire to yield time?

THE WHITE HOUSE

WASHINGTON

September 28, 1976

MEMORANDUM FOR: JIM CANNON

FROM: BOBBIE GREENE KILBERG Bobbie

SUBJECT: S. 522 - Indian Health Care Improvement Act

I recommend that the President sign the Indian Health Care Improvement Act for the following reasons:

(1) S. 522 would provide Medicare and Medicaid reimbursement for Indian Health Service hospitals. HEW states that this would enable Native Americans to effectively use the Medicare and Medicaid benefits for which they are eligible.

(2) In arguing against new categorical programs, OMB states that all of the proposed program activities could be conducted under the broad flexible legislative authorities of the Snyder Act and other laws. However, in fact, many of these program activities are not being conducted under those legislative authorities, either because of a lack of Departmental or bureaucratic initiative and creativity or because of active policy opposition.

(3) The trust responsibility which the Federal government has to federally recognized tribes is unique and must be weighed very carefully before turning down programmatic legislation.

(4) It is my perception that Indian life expectancy rates are significantly lower and Indian infant mortality rates are significantly higher than the rates for the general population in the United States. Dan McGurk says that this statement cannot be borne out when one eliminates alcoholism, suicide and accident rates. Ted Marrs, however, had consistently asserted that the figures

were still substantially different from the national average even when alcoholism, suicide and accidents are not counted. Further, S. 522 would authorize new programs specifically aimed at the alcoholism, suicide and accident rates which take such a serious toll in Indian lives. According to the OMB memo, S. 522 programs would include mental health (including community and inpatient mental health services, model dormitory mental health services, therapeutic and residential treatement centers, and the training of traditional Indian practitioners in mental health) and alcoholism treatment and control.

(5) I strongly agree with Brad Patterson's statement that the physical defects in Indian health facilities are not limited to the lack of 8 foot-wide halls, as No. 4 of OMB's arguments against approval might imply. From my personal experience, I think a tour of Indian health facilities would reveal buildings and equipment in such condition as to raise serious questions about the health care and safety of patients.

(6) While S. 522 contains a significantly higher authorization than OMB believes is warranted, OMB does indicate that more realistic appropriations levels can probably be achieved through the budget process.

(7) While I agree with OMB's criticism of the urban Indian provision in S. 522, I would not recomment veto of the bill because of it.

(8) It is my understanding that Congress will override a Presidential veto and that a majority of Republican Senators and Congresspersons will vote for that override. This includes Congressman Rhodes, who has written the President requesting that he sign the bill; Senator Fannin, ranking minority member of the Senate Interior & Insular Affairs Committee; and apparently Congressman Skubitz, ranking minority member of the House Interior & Insular Affairs Committee, and Senators Dole, Goldwater, Bartlett, Domenici, Stevens and Hatfield.

(9) As a political matter, a veto of this bill will be portrayed as direct Presidential action against the improvement of health care for the Native American community, a group which the majority of people in this

country still has substantial empathy for. The fact that we have made significant progress in the area of Indian health care and are devoting substantial resources to it will be lost in the negative headlines.

cc: Phil Buchen

THE WHITE HOUSE

WASHINGTON

SARAH MASSENGALE'S OFFICE CALLED WITH LIST OF NAMES OF CONGRESSIONAL PEOPLE WHO CALLED IN REGARDING INDIAN HEALTH BILL.

JOHN RHODES
PAUL FANNIN
BOB DOLE
BARRY GOLDWATER
TED STEVENS
MARK HATFIELD
DEWEY BARTLETT
PETER DOMENICI
BOB PACKWOOD

MEMORANDUM OF CALL

TO: Brad

☐ YOU WERE CALLED BY— ☐ YOU WERE VISITED BY—

Sarah Massengale

OF (Organization)

☐ PLEASE CALL → PHONE NO. CODE/EXT.

☐ WILL CALL AGAIN ☐ IS WAITING TO SEE YOU

☐ RETURNED YOUR CALL ☐ WISHES AN APPOINTMENT

MESSAGE

add

Tom Steiger

Don Clausen

to list

RECEIVED BY | DATE | TIME

STANDARD FORM 63
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-11.6

GPO : 1969—048—16—80341-1 332-389

63-108

BHP-4

RESTRICTED USAGE

RE: Indian Health Care Improvement Act (S.522)

THE WHITE HOUSE

WASHINGTON

, 1976

Dear /s/

In response to your expression of interest in the Indian Health Care Improvement Act (S. 522), I am very pleased to tell you that the President has just signed this significant piece of legislation.

I enclose a copy of the President's Signing Statement and with it goes the President's appreciation to you for your own support on this important matter.

Cordially,

Bradley H. Patterson, Jr.

///s///
///////
///////

10/1/76 - plr
proofed plr/cbs

Enclosure

(Rec. 10/1/76)

BHP:
BHP-4

FOR IMMEDIATE RELEASE

OCTOBER 1, 1976

Office of the White House Press Secretary

THE WHITE HOUSE

STATEMENT BY THE PRESIDENT

I am signing S. 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have decided that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill.

While spending for Indian Health Service activities has grown from $128 million in FY 1970 to $425 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our First Americans should not be last in opportunity.

Some of the authorizations in this bill are duplicative of existing authorities and there is an unfortunate proliferation of narrow categorical programs. Nevertheless, S. 522 is a statement of direction of effort which is commendable.

Title VII of this bill provides for future reports to the Congress from the Secretary of Health, Education, and Welfare, including a review of progress under the terms of the new Act. I believe the Administration can in this way bring to the attention of the Congress any changes needed to improve the provisions of S. 522.

On balance, this bill is a positive step and I am pleased to sign it.

# # # #

September 30, 1976

STATEMENT BY THE PRESIDENT

I am today signing S. 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have decided that the well-documented needs for improvement in Indian health manpower, services and facilities outweigh the defects in the bill.

While spending for Indian Health Service activities has grown from $128 million in FY 1970 to $425 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our First Americans should not be last in opportunity.

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On balance, this bill is a positive step and I am pleased to sign it.

Gerald R. Ford

Approved 9/30/76

BRIEFING MATERIALS

for

THE INDIAN HEALTH CARE IMPROVEMENT ACT

P.L. 94-437

Provided by the

INDIAN HEALTH SERVICE

October 14, 1976

PUBLIC LAW 94-437

INDIAN HEALTH CARE IMPROVEMENT ACT

TITLE I INDIAN HEALTH MANPOWER

Title I of the Bill would authorize the Secretary of Health, Education and Welfare, acting through the Indian Health Service: to make grants to public or non-profit or tribal organizations for the recruitment of Indian persons having a potential for health professional careers; to provide grants by Indian Health Service to Indians for up to two years of conpensatory pre-professional education; to provide Indian Health Scholarships to be awarded to persons who will eventually provide services to Indians, with selection by IHS and priority for Indians; to entitle those receiving professional scholarship grants to employment in the Indian Health Service during the non-academic portions of the year without regard to employment ceilings; and to authorize appropriations for continuing educational allowances for health professional employees of the Indian Health Service.

	FY 1978	FY 1979	FY 1980
Health Professions Recruitment Program	$ 900,000	$ 1,500,000	$ 1,800,000
Health Professions Preparatory Scholarship	800,000	1,000,000	1,300,000
Health Professions Scholarship Program	5,450,000	6,300,000	7,200,000
IHS Extern Programs	600,000	800,000	1,000,000
Continuing Education Allowance	100,000	200,000	250,000
	$ 7,850,000	9,800,000	11,550,000

TITLE II HEALTH SERVICES

Title II of the Bill would authorize additional appropriations totaling over $84 million to eliminate the backlog of unmet health services needs.

	10,025,000		
Patient Care		8,500,000	16,200,000
Field Health		3,350,000	5,550,000
Dental		1,500,000	1,500,000
Mental Health (Community Mental Health		1,300,000	2,000,000
Inpatient Mental Health		400,000	600,000
Model Dormitory Mental Health Services		1,250,000	1,875,000
Therapeutic and Residential Treatment Centers		300,000	400,000
Training of Traditional Indian Practitioners		150,000	200,000
Treatment and Control of Alcoholism	4,000,000	9,000,000	9,200,000
Maintenance and Repair		3,000,000	4,000,000
	$14,025,000	28,750,000	41,525,000

TITLE III HEALTH FACILITIES

Title III would authorize additional appropriation authority of $234 million over the next three years for construction and renovation of Indian Health Service facilities and $103 million for sanitation facilities for Indian homes and communities.

	FY 1978	FY 1979	FY 1980
Hospitals	$67,180,000	73,256,000	49,742,000
Health Centers and Health Stations	6,960,000	6,226,000	3,720,000
Staff Housing	1,242,000	21,725,000	4,116,000
Safe Water and Sanitary Waste Disposal	43,000,000	30,000,000	30,000,000
	$118,382,000	131,207,000	87,578,000

TITLE IV ACCESS TO HEALTH SERVICES

Title IV of the Bill would authorize Medicare and Medicaid eligible Indian persons served by Indian Health Service facilities to participate in those programs by having those programs reimburse the Indian Health Service for services it provides.

TITLE V HEALTH SERVICES FOR URBAN INDIANS

Title V would establish a program of contracts with Indian organizations in urban areas for the purpose of making health services more accessible to the Urban Indian population.

5,000,000	10,000,000	15,000,000

TITLE VI AMERICAN INDIAN SCHOOL OF MEDICINE FEASIBILITY STUDY

Title VI would provide for a study to determine the extent of need and the feasibility of establishing a school of medicine to train Indians to provide health services for Indians.

TITLE VII MISCELLANEOUS

Title VII would require the Secretary to report annually to the President and the Congress on progress made in effecting the purposes of this Act; would authorize regulations and a preparation of a plan to implement the Act; and would authorize the Secretary to enter into leases with Indian tribes for periods not in excess of twenty years.

TOTAL	145,257,000	179,757,000	155,653,000

Administration of Gerald R. Ford

PRESIDENTIAL DOCUMENTS

Week Ending Friday, October 1, 1976

Indian Health Care Improvement Act

Statement by the President on Signing S. 522 Into Law, October 1, 1976

I am signing S. 522, the Indian Health Care Improvement Act.

This bill is not without its faults, but after personal review I have decided that the well-documented needs for improvement in Indian health manpower, services, and facilities outweigh the defects in the bill.

While spending for Indian Health Service activities has grown from $128 million in FY 1970 to $425 million in FY 1977, Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our first Americans should not be last in opportunity.

Some of the authorizations in this bill are duplicative of existing authorities, and there is an unfortunate proliferation of narrow categorical programs. Nevertheless, S. 522 is a statement of direction of effort which is commendable.

Title VII of this bill provides for future reports to the Congress from the Secretary of Health, Education, and Welfare, including a review of progress under the terms of the new act. I believe the administration can in this way bring to the attention of the Congress any changes needed to improve the provisions of S. 522.

On balance, this bill is a positive step, and I am pleased to sign it.

NOTE: As enacted, the Indian Health Care Improvement Act is Public Law 94-437.

P.L. 94-437: AUTHORIZATION VS. APPROPRIATION

Public Law 94-437, the Indian Health Care Improvement Act, is landmark legislation with great potential for helping to overcome long-standing health problems of American Indians and Alaska Natives.

This Act is an example of what is known as authorization legislation. This means that it provides the legal authority to spend Federal funds for the purposes set forth in the Act. It does not, however, make those funds available. Funds will become available only through other Acts of Congress, i.e., appropriations acts.

Authorization legislation authorizes spending funds needed for prescribed actions. Appropriations legislation makes the needed funds available.

For this reason, program improvements authorized by P.L. 94-437 will begin to happen only after funds are made available through the appropriations process.

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S. 522 as passed by Congress and presented to the Presid for signature

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House of Representatives

SENATE AMENDMENT TO S. 522, IMPROVING SERVICES AND FACILITIES OF FEDERAL INDIAN HEALTH PROGRAMS

Mr. MEEDS. Mr. Speaker, I ask unanimous consent to take from the Speaker's desk the bill (S. 522) 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, with a Senate amendment to the House amendment thereto, and concur in the Senate amendment to the House amendment.

The Clerk read the title of the bill.

The Clerk read the Senate amendment to the House amendment, as follows:

In lieu of the matter proposed to be inserted by the House engrossed amendment, insert:

That this Act may be cited as the "Indian Health Care Improvement Act".

FINDINGS

SEC. 2. The Congress finds that—

(a) Federal 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, and 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 reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature death of, Indians.

(d) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States. For example, 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 approximately 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-four of fifty-one Indian Health Service hospitals are accredited by the Joint Commission on Accreditation of Hospitals; only thirty-one meet national fire and safety codes; and fifty-two locations 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 one-half of the Service hospitals, four-fifths of the 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 90 per centum of the surgical operations needed for otitis media have not been performed, over 57 per centum of required dental services remain to be provided, and about 98 per centum of hearing aid requirements are unmet;

(4) unrelated 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, climate conditions; and

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

(g) The Indian people's growth of 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 upon 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) "Secretary", unless otherwise designated, means the Secretary of Health, Education, and Welfare.

(b) "Service" means the Indian Health Service.

(c) "Indians" or "Indian", unless otherwise designated, means any person who is a member of an Indian tribe, as defined in subsection (d) hereof, except that, for the purpose of sections 102, 103, and 201(c)(5), such terms shall mean any individual who (1), irrespective of whether he or she lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member, or (2) is an Eskimo or Aleut or other Alaska Native, or (3) is considered by the Secretary of the Interior to be an Indian for any purpose, or (4) is determined to be an Indian under regulations promulgated by the Secretary.

(d) "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to 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.

(e) "Tribal organization" means the elected governing body of any Indian tribe or any legally established organization of Indians which is controlled by one or more such bodies or by a board of directors elected or selected by one or more such bodies (or elected by the Indian population to be served by such organization) and which includes the maximum participation of Indians in all phases of its activities.

(f) "Urban Indian" means any individual who resides in an urban center, as defined in subsection (g) hereof, and who meets one or more of the four criteria in subsection (c) (1) through (4) of this section.

(g) "Urban center" means any community which has a sufficient urban Indian population with unmet health needs to warrant assistance under title V, as determined by the Secretary.

(h) "Urban Indian organization" means a nonprofit corporate body situated in an urban center, composed of urban Indians, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 503(a).

TITLE I—INDIAN HEALTH MANPOWER

PURPOSE

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.

HEALTH PROFESSIONS RECRUITMENT PROGRAM FOR INDIANS

SEC. 102. (a) The Secretary, acting through the Service, shall make grants to public or nonprofit private health or educational entities or Indian tribes or tribal organizations to assist such entities in meeting the costs of—

(1) identifying Indians with a potential for education or training in the health professions and encouraging and assisting them (A) to enroll in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health nursing, or allied health professions; or (B) if they are not qualified to enroll in such school, to undertake such postsecondary education or training as may be required to qualify them for enrollment;

(2) publicizing existing sources of financial aid available to Indians enrolled in any such school referred to in clause (1)(A) of this subsection or who are undertaking training necessary to qualify them to enroll in any such school; or

(3) establishing other programs which the Secretary determines will enhance and facilitate the enrollment of Indians, and the subsequent pursuit and completion by them, of courses of study, in any school referred to in clause (1)(A) of this subsection.

(b)(1) No grant may be made under this section unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe: *Provided*, That the Secretary shall give a preference to applications submitted by Indian tribes or tribal organizations.

(2) The amount of any grant under this section shall be determined by the Secretary. Payments pursuant to grants under this section may be made in advance or by way of reimbursement, and at such intervals and on such conditions as the Secretary finds necessary.

(c) For the purpose of making payments pursuant to grants under this section, there are authorized to be appropriated $900,000 for fiscal year 1978, $1,500,000 for fiscal year 1979, and $1,800,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for such payments such sums as may be specifically authorized by an Act enacted after this Act.

HEALTH PROFESSIONS PREPARATORY SCHOLARSHIP PROGRAM FOR INDIANS

SEC. 103. (a) The Secretary, acting through the Service, shall make scholarship grants to Indians who—

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

(2) have demonstrated the capability to successfully complete courses of study in schools of medicine, osteopathy, dentistry, veterinary medicine, optometery, podiatry, pharmacy, public health, nursing, or allied health professions.

(b) Each scholarship grant made under this section shall be for a period not to exceed two academic years, which years shall be for compensatory preprofessional education of any grantee.

(c) Scholarship grants made under this section 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 section: $800,000 for fiscal year 1978, $1,000,000 for fiscal year 1979, and $1,300,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act.

HEALTH PROFESSIONS SCHOLARSHIP PROGRAM

SEC. 104. Section 225(1) of the Public Health Service Act (42 U.S.C. 234(1)) is amended (1) by inserting "(1)" after "(1)", and (2) by adding at the end the following:

"(2)(A) In addition to the sums authorized to be appropriated under paragraph (1) to carry out the Program, there are authorized to be appropriated for the fiscal year ending September 30, 1978, $5,450,000; for

the fiscal year ending September 30, 1979, $6,300,000; for the fiscal year ending September 30, 1980, $7,200,000; and for fiscal years 1981, 1982, 1983, and 1984 such sums as may be specifically authorized by an Act enacted after the Indian Health Care Improvement Act, to provide scholarships under the Program to provide physicians, osteopaths, dentists, veterinarians, nurses, optometrists, podiatrists, pharmacists, public health personnel, and allied health professionals to provide services to Indians. Such scholarships shall be designated Indian Health Scholarships and shall be made in accordance with this section except as provided in subparagraph (B).

"(B)(i) The Secretary, acting through the Indian Health Service, shall determine the individuals who receive the Indian Health Scholarships, shall accord priority to applicants who are Indians, and shall determine the distribution of the scholarships on the basis of the relative needs of Indians for additional service in specific health professions.

"(ii) The active duty service obligation prescribed by subsection (e) shall be met by the recipient of an Indian Health Scholarship by service in the Indian Health Service, in a program assisted under title V of the Indian Health Care Improvement Act, or in the private practice of his profession if, as determined by the Secretary in accordance with guidelines promulgated by him, such practice is situated in a physician or other health professional shortage area and addresses the health care needs of a substantial number of Indians.

"(C) For purposes of this paragraph, the term 'Indians' has the same meaning given that term by subsection (c) of section 4 of the Indian Health Care Improvement Act and includes individuals described in clauses (1) through (4) of that subsection.".

INDIAN HEALTH SERVICE EXTERN PROGRAMS

SEC. 105. (a) Any individual who receives a scholarship grant pursuant to section 104 shall be entitled to employment in the Service during any nonacademic period of the year. Periods of employment pursuant to this subsection shall not be counted in determining the fulfillment of the service obligation incurred as a condition of the scholarship grant.

(b) Any individual enrolled in a school of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, or allied health professions may be employed by the Service during any nonacademic period of the year. Any such employment shall not exceed one hundred and twenty days during any calendar year.

(c) Any employment pursuant to this section shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is engaged in study. Any individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive system. Any individual so employed shall not be counted against any employment ceiling affecting the Service or the Department of Health, Education, and Welfare.

(d) There are authorized to be appropriated for the purpose of this section: $600,000 for fiscal year 1978, $800,000 for fiscal year 1979, and $1,000,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the use of this section such sums as may be specifically authorized by an Act enacted after this Act.

CONTINUING EDUCATION ALLOWANCES

SEC. 106. (a) In order to encourage physicians, dentists, and other health professionals to join or continue in the Service and to provide their services in the rural and remote areas where a significant portion of the Indian people resides, the Secretary, acting through the Service, may provide allowances to health professionals employed in the Service 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: $100,000 for fiscal year 1978, $200,000 for fiscal year 1979, and $250,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the purpose of this section such sums as may be specifically authorized by an Act enacted after this Act.

TITLE II—HEALTH SERVICES

HEALTH SERVICES

SEC. 201. (a) For the purpose of eliminating backlogs in Indian health care services and to supply known, unmet medical, surgical, dental, optometrical, and other Indian health needs, the Secretary is authorized to expend, through the Service, over the seven-fiscal-year period beginning after the date of the enactment of this Act the amounts authorized to be appropriated by subsection (c). Funds appropriated pursuant to this section for each fiscal year shall not be used to offset or limit the appropriations required by the Service under other Federal laws to continue to serve the health needs of Indians during and subsequent to such seven-fiscal-year period, but shall be in addition to the level of appropriations provided to the Service under this Act and such other Federal laws in the preceding fiscal year plus an amount equal to the amount required to cover pay increases and employee benefits for personnel employed under this Act and such laws and increases in the costs of serving the health needs of Indians under this Act and such laws, which increases are caused by inflation.

(b) The Secretary, acting through the Service, is authorized to employ persons to implement the provisions of this section during the seven-fiscal-year period in accordance with the schedule provided in subsection (c). Such positions authorized each fiscal year pursuant to this section shall not be considered as offsetting or limiting the personnel required by the Service to serve the health needs of Indians during and subsequent to such seven-fiscal-year period but shall be in addition to the positions authorized in the previous fiscal year.

(c) The following amounts and positions are authorized, in accordance with the provisions of subsections (a) and (b), for the specific purposes noted:

(1) Patient care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $8,500,000 and two hundred and twenty-five positions for fiscal year 1979, and $16,200,000 and three hundred positions for fiscal year 1980.

(2) Field health, excluding dental care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $3,350,000 and eighty-five positions for fiscal year 1979, and $5,550,000 and one hundred and thirteen positions for fiscal year 1980.

(3) Dental care (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $1,500,000 and eighty positions for fiscal year 1979, and $1,500,000 and fifty positions for fiscal year 1980.

(4) Mental health: (A) Community mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,300,000 and thirty positions for fiscal year 1979, and $2,000,000 and thirty positions for fiscal year 1980.

(B) Inpatient mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $400,000 and fifteen positions for fiscal year 1979, and $600,000 and fifteen positions for fiscal year 1980.

(C) Model dormitory mental health services: sums and positions as provided in subsection (e) for fiscal year 1978, $1,250,000 and fifty positions for fiscal year 1979, and $1,875,000 and fifty positions for fiscal year 1980.

(D) Therapeutic and residential treatment centers: sums and positions as provided in subsection (e) for fiscal year 1978, $300,000 and ten positions for fiscal year 1979, and $400,000 and five positions for fiscal year 1980.

(E) Training of traditional Indian practitioners in mental health: sums as provided in subsection (e) for fiscal year 1978, $150,000 for fiscal year 1979, and $200,000 for fiscal year 1980.

(5) Treatment and control of alcoholism among Indians: $4,000,000 for fiscal year 1978, $9,000,000 for fiscal year 1979, and $9,200,000 for fiscal year 1980.

(6) Maintenance and repair (direct and indirect): sums and positions as provided in subsection (e) for fiscal year 1978, $3,000,000 and twenty positions for fiscal year 1979, and $4,000,000 and thirty positions for fiscal year 1980.

(7) For fiscal years 1981, 1982, 1983, and 1984 there are authorized to be appropriated for the items referred to in the preceding paragraphs such sums as may be specifically authorized by an Act enacted after this Act. For such fiscal years, positions are authorized for such items (other than the items referred to in paragraphs (4)(E) and (5)) as may be specified in an Act enacted after the date of the enactment of this Act.

(d) The Secretary, acting through the Service, shall expend directly or by contract not less than 1 per centum of the funds appropriated under the authorizations in each of the clauses (1) through (5) of subsection (c) for research in each of the areas of Indian health care for which such funds are authorized to be appropriated.

(e) For fiscal year 1978, the Secretary is authorized to apportion not to exceed a total of $10,025,000 and 425 positions for the programs enumerated in clauses (c) (1) through (4) and (c) (6) of this section.

TITLE III—HEALTH FACILITIES

CONSTRUCTION AND RENOVATION OF SERVICE FACILITIES

SEC. 301. (a) The Secretary, acting through the Service, is authorized to expend over the seven-fiscal-year period beginning after the date of the enactment of this Act the sums authorized by subsection (b) for the construction and renovation of hospitals, health centers, health stations, and other facilities of the Service.

(b) The following amounts are authorized to be appropriated for purposes of subsection (a):

(1) Hospitals: $67,180,000 for fiscal year 1978, $73,256,000 for fiscal year 1979, and $49,742,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for hospitals such sums as may be specifically authorized by an Act enacted after this Act.

(2) Health centers and health stations: $6,960,000 for fiscal year 1978, $6,226,000 for fiscal year 1979, and $3,720,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for health centers and health stations such sums as may be specifically authorized by an Act enacted after this Act.

(3) Staff housing: "$1,242,000 for fiscal

year 1978, $21,725,000 for fiscal year 1979, and $24,116,000 for fiscal year 1980. For fiscal years 1981, 1982, 1983, and 1984, there are authorized to be appropriated for staff housing such sums as may be specifically authorized by an Act enacted after this Act.

(c) Prior to the expenditure of, or the making of any firm commitment to expend, any funds authorized in subsection (a), the Secretary, acting through the Service, shall—

(1) consult with an Indian tribe to be significantly affected by any such expenditure for the purpose of determining and, wherever practicable, honoring tribal preferences concerning the size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

(2) be assured that, wherever practicable, such facility, not later than one year after its construction or renovation, shall meet the standards of the Joint Committee on Accreditation of Hospitals.

CONSTRUCTION OF SAFE WATER AND SANITARY WASTE DISPOSAL FACILITIES

SEC. 302. (a) During the seven-fiscal-year period beginning after the date of the enactment of this Act, the Secretary is authorized to expend under section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the sums authorized under subsection (b) to supply unmet needs for safe water and sanitary waste disposal facilities in existing and new Indian homes and communities.

(b) For expenditures of the Secretary authorized by subsection (a) for facilities in existing Indian homes and communities there are authorized to be appropriated $43,000,000 for fiscal year 1978, $30,000,000 for fiscal year 1979, and $30,000,000 for fiscal year 1980. For expenditures of the Secretary authorized by subsection (a) for facilities in new Indian homes and communities there are authorized to be appropriated such sums as may be necessary for fiscal years 1978, 1979, and 1980. For fiscal years 1981, 1982, 1983, and 1984 for expenditures authorized by subsection (a) there are authorized to be appropriated such sums as may be specifically authorized in an Act enacted after this Act.

(c) Former and currently federally recognized Indian tribes in the State of New York shall be eligible for assistance under this section.

PREFERENCE TO INDIANS AND INDIAN FIRMS

SEC. 303. (a) The Secretary, acting through the Service, may utilize the negotiating authority of the Act of June 25, 1910 (25 U.S.C. 47), to give preference to any Indian or to any enterprise, partnership, corporation, or other types of business organization owned and controlled by an Indian or Indians including former or currently federally recognized Indian tribes in the State of New York (hereinafter referred to as an "Indian firm") in the construction and renovation of Service facilities pursuant to section 301 and in the construction of safe water and sanitary waste disposal facilities pursuant to section 302. Such preference may be accorded by the Secretary unless he finds, pursuant to rules and regulations promulgated by him, that the project or function to be contracted for will not be satisfactory or such project or function cannot be properly completed or maintained under the proposed contract. The Secretary, in arriving at his finding, shall consider whether the Indian or Indian firm will be deficient with respect to (1) ownership and control by Indians, (2) equipment, (3) bookkeeping and accounting procedures, (4) substantive knowledge of the project or function to be contracted for, (5) adequately trained personnel, or (6) other necessary components of contract performance.

(b) For the purpose of implementing the provisions of this title, the Secretary shall assure that the rates of pay for personnel engaged in the construction or renovation of facilities constructed or renovated in whole or in part by funds made available pursuant to this title are not less than the prevailing local wage rates for similar work as determined in accordance with the Act of March 3, 1931 (40 U.S.C. 276a–276a–5, known as the Davis-Bacon Act).

SOBOBA SANITATION FACILITIES

SEC. 304. The Act of December 17, 1970 (84 Stat. 1465), is hereby amended by adding the following new section 9 at the end thereof:

SEC. 9. Nothing in this Act shall preclude the Soboba Band of Mission Indians and the Soboba Indian Reservation from being provided with sanitation facilities and services under the authority of section 7 of the Act of August 5, 1954 (68 Stat. 674), as amended by the Act of July 31, 1959 (73 Stat. 267).".

TITLE IV—ACCESS TO HEALTH SERVICES

ELIGIBILITY OF INDIAN HEALTH SERVICE FACILITIES UNDER MEDICARE PROGRAM

SEC. 401. (a) Sections 1814(c) and 1835(d) of the Social Security Act are each amended by striking out "No payment" and inserting in lieu thereof "Subject to section 1880, no payment".

(b) Part C of title XVIII of such Act is amended by adding at the end thereof the following new section:

"INDIAN HEALTH SERVICE FACILITIES

"SEC. 1880. (a) A hospital or skilled nursing facility of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for payments under this title, notwithstanding sections 1814(c) and 1835(d), if and for so long as it meets all of the conditions and requirements for such payments which are applicable generally to hospitals or skilled nursing facilities (as the case may be) under this title.

"(b) Notwithstanding subsection (a), a hospital or skilled nursing facility of the Indian Health Service which does not meet all of the conditions and requirements of this title which are applicable generally to hospitals or skilled nursing facilities (as the case may be), but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for payments under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first 12 months after the month in which such plan is submitted.

"(c) Notwithstanding any other provision of this title, payments to which any hospital or skilled nursing facility of the Indian Health Service is entitled by reason of this section shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the hospitals and skilled nursing facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of this title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the hospitals and skilled nursing facilities of such Service in the United States are in compliance with such conditions and requirements.

"(d) The annual report of the Secretary which is required by section 701 of the Indian Health Care Improvement Act shall include (along with the matters specified in section 403 of such Act) a detailed statement of the status of the hospitals and skilled nursing facilities of the Service in terms of their compliance with the applicable conditions and requirements of this title and of the progress being made by such hospitals and facilities (under plans submitted under subsection (b) and otherwise) toward the achievement of such compliance.".

(c) Any payments received for services provided to beneficiaries hereunder 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.

SERVICE PROVIDED TO MEDICAID ELIGIBLE INDIANS

SEC. 402. (a) Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

"INDIAN HEALTH SERVICE FACILITIES

"SEC. 1911. (a) A facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.

"(b) Notwithstanding subsection (a), a facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.".

(b) The Secretary is authorized to enter into agreements with the appropriate State agency for the purpose of reimbursing such agency for health care and services provided in Service facilities to Indians who are eligible for medical assistance under title XIX of the Social Security Act, as amended.

(c) Notwithstanding any other provision of law, payments to which any facility of the Indian Health Service (including a hospital, intermediate care facility, or skilled nursing facility) is entitled under a State plan approved under title XIX of the Social Security Act by reason of section 1911 of such Act shall be placed in a special fund to be held by the Secretary and used by him (to such extent or in such amounts as are provided in appropriation Acts) exclusively for the purpose of making any improvements in the facilities of such Service which may be necessary to achieve compliance with the applicable conditions and requirements of such title. The preceding sentence shall cease to apply when the Secretary determines and certifies that substantially all of the health facilities of such Service in the United States are in compliance with such conditions and requirements.

(d) Any payments received for services provided recipients hereunder shall not be considered in determining appropriations for the provision of health care and services to Indians.

(e) Section 1905(b) of the Social Security Act is amended by inserting at the end thereof the following: "Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts

pended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian ... or tribal organization (as defined in ...ion 4 of the Indian Health Care Improvement Act).".

REPORT

SEC. 403. The Secretary shall include in his annual report required by section 701 an accounting on the amount and use of funds made available to the Service pursuant to this title as a result of reimbursements through title XVIII and XIX of the Social Security Act, as amended.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

PURPOSE

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

CONTRACTS WITH URBAN INDIAN ORGANIZATIONS

SEC. 502. The Secretary, acting through the Service, shall enter into contracts with urban Indian organizations to assist such organizations to establish and administer, in the urban centers in which such organizations are situated, programs which meet the requirements set forth in sections 503 and 504.

CONTRACT ELIGIBILITY

SEC. 503. (a) The Secretary, acting through the Service, shall place such conditions as he deems necessary to effect the purpose of this title 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 activities:

(1) determine the population of urban Indians which are or could be recipients of health referral or care services;

(2) identify all public and private health ...ce 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) establish and implement manpower training programs to accomplish the referral and education tasks set forth in clauses (3) through (5) of this subsection;

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

(8) 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; and

(9) where necessary, provide or contract for health care services to urban Indians.

(b) The Secretary, acting through the Service, 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 urban Indians in the urban center involved;

(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, to which the activities set forth in subsection (a) would duplicate any previous or current public or private ...lth services project funded by another source in such urban center;

(5) the appropriateness and likely effectiveness of the activities set forth in subsection (a) in such urban center;

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

(7) the extent of existing or likely future participation in the activities set forth in subsection (a) by appropriate health and health-related Federal, State, local, and other resource agencies.

OTHER CONTRACT REQUIREMENTS

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 to the provisions of the Act of August 24, 1935 (48 Stat. 793), as amended.

(b) Payments under any contracts pursuant to this title 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) Contracts with urban Indian organizations and regulations adopted pursuant to this title shall include provisions to assure the fair and uniform provision to urban Indians of services and assistance under such contracts by such organizations.

REPORTS AND RECORDS

SEC. 505. For each fiscal year during which an urban Indian organization receives or expends funds pursuant to a contract under this title, such organization shall submit to the Secretary a report including information gathered pursuant to section 503(a) (7) and (8), 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 shall be subject to audit by the Secretary and the Comptroller General of the United States.

AUTHORIZATIONS

SEC. 506. There are authorized to be appropriated for the purpose of this title: $5,000,000 for fiscal year 1978; $10,000,000 for fiscal year 1979; and $15,000,000 for fiscal year 1980.

REVIEW OF PROGRAM

SEC. 507. Within six months after the end of fiscal year 1979, the Secretary, acting through the Service and with the assistance of the urban Indian organizations which have entered into contracts pursuant to this title, shall review the program established under this title and submit to the Congress his assessment thereof and recommendations for any further legislative efforts he deems necessary to meet the purpose of this title.

RURAL HEALTH PROJECTS

SEC. 508. Not to exceed 1 per centum of the amounts authorized by section 506 shall be available for not to exceed two pilot projects providing outreach services to eligible Indians residing in rural communities near Indian reservations.

TITLE VI—AMERICAN INDIAN SCHOOL OF MEDICINE; FEASIBILITY STUDY

FEASIBILITY STUDY

SEC. 601. The Secretary, in consultation with Indian tribes and appropriate Indian organizations, shall conduct a study to determine the need for, and the feasibility of, establishing a school of medicine to train Indians to provide health services for Indians. Within one year of the date of the enactment of this Act the Secretary shall complete such study and shall report to the Congress findings and recommendations based on such study.

TITLE VII—MISCELLANEOUS

REPORTS

SEC. 701. 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 1979, the Secretary shall review expenditures and progress made under this Act and make recommendations to the Congress concerning any additional authorizations for fiscal years 1981 through 1984 for programs authorized under this Act which he deems appropriate. In the event the Congress enacts legislation authorizing appropriations for programs under this Act for fiscal years 1981 through 1984, within three months after the end of fiscal year 1983, the Secretary shall review programs established or assisted pursuant to this Act and shall submit to the Congress his assessment 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 are at a parity with the health services available to, and the health status, of the general population.

REGULATIONS

SEC. 702. (a)(1) Within six months from the date of enactment of this Act, the Secretary shall, to the extent practicable, consult with national and regional Indian organizations to consider and formulate appropriate rules and regulations to implement the provisions of this Act.

(2) Within eight months from the date of enactment of this Act, the Secretary shall publish proposed rules and regulations in the Federal Register for the purpose of receiving comments from interested parties.

(3) Within ten months from the date of enactment of this Act, the Secretary shall promulgate rules and regulations to implement the provisions of this Act.

(b) The Secretary is authorized to revise and amend any rules or regulations promulgated pursuant to this Act: *Provided,* That prior to any revision of or amendment to such rules or regulations, the Secretary shall, to the extent practicable, consult with appropriate national or regional Indian organizations and shall publish any proposed revision or amendment in the Federal Register not less than sixty days prior to the effective date of such revision or amendment in order to provide adequate notice to, and receive comments from, other interested parties.

PLAN OF IMPLEMENTATION

SEC. 703. Within two hundred and forty days after enactment of this Act, a plan will be prepared by the Secretary and will be submitted to the Congress. The plan will explain the manner and schedule (including a schedule of appropriation requests), by title

and section, by which the Secretary will implement the provisions of this Act.

LEASES WITH INDIAN TRIBES

SEC. 704. Notwithstanding any other provision of law, the Secretary is authorized, in carrying out the purposes of this Act, to enter into leases with Indian tribes for periods not in excess of twenty years.

AVAILABILITY OF FUNDS

SEC. 705. The funds appropriated pursuant to this Act shall remain available until expended.

Mr. MEEDS (during the reading). Mr. Speaker, I ask unanimous consent that the Senate amendment to the House amendment be considered as read and printed in the RECORD.

The SPEAKER. Is there objection to the request of the gentleman from Washington?

There was no objection.

Mr. MEEDS. Mr. Speaker, on July 30, the full House, by a vote of 310 to 9, passed the Indian Health Care Improvement Act. The purpose of that bill is to bring the health status of Indians up to par with the rest of our Nation's population. The bill attempts to achieve this by providing: Broadened scholarship assistance to those interested in serving in the Indian Health Service with priority to Indian applicants; funds for additional health services and for construction of new health facilities; funds for urban Indian health centers; a feasibility study for an American Indian School of Medicine, and by allowing Indian citizens to take full advantage of their medicare and medicaid eligibility. The total cost of the House bill was around $470 million over 3 fiscal years.

The Senate had passed a much more liberal bill calling for the expenditure of $1.8 billion over 7 fiscal years. By a vote of 78 to 0, the Senate has decided to accept the House amendments, with 19 further amendments. Sixteen of those amendments are purely technical and/or clarifying. Three of the amendments are more substantive. The first amendment amends the definition of Indian tribe as it relates to Alaska Natives so that the definition will be in line with that used in the Indian Self-Determination and Educational Assistance Act of 1974. The second major amendment makes certain that osteopaths and veterinarian students are included in the scholarship provision of the bill. The third amendment increases the funding level for programs in title II to $10 million for fiscal 1978, rather than the $5 million limitation established by the House bill.

All of these amendments have been cleared with the three House committees which worked on this bill, and I know of no congressional opposition to their adoption.

The SPEAKER. Is there objection to the request of the gentleman from Washington?

There was no objection.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. MEEDS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the Senate amendment to the House amendment to S. 522.

The SPEAKER. Is there objection to the request of the gentleman from Washington?

There was no objection.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
ROCKVILLE, MARYLAND 20852

INDIAN HEALTH SERVICE

October 13, 1976

Indian Health Service Progress Report and Some Planned Activities
Indian Health Care Improvement Act, P.L. 94-437

On September 30, 1976, President Ford signed S. 522, the Indian Health Care Improvement Act, into Law. A copy of his signing message is enclosed along with a copy of the Congressional Record of September 16, which includes S. 522 as passed by Congress and presented to the President for signature. The Government Printing Office has advised us that copies of P.L. 94-437 will be available in two-four weeks. A large distribution of copies will be made from the Indian Health Service at that time.

On October 1, 1976, the Director, Indian Health Service, designated Dr. Robert C. Birch, Deputy Chief, Dental Services Branch, IHS, as Project Manager, P.L. 94-437, to serve as the coordinator of the IHS's preparations to implement P.L. 94-437. Dr. Birch, with the approval of the Director, Indian Health Service, has selected members of the IHS Headquarters' staff to serve, under his leadership, as the IHS Core Team for P.L. 94-437. The objective of the Core Team is:

> "To assist the Director, Indian Health Service, in preparing for the Indian Health Service to implement the provisions of this Act in an orderly, timely, and complete manner."

The Core Team consists of a Title Manager for each title of the Act who is responsible for developing all aspects of the title, and any other parts of the Act which affect the title, required for IHS to implement the Act. The Title Manager will be working with American Indian and Alaska Native people and other IHS and non-IHS personnel. The Core Team members are:

	Title	Title Manager	Phone No. (Area Code 301)
I.	Indian Health Manpower	Mr. Pierre Colombel	443-4680
II.	Health Services	Mr. Gene Lewis	443-4725
III.	Health Facilities	Mr. Jimmy Neifert	443-4700
IV.	Access to Health Services	Ms. Joe Graber	443-4680
V.	Health Services for Urban Indians	Mr. Wes Halsey	443-6840

	Title	Title Manager	Phone No. (Area Code 301)
VI.	Amer. Ind. Sch. of Med. (Feasibility Study)		
	Staff Support	Mr. Hal Thompson	443-3024
	Project Manager	Mr. Hampton Anderson	443-4243/4/5/6
		Dr. Robert Birch	443-1107

Every effort is being made to provide clear and correct information about P.L. 94-437 initiated from one IHS source--the Core Team. Each IHS Area and Program Office Director is identifying a person as the P.L. 94-437 Coordinator to serve as the communicator with the Core Team. Please direct all P.L. 94-437 communications (phone calls, letters, etc.) to the P.L. 94-437 Coordinator at your nearest IHS Area or Program Office. This should result in the best possible transfer of information.

Immediate Planned Activities

Oct. 1-15 - IHS organizing P.L. 94-437 activities including selecting and orienting Core Team and Area and Program Office Coordinators, selecting Title Teams, developing work plans, and establishing methods for communicating with American Indian and Alaska Native people through IHS Area and Program Offices and National Indian Organizations.

Oct. 14 - Presentation on P.L. 94-437 to the National Tribal Chairmen's Association by the Director, Indian Health Service. Distribution of written briefing materials describing P.L. 94-437 to National Indian Organizations and to IHS Area and Program Offices for their distribution to American Indian and Alaska Native groups.

Oct. 19 - Briefing on P.L. 94-437 to IHS Council of Area Directors by the Core Team.

- Briefing on P.L. 94-437 to IHS Headquarters Staff by the Core Team.

Oct. 21 - Presentation on P.L. 94-437 to the National Congress of American Indians Annual Meeting by the Director, Indian Health Service, plus participation including the Core Team in a Workshop Session at NCAI to discuss P.L. 94-437.

Oct. 25-Nov. 3 - Briefings on P.L. 94-437 by Core Team and other IHS staff at Area and Program Offices and to groups of American Indian and Alaska Native people at meetings organized by IHS Area and Program Offices.

These activities during October are intended to:

1. Provide basic information about P.L. 94-437 to as many American Indian and Alaska Native people as possible.

2. Provide an opportunity, through personal communication, for many American Indian and Alaska Native people to identify issues of their concern about P.L. 94-437 as a first step in making the eventual implementation of P.L. 94-437 as successful as possible.

Planned Activities in Near Future:

1. Presentation on P.L. 94-437 to the National Indian Health Board.
2. Formation of P.L. 94-437 Policy Council including representatives of several National Indian Organizations and the Core Team.
3. Implementation of activities to make sure Indian and Alaska Native people have the opportunity to participate fully in identifying issues, making recommendations about policy and rules and regulations, and being involved in other planning activities at the facility, Service Unit, Area, and Headquarters levels of IHS. The method used will be based on a plan developed by personnel at the IHS Office of Research and Development in Tucson, Arizona, for ensuring maximum participation of American Indian and Alaska Native people in the planning and implementation of P.L. 94-437.

Much hard work remains ahead before P.L. 94-437 can be implemented. However, if we all work together in a spirit of understanding and cooperation, the result should be one of which we'll all be proud.

Robert C. Birch, D.D.S.
Project Manager, P.L. 94-437

Approved:

Emery A. Johnson, M.D.
Assistant Surgeon General
Director, Indian Health Service

THE WHITE HOUSE

WASHINGTON

October 1, 1976

Dear Mr. Tonasket:

In response to your expression of interest in the Indian Health Care Improvement Act (S. 522), I am very pleased to tell you that the President has just signed this significant piece of legislation.

I enclose a copy of the President's Signing Statement and with it goes the President's appreciation to you for your own support on this important matter.

Cordially,

Brad

Bradley H. Patterson, Jr.

Mr. Mel Tonasket
Vice Chairman
Colville Business Council
Post Office Box 150
Nespelem, Washington 99155

Enclosure

El Paso NATURAL GAS COMPANY

310 SUFFRIDGE BUILDING
1775 K STREET N.W.
WASHINGTON, D. C. 20006
PHONE: 202-872-8133

October 21, 1976

Dear Brad:

When Ted Marrs was still on board at the White House, he was kind enough to obtain a facsimile signature of President Ford on a copy of Public Law 93-638, the Indian Self-Determination and Educational Assistance Act. If you could arrange for a similar signature on a copy of Public Law 94-437, the Indian Health Care Improvement Act, I would greatly appreciate it. I am enclosing a copy of the Act which you could have signed on page 15, just below the date indicating approval.

Sincerely,

Rick C. Lavis

Mr. Brad Patterson
The White House
Washington, D. C. 20500

Colville Confederated Tribes

P. O. Box 150 - Nespelem, Wash. 99155 (509) 634-4591

October 26, 1976

Mr. Brad Patterson
Special Assistant to the President
The White House
Washington, D.C. 20500

Dear Brad;

The Colville Tribe would like to take this time to express our appreciation to you for your valuable support and assistance in getting the Indian Health Care Improvement Act signed by the President.

Would you please thank President Ford for our Tribe. Not only for signing the bill but also for the very fine statement that the President made at the signing.

Cordially;

Lucy F. Covington, Chairperson
Colville Business Council

Mel Tonasket, Vice-Chairman
Colville Business Council

FRIENDS COMMITTEE ON NATIONAL LEGISLATION

245 Second Street, N.E.
Washington, D.C. 20002
(202) 547-4343

October 28, 1976

Bradley H. Patterson, Jr.
The White House
Washington, D. C. 20500

Dear Bradley Patterson:

Thank you for your letter of October sixth regarding comments on the Ford Administration's policies regarding American Indians in the FCNL August-September Newsletter. I hope this response will indicate to you the basis of our assessment.

Onr Newsletter analysis of President Ford's position on Indians focussed on the two years he has been in office, since there have been few Congressional votes on Indian issues. Moreover, as you will note on other issues, we took events during President Ford's administration, not President Nixon's administration, whenever possible. I note that a number of the items on the information sheet you enclosed on "Protecting Indian Land and Water Rights" pertain to the Nixon presidency.

Among the major factors influencing our assessment was the Indian Health Care Improvement Act. As you know, we spent considerable time urging passage of a strong bill. When the bill was before both the Senate and the House, the Administration, through HEW, impeded passage of such a bill. Even after Congress agreed on a less comprehensive, severely weakened form of the bill, I understand you told a former member of our staff that the President might still veto the bill. When our Newsletter went to press, that was all the information we had. We are pleased that the President has signed the much needed Indian health bill and hope that this will be the first step to assuring improved health care and conditions for the first Americans. We plan to note his signing in our next Newsletter.

The establishment of a special division within the Justice Department for protection of Indian resources has not provided a guarantee that Indian land and water will be safe from corporate, state, and private interests. It does offer more opportunity for Indian conflict cases to have legal representation but does not deal with legislative proposals.

During the Ford Administration, legislation which would have assured some protection or preservation of land and/or water has had a very low priority, in our opinion. The most obvious example was the veto of strip mine reclamation and control legislation. In its weakest version it still called for regulations stronger than currently exist on Indian land.

Attempts to assure a fair amount of water for tribes in Central Arizona and in Northwest New Mexico in the wake of reclamation projects have also met with opposition from the Administration. Administration support for the Synthetic Fuels bill, which included funds for gasification, can be seen as an approval for destruction of more Navajo land in building six proposed gasification plants. Both strip mining and the gasification process would require large quantities of Indian water.

The Administration also supported, I believe, Sec. 15 of S. 1824, which would have freed oil companies from paying damages to those Alaskan natives whose land had been trespassed upon by illegal exploration and drillings prior to 1971. Fortunately this section died in Committee.

We also feel that the BIA policy of supporting Richard Wilson from Pine Ridge (who sold tribal land without approval from the tribe) can be seen as opposition to Indian efforts to protect land and water resources. I would include timber and fishing in those valuable resources, also.

The small amount of space available in our Newsletter has meant we have not carried letters to the editor. Our voting record newsletter (copy enclosed) was in the final production stage when your letter arrived and the next issue will be mailed in early November. I hope the inclusion in the November Newsletter of reference to the President's signing the Indian Health Care Improvement Act will meet your purposes.

Sincerely yours,

Edward F. Snyder

Edward F. Snyder

EFS/ewb
Enclosure

FRIENDS COMMITTEE ON NATIONAL LEGISLATION **WASHINGTON NEWSLETTER**

FCNL

"It is the place of Christian (and other) citizens, whether in legislatures or in municipal bodies, to try to appeal to the best in all persons, to the best in their colleagues, not only in their own party, but in other parties, and in that way they may sometimes be able to bring about an agreement which would otherwise never have been achieved."
— From T. Edmund Harvey, 1937. (REV.)

No. 385 Telephone (202) 547-4343 **October 1976**

1976 Congressional Voting Record

This Newsletter shows how your two Senators and Representative stood on fifteen important issues since publication of our 1975 voting record. Two caveats: One, we have attempted to pick votes where the issue was clearly defined, but some members may have specialized reasons for their particular votes. Write them directly, or us, if you need clarification. Two, voting is only one of a member's responsibilities. Look elsewhere for information on other important factors such as leadership roles in committees, on the floor and with constituents.

For more information, check the *Congressional Record* **or** *Congressional Quarterly* **in your local library.**

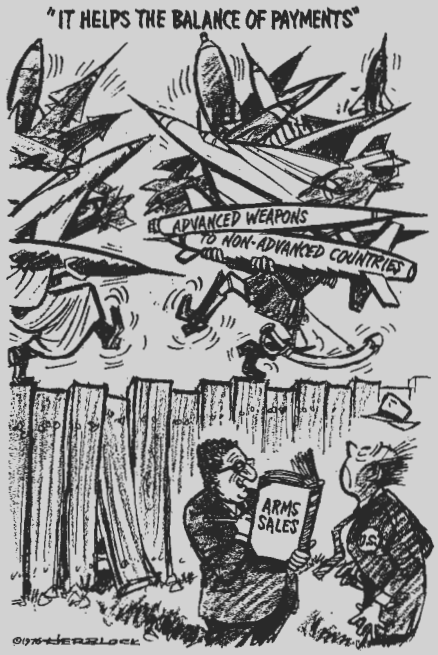
The following information attempts to put these votes in an overall context.

GLOBAL DEVELOPMENT

In 1976 Congress beat back several efforts to put severe restrictions on U.S. commitments to international organizations.

In the Senate, Virginia Sen. Harry Byrd's amendment to the FY76 foreign aid appropriations bill would have deleted $64 million from voluntary funds for international organizations. Much of the bite would have been felt by the UN Development Program. In opposing the amendment Sen. Dick Clark IA stated, "We argue vociferously here over whether we will contribute $190 million or $125 million and yet two weeks ago we heard the Secretary of Defense say we are going to build Tridents [submarines] which will cost us $1.5 billion and no one on this floor raised the slightest objection." The Senate rejected Byrd's amendment by a vote of 37-50 (**S. Vote 1**). Similarly, the House rejected an amendment by Rep. Jack Edwards AL that would have cut $85.5 million from the UN Development Program (**H. Vote 1**).

Authorizations for $720 million for the three-year replenishment of the Inter-American Development Bank and $25 million as the initial U.S. contribution to the African Development Fund passed the House by 249-166 (**H. Vote 2**), and



passed the Senate by voice vote. Authorization for the Asian Development Fund passed the Senate by a vote of 52-32 (**S. Vote 2**), but the House failed to act. Paid-in capital for all three of these regional financial institutions would go largely to provide loans on favorable terms to developing countries.

Congress voted in May to provide $200 million in start-up funding for the International Fund for Agricultural Development (IFAD), which had been recommended by the World Food Conference in November, 1974, and authorized by Congress last autumn. The Fund will receive about half of its capital from the U.S. and other industrialized nations and half from the Organization of Petroleum Exporting Countries (OPEC). Agricultural research and development efforts aimed at reaching those most in need would be carried out under the auspices of IFAD, using existing international channels such as the UN's affiliated agencies and the various regional development banks.

DIVIDING UP THE SEAS

Congress this year joined the global rush to gain economic control of the seas by voting to extend unilaterally the U.S. fishing zone from 12 miles to 200 miles. The 200-mile extension had won handily in the House in October, 1975, by a vote of 208-101. Sens. Alan Cranston CA and Robert Griffin MI attempted to prevent unilateral extension while maintaining stringent conservation efforts, but an amendment by Sen. Edmund Muskie ME to keep the language intact was adopted 58-37 (**S. Vote 5**). Both houses agreed to delay implementation of the extension until March, 1977, and thus allow the Law of the Sea Conference to deal with the matter on a multilateral and legal basis.

VIETNAM EMBARGO

A major citizen effort helped the House International Relations Cmte. add a provision to the military aid bill lifting the U.S. trade embargo on Vietnam at least temporarily. An effort to delete this provision on the House floor was defeated 185-223 (**H. Vote 5**). Unfortunately Pres. Ford vetoed the bill containing this provision, in part because of this section. It was not included in the revised bill, to avoid another veto; hence the Administration's embargo is still in effect.

COLONIALISM REVISITED

In August, 1975, Harrop Freeman submitted written testimony for FCNL stating, "I consider that the attempt by the United States to make the northern Marianas a Commonwealth of the United States and to use its territories for the United States military defense policies is contrary to international law, the United Nations Charter, the United States Constitution, and the Trust Territory Agreement." In February the Senate sustained earlier House action in voting to make the northern Marianas a U.S. Commonwealth. The crucial vote came on the amendment by Sens. Claiborne Pell RI and Byrd VA which would have effectively killed the proposal; it lost 25-63 (**S. Vote 4**).

TAX REFORM

A modest tax reform package passed the House in Dec. 1975. In the summer of 1976 the Senate substantially watered down the House's version. Tax reformers generally failed to tighten tax loopholes; tax expenditures cost the federal government $105 billion in potential revenues for FY77 (**S. Vote 14**; **H. Vote 14**).

(text continued on Page 5)

SOME KEY SENATE VOTES

1. **International Organizations.** Byrd VA amendment to cut $64 million from $189.5 million to international organizations. Rejected 37-50, March 23. **FCNL against.**

2. **Multilateral Financial Institutions.** Authorization for $50 million as U.S. contribution to the Asian Development Fund. Passed 52-32, May 6. **FCNL for.**

3. **Human Rights.** Chile. Kennedy amendment to prohibit govemment cash sales or commercial sales of arms and military equipment to Chile. Adopted 48-39, Feb. 18. **FCNL for.**

4. **Northern Marianas Status.** Pell-Byrd VA substitute amendment to delete language making the Islands a commonwealth of the U.S. Rejected 25-63, Feb. 24. **FCNL for.**

5. **200-Mile Fishing Extension.** Muskie amendment to weaken the Cranston-Griffin amendment striking language that would have prohibited a unilateral extension. Adopted 58-37, Jan. 28. **FCNL against.**

6. **Military Spending.** Bayh amendment to First Budget Resolution to cut $2.6 billion in budget authority and $500 million in outlays from military. Rejected 27-58, April 12. **FCNL for.**

7. **B-1.** McGovern amendment to cut $948 million which would begin production of three B-1 bombers. Rejected 33-48, May 20. **FCNL for.**

8. **Foreign Arms Sales.** Tower amendment to delete provision requiring public reports of arms transactions. Rejected 36-44, Feb. 17. **FCNL against.**

9. **Intelligence.** Tower-Stennis amendment to deny new Senate Intelligence Cmte. legislative jurisdiction over intelligence activities of Dept. of Defense and its agencies. Rejected 31-63, May 19. **FCNL against.**

10. **Angola.** Tunney amendment to Defense Appropriations Conference Report FY76 limiting U.S. activities to intelligence gathering. Adopted 54-22, Dec. 19, 1975. **FCNL for.**

11. **Food Stamps.** Allen motion to table and thus kill the Dole-McGovem substitute food stamp reform bill providing for decreased purchase price, deduction for working families, and a pilot project on eliminating the purchase requirement. Rejected 31-58, April 8. **FCNL against.**

12. **Jobs.** Kennedy motion to First Budget Resolution for $3.2 billion increase for jobs and health care programs. Rejected 27-58, April 12. **FCNL for.**

13. **Energy Conservation.** Final passage of bill setting federal minimum standards for energy conservation in new commercial and residential buildings and providing $55 million a year in grants to states and community action agencies to insulate low-income dwellings. Adopted 52-35, March 9. **FCNL for.**

14. **Tax Reform.** Long motion to table and thus kill the Nelson amendment which would have reduced tax shelters for the wealthy. Passed 46-33, June 17. **FCNL against.**

15. **Day Care.** H.R. 9803. Attempt to pass over President's veto a bill to provide $125 million for states to meet health and safety standards for day care centers. Rejected 60-34, May 5. (2/3 required) **FCNL for.**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
ALABAMA															
Sparkman	N	Y	Y	N	Y	N	?	N	Y	N	Y	N	Y	Y	X
Allen	Y	N	N	Y	Y	N	N	Y	Y	Y	Y	N	N	Y	N
ALASKA															
Stevens	N	Y	N	N	Y	?	□	Y	Y	Y	N	?	Y	Y	N
Gravel	■	Y	Y	N	N	?	N	■	N	Y	■	?	Y	Y	Y
ARIZONA															
Fannin	Y	N	N	N	N	N	N	Y	Y	?	Y	N	N	Y	N
Goldwater	Y	?	N	N	N	N	N	Y	Y	□	Y	N	N	?	N
ARKANSAS															
McClellan	Y	N	N	?	Y	?	N	Y	Y	N	?	?	N	?	N
Bumpers	Y	N	Y	N	Y	N	N	N	N	Y	N	N	●	Y	Y
CALIFORNIA															
Cranston	N	Y	Y	N	N	Y	N	N	N	Y	N	Y	Y	Y	Y
Tunney	N	?	Y	X	N	?	X	N	N	Y	?	?	?	Y	Y
COLORADO															
Haskell	N	Y	Y	Y	N	Y	Y	?	N	Y	N	Y	Y	N	Y
Hart	N	Y	?	Y	N	Y	Y	?	N	Y	N	N	Y	N	Y
CONNECTICUT															
Ribicoff	Y	?	Y	Y	Y	N	Y	N	N	Y	N	Y	Y	N	●
Weicker	N	Y	Y	N	Y	Y	N	N	N	Y	N	Y	Y	?	Y
DELAWARE															
Roth	Y	?	N	N	Y	N	?	N	■	Y	?	N	N	Y	N
Biden	N	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y	?	N	Y
FLORIDA															
Chiles	N	Y	Y	N	N	N	N	N	N	?	N	N	N	Y	?
Stone	Y	?	Y	N	N	N	N	N	N	★	N	N	N	N	Y
GEORGIA															
Talmadge	Y	N	N	Y	Y	N	N	Y	Y	?	N	N	N	Y	N
Nunn	?	Y	N	N	N	N	N	Y	Y	N	Y	N	N	Y	N
HAWAII															
Fong	N	Y	?	N	N	?	N	?	Y	?	Y	?	N	Y	N
Inouye	N	?	Y	N	Y	?	N	N	N	Y	N	?	?	Y	Y
IDAHO															
Church	?	?	?	?	N	?	★	?	N	★	N	?	Y	?	Y
McClure	Y	N	N	N	N	□	N	?	Y	N	Y	□	N	Y	N
ILLINOIS															
Percy	N	Y	N	N	N	N	?	Y	N	Y	N	N	Y	Y	Y
Stevenson	N	Y	?	?	N	Y	Y	?	N	?	N	N	Y	?	Y
INDIANA															
Hartke	?	?	Y	?	N	?	Y	N	?	?	?	?	Y	■	●
Bayh	?	Y	?	?	?	Y	Y	?	N	?	N	Y	Y	?	Y
IOWA															
Clark	N	Y	Y	Y	N	Y	Y	N	N	Y	N	Y	Y	N	Y
Culver	?	Y	Y	Y	N	Y	Y	■	N	Y	?	Y	Y	N	Y
KANSAS															
Pearson	?	Y	Y	N	Y	N	N	N	N	Y	N	N	Y	?	Y
Dole	Y	Y	N	N	Y	N	N	Y	N	?	N	N	N	Y	N
KENTUCKY															
Huddleston	N	?	Y	N	Y	N	Y	?	N	Y	N	N	Y	N	Y
Ford	N	Y	Y	Y	Y	?	Y	Y	N	Y	N	?	?	?	Y
LOUISIANA															
Long	Y	N	N	N	Y	N	Y	Y	Y	N	N	N	N	Y	Y
Johnston	N	N	N	N	?	N	?	Y	Y	?	Y	N	N	Y	Y
MAINE															
Muskie	N	?	Y	?	Y	N	Y	N	N	Y	N	N	Y	N	Y
Hathaway	N	Y	Y	N	Y	Y	Y	N	N	Y	N	Y	Y	N	Y
MARYLAND															
Mathias	N	Y	Y	N	Y	?	Y	?	N	?	N	?	Y	N	Y
Beall	N	Y	Y	N	Y	N	N	Y	N	N	Y	N	N	Y	Y
MASSACHUSETTS															
Kennedy	N	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y	?	N	Y
Brooke	N	Y	Y	N	Y	N	Y	?	N	Y	N	Y	Y	N	Y
MICHIGAN															
Hart	N	?	?	?	Y	Y	?	?	?	Y	N	Y	Y	N	Y
Griffin	N	Y	N	N	N	N	N	Y	N	N	Y	N	N	?	N
MINNESOTA															
Mondale	N	Y	Y	N	Y	Y	Y	N	N	Y	■	Y	Y	N	Y
Humphrey	N	Y	Y	N	N	N	Y	N	N	Y	N	Y	Y	N	Y
MISSISSIPPI															
Eastland	Y	N	N	Y	Y	N	N	Y	Y	?	Y	N	?	Y	N
Stennis	Y	N	N	●	Y	N	N	Y	Y	N	Y	N	Y	Y	N
MISSOURI															
Symington	Y	N	Y	●	?	N	N	N	N	Y	N	N	N	?	Y
Eagleton	Y	N	Y	N	Y	?	N	N	N	?	N	?	N	N	Y
MONTANA															
Mansfield	N	Y	Y	Y	Y	N	Y	N	N	Y	N	N	?	N	Y
Metcalf	N	Y	Y	?	Y	Y	N	N	N	Y	N	Y	Y	N	Y
NEBRASKA															
Hruska	Y	N	N	N	N	N	N	Y	Y	N	☆	N	N	?	N
Curtis	Y	N	N	N	?	N	N	?	Y	N	Y	N	N	Y	N
NEVADA															
Cannon	Y	N	Y	N	Y	N	N	Y	Y	?	N	N	N	Y	Y
Laxalt	Y	N	?	N	Y	N	N	?	Y	?	Y	N	N	Y	N
NEW HAMPSHIRE															
McIntyre	Y	Y	?	Y	Y	N	N	N	N	Y	N	N	Y	N	Y
Durkin	N	?	Y	Y	Y	Y	Y	N	N	Y	N	Y	Y	N	?
NEW JERSEY															
Case	?	Y	Y	N	Y	Y	Y	N	N	Y	N	Y	Y	N	Y
Williams	N	Y	Y	N	Y	Y	Y	?	N	Y	N	Y	Y	N	Y
NEW MEXICO															
Montoya	Y	N	Y	N	Y	N	?	Y	N	?	?	N	Y	Y	Y
Domenici	Y	N	N	N	N	N	N	?	N	N	Y	N	N	Y	N
NEW YORK															
Javits	N	?	Y	N	N	Y	Y	N	N	Y	N	Y	Y	?	?
Buckley (C)	Y	N	N	N	N	N	X	Y	Y	N	Y	N	N	?	N
NORTH CAROLINA															
Helms	Y	N	Y	N	N	N	N	Y	○	Y	Y	N	N	Y	N
Morgan	N	Y	N	N	N	□	N	Y	N	N	Y	□	X	Y	N
NORTH DAKOTA															
Young	Y	N	?	N	Y	N	?	?	Y	N	Y	N	?	?	N
Burdick	N	N	Y	N	Y	Y	N	N	N	Y	N	N	N	Y	Y
OHIO															
Taft	N	Y	N	N	Y	N	□	Y	Y	Y	N	N	Y	☆	N
Glenn	N	Y	N	N	N	N	N	Y	N	Y	N	N	Y	?	Y
OKLAHOMA															
Bellmon	N	Y	N	N	Y	N	N	Y	Y	N	Y	N	N	?	N
Bartlett	Y	N	N	N	N	N	N	Y	Y	N	Y	N	N	Y	N
OREGON															
Hatfield	N	Y	Y	N	Y	Y	●	N	N	Y	N	Y	Y	Y	Y
Packwood	N	Y	N	Y	Y	N	Y	N	N	Y	N	N	Y	Y	N
PENNSYLVANIA															
Scott	N	Y	N	N	N	N	N	N	Y	N	N	N	Y	Y	Y
Schweiker	N	Y	Y	N	Y	Y	Y	N	N	Y	N	N	Y	N	Y
RHODE ISLAND															
Pastore	N	Y	★	Y	Y	N	●	N	N	★	■	Y	Y	Y	Y
Pell	N	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y	Y	N	Y
SOUTH CAROLINA															
Thurmond	Y	N	N	N	N	N	N	Y	Y	N	Y	N	N	Y	N
Hollings	N	Y	N	N	Y	N	N	Y	N	?	N	N	Y	N	Y
SOUTH DAKOTA															
McGovern	N	Y	Y	Y	Y	Y	Y	N	N	Y	N	Y	Y	N	Y
Abourezk	N	Y	Y	Y	Y	?	Y	N	N	Y	N	?	Y	?	Y
TENNESSEE															
Baker	N	Y	N	N	?	N	?	Y	X	N	Y	N	Y	Y	N
Brock	?	N	N	N	N	N	?	Y	Y	?	Y	N	N	Y	N
TEXAS															
Tower	N	N	N	N	N	N	N	Y	Y	N	Y	N	N	Y	N
Bentsen	Y	Y	N	N	Y	N	?	Y	N	?	Y	N	?	?	Y
UTAH															
Moss	N	Y	Y	N	Y	N	?	N	N	Y	N	N	?	?	Y
Garn	Y	?	?	N	N	N	N	Y	Y	Y	N	N	N	Y	N
VERMONT															
Stafford	?	Y	N	N	N	N	N	N	N	Y	N	Y	Y	N	Y
Leahy	?	Y	Y	N	Y	Y	Y	N	N	Y	N	N	Y	N	Y
VIRGINIA															
Byrd (I)	Y	N	N	Y	Y	N	N	N	Y	N	Y	N	N	Y	N
Scott	Y	N	N	Y	Y	N	N	Y	Y	Y	Y	N	N	Y	N
WASHINGTON															
Magnuson	Y	N	Y	N	Y	N	N	N	N	Y	N	N	Y	N	Y
Jackson	■	★	★	X	Y	N	N	■	N	X	■	Y	★	N	Y
WEST VIRGINIA															
Randolph	Y	N	Y	Y	Y	Y	N	Y	N	Y	N	Y	Y	Y	Y
Byrd	Y	N	N	Y	Y	N	Y	N	N	Y	N	N	Y	Y	Y
WISCONSIN															
Proxmire	Y	N	Y	Y	N	Y	Y	N	N	Y	Y	N	Y	N	Y
Nelson	N	Y	?	Y	Y	Y	Y	?	N	Y	N	Y	Y	N	Y
WYOMING															
McGee	?	Y	N	N	N	?	?	N	?	●	N	?	Y	Y	Y
Hansen	Y	?	N	N	N	N	N	Y	Y	N	Y	N	N	Y	N

Y = voted in favor; N = voted in opposition; ○ or ● = paired for; X = paired against; ☆ or ★ = announced for; □ or ■ = announced against; ? = absent or not announced; P = Present.

Bold type indicates positions preferred by FCNL, i.e., as expressed in the Statement of Legislative Policy, testimony, etc.
Roman type = Democrats; *Italics = Republicans*; (C) = elected as Conservative; (I) = elected as Independent; AL = At Large. Source of votes: **Congressional Quarterly Service**.

SOME KEY HOUSE VOTES

1. **International Organizations.** Edwards AL amendment to the FY77 Foreign Aid Appropriations to delete $85.5 million from funds for the UN Development Program. Rejected 179-208, March 4. **FCNL against.**

2. **Multilateral Financial Institutions.** Final passage of bill authorizing $720 million for the replenishment of the Inter-American Development Bank and $25 million for the African Development Fund. Adopted 249-166, Dec. 9, 1975. **FCNL for.**

3. **Human Rights/Security.** Derwinski amendment to delete ceiling on military aid to S. Korea. Adopted 241-159, June 12. **FCNL against.**

4. **Troop Levels.** Dellums amendment to reduce the number of U.S. troops overseas by 47,000. Rejected 88-275, April 9. **FCNL for.**

5. **Vietnam Trade Embargo.** Bauman amendment to delete provision lifting embargo. Rejected 185-223, March 3. **FCNL against.**

6. **Military Spending.** Holtzman amendment to cut $7.5 billion in budget authority and $2.5 billion in outlays from the military, transferring all of the outlay cut and $2.8 billion in budget authority to domestic programs. Rejected 85-317, April 29. **FCNL for.**

7. **B-1.** Addabbo amendment to delay until Feb. 1977 production funds for B-1 bomber. Rejected 186-207, June 17. **FCNL for.**

8. **Nuclear Weapons.** Abzug amendment to delete $1.2 billion in the Energy Research and Development Administration (ERDA) authorization for nuclear weapons development, testing, and production. Rejected 97-286, May 20. **FCNL for.**

9. **Intelligence Report.** House vote to block release of Intelligence Committee report. Adopted 246-124, Jan. 29. **FCNL against.**

10. **Human Rights.** Passage of joint resolution to amend the U.S. Constitution to provide for voting representation for the District of Columbia in Congress. Rejected 229-181, March 23. (2/3 required) **FCNL for.**

11. **Food Stamps.** Rousselot amendment to cut $794 million from the program. Rejected 184-222, June 16. **FCNL against.**

12. **Jobs, Full Employment.** Sarasin amendment to First Budget Resolution to eliminate $50 million in startup funds for full employment. Rejected 177-206, April 29. **FCNL against.**

13. **Uranium Enrichment.** Bingham amendment to delete from the bill (H.R. 8401) those sections authorizing ERDA to contract with private industry for development of nuclear fuel enrichment plants. Rejected 192-193, Aug. 4. **FCNL for.**

14. **Tax Reform.** Mikva amendment to reduce real estate tax shelters for wealthy individuals. Rejected 192-226, Dec. 4, 1975. **FCNL for.**

15. **Revenue Sharing.** Fountain amendment deleting provisions of committee bill which would have channeled more money to big cities and poor rural areas and strengthened anti-discrimination provisions. Adopted 233-172, June 10. **FCNL against.**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
ALABAMA															
1 *Edwards*	Y	Y	Y	N	Y	N	N	N	?	N	Y	Y	N	N	Y
2 *Dickinson*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
3 Nichols	Y	N	○	N	Y	?	N	?	Y	N	Y	?	N	N	Y
4 Bevill	Y	Y	Y	N	Y	?	N	N	Y	N	Y	?	N	Y	Y
5 Jones	?	Y	?	N	N	N	N	N	Y	N	N	?	N	Y	Y
6 *Buchanan*	N	Y	?	N	Y	N	Y	?	Y	Y	Y	Y	N	N	Y
7 Flowers	Y	N	Y	?	Y	?	N	N	○	N	Y	?	N	N	Y
ALASKA															
AL *Young*	Y	N	?	?	Y	N	X	?	Y	N	Y	Y	N	N	Y
ARIZONA															
1 *Rhodes*	N	Y	Y	?	Y	N	N	X	○	N	Y	Y	N	N	Y
2 Udall	?	●	X	?	N	Y	Y	●	X	●	N	X	Y	●	?
3 *Steiger*	?	N	Y	?	Y	N	X	?	Y	N	○	Y	X	N	?
4 *Conlan*	?	N	?	?	○	N	N	N	Y	N	Y	○	X	N	Y
ARKANSAS															
1 Alexander	N	Y	Y	N	Y	N	N	N	Y	N	N	Y	?	N	N
2 Mills	N	N	Y	N	Y	N	?	?	Y	Y	Y	Y	X	N	Y
3 *Ham'schmidt*	N	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
4 Thornton	N	N	Y	?	Y	N	Y	?	Y	N	N	Y	N	N	N
CALIFORNIA															
1 Johnson	N	Y	Y	N	N	N	N	N	?	Y	N	N	N	Y	N
2 *Clausen*	?	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
3 Moss	N	Y	N	Y	N	Y	Y	?	X	Y	N	N	Y	Y	N
4 Leggett	N	Y	?	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
5 Burton, J.	N	●	N	●	N	Y	Y	Y	N	Y	N	N	Y	Y	N
6 Burton, P.	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
7 Miller	?	N	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
8 Dellums	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
9 Stark	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
10 Edwards	N	Y	N	●	N	Y	●	Y	N	Y	N	N	Y	Y	N
11 Ryan	N	Y	N	Y	N	Y	Y	N	N	N	N	N	Y	Y	Y
12 *McCloskey*	N	Y	Y	Y	N	N	Y	N	Y	Y	Y	?	N	Y	N
13 Mineta	N	Y	Y	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
14 McFall	N	Y	Y	N	N	N	N	N	N	Y	N	N	N	Y	N
15 Sisk	Y	N	Y	N	?	N	N	N	Y	N	N	N	?	N	N
16 *Talcott*	Y	N	Y	?	Y	N	?	N	?	N	Y	Y	N	N	Y
17 Krebs	Y	N	N	Y	Y	N	Y	Y	N	Y	N	N	Y	Y	Y
18 *Ketchum*	?	N	Y	N	Y	?	N	N	?	N	Y	?	N	N	Y
19 *Lagomarsino*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
20 *Goldwater*	Y	Y	Y	N	Y	N	N	N	Y	N	Y	○	N	N	?
21 Corman	N	Y	N	N	N	Y	Y	Y	N	Y	N	N	●	Y	N
22 *Moorhead*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	?	Y
23 Rees	N	Y	Y	●	N	N	Y	?	N	Y	N	N	Y	Y	N
24 Waxman	N	Y	N	N	N	N	?	Y	N	Y	X	N	Y	Y	N
25 Roybal	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
26 *Rousselot*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	?
27 *Bell*	Y	N	?	?	Y	?	?	?	?	?	?	?	N	P	?
28 Burke	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
29 Hawkins	N	Y	N	Y	N	Y	X	N	N	●	N	N	Y	Y	N
30 Danielson	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y	N
31 Wilson	N	Y	Y	N	Y	N	N	N	N	Y	N	X	N	Y	N
32 Anderson	N	N	N	Y	N	Y	N	N	N	N	N	N	N	N	N
33 *Clawson*	Y	N	○	N	Y	N	N	?	Y	N	Y	Y	N	N	?
34 Hannaford	N	Y	N	Y	N	N	N	N	N	N	N	N	Y	Y	Y
35 Lloyd	N	N	Y	N	N	N	N	N	Y	N	Y	N	Y	Y	Y
36 Brown	N	Y	N	Y	N	?	N	N	N	Y	N	N	Y	Y	N
37 *Pettis*	Y	N	Y	N	Y	N	N	?	Y	X	Y	Y	N	N	Y
38 Patterson	?	Y	N	N	N	N	N	Y	X	Y	Y	N	Y	Y	X
39 *Wiggins*	?	Y	Y	N	Y	N	N	N	?	N	Y	Y	N	N	Y
40 *Hinshaw**	?	?	?	?	?	?	?	?	?	?	?	?	?	?	?
41 *Wilson*	N	Y	Y	N	Y	N	?	N	Y	N	?	Y	N	N	Y
42 Van Deerlin	N	Y	N	Y	N	N	N	N	Y	Y	N	N	Y	Y	Y
43 *Burgener*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
COLORADO															
1 Schroeder	N	Y	N	Y	N	N	Y	Y	N	Y	N	N	Y	Y	N
2 Wirth	N	Y	N	N	N	N	?	Y	Y	Y	N	N	Y	Y	N
3 Evans	N	Y	N	N	N	N	Y	N	N	Y	N	N	Y	Y	Y
4 *Johnson*	Y	N	N	Y	N	N	Y	N	N	Y	Y	Y	N	N	?
5 *Armstrong*	Y	N	Y	N	Y	N	N	N	?	N	Y	Y	N	N	Y
CONNECTICUT															
1 Cotter	Y	N	?	N	N	N	Y	N	Y	Y	N	N	N	N	N
2 Dodd	N	N	X	N	X	N	Y	Y	?	Y	N	N	Y	Y	N
3 Giaimo	?	Y	?	Y	N	N	N	?	N	Y	N	N	N	Y	?
4 *McKinney*	N	●	N	Y	N	Y	Y	Y	Y	Y	Y	Y	N	P	Y
5 *Sarasin*	Y	Y	N	N	N	N	Y	N	Y	Y	Y	Y	N	N	Y
6 Moffett	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
DELAWARE															
AL *du Pont*	N	Y	Y	?	N	N	Y	N	Y	Y	?	Y	Y	Y	■
FLORIDA															
1 Sikes	?	N	Y	N	?	?	N	?	Y	N	N	○	N	N	Y
2 Fuqua	Y	N	Y	N	N	N	N	N	Y	N	Y	?	N	N	Y
3 Bennett	Y	N	N	N	Y	N	N	N	Y	Y	Y	Y	N	Y	Y
4 Chappell	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
5 *Kelly*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
6 *Young*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
7 Gibbons	?	N	N	N	N	N	Y	N	○	N	Y	Y	Y	Y	N
8 Haley	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
9 *Frey*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
10 *Bafalis*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
11 Rogers	Y	N	N	N	Y	N	Y	N	Y	N	N	Y	Y	N	N
12 *Burke*	Y	X	Y	N	N	N	Y	N	Y	N	Y	Y	N	?	Y
13 Lehman	?	Y	Y	Y	N	N	Y	Y	N	Y	N	N	Y	Y	N
14 Pepper	N	Y	Y	X	N	?	N	N	X	●	N	X	Y	Y	N
15 Fascell	N	Y	N	N	N	N	Y	Y	?	Y	N	N	Y	Y	N
GEORGIA															
1 Ginn	Y	Y	Y	N	Y	N	N	N	Y	Y	Y	Y	N	N	Y
2 Mathis	Y	N	Y	N	Y	N	N	N	○	Y	Y	Y	N	N	○
3 Brinkley	Y	N	Y	N	Y	N	N	N	Y	Y	Y	Y	?	N	Y
4 Levitas	Y	N	Y	N	Y	N	Y	N	Y	Y	Y	N	Y	N	Y
5 Young	N	Y	N	●	N	Y	●	Y	N	Y	N	X	Y	Y	N
6 Flynt	Y	N	Y	X	Y	N	N	?	Y	N	Y	Y	?	N	Y
7 McDonald	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
8 Stuckey	Y	Y	Y	?	Y	N	X	N	Y	?	○	Y	X	N	N
9 Landrum	?	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
10 Stephens	Y	Y	?	?	Y	N	N	N	○	N	○	N	?	N	Y
HAWAII															
1 Matsunaga	N	Y	X	N	N	N	?	Y	Y	Y	N	N	Y	N	N
2 Mink	N	Y	N	N	N	N	?	Y	N	Y	X	N	Y	Y	N
IDAHO															
1 *Symms*	?	N	?	?	○	N	N	N	Y	N	Y	Y	N	N	Y
2 *Hansen*	Y	N	?	?	Y	N	N	N	Y	N	Y	Y	X	N	Y
ILLINOIS															
1 Metcalfe	?	Y	N	●	X	Y	?	Y	X	Y	N	N	Y	Y	N
2 Murphy	N	Y	Y	N	N	N	N	N	N	Y	N	N	N	N	N
3 Russo	N	N	N	N	Y	N	Y	Y	Y	Y	N	N	Y	N	Y
4 *Derwinski*	N	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
5 Fary	N	Y	Y	N	N	N	N	N	Y	Y	N	N	N	Y	N
6 *Hyde*	Y	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
7 Collins	?	Y	N	Y	?	Y	Y	Y	N	Y	N	N	●	Y	N
8 Rostenk'ski	N	Y	Y	?	N	N	?	?	Y	Y	N	N	Y	Y	N
9 Yates	N	Y	Y	N	N	N	Y	Y	N	Y	N	N	Y	Y	N
10 Mikva	N	Y	N	●	■	N	Y	N	N	Y	N	N	Y	Y	N
11 Annunzio	N	Y	Y	N	N	N	N	N	N	Y	Y	N	N	N	N
12 *Crane*	?	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
13 *McClory*	?	Y	Y	?	N	N	Y	?	Y	N	Y	Y	N	N	Y
14 *Erlenborn*	?	Y	Y	N	?	N	N	?	Y	N	Y	Y	N	N	Y
15 Hall, T.	N	N	Y	N	N	N	Y	N	Y	Y	N	N	N	Y	N
16 *Anderson*	N	Y	Y	N	N	N	Y	N	Y	Y	N	Y	N	Y	Y
17 *O'Brien*	?	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
18 *Michel*	?	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
19 *Railsback*	N	Y	Y	N	N	N	N	N	Y	N	Y	Y	Y	Y	Y
20 *Findley*	N	Y	Y	N	N	N	Y	N	Y	Y	Y	?	?	N	Y
21 *Madigan*	Y	Y	Y	?	Y	N	N	N	?	Y	Y	Y	N	N	Y
22 Shipley	Y	N	Y	N	N	N	N	N	N	N	Y	N	N	Y	N
23 Price	N	Y	Y	N	N	N	N	N	N	Y	N	N	N	Y	N
24 Simon	N	Y	N	N	N	?	Y	Y	N	Y	N	?	Y	Y	N
INDIANA															
1 Madden	N	Y	Y	?	N	?	Y	N	N	Y	N	?	Y	Y	N
2 Fithian	Y	N	N	N	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y
3 Brademas	N	Y	N	N	N	N	Y	N	N	Y	N	N	Y	Y	N
4 Roush	Y	N	N	Y	N	N	Y	N	Y	Y	N	Y	Y	Y	N
5 *Hillis*	?	Y	Y	N	Y	N	N	N	?	N	Y	Y	N	N	Y
6 Evans	Y	N	N	N	Y	N	Y	N	Y	Y	Y	Y	Y	Y	Y
7 *Myers*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
8 Hayes	?	Y	N	?	N	?	Y	N	N	●	N	?	?	Y	Y
9 Hamilton	N	Y	N	N	N	N	Y	N	Y	Y	N	Y	Y	Y	Y
10 Sharp	N	Y	N	N	N	N	Y	N	Y	Y	N	Y	Y	Y	N
11 Jacobs	N	N	N	●	N	N	Y	Y	N	Y	N	Y	Y	Y	N
IOWA															
1 Mezvinsky	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
2 Blouin	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
3 *Grassley*	Y	N	Y	N	Y	N	Y	N	Y	N	Y	Y	N	Y	Y
4 Smith	N	Y	Y	?	N	N	Y	N	N	Y	N	N	Y	Y	N
5 Harkin	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
6 Bedell	N	N	N	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
KANSAS															
1 *Sebelius*	Y	N	Y	N	Y	N	N	N	?	N	Y	Y	X	N	Y
2 Keys	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	Y
3 *Winn*	N	Y	Y	N	Y	N	N	N	?	Y	Y	Y	N	N	○
4 *Shriver*	N	Y	Y	N	Y	N	N	N	?	Y	Y	Y	N	N	Y
5 *Skubitz*	Y	N	Y	N	Y	?	N	N	?	N	Y	?	Y	N	Y
KENTUCKY															
1 Hubbard	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	Y	Y	Y
2 Natcher	Y	N	Y	N	Y	N	Y	N	Y	Y	N	N	Y	N	Y
3 Mazzoli	N	□	N	N	N	N	Y	N	Y	Y	N	N	Y	N	Y
4 *Snyder*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
5 *Carter*	Y	N	Y	?	Y	N	N	?	Y	N	N	N	N	N	Y
6 Breckinridge	N	Y	Y	N	Y	N	N	N	Y	Y	N	Y	Y	N	Y
7 Perkins	Y	Y	Y	N	N	N	Y	N	Y	Y	N	N	N	N	N
LOUISIANA															
1 Hebert	Y	X	Y	N	N	?	N	X	○	N	○	○	N	X	Y
2 Boggs	N	Y	N	N	○	N	N	N	Y	Y	N	N	X	N	Y
3 *Treen*	Y	X	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
4 Waggonner	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
5 Passman	N	N	Y	N	Y	N	N	N	Y	N	Y	Y	?	N	○
6 *Moore*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
7 Breaux	Y	N	○	N	N	N	N	N	Y	N	Y	Y	N	N	Y
8 Long	N	Y	Y	N	Y	N	N	N	Y	Y	N	N	N	N	Y
MAINE															
1 *Emery*	Y	N	N	N	Y	N	Y	N	Y	Y	Y	Y	N	Y	Y
2 *Cohen*	Y	Y	Y	N	Y	N	Y	N	Y	Y	N	Y	N	Y	Y
MARYLAND															
1 *Bauman*	Y	N	?	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
2 Long	N	Y	N	N	N	N	Y	Y	N	N	N	N	Y	Y	Y
3 Sarbanes	N	Y	N	?	N	?	Y	?	N	Y	N	?	Y	Y	N
4 *Holt*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
5 Spellman	N	Y	N	X	Y	N	Y	Y	Y	Y	N	N	Y	N	Y
6 Byron	Y	N	N	N	Y	N	N	N	Y	N	Y	Y	Y	N	Y
7 Mitchell	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	●	N
8 *Gude*	N	Y	N	N	N	N	Y	Y	Y	Y	N	N	Y	Y	N

* On Mar. 8, **Stanley Lundine NY** replaced James Hastings, who resigned Jan. 20. On Apr. 7, **Ron Paul TX** replaced Bob Casey, who resigned Jan. 22. **Sam Hall TX** replaced the late Wright Patman on June 28. **William Barrett PA** died Apr. 12, **Torbert Macdonald MA** died May 21, and **Jerry Litton MO** died Aug. 3; no replacements have been named.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
MASSACHUSETTS															
1 *Conte*	N	Y	Y	Y	N	N	Y	N	Y	Y	N	N	Y	N	N
2 Boland	N	Y	N	N	N	N	Y	N	N	Y	N	N	Y	Y	N
3 Early	Y	Y	N	Y	Y	Y	Y	Y	N	Y	N	N	Y	Y	N
4 Drinan	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
5 Tsongas	N	Y	N	N	N	N	Y	?	N	Y	N	N	Y	Y	N
6 Harrington	Y	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
7 Macdonald*	Y	Y		?	X	?		?	N	X		?		Y	
8 O'Neill	N	Y	Y	N	N	N	Y	N	N	Y	N	N	N	Y	N
9 Moakley	N	Y	N	Y	N	N	Y	Y	N	Y	N	N	N	Y	N
10 *Heckler*	N	Y	N	N	N	N	Y	Y	Y	Y	N	N	N	Y	N
11 Burke	N	Y	Y	X	Y	N	Y	N	Y	Y	N	N	N	Y	N
12 Studds	N	Y	N	Y	N	Y	★	Y	N	Y	N	N	N	Y	N
MICHIGAN															
1 Conyers	N	Y	N	Y	X	Y	Y	Y	N	Y	N	N	●	Y	N
2 *Esch*	N	Y	Y	Y	Y	?	N	N	Y	Y	?	?	?	N	Y
3 *Brown*	N	Y	Y	N	Y	N	N	?	Y	N	N	Y	N	N	Y
4 *Hutchinson*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
5 Vander Veen	N	Y	N	N	N	Y	Y	N	N	Y	N	N	●	Y	Y
6 Carr	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
7 Riegle	N	●	N	Y	N	?	?	●	X	●	X	?	?	Y	N
8 Traxler	Y	N	N	N	N	N	Y	N	?	Y	N	N	Y	Y	Y
9 *Vander Jagt*	N	Y	Y	?	Y	N	N	N	Y	N	Y	Y	N	N	Y
10 *Cederberg*	N	Y	Y	?	N	N	N	N	Y	N	Y	Y	N	N	Y
11 *Ruppe*	N	N	N	?	Y	N	N	N	?	N	?	?	N	N	Y
12 O'Hara	N	Y	N	N	N	N	●	N	Y	N	X	N	?	Y	N
13 Diggs	N	Y	N	N	N	Y	Y	Y	X	Y	N	N	●	Y	N
14 Nedzi	N	Y	N	?	N	N	Y	N	Y	N	N	N	Y	Y	N
15 Ford	N	Y	X	N	N	N	Y	?	N	N	N	N	?	Y	N
16 Dingell	Y	Y	?	N	N	N	Y	N	N	N	N	N	Y	Y	N
17 Brodhead	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
18 Blanchard	N	Y	Y	N	N	N	Y	N	Y	Y	N	N	Y	Y	N
19 *Broomfield*	Y	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
MINNESOTA															
1 *Quie*	N	Y	Y	N	Y	N	N	N	?	N	Y	Y	N	N	Y
2 *Hagedorn*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	X	N	Y
3 *Frenzel*	N	Y	N	Y	N	N	Y	N	Y	N	Y	○	N	N	○
4 Karth	N	N	?	?	N	N	?	?	X	N	?	N	Y	Y	?
5 Fraser	N	Y	N	Y	N	Y	Y	Y	?	Y	N	N	Y	Y	N
6 Nolan	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
7 Bergland	N	Y	N	N	N	N	Y	Y	Y	N	Y	N	N	Y	Y
8 Oberstar	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	N	Y	N
MISSISSIPPI															
1 Whitten	Y	N	Y	N	Y	N	N	N	Y	N	N	N	Y	N	Y
2 Bowen	Y	?	Y	N	N	N	N	N	Y	N	N	Y	N	N	Y
3 Montgomery	Y	N	Y	N	N	N	N	N	Y	N	Y	Y	N	N	Y
4 *Cochran*	Y	N	Y	N	N	N	N	N	Y	N	Y	Y	N	N	Y
5 *Lott*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
MISSOURI															
1 Clay	?	Y	N	Y	N	Y	●	Y	X	Y	N	N	●	Y	N
2 Symington	N	Y	N	N	N	N	Y	N	Y	●	N	N	?	Y	?
3 Sullivan	N	N	Y	N	Y	N	Y	N	?	N	N	N	?	N	N
4 Randall	?	N	Y	N	?	N	N	N	?	N	N	N	?	N	N
5 Bolling	?	Y	N	N	?	N	Y	?	N	Y	N	N	?	Y	N
8 Litton*	Y	Y	N	N	N	N	Y	?	Y	Y	?	?		?	Y
7 *Taylor*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
8 Ichord	Y	N	Y	N	Y	N	N	N	○	N	Y	Y	N	N	Y
9 Hungate	Y	N	N	X	Y	?	Y	N	N	Y	Y	N	Y	?	Y
10 Burlison	N	N	N	N	N	N	N	N	Y	N	N	N	X	Y	N
MONTANA															
1 Baucus	N	Y	N	N	N	N	Y	Y	N	Y	N	Y	Y	Y	N
2 Melcher	Y	Y	N	●	N	Y	Y	N	N	Y	N	Y	Y	Y	N
NEBRASKA															
1 *Thone*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
2 *McCollister*	Y	N	Y	N	Y	N	N	N	?	N	Y	Y	N	N	Y
3 *Smith*	?	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
NEVADA															
AL Santini	Y	N	Y	N	Y	N	Y	N	Y	N	Y	Y	X	N	Y
NEW HAMPSHIRE															
1 D'Amours	Y	N	N	N	N	N	Y	N	Y	Y	N	Y	Y	Y	N
2 *Cleveland*	Y	Y	Y	N	N	N	N	N	Y	N	N	Y	N	N	Y
NEW JERSEY															
1 Florio	Y	N	N	N	N	N	Y	Y	Y	Y	N	N	Y	N	N
2 Hughes	Y	Y	N	N	N	N	Y	N	Y	Y	Y	Y	Y	N	Y
3 Howard	N	Y	Y	?	N	Y	Y	?	N	Y	N	N	N	Y	N
4 Thompson	?	Y	X	Y	N	Y	Y	X	N	Y	N	N	Y	Y	X
5 *Fenwick*	N	Y	N	N	N	N	Y	N	Y	Y	Y	N	Y	Y	N
6 *Forsythe*	N	Y	N	Y	Y	N	Y	N	Y	N	Y	Y	N	N	Y
7 Maguire	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
8 Roe	Y	Y	Y	N	N	N	Y	N	Y	Y	N	N	Y	N	N
9 Helstoski	N	●	○	Y	N	Y	●	Y	N	Y	X	N	Y	X	X
10 Rodino	N	Y	Y	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
11 Minish	Y	Y	Y	N	N	N	Y	N	Y	Y	N	N	Y	Y	N
12 *Rinaldo*	Y	Y	N	N	N	N	N	N	Y	Y	N	N	Y	N	N
13 Meyner	N	Y	N	N	N	Y	Y	●	N	Y	N	N	Y	Y	○
14 Daniels	N	Y	Y	N	N	N	●	N	Y	Y	X	N	Y	N	X
15 Patten	N	Y	Y	N	N	N	N	Y	Y	Y	N	N	Y	N	N
NEW MEXICO															
1 *Lujan*	Y	Y	?	N	N	?	N	N	Y	N	Y	?	N	N	Y
2 Runnels	?	N	Y	N	X	N	X	?	○	N	Y	?	N	N	Y
NEW YORK															
1 Pike	N	Y	N	N	N	N	Y	N	N	N	N	N	Y	Y	N
2 Downey	N	N	N	N	N	N	Y	Y	N	Y	N	N	Y	Y	N
3 Ambro	Y	N	Y	N	Y	N	Y	N	N	Y	N	N	Y	Y	Y
4 *Lent*	Y	Y	Y	N	Y	N	N	N	Y	Y	Y	Y	N	N	Y
5 *Wydler*	Y	Y	Y	N	Y	N	?	N	Y	N	Y	Y	N	N	Y
6 Wolff	Y	N	Y	N	Y	Y	Y	Y	N	Y	N	X	Y	N	N
7 Addabbo	N	Y	Y	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
8 Rosenthal	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
9 Delaney	Y	Y	Y	N	Y	N	Y	N	Y	N	Y	N	Y	Y	N
10 Biaggi	N	N	Y	N	Y	N	Y	N	Y	N	Y	N	?	Y	N
11 Scheuer	N	N	N	N	N	Y	Y	Y	N	Y	N	N	Y	Y	N
12 Chisholm	N	Y	N	Y	N	Y	?	Y	N	Y	X	N	Y	Y	N
13 Solarz	N	Y	N	N	N	Y	Y	Y	N	Y	N	N	Y	Y	N
14 Richmond	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
15 Zeferetti	Y	N	Y	N	Y	N	Y	N	Y	N	N	N	Y	N	N
16 Holtzman	N	N	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
17 Murphy	N	Y	Y	N	Y	N	N	?	?	Y	N	X	Y	N	N
18 Koch	N	N	N	N	N	Y	Y	Y	N	Y	N	N	Y	Y	N
19 Rangel	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
20 Abzug	N	Y	N	Y	N	Y	Y	Y	N	Y	N	X	Y	Y	N
21 Badillo	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	●	Y	N
22 Bingham	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
23 *Peyser*	Y	Y	Y	?	N	N	?	?	?	?	N	N	Y	N	Y
24 Ottinger	N	Y	N	N	N	Y	Y	Y	N	Y	N	N	Y	Y	N
25 *Fish*	N	N	Y	N	Y	N	N	N	Y	Y	Y	N	Y	N	Y
26 *Gilman*	Y	N	Y	N	N	N	N	N	Y	Y	N	Y	N	N	Y
27 McHugh	?	Y	N	N	N	Y	Y	?	N	Y	N	N	Y	Y	Y
28 Stratton	Y	Y	Y	N	Y	N	N	N	Y	X	Y	N	N	Y	Y
29 Pattison	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
30 *McEwen*	Y	Y	Y	N	N	N	N	N	○	N	Y	Y	N	N	Y
31 *Mitchell*	Y	Y	Y	N	Y	N	N	N	Y	Y	Y	Y	N	N	Y
32 Hanley	N	Y	Y	N	N	N	Y	N	○	Y	N	N	Y	Y	N
33 *Walsh*	Y	N	Y	N	N	N	N	N	Y	Y	Y	Y	N	N	Y
34 *Horton*	N	Y	Y	N	Y	N	Y	N	Y	Y	N	N	N	N	Y
35 *Conable*	Y	Y	Y	N	Y	N	N	N	Y	Y	Y	N	N	N	Y
36 LaFalce	N	Y	N	N	N	N	Y	N	?	Y	N	N	Y	Y	Y
37 Nowak	N	Y	N	N	N	Y	Y	Y	Y	Y	N	N	Y	Y	N
38 *Kemp*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
39 Lundine*			N	Y		Y	Y	N		Y	N	N	Y		Y
NORTH CAROLINA															
1 Jones	Y	N	Y	N	Y	?	N	?	Y	N	Y	○	?	N	Y
2 Fountain	Y	N	Y	N	○	N	N	N	Y	N	Y	Y	X	N	Y
3 Henderson	?	N	Y	?	Y	?	N	N	Y	N	Y	Y	N	N	Y
4 Andrews	Y	X	Y	N	Y	N	Y	N	Y	Y	Y	Y	Y	N	Y
5 Neal	N	N	?	N	N	N	Y	N	Y	Y	Y	Y	Y	Y	Y
6 Preyer	N	Y	Y	N	N	N	N	N	Y	N	N	Y	●	N	Y
7 Rose	Y	Y	Y	N	N	N	N	?	○	Y	N	Y	N	N	Y
8 Hefner	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	●	N	Y
9 *Martin*	Y	Y	Y	N	Y	N	N	?	Y	N	Y	Y	N	N	Y
10 *Broyhill*	Y	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
11 Taylor	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
NORTH DAKOTA															
AL *Andrews*	N	N	Y	N	Y	N	N	N	?	N	N	Y	N	N	Y
OHIO															
1 *Gradison*	N	Y	Y	N	Y	?	N	N	Y	Y	Y	?	Y	N	Y
2 *Clancy*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
3 *Whalen*	N	Y	N	Y	N	N	Y	N	Y	Y	N	N	Y	N	Y
4 *Guyer*	?	Y	Y	N	○	N	N	N	○	?	Y	Y	N	N	Y
5 *Latta*	Y	N	Y	N	Y	?	N	N	Y	N	Y	N	N	N	Y
6 *Harsha*	Y	N	Y	N	Y	?	N	N	Y	N	Y	N	N	N	?
7 *Brown*	Y	Y	Y	N	Y	N	N	N	Y	Y	Y	Y	N	N	Y
8 *Kindness*	?	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
9 Ashley	N	Y	N	?	N	N	Y	N	Y	N	N	N	Y	Y	N
10 *Miller*	Y	N	Y	Y	Y	N	N	N	Y	N	Y	Y	N	N	Y
11 *Stanton, J.W.*	N	Y	Y	N	Y	N	N	N	Y	Y	N	Y	N	N	Y
12 *Devine*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
13 *Mosher*	N	Y	N	●	N	N	Y	?	Y	Y	N	Y	Y	Y	Y
14 Seiberling	N	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
15 *Wylie*	Y	N	Y	N	Y	N	N	N	?	N	Y	Y	N	N	Y
16 *Regula*	Y	Y	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
17 *Ashbrook*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
18 Hays	?	Y	Y	?	N	N	?	N	Y	N	?	N	Y	Y	?
19 Carney	N	N	○	Y	N	Y	Y	N	N	Y	N	N	N	Y	N
20 Stanton, J.V.	N	Y	?	?	Y	N	Y	?	N	Y	N	X	N	Y	Y
21 Stokes	N	Y	X	Y	N	Y	Y	Y	N	Y	N	N	●	?	N
22 Vanik	N	N	N	Y	N	Y	?	Y	N	Y	?	N	Y	Y	N
23 Mottl	N	N	N	Y	N	N	Y	Y	○	Y	Y	N	Y	Y	Y
OKLAHOMA															
1 Jones	Y	N	Y	?	Y	N	N	N	?	N	Y	Y	Y	N	N
2 Risenhoover	Y	N	Y	Y	N	N	N	N	?	Y	N	N	N	N	Y
3 Albert*											N	N			
4 Steed	Y	N	Y	N	N	N	N	N	Y	N	N	N	N	N	Y
5 *Jarman*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
6 English	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	N
OREGON															
1 AuCoin	Y	?	N	?	N	N	Y	?	?	Y	N	N	Y	N	Y
2 Ullman	N	Y	N	N	N	N	■	N	N	Y	N	Y	Y	Y	Y
3 Duncan	N	Y	Y	N	N	N	Y	?	?	Y	Y	N	N	Y	Y
4 Weaver	?	Y	N	Y	N	Y	Y	Y	N	Y	N	N	Y	Y	N
PENNSYLVANIA															
1 Barrett*	?	Y		?	X			N	Y	●			N		
2 Nix	N	Y	N	●	N	?	Y	Y	X	●	N	X	Y	Y	N
3 Green	N	Y	N	Y	N	Y	Y	Y	X	Y	N	N	Y	Y	N
4 Eilberg	N	N	N	N	N	Y	Y	N	N	Y	N	N	Y	Y	N
5 *Schulze*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	Y	N	Y
6 Yatron	Y	N	Y	N	Y	N	Y	Y	Y	Y	Y	N	N	N	Y
7 Edgar	N	Y	N	N	N	Y	Y	N	Y	Y	N	N	Y	Y	N
8 *Biester*	N	Y	N	N	N	N	Y	N	Y	?	N	N	Y	Y	?
9 *Shuster*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
10 *McDade*	N	Y	Y	N	N	N	N	N	Y	Y	N	N	N	N	Y
11 Flood	N	Y	○	N	N	N	N	N	Y	Y	N	N	N	N	Y
12 Murtha	Y	N	Y	N	Y	N	N	N	Y	Y	Y	N	N	Y	N
13 *Coughlin*	N	Y	Y	Y	N	N	Y	N	Y	N	Y	Y	Y	N	Y
14 Moorhead	N	Y	N	N	N	Y	?	N	N	Y	N	N	Y	Y	N
15 Rooney	N	Y	Y	N	N	N	Y	N	Y	Y	N	N	N	Y	N
18 *Eshleman*	Y	N	N	?	Y	?	N	N	Y	Y	Y	○	N	N	Y
17 *Schneebeli*	?	Y	Y	Y	N	N	N	N	Y	N	○	Y	N	N	Y
18 *Heinz*	N	Y	Y	?	Y	N	Y	N	?	?	N	N	?	Y	Y
19 *Goodling*	Y	N	Y	Y	Y	N	N	N	Y	Y	Y	Y	N	N	Y
20 Gaydos	Y	?	N	N	N	Y	Y	N	Y	Y	N	N	Y	?	Y
21 Dent	N	N	Y	X	Y	N	N	N	Y	Y	N	N	Y	N	N
22 Morgan	N	Y	Y	N	N	N	N	N	?	Y	N	N	Y	Y	N
23 *Johnson*	Y	Y	Y	?	Y	N	N	N	Y	N	Y	Y	N	N	Y
24 Vigorito	N	Y	N	N	N	N	Y	N	Y	Y	N	N	Y	N	N
25 *Myers*	N	Y	Y	N	N	N	N	Y	Y	N	Y	Y	N	Y	Y
RHODE ISLAND															
1 St Germain	?	Y	N	X	N	Y	Y	●	N	Y	N	N	Y	Y	N
2 Beard	N	Y	N	N	N	Y	Y	Y	N	Y	N	N	Y	Y	N
SOUTH CAROLINA															
1 Davis	Y	?	Y	N	Y	N	N	N	N	Y	Y	N	Y	N	Y
2 *Spence*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
3 Derrick	N	Y	Y	N	Y	N	N	N	Y	Y	N	Y	Y	Y	Y
4 Mann	Y	Y	Y	N	N	N	N	N	Y	N	Y	Y	Y	N	Y
5 Holland	N	●	Y	●	N	N	N	N	X	Y	Y	N	Y	Y	Y
6 Jenrette	Y	N	Y	N	N	N	N	N	Y	Y	N	Y	Y	N	Y
SOUTH DAKOTA															
1 *Pressler*	Y	N	N	Y	Y	N	Y	N	Y	N	Y	Y	N	N	Y
2 *Abdnor*	Y	X	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
TENNESSEE															
1 *Quillen*	Y	Y	Y	?	Y	N	N	N	Y	N	Y	Y	N	N	Y
2 *Duncan*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
3 Lloyd	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
4 Evins	Y	N	Y	N	○	N	N	N	Y	N	○	N	●	N	Y
5 Allen	Y	Y	N	N	N	Y	Y	Y	Y	N	N	Y	Y	Y	Y
6 *Beard*	Y	N	Y	N	N	N	N	N	Y	N	Y	Y	N	N	Y
7 Jones	Y	N	N	N	Y	N	N	N	Y	N	Y	Y	?	N	Y
8 Ford	Y	Y	N	Y	N	Y	Y	Y	N	Y	N	N	●	Y	N
TEXAS															
1 Hall*													N		
2 Wilson	N	?	Y	?	?	?	?	N	Y	N	Y	?	N	N	Y
3 *Collins*	Y	N	Y	N	Y	N	N	N	Y	X	Y	Y	N	N	Y
4 Roberts	Y	N	Y	?	Y	?	X	N	Y	N	Y	?	N	N	N
5 *Steelman*	Y	Y	Y	●	Y	N	?	N	Y	N	Y	Y	?	N	Y
6 Teague	Y	X	Y	X	Y	N	N	N	Y	N	Y	○	N	N	Y
7 *Archer*	Y	N	Y	N	Y	N	N	N	Y	N	Y	○	N	N	Y
8 Eckhardt	N	Y	N	Y	?	N	Y	Y	?	Y	N	N	Y	Y	N
9 Brooks	Y	Y	Y	X	Y	N	?	N	?	N	N	N	Y	N	N
10 Pickle	Y	Y	Y	Y	N	N	N	N	Y	N	Y	N	N	N	N
11 Poage	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
12 Wright	N	Y	Y	N	Y	N	N	N	Y	Y	N	N	N	N	Y
13 Hightower	Y	N	Y	N	N	N	N	N	Y	N	Y	Y	N	N	Y
14 Young	Y	Y	Y	?	Y	N	N	N	Y	N	N	N	N	N	N
15 de la Garza	Y	N	Y	?	Y	?	N	N	Y	Y	N	?	N	N	Y
16 White	Y	N	Y	X	Y	?	N	N	Y	■	N	○	N	N	Y
17 Burleson	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
18 Jordan	N	Y	N	Y	N	N	Y	Y	N	Y	N	N	Y	Y	N
19 Mahon	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	N
20 Gonzalez	Y	Y	Y	N	N	N	N	N	Y	N	N	N	Y	N	N
21 Krueger	Y	Y	Y	N	Y	N	N	N	Y	Y	Y	Y	N	N	Y
22 *Paul*			Y	N		N	Y	N			Y	Y	Y		Y
23 Kazen	Y	N	Y	N	Y	N	N	N	Y	N	N	N	N	N	Y
24 Milford	Y	N	Y	N	N	N	?	X	Y	N	○	Y	N	?	?
UTAH															
1 McKay	N	Y	Y	N	Y	N	N	N	N	N	N	?	Y	N	N
2 Howe	?	Y	N	N	N	N	?	N	N	Y	?	X	?	Y	N
VERMONT															
AL *Jeffords*	N	Y	N	N	N	N	Y	Y	Y	Y	Y	N	Y	Y	Y
VIRGINIA															
1 Downing	?	N	?	N	Y	N	N	N	Y	N	Y	?	N	N	Y
2 *Whitehurst*	Y	N	Y	N	Y	N	N	N	Y	N	Y	?	N	N	Y
3 Satterfield	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
4 *Daniel, R.*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
5 Daniel, D.	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
6 *Butler*	?	Y	Y	N	N	N	N	N	Y	N	Y	Y	N	N	Y
7 *Robinson*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
8 Harris	N	Y	N	Y	N	N	Y	N	N	Y	N	N	Y	Y	N
9 *Wampler*	Y	N	Y	N	Y	N	N	N	Y	N	Y	Y	N	N	Y
10 Fisher	N	Y	N	N	N	N	N	N	Y	Y	N	Y	Y	Y	Y
WASHINGTON															
1 *Pritchard*	N	Y	N	Y	N	N	Y	N	N	N	Y	Y	N	N	Y
2 Meeds	?	Y	N	N	N	N	Y	N	X	Y	N	N	Y	Y	N
3 Bonker	N	Y	N	N	N	N	Y	?	Y	Y	N	Y	Y	Y	Y
4 McCormack	N	Y	Y	Y	Y	N	N	N	Y	Y	N	N	N	Y	Y
5 Foley	N	Y	Y	N	?	N	Y	N	N	Y	N	Y	N	?	Y
6 Hicks	N	Y	?	N	Y	N	N	N	Y	Y	N	N	N	N	N
7 Adams	N	Y	N	?	N	N	Y	N	N	Y	N	N	X	Y	N
VEST VIRGINIA															
1 Mollohan	N	N	Y	N	N	N	N	?	Y	N	N	N	Y	Y	Y
2 Staggers	N	Y	Y	X	N	N	N	N	Y	Y	N	N	Y	Y	N
3 Slack	N	N	Y	N	Y	N	N	N	Y	N	N	N	Y	N	N
4 Hechler	N	N	N	Y	N	Y	Y	Y	N	Y	Y	?	Y	Y	N
WISCONSIN															
1 Aspin	N	Y	N	Y	N	Y	Y	Y	N	N	?	N	N	Y	Y	N
2 Kastenmeier	N	Y	N	Y	N	Y	Y	Y	Y	N	Y	N	N	Y	Y	N
3 Baldus	N	Y	N	N	Y	N	Y	Y	Y	Y	Y	N	N	Y	Y	Y
4 Zablocki	N	Y	Y	N	Y	N	N	N	Y	Y	N	N	Y	Y	Y	N
5 Reuss	N	Y	N	Y	N	Y	Y	Y	Y	N	Y	N	N	Y	Y	N
6 *Steiger*	N	Y	Y	N	Y	N	N	N	Y	?	Y	Y	N	N	Y
7 Obey	N	Y	N	N	N	Y	Y	Y	N	N	Y	N	N	Y	Y	N
8 Cornell	N	Y	N	N	N	Y	Y	Y	N	Y	N	N	N	Y	Y	N
9 *Kasten*	Y	N	Y	N	N	N	N	N	Y	Y	Y	Y	N	N	Y
WYOMING															
AL Roncalio	N	Y	N	N	N	Y	Y	N	N	Y	N	N	Y	?	X

Andrew Hinshaw CA was convicted Jan. 26 of bribery relating to his former office as county assessor; House rules prohibit convicted felons from voting on the House floor. Speaker **Carl Albert OK** ordinarily does not vote. **Delegates** Walter E. Fauntroy, District of Columbia; Antonio Borja Won Pat, Guam; Ron de Lugo, Virgin Islands; and Resident Commissioner Jaime Benitez, Puerto Rico, cannot vote on the House floor, but may do so in committee.

ARMS RACE OUT OF CONTROL

Efforts to cut **military spending** failed repeatedly in 1976, because of election year politics, fear of increased Soviet spending, and inflation. Pres. Ford's revised request of $113.3 billion in budget authority for "national defense" received only token cuts by the House and Senate Budget, Armed Services, and Appropriations Committees. On the First Budget Resolution, Indiana Sen. Birch Bayh's modest amendment was defeated 27-58 April 12 (**S. Vote 6**). An amendment by Sens. Thomas Eagleton MO and Mark Hatfield OR Aug. 2 to cut $1 billion from the $104 billion Defense Dept. total was defeated 27-63.

In the House, NY Rep. Elizabeth Holtzman's amendment to cut $7.5 billion in budget authority and $2.5 billion in outlays from the military, transferring all of the outlay cut and $2.8 in budget authority to civilian needs, was defeated 85-317 on April 29 (**H. Vote 6**).

Another attempt by Rep. Ron Dellums CA to reduce the number of **U.S. troops abroad** by 47,000 was defeated April 9 by 88-275 (**H. Vote 4**).

Sen. McGovern's amendment to cut $948 million earmarked to begin **production of three B-1 bombers** was defeated May 20 in the Senate 33-48 (**S. Vote 7**). A later amendment by Sen. John Culver IA to delay a decision on production until Feb. 1, 1977, passed 44-37 but was deleted in conference. The following senators voted for production but then switched to vote for the Culver delay:

Bumpers AR, Nunn GA, Inouye HI, Pearson KS, Eagleton and Symington MO, Metcalf MT, McIntyre NH, Burdick ND, Jackson and Magnuson WA, Randolph WV.

There was no vote in the House to stop B-1 production. OH Rep. John Seiberling's amendment to the military authorization bill to delay production until Feb. 1 was defeated 177-210 on Apr. 8. A later attempt by Rep. Joseph Addabbo NY to amend the $105 billion Dept. of Defense appropriations bill to include the Feb. 1 delay also failed 186-207 on June 17 (**H. Vote 7**). The Senate again added the Feb. 1 delay to the appropriations bill and in conference it was accepted with $87 million a month slated to keep production lines open for four months.

NY Rep. Bella Abzug's attempt to delete $1.2 billion for **nuclear weapons** development, testing, and production was defeated May 20 by 97-286 (**H. Vote 8**). In the Senate a similar amendment offered by Mike Gravel AK lost June 25 by 5-77. Joining Gravel were Sens. Abourezk, McGovern, William Proxmire WI, and William Hathaway ME.

HUMAN RIGHTS

Congress continued its human rights thrust begun last year when the Harkin and McGovern-Abourezk amendment was added to the economic aid bill. This year Con-Congress strengthened Sec. 502B, the human rights provision regarding military aid so much that Pres. Ford vetoed the bill as initially passed, citing this provision as one of the several causing his action. A revived and somewhat weakened bill was passed and signed. It requires the Administration to report on the human rights situation in each country receiving U.S. military aid and provides a procedure for Congress to review and to reverse, if it so determines, an Executive Branch request for military aid.

But when human rights in South Korea were pitted against perceived U.S. security interests, human rights lost. The House Intl. Relations Cmte. on the motion of Rep. Don Fraser MN, had limited U.S. military aid to South Korea to the FY75 level, "because of the gross violations of human rights which continue in South Korea." On June 12 the House deleted the $290 million ceiling on military aid to South Korea, in effect accepting the Administration's request for $488 million for FY76 and 77 (**H. Vote 3**).

However, the Senate on Feb. 18 by a vote of 48-39 adopted an amendment by Sen. Edward Kennedy MA which broadened a ban on U.S. military grants and credit sales to Chile to include government cash or commercial sales of arms and military equipment as well (**S. Vote 3**).

WEAPONS FOR ISRAEL

In seeking to reduce U.S. arms shipments to Israel, Rep. David Obey WI stated, "I deeply believe that if we do not show that we are willing to trim at least some amount from this bill, we diminish the possibilities for peace in the Middle East and increase the likelihood that any further war will be at a much higher violence level than we have had in the past." Obey's amendment to FY76 foreign aid appropriations would have cut a modest $200 million from the $1.5 billion for military credits and grants to Israel. It lost 32-342 on March 4, 1976. The following voted for the cut:

Ashbrook OH, Baucus MT, Bergland MN, Burlison MO, Conyers MI, Evans CO, Evans IN, Evins TN, Findley IL, Frenzel MN, Hamilton IN, Hansen ID, Hungate MO, Ichord MO, Jacobs IN, Johnson CO, Karth MN, Kastenmeier WI, Keys KS, McDonald GA, Moffett CT, Montgomery MS, Mosher OH, Mottl OH, Myers PA, Nolan MN, Obey WI, Roush IN, Shuster PA, Skubitz KS, Wylie OH, and Zablocki WI.

WHOSE RIGHT TO KNOW?

Congress and the President carried on a running battle over intelligence data in 1976, primarily over the work of the Select Cmtes. on Intelligence chaired by Rep. Otis Pike NY and Sen. Frank Church ID.

The issue came to a head in the House Jan 29 when the House voted 246-124 to block the release of the Pike Cmte.'s final report (**H. Vote 9**). The Administration contended that the report contained classified material which must be sanitized before publication. The House vote and the prior leak of the report to the press has left the House in turmoil and killed any hope of creating in this Congress a permanent House or joint Congressional Intelligence Cmte.

In the Senate, however, the Church Cmte.'s final report was published, revealing a long history of violations of citizens' rights by government agencies. On May 19 the Senate 72-22 established a permanent Senate Intelligence Cmte. But the vote which really determined whether the new committee would exercise authority came earlier that day, when the Senate by a vote of 31-63 rejected an amendment which would have denied the new committee legislative and budgetary jurisdiction over the intelligence activities of the Department of Defense (**S. Vote 9**).

Another relevant Senate vote came Feb. 17 on the $4 billion FY76 military aid authorization bill (S. 2662), when the Senate rejected, 36-44, an amendment which would have deleted language in the bill requiring the President to disclose publicly all military assistance and arms sales transactions (**S. Vote 8**).

INTERVENTION

Sec. of State Kissinger's Dec. 9, 1975, acknowledgement that the U.S. was covertly supplying arms and aid to anti-Soviet factions in the Angolan civil war brought sharp reactions from Congress. After two secret sessions, the Senate on Dec. 19, 1975, adopted 54-22 an amendment offered by Sen. John Tunney CA which limited U.S. activities in Angola to intelligence gathering (**S. Vote 10**).

On Jan. 27, 1976, the House, on a motion from Robert Giaimo CT, approved the Tunney amendment 323-99.

ENERGY

The Senate March 9 adopted H.R. 8650 (**S. Vote 13**) which, like the House version adopted in 1975, directed the Dept. of Housing and Urban Development to draw up energy-efficiency standards for new homes and commercial buildings and to help state and local governments work

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(continued from Page 5)

those requirements into their building codes. The Senate vote stiffened H.R. 8650 to force state and local compliance with those standards by threatening to cut off mortgage credit.

On the nuclear front, the House July 30 adopted a controversial amendment by Rep. Jonathan Bingham NY to the Nuclear Fuels Assurance Act (H.R. 8401) by the narrow margin of 170-168. On Aug. 4, the House reversed itself and by a 192-193 roll call (**H. Vote 13**) rejected Bingham's proposal. On this vote, a 192-192 tie was broken when Speaker Carl Albert voted against the amendment.

As passed, H.R. 8401 would open the door for private industry to begin production of enriched uranium, a technology which the federal government has monopolized for 30 years, and which Bingham sought to continue. Opponents of private development feared waste and increased dangers of proliferation and environmental hazards.

FOOD STAMPS

The Senate passed April 8 a moderate food stamp reform bill which limited food stamps to households with less than $8,100 income and set standard deductions of $100 for all households, plus extra deductions for the elderly and working poor (**S. Vote 11**).

In meetings of the House Agriculture Committee, food stamp supporters and opponents stalemated, reporting out a bill Aug. 10 that is satisfactory to few on either side. The scaled-down committee bill, H.R. 13613, is estimated to be within current program costs. This bill is pending on the House floor. (Write for G-52.) The House previously rejected efforts to cut back food stamp appropriations. (**H. Vote 11**)

JOBS

The First Budget Resolution provided both the House and the Senate an opportunity to place high priority on providing jobs for the seven million unemployed persons in the U.S.

The House Budget Committee included $50 million in startup funds in the First Budget Resolution for any full employment legislation which is passed prior to October, 1977. A motion by Rep. Ronald Sarasin CT to delete these funds was defeated 177-206 on Apr. 29 (**H. Vote 12**). This vote shows that only a narrow majority, one which has not increased since April, was ready at that time to consider seriously far-ranging jobs legislation such as H.R. 50, the Hawkins-Humphrey bill.

Sen. Edward Kennedy MA proposed a $3.2 billion amendment to the Budget Resolution which would have doubled the number of public service jobs from 300,000 to 600,000 and also would have increased various health programs. As Sen. Alan Cranston CA noted, the Budget Resolution "fails to deal sufficiently with the immediate, desperate need to get millions of unemployed workers back to work," and thus the Senate, "failed . . . its responsibility [of] allocating Federal spending in accord with an appropriate set of national priorities." (**S. Vote 12**) The amendment was defeated 27-58.

REVENUE-SHARING

The House voted 361-35 on June 10 for a 45-month extension of revenue-sharing, a program of federal financial assistance to state and local governments. The program would disburse $6.65 billion each year. The House-passed bill includes improvements in the citizens' participation and anti-discrimination provisions of revenue-sharing. A substitute containing more improvements of the revenue-sharing program was defeated 172-233 (**H. Vote 15**).

D.C. REPRESENTATION IN CONGRESS

The House failed to obtain the 2/3 majority needed to adopt a constitutional amendment to give voting representation to the District of Columbia in both the House and Senate. This constitutional amendment was viewed as a civil rights issue (**H. Vote 10**). As co-sponsor Rep. John Buchanan AL, who is also a minister to an inter-racial congregation in the District of Columbia, stated, "One cannot say that the 750,000 persons who reside in the District of Columbia . . . fully participate in the rights of American citizenship until they are represented in both of the houses of this bicameral body."

DAY CARE STANDARDS

Congress passed a $125 million Day Care Standards Act to help day care centers meet the strict staff-children ratios which went into effect February, 1976. The President vetoed the bill on April 6 because he believed the new regulations were an excessive federal interference in local affairs, and he noted also the unfavorable budgetary impact of the $125 million price tag. The House overrode the veto 301-101 on May 4, but the Senate sustained 60-34 (**S. Vote 15**). A compromise bill which would postpone the standards for a year was signed by President Ford on Sept. 7.

AMERICAN INDIANS

Few recorded votes have been taken on Indian legislation during the 94th Congress. The Pueblo Lands bill, repealing an earlier act which gave New Mexico condemnation rights over certain pueblos, passed without a recorded vote. The Indian health bill, unanimously passed in the Senate (May, 1975), passed the House with a vote of 310 to 9. Significant increases and policy mandates regarding Indian programs came through Appropriations Committees, showing a greater sensitivity by the 94th Congress to Indian needs.

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