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TO ELEVATE THE POSITION OF DIRECTOR OF THE INDIAN HEALTH SERVICE WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ASSISTANT SECRETARY FOR INDIAN HEALTH, AND FOR OTHER PURPOSES

JUNE 24, 2002.—Ordered to be printed

Mr. INOUE, from the Committee on Indian Affairs,
submitted the following

R E P O R T

[To accompany S. 214]

The Committee on Indian Affairs, to which was referred the bill (S. 214) to elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for other purposes, having considered the same, reports favorably thereon with out amendment and recommends that the bill do pass.

PURPOSE

The purpose of S. 214 is to elevate the position of the Director of the Indian Health Service to the status of an Assistant Secretary within the Department of Health and Human Services. The bill establishes the Office of Assistant Secretary for Indian Health in order to further the unique government-go-government relationship between Indian tribes and the United States, facilitate advocacy for the development of Indian health policy, and promote consultation on matters related to Indian health.

BACKGROUND

In exchange for ceding millions of acres of land to which Indian tribes held aboriginal title, the United States entered into treaties with the Indian nations. Many of the treaties provide that health care services would be provided to the citizens of Indian nations. Some have asserted that these contracts between the United States and Indian governments represent the “first pre-paid health care plan” in America.

The Federal obligation for the provision of health care services to Indians also arises out of the special trust relationship between the United States and Indian tribes, which reflects the authority found in Article I, Section 8, Clause 3 of the U.S. Constitution, and which has been given form and substance by numerous treaties, Federal statutes, Supreme Court decisions, and Executive Orders.

The first Federal statute authorizing the appropriation of federal funds to carry out the United States' responsibilities, including the provision of health care, to Indian people was the Snyder Act of 1921 (25 U.S.C. 13). The Snyder Act served as the authorization for provision of health care services to American Indians and Alaska Natives until 1976, when the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) ("IHCIA") became law. The IHCIA was the first comprehensive statute specifically addressing the provision of health care to Indians and the Federal administration of health care.

a. Evolution of the Indian Health Service

Prior to 1954, the Bureau of Indian Affairs within the U.S. Department of the Interior was charged with carrying out the United States' responsibility for the provision of health care to Federally-recognized tribes and tribal members. However, in 1954, in response to increasing pressure from the public health community that Indian health care responsibility should be transferred to his authority, the Surgeon General, acting through the Public Health Service ("PHS"), established the Division of Indian Health ("DIH") to administer the Indian health program. In 1968, the Division became the Indian Health Service ("IHS") and operated as a sub-agency of other agencies within the Public Health Service including the Health Resources and Services Administration. In 1988, the Indian Health Service was established as a separate agency within the Public Health Service.

On October 1, 1995, the Department of Health and Human Services ("DHHS") reorganized its internal administrative structure and the Indian Health Service, along with the other agencies of the Public Health Service, became a separate operating division of the Department. Presently, the Director of the Indian Health Service is appointed by the President and is subject to Senate confirmation pursuant to 25 U.S.C. 1661(a). Under current law, the IHS Director reports to the DHHS Secretary through the Assistant Secretary for Health.

Since the 1995 reorganization, all agencies, operating divisions, and programs within the Department, including those previously part of the Public Health Service and under the direction of the Assistant Secretary for Health, have been required to report directly to the Secretary. Under the DHHS restructuring, the position of Assistant Secretary for Health was combined with the position of Surgeon General and the Office of Public Health and Science ("OPHS") was established. The Assistant Secretary for Health directs the OPHS, serves as the Secretary's senior advisor for public health and science, and provides leadership and coordination across the Department on public health and science issues.

A key component to the IHS health care system is the Public Health Service's Commissioned Corps. The Corps was established by the Congress in 1889 as part of the Marine Hospital Service,

which later became the Public Health Service. The original mission of the Corps was to provide medical care to sick and disabled naval and merchant seamen. While the Corps' duties were expanded during the World War I and II, its original mission now serves as the basis for its continuing status as a uniformed service. The Surgeon General is statutorily responsible for supervising the activities of the Commissioned Corps. The Corps is also charged with providing technical and financial assistance to a variety of other Federal agencies, state, and local public health departments.

At the request of this Committee, the General Accounting Office (GAO) conducted a study of the role of the Corps in the Indian Health Service system. Corps officers have been assigned to Indian health agencies since 1926 and the Corps continues to provide many of the physicians, registered nurses, dentists, pharmacists, engineers, and sanitarians in Indian health facilities. As of August 1999, the Public Health Service employed 5,936 Corps officers of which 2,204 or about 37%, are assigned to the Indian Health Service.

Like its legislative predecessors in previous sessions of the Congress, S. 214 seeks to honor the government-to-government relationship between the United States and Indian tribes, to provide the necessary leadership within the Administration on Indian health issues, and to bring focus and national attention to the health care status of American Indians and Alaska Natives. The bill is intended to enhance the Federal capacity to respond to the ongoing health crisis in Indian country and the continuing frustrations of Indian patients that their needs and concerns are not adequately addressed under the current administration policy and budgetary processes.

b. Indian health care and status of the IHS

The IHS employs approximately 15,320 employees or about 26% of all DHHS personnel. The IHS is a comprehensive health care delivery system operating nationwide through a variety of health care facilities. The IHS provides care services directly and through tribally contracted and operated health care programs. Health services are also purchased from more than two thousand private providers. As of 1998, the IHS system consisted of 550 direct health care delivery facilities funded through the IHS: 144 of these were directly operated by the IHS and 406 were operated by tribes or tribal consortia.

These facilities include, among others, 49 hospitals, 214 health care centers, 280 health stations, seven school centers, and 34 urban Indian health programs. Each year the IHS provides health care services to 561 Indian tribes in 35 states and in 1998 provided services to 1.46 million American Indians and Alaska Natives. In 1998, IHS and tribal hospitals registered some 68,000 admissions and IHS and tribal direct health clinics provided 7 million outpatient visits.

Previous legislative attempts to bring attention to Indian health care needs and concerns within the Administration have not succeeded, and have failed to halt the steady decline of the IHS budget. The disparity between Indian and non-Indian communities in Federal health care expenditures continues to grow. Health expenditures for 1998 reflect a \$3,383 per capita outlay for non-Indi-

ans, compared with a \$1,507 per capita expenditure for Indians. The Committee believes that the institutionalization of a senior policy official responsible for Indian health within the DHHS is necessary to begin to bring parity to Indian health care needs. S. 214 is intended to complement and strengthen past Executive Orders recognizing the government-to-government relationship between the United States and the tribes.

One of the principal justifications for this legislation has been past Administrations' failure to incorporate tribal recommendations in the final budget request, despite tribal participation throughout the budget process. As an example, prior to the FY 1999 budget request, the tribes met with the Administration to provide their input, but the FY 1999 budget request was \$153 million below the expected Presidential request.

The tribes expressed disappointment that the President's FY 1999 budget requests for the IHS included only a 0.9% increase over the FY 1998 budget levels. The IHS budget requested by the Administration ignored factors such as the 3.8% inflation rate of health care costs, mandatory cost increases for Federal personnel as enacted through the Federal Pay Act, limited third party cost collections (such as Medicaid, Medicare and private insurance), a 2.1% annual service population increase, and increasing chronic and acute care costs because of a lack of screening, diagnosis and early treatment.

At current budget levels, the IHS estimates that it can meet only 62% of tribal health care needs, as opposed to tribes, who estimate that the current funding levels meet only 36% of their health care needs. These deficits are even more disturbing in light of the fact that almost half the Indian population is now under the age of 25, and half of those under age five live in poverty. The gap between health care needs and Federal funding levels has never been more apparent or more critical. The growing and alarming disparity between the health status of American Indians and Alaska Natives as compared to other Americans is well documented. On May 20, 1998, the Assistant Secretary of Health reported to the Committee on Indian Affairs that Indians have the second highest infant mortality rate in the United States, the lowest prenatal care rate and lower breast and cervical cancer screening and treatment rates because of limited access to screening and treatment. In addition, Indian teen pregnancy rates are double that of their white counterparts, cardiovascular disease continues to be the leading cause of death, diabetes rates are four to eight times the national average, and as many as 40% of Indians over the age of 18 use tobacco.

c. The Role of the Assistant Secretary for Indian Health

Past Administrations have expressed a commitment to working with the Congress to elevate the position of the Indian Health Service Director to the rank of Assistant Secretary for Health and Human Services.

During the 106th Congress, at a hearing of the Committee to discuss the predecessor bill to S. 214, overwhelming evidence was presented in support of the elevation of the Director of the Indian Health Service to Assistant Secretary for Indian Health. Witnesses who presented testimony included tribal officials, health care pro-

viders, and the Administration. One witness, summed it up this way,

“The IHS, the largest direct health care provider in the Department of Health and Human Services (HHS), should answer directly to the HHS Secretary to insure that the issues that impact tribes are addressed.” Testimony of W. Ron Allen, National Congress of American Indians, before the Indian Affairs Committee, August 4, 1999.

The Committee also recognizes the role of the Assistant Secretary for Health (Surgeon General) in addressing the health needs of all citizens of this country, including the American Indian and Alaska Native populations. S. 214 does not alter the important role the Assistant Secretary for Health (Surgeon General) serves, particularly as principal adviser to the Secretary of DHHS for public health matters affecting the general population. It is the Committee’s hope that a close collaboration between the Assistant Secretary for Health and the Assistant Secretary for Indian Health will be a model of interagency cooperation and partnership and raise the health status of American Indian and Alaska Natives.

S. 214 elevates the position of the IHS Director, but more importantly, recognizes the unique government-to-government relationship between Federally recognized Indian tribes and the United States. The Assistant Secretary for Indian Health will provide the necessary leadership and consultation to the Secretary, the Assistant Secretary for Health, and others, on the important health issues facing Indian people. S. 214 supports the Federal policy of tribal self-determination and ensures that Indian people are heard and their concerns are brought to the table when important policy and budget decisions are made on their behalf.

The establishment of an Assistant Secretary for Indian Health will ensure that there is at least one senior official in current and future administrations who is knowledgeable about the United States’ legal and moral obligations to Indian people, the mission of the IHS, and who has the status to advocate within the DHHS and the Office of Management and Budget (OMB) for the funding resources and policies that are necessary to effectively and efficiently address the health care needs and concerns of Indian people. S. 214 places this important and special leadership role with the Assistant Secretary for Indian Health.

S. 214, as introduced, closely resembles previous versions of proposed legislation introduced in the last several Congresses, which resulted from discussions with tribal leaders and representatives of the DHHS.

LEGISLATIVE HISTORY

S. 214 was introduced on January 30, 2001 by Senator McCain for himself, and Senators Campbell, Inouye, Daschle, Johnson, Reid, and Conrad, and was referred to the Committee on Indian Affairs. S. 214 was ordered to be reported to the full Senate on March 21, 2002.

SECTION-BY-SECTION ANALYSIS

Section 1. Office of Assistant Secretary for Indian Health.

Subsection (a) provides that the Office of Assistant Secretary for Indian Health is established within the Department of Health and Human Services.

Subsection (b) provides that the Assistant Secretary for Indian Health shall report directly to the Secretary on all policy and budget related matters affecting Indian health, collaborate with the Assistant Secretary for Health on Indian health matters, advise other Assistant Secretaries and others within DHHS concerning matters of Indian health, perform the functions of the Director of the Indian Health Service, and other functions as designated by the Secretary of Health and Human Services.

Subsection (c) provides that any references to the Director of Indian Health Service in any other Federal law, Executive order, rule, regulation, or delegation of authority, or any document will be deemed to refer to the Assistant Secretary for Indian Health.

Subsection (d)(1) provides a technical change to comply with the section. The elevation of the Director of Indian Health Service to Assistant Secretary would increase the number of assistant secretaries to seven.

Subsection (d)(2) abolishes the position of the Director of Indian Health Service.

Subsections (e)(1) and (e)(2) amend section 601 of the Indian Health Care Improvement Act, 25 U.S.C. 1661, and other Acts by deleting all provisions referring to “the Director” or “Director of Indian Health Service” and inserting in lieu thereof “the Assistant Secretary for Indian Health.”

Subsection (e)(3) further outlines and clarifies the duties of Assistant Secretary for Indian Health.

Subsection (f) provides that the individual serving as the IHS Director at the time of the enactment of this Act may serve, at the pleasure of the President, as the Assistant Secretary for Indian Health.

Subsection (g) provides for conforming amendments to other statutes to comply with this Act.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

On March 21, 2001, the Committee on Indian Affairs, in an open business session, considered S. 214. The bill, without amendment, was ordered favorably reported with a recommendation that the bill do pass.

COST AND BUDGETARY CONSIDERATIONS

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

The cost estimate for S. 214, as calculated by the Congressional Budget Office, is set forth below:

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CBO estimates that enacting this bill would have no significant effect on the federal budget. Because this bill would not affect direct spending or receipts, pay-as-you-go procedures would not apply. S. 214 contains no intergovernmental or private-sector man-

dates as defined in the Unfunded Mandates Reform Act and would not affect the budgets of state, local, or tribal governments.

S. 214 would establish the position of Assistant Secretary for Indian Health in lieu of the current position of Director of the Indian Health Service. The duties and responsibilities of the office would not be changed significantly. The rate to pay would increase from level V to level IV of the Executive Schedule, an increase of \$8,400. This change would not affect the salary of the current Director of the Indian Health Service, because his pay is governed by the pay structure of the Public Health Service Commissioned Corps.

The CBO staff contact for this estimate is Eric Rollins. This estimate was approved by Peter A. Fontaine, Deputy Assistant Director for Budget Analysis.

REGULATORY AND PAPERWORK IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires that each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 214 will have minimal regulatory or paperwork impact.

EXECUTIVE COMMUNICATIONS

The Committee has received no official communication from the Administration on the provisions of the bill.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states that enactment of S. 214 will result in the following changes in the following statutes as noted below, with existing language which is to be deleted in brackets and the new language which is to be added in italic.

(1) Section 5315 of title 5, United States Code:

“Level IV of the Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title: Assistant Secretaries of Health and Human Services ~~[(6)]~~ (7).”

(2) Section 5316 of title 5, United States Code:

“Level V of Executive Schedule applies to the following positions, for which the annual rate of basic pay shall be the rate determined with respect to such level under chapter 11 of title 2, as adjusted by section 5318 of this title: ~~[(Director, Indian Health Service, Department of Health and Human Services.)]~~”

(3) Section 1661 of title 25 of the United States Code:

(a)(1) Establishment.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide health care services to Indians and Indian tribes, as are or may be on or after November 23, 1988, provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service. The Indian Health Service shall be administered by ~~[(a Director)]~~ *the Assistant Secretary for Indian Health*, who shall be appointed by the President, by and with the advice and consent of the Senate. ~~[(The Director of the Indian~~

Health Service shall report to the Secretary through the Assistant Secretary for Health of the Department of Health and Human Services. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate, after January 1, 1993, the term of service of the Director shall be 4 years. A Director may serve more than 1 term.】 *The Assistant Secretary for Indian Health shall carry out the duties specified in paragraph (2).*

(2) *The Assistant Secretary for Indian Health shall—*

(A) *report directly to the Secretary concerning all policy- and budget-related matters affecting Indian health;*

(B) *collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;*

(C) *advise each Assistant Secretary of the Department of Health and Human Services concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;*

(D) *advise the heads of other agencies and programs of the Department of Health and Human Services concerning matters of Indian health with respect to which those heads have authority and responsibility; and*

(E) *coordinate the activities of the Department of Health and Human Services concerning matters of Indian health.*

(4) Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661):

(i) “(c) The Secretary shall carry out through the [Director of the Indian Health Service] *Assistant Secretary for Indian Health—*

(1) all functions which were, on the day before November 23, 1988, carried out by or under the direction of the individual serving as Director of the Indian Health Service Assistant Secretary for Indian Health.”

(ii) “(d)(1) The Secretary, acting through the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*, shall have the authority—”

(B) Section 816(c)(1) of the Indian Health Care Improvement Act (25 U.S.C. 1680f(c)(1): “Cross utilization of services (1) Not later than December 23, 1988, the [Director of the Indian Health Service] *Assistant Secretary for Indian Health* and the Secretary of Veterans Affairs shall implement an agreement under which—* * *

(5) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)):

“(a) Establishment; membership; meetings, (1) In order to promote coordination and cooperation among Federal departments and agencies conducting rehabilitation research programs, there is established within the Federal Government an Interagency Committee on Disability Research (hereinafter in this section referred to as the “Committee”), chaired by the Director and comprised of such members as the President may designate, including the following (or their designees): the Director, the Commissioner of the Rehabilitation Services Administration, the Assistant Secretary for Special Education and Rehabilitative Services, the Secretary of Education, the Secretary of Veterans Affairs, the Director of the National Institutes of Health, the Director of the National Institute

of Mental Health, the Administrator of the National Aeronautics and Space Administration, the Secretary of Transportation, the Assistant Secretary of the Interior for Indian Affairs, the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*, and the Director of the National Science Foundation.”

(6) Subsections (B) and (E) of Section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377 (b) and (e)):

“(b) Assessment of sewage treatment needs; report: The Administrator, in cooperation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*, shall assess the need for sewage treatment works to serve Indian tribes, the degree to which such needs will be met through funds allotted to States under section 1285 of this title and priority lists under section 1296 of this title, and any obstacles which prevent such needs from being met.”

“(e) Treatment as States: * * * Such treatment as a State may include the direction provision of funds reserved under subsection (c) of this section to the governing bodies of Indian tribes, and the determination of priorities by Indian tribes, where not determined by the Administrator in cooperation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*. The Administrator, in cooperation with the [Director of the Indian Health Service] *Assistant Secretary for Indian Health*, is authorized to make grants under subchapter II of this chapter in an amount not to exceed 100 percent of the cost of a project. * * *”

(7) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b-2(d)(1)):

“(d) the Intra-Departmental Council on Native American Affairs: * * * The [Director of the Indian Health Service] *Assistant Secretary for Indian Health* shall serve as vice chairperson of the council.”