

executive orders, and moral obligations, the United States owes a singular debt to its Native Americans.

In partial fulfillment of that obligation, in 1976, Congress passed the first Indian Health Care Improvement Act. That 1976 law was the first legislative statement of goals for Federal Indian health care programs. That law established the first statutory requirements for the provision of resources to meet those goals.

In that 1976 act, the Congress found that:

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.

Today, when we get to the bill—I think roughly in about an hour from now—at long last, we will have before us the Indian Health Care Improvement Act of 2007. It has been a long trail that has led us here today. It is important we made the journey to get here. This bill will provide better health care for nearly 2 million American Indians from 562 federally recognized American Indian and Alaska Native tribes. We need to improve the health care of Native Americans. Native Americans suffer from tuberculosis at a rate 7½ times higher than the non-Indian population. The Native American suicide rate is 60 percent higher than in the general population.

Medicare—our program for seniors—spends about \$6,800 per person a year. Medicaid—the low-income program for health care—spends about \$4,300 per person. The Bureau of Prisons spends about \$3,200 per person for health care. But the Bureau of Indian Affairs and the Indian Health Service spends only \$2,100 for health care. That is less than a third of Medicare, less than half of Medicaid, and a third less than what the Federal Government spends for medical care for prisoners.

From the beginning of the Indian Health Care Improvement Act of 1976, Medicare and Medicaid have played a part in paying for health care delivered to Native Americans. The 1976 act amended the Social Security Act “to permit reimbursement by Medicare and Medicaid for covered services provided by the Indian Health Service.” Today, Medicare, Medicaid, and now the Children's Health Insurance Program are a significant source of funding for health care delivered to Native Americans.

I am proud that an important part of the Indian Health Care Improvement Act before us today is a product of the Finance Committee. That committee's provisions address health care provided to Indians through Medicare, Medicaid, and the Children's Health Insurance Program. Those provisions would increase outreach and enrollment of Indians in Medicaid and the Children's Health Insurance Program. These provisions would protect Indian health care providers from discrimination in payment for services and require

States and the Secretary of HHS to consult with Indian health providers, and they would ensure that Medicaid managed care organizations pay Indian health providers appropriately.

It is a good package. It is not near enough. It is an abomination—it is a tragedy what little attention we pay to Native Americans' health care needs. I wish more people in the country would visit Indian reservations. I wish they would visit Indian Health Service hospitals. They would realize the abysmal plight of so many people in America. But this bill helps. It helps provide more resources where people need it—not near enough but more—and I strongly encourage the Senate to pass this bill when we get to it in the next hour or so. Congress should reauthorize the Indian Health Care Improvement Act.

The United States owes a debt to the Native American population whose ancestors are tied up with the very soil all Americans share. The Federal Government owes a duty to help improve the health of American Indians. And we in this Senate have the obligation to pass this act and honor the flesh, the bones, and the blood of our Indian brethren.

Madam President, I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. DORGAN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

#### CONCLUSION OF MORNING BUSINESS

Mr. DORGAN. Madam President, what is the order of the Senate?

The PRESIDING OFFICER. Morning business is now closed.

#### INDIAN HEALTH CARE IMPROVEMENT ACT AMENDMENTS OF 2007

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of S. 1200, which the clerk will report.

The legislative clerk read as follows:

A bill (S. 1200) to amend the Indian Health Care Improvement Act to revise and extend the act.

Mr. DORGAN. Madam President, this is a piece of legislation we have reported out of the Committee on Indian Affairs in the Senate. Senator MURKOWSKI, the vice chair, and I have worked hard on these issues. We have also made some changes since reporting the bill out of the Committee on Indian Affairs and will offer a substitute that will be cosponsored by both of us. We are now clearing that substitute, and I will, at the appropriate time today, I hope, offer the substitute version.

Some might wonder why there is a separate Indian health care bill, and the answer is relatively simple: because this country has a trust responsibility—a trust responsibility that has grown over a long period of time and has been reaffirmed by the Supreme Court, affirmed by treaties with various Indian tribes—a trust responsibility to provide health care for Native Americans.

The last comprehensive reauthorization of the Indian Health Care Improvement Act was 15 years ago in 1992. The act itself has been expired for the last 7 years, and it is long past the time for this Congress to reauthorize this program. Even though the act has expired, the Indian Health Service continues to provide Indian health care, despite not having a current authorization. But with advances in medicine and in the delivery and in the administration of health care, we need to finally pass this reauthorization and give the Indian population of this country the advantage of the expansions we will do in this reauthorization bill.

This legislation reflects the voices and the visions of Indian Country. It also responds to a number of concerns that have been raised by others, including the administration. The enactment of this reauthorization has been the top priority of myself and the vice chair of the committee, Senator MURKOWSKI. I also wish to say the former vice chair of the committee, the late Senator Craig Thomas from Wyoming, at the start of this Congress, worked very hard on this legislation and cared very deeply about it. We bring this to the floor, remembering the work of Senator Thomas and recognizing his important work.

I wish to describe the need for the legislation as I begin before I describe the legislation itself. I have in the past couple weeks done some listening tours on Indian reservations, particularly in North Dakota, and we heard and saw many examples of deplorable conditions in Indian health care. It is true there are some health care providers in the Indian Health Service that are making very strong efforts to do the best they can, but they are overburdened and understaffed, underfunded. I wish to give some examples of that.

I wish to show a picture—a photograph, rather—of someone I have shown to the Senate before. This is a woman on the reservation in North Dakota, the Three Affiliated Tribes near New Town, ND. Her name is Ardel Hale Baker. Ardel Hale Baker has given me consent to use her image. She had chest pains that wouldn't quit. Her blood pressure was very high. So they went to the Indian health clinic, and she was diagnosed as having a heart attack. The clinic staff determined she needed to be sent immediately to the nearest hospital 80 miles away. She told the staff she didn't want to go in an ambulance because she knew she would end up being billed for the trip, and she didn't have the money. So she