UPDATE ON THE 110th LAME DUCK SESSION, HELD NOVEMBER 17 – 21, 2008:

During the week of November 17-21, 2008, Congress returned for a Lame Duck Session to take up debate on whether U.S. automakers should receive federal financial assistance under the $700 billion bailout created for financial institutions. Congressional Members, on both the right and left, questioned whether a bailout of the auto industry was warranted when automakers have been in trouble for decades and have done little to address consumer demand by producing more energy efficient automobiles. On November 20th, Democratic leaders postponed any action and set a December 2nd deadline for automakers to submit plans to explain how the federal aid would be used to improve the financial health of the auto industry. Both chambers will then hold hearings and Congress might return for a resumed Lame Duck Session the week of December 8th.

Indian Health Care Improvement Act Update:

On November 14, 2008, the National Indian Health Board (NIHB) sent a message to Senate Majority Leader Reid (R-NV) and Speaker Nancy Pelosi (D-CA) declaring a State of Emergency in Indian Health. The NIHB called upon Senate and House Leadership to take all necessary actions to pass the reauthorization of the Indian Health Care Improvement Act (IHCIA) during the Lame Duck Session. During the Lame Duck Session, Democratic Senate Indian Committee staff “hotlined” an abbreviated version of some of the Title I provisions of S. 1200 (a bill to reauthorize and amend the IHCIA that passed the Senate by an overwhelming majority of 83-10). Many of the non-controversial provisions included in the smaller bill provide new and expanded authorities, such as long term care services, that would improve health care to American Indians and Alaska Natives. Unfortunately, time ran out before action could be taken on the bill.

As reported previously, the NIHB worked tirelessly to have the House take up H.R. 1328, the House companion bill. The NIHB pursued several legislative strategies to move H.R. 1328, but at the 11th hour our efforts were shut down when Congress could not find funding to pay for the bill.

Although H.R. 1328 cleared all three committees of jurisdiction on June 6, 2008, the bill was not moved to the Floor for a vote because the National Right to Life Committee threatened to “score” any votes on the bill unless there was an opportunity to file an amendment to codify the Hyde Amendment (restrictions on use of Federal funds for abortions). Indian Country’s position was consistent – the IHCIA reauthorization is an Indian health
bill and a debate on codifying Hyde, especially when restrictions exist in current law, is not appropriate. Because of the national elections, any attempts to move the IHCIA reauthorization to the Floor were thwarted.

The NIHB attempted to have the bill included in the Continuing Resolution (CR) passed by the House on September 24th and the Senate on September 27th. Unfortunately, the House Leadership decided to put forward a “clean” CR, funding federal agencies through March 6, 2009 and providing for appropriation increases for specific programs, such as low-income energy assistance, low-income food programs, and school loans.

During the last week of September, the NIHB tried to move Title II of H.R. 1328 as a stand alone bill. Title II contains amendments to the Social Security Act to improve American Indian and Alaska Native (AI/AN) access to Medicare, Medicaid and State Children’s Health Insurance Program (SCHIP). Title II includes those provisions of the bill that result in increases in direct spending attributable to the Medicaid cost-sharing and Medicaid managed care exemptions. Unfortunately, House Leadership was not able to identify funding to pay for the first five years ($53 million) of the bill.

The NIHB will continue to pursue legislative strategies to move the IHCIA if Congress resumes its Lame Duck Session in December. If that effort is not successful, the NIHB will pursue reauthorization of the IHCIA in the 111th Congress.

NIHB MONITORS HEALTH CARE REFORM:
Health care reform was not just campaign rhetoric; in the coming year meaningful change in the health care system will begin. President-Elect Barack Obama named health care reform as a top priority in his administration and he is nominating individuals to his Cabinet, such as Senator Thomas Daschle, that will make reform a reality. Beyond the White House, Capitol Hill stands ready to hit the ground running in January.

Chairman Max Baucus (D-MT) and Ranking Member Chuck Grassley (R-IA), Senate Finance Committee, declared their desire to work together with the Health, Education, Labor and Pensions (HELP) Committee in the next Congress to put forth legislation. The Senate Finance Committee held a hearing to discuss health care reform and will continue to hold hearings and propose bi-partisan legislation in the 111th Congress.

“I am committed to working with my colleagues here on Capitol Hill – Democrats and Republicans – and to working with the incoming Obama Administration to really move the ball forward on health reform. In human and economic terms, there is really just no more time to waste.” – Senator Baucus

Senate Finance Committee issues Call to Action: Health Care Reform 2009:
On November 12, 2008, Senate Finance Committee Chairman Max Baucus (D-MT) issued a Call to Action: Health Care Reform 2009. The white paper is a “blueprint for comprehensive health care reform” and an outline of policy options for consideration by the 111th Congress; it is not intend to be a legislative proposal. Senator Baucus hopes that this “offers a starting point for the dialogue that [Congress] will have on health reform next year,” however he is not waiting until next year to begin the dialogue.

The Call to Action has three main objectives:

1. To provide universal health coverage for all Americans;
2. To reduce health care costs;
3. To improve the quality of health care.
| **Universal Health Care Coverage** | - Establishes a national requirement that everyone have health care coverage. Individuals will be able to retain their own health care coverage, but for those who need health care coverage, individuals will be able to purchase health insurance from a nationwide insurance pool, called the Health Insurance Exchange.  
- The Health Insurance Plan would include private coverage options and a public plan option. Premium subsidies will be available to qualifying families and small businesses.  
- Private insurance plans participating in the Exchange could operate nationally, regionally, state-wide or locally. The plans would offer high, medium or low-benefit options with differences in premiums due to the difference in benefits offered. The plans would be available for comparison.  
- The public plan option would have similar rules – different benefit and premium options. The public plan would be similar to Medicare with options to be developed to determine rates paid to health care providers, and who would run the plan, and who would be eligible for it.  
- Establishes an Independent Health Coverage Council to make decisions regarding the private and public plan options and make key decisions regarding implementation of health care reform. Members would be appointed by the President, with the advice and consent of the Senate, and chosen based on geographic diversity and expertise from varied disciplines. |
| **Temporary Medicare buy-in** | - Provides that until a national Health Insurance Exchange is established, Medicare coverage would be extended to individuals ages 55 to 64 and to disabled individuals, by phasing-out the two-year waiting period for Medicare coverage for persons with disabilities.  
- Medicare would charge enrollees electing the Medicare buy-in coverage an annual premium. |
| **Medicaid Coverage** | - Extend Medicaid eligibility to all Americans with incomes up to 100% of Federal poverty level, while maintaining existing Medicaid coverage above that level per existing state Medicaid programs.  
- Currently, States are not required to provide eligibility to adults, except if they are disabled, elderly or pregnant. The plan extends eligibility to all Americans and streamlines eligibility and enrollment. |
| **State Children’s Health Insurance Plan** | - Extends the State Children’s Health Insurance Program (SCHIP), at a minimum, to children with family incomes at or below 250% of Federal poverty level and who are not Medicaid eligible.  
- Those States that cover children over 250% of poverty level would continue under existing policies. |
| **Improving Health Care Quality and Value** | - The plan calls for improvements to health care quality by:  
  - Strengthening the role of primary care and chronic management.  
  - Refocusing payment incentives toward quality.  
  - Promoting provider collaboration and accountability.  
  - Improving the health care infrastructure. |
Financing a More Efficient Health Care System

The plan calls for reducing excess health care spending by:

- Detecting and eliminating fraud, waste and abuse.
- Requiring public reporting of costs and quality of care.
- Reforming medical malpractice laws.
- Eliminating overpayments to Medicare private insurance plans.
- Improving the quality and delivery of long-term care services.
- Developing tax incentives for health care coverage.

How does the Call to Action Address Indian Health:

The Baucus plan calls for increased funding for the Indian Health Service (IHS). In the plan, Chairman Baucus recognizes “that America cannot keep its promise to provide care to Native Americans and Alaska Natives with the current level of Indian Health Service funding.” The plan calls for improving and strengthening existing public health programs, including increased funding for IHS and encouraging AI/AN enrollment in other programs, such as Medicare, Medicaid and the State Children’s Health Insurance Program (SCHIP). It is significant that the Senate Finance Committee, who does not have primary jurisdiction over Indian issues, recognizes the tremendous need for increase in IHS funding and improved access to services offered by other Federal health programs.

There are a lot of questions as to what role the IHS, Tribal and Urban Indian health programs (I/T/Us) will play in the upcoming health care reform efforts. The IHS is not an entitlement program and does not have a defined benefit package. Although AI/AN have access to private insurance and Federal health programs such as Medicare, Medicaid, and SCHIP, over 30% of the AI/AN population remains uninsured.

The NIHBB commends the Senate Finance Committee for beginning the discussion of health care reform. But Tribal leaders and experts in Indian health need to be at the table for future discussions to ensure that the Federal government’s responsibility to provide health care to AI/ANs is fulfilled. We need to ensure that any health care reform protects the Indian health delivery system of providing culturally competent health care, increases access to health services and funding streams, and recognizes that the responsibility to provide health care to AI/ANs is based on a trust responsibility found in the U.S Constitution and confirmed through Treaties, where Indian people “pre-paid” for their health care through the cessation of land that now forms the basis of this great Country.

Senate Finance Committee Holds Hearing: Health Care Reform: An Economic Perspective:

On November 19th, the Senate Finance Committee held a hearing, Health Care Reform: An Economic Perspective. This hearing was the tenth in a series on health reform held by the Committee this year. The Chairman of the Committee Senator Baucus (D-MT) and the Ranking Member Senator Chuck Grassley (R-IA) were present along with Senators Rockefeller (D-WV), Bingaman (D-NM), Wyden (D-OR), Stabenow (D-MI), Salazar (D-CO), Hatch (R-UT), and Snowe (R-ME).

Four individuals were invited to present testimony before the Committee on health care reform from an economic perspective:

- Ivan G. Seidenberg, Chairman and Chief Executive Officer, Verizon Communications, Inc. New York, New York
- Andy Stern, President, Service Employees International Union (SEIU), Washington, D.C.
- Uwe E. Reinhardt, Ph.D., James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University, Princeton, New Jersey
- Amitabh Chandra, Ph.D., Assistant Professor of Public Policy, John F. Kennedy School of Government, Harvard University, Cambridge, Massachusetts
Mr. Ivan Seidenberg, testified on behalf of the Business Roundtable, an association of chief executive officers of leading U.S. companies. The Business Roundtable released a report in September 2008, *Health Care Reform in America*. Mr. Seidenberg reviewed the plan’s four pillars for improving the health care system: creating greater consumer value and efficiency in the health care marketplace; providing more affordable health insurance options for all Americans; placing an obligation on all Americans to have health insurance coverage and encouraging all Americans to participate in prevention and chronic care programs; and offering assistance to uninsured, low income families to meet their obligation.

Mr. Andy Stern, of the SEIU, stated that this is a once in a lifetime chance to address the health care crisis. With 72 million Americans struggling with medical debt he believes that it is hard to argue that health care is not linked with the economy. He continued on to say that American families should not have to choose between paying health insurance premiums, paying for groceries or their mortgage, or taking their prescriptions every other day. On behalf of the SEIU, Mr. Stern reaffirmed its commitment to work with the Committee and other organizations such as the Business Roundtable and AARP’s Divided We Fail. An important message to take away from Mr. Stern’s testimony is that unlikely partnerships and coalitions are necessary to reform health care. They may “disagree on a lot of other issues,” but they “all agree that we need to fix health care now.”

Dr. Uwe Reinhardt and Dr. Amitabh Chandra both presented an academic, economic perspective to the Committee. Both agreed that health care reform is necessary to rebuild the American economy. Dr. Reinhardt spoke on how money spent on health coverage for the uninsured is money well spent – there is a high rate of return because the health care industry employs people and creates jobs. Dr. Chandra addressed the issue that the key to any health care reform must be linked to Medicare reform that is a value based reimbursement system tied to quality of care.

The Committee members asked the panelists several broad questions about health care and the economy. Senator Baucus reiterated that this hearing and the *Call to Action* were intended to begin the discussion that will take place during the next Congressional Session.

**NIHB PRESENTS SENATOR DORGAN (D-ND) WITH THE JAKE WHITE CROW AWARD:**

On November 13, 2008, the National Indian Health Board (NIHB) Vice-Chairman Buford Rolin presented the Jake White Crow Award to the Honorable Byron Dorgan (D-ND) for his ongoing commitment to the improvement of health care for all Indian people. This prestigious award was announced September 24, 2008 during the NIHB’s 25th Annual Consumer Conference in Temecula, California.

Despite his busy schedule, Senator Dorgan sat down with Vice Chairman Rolin and NIHB staff to further assert his commitment to the improvement of Indian health care. He stated that this Congress has seen many successes and failures for Indian Country, but to not be dismayed as the next Congressional Session will bring many opportunities. Senator Dorgan will continue to champion the reauthorization of the Indian Health Care Improvement Act and other legislation for Indian Country.

Senator Dorgan has a longstanding history of working for and advocating with Indian Country to support the improvement of the Indian health system. He serves on four Senate committees and is the Chairman of the Indian Affairs Committee. Senator Dorgan has consistently supported Tribal sovereignty, working to secure needed tribal social services and research resources, and to ensure that federal government services provided to tribes are of the highest standard. During the 110th Congress, Senator Dorgan championed the reauthorization of the Indian Health Care Improvement Act through successful passage in the Senate. He offered an amendment to the Global AIDS Bill to allocate $250 million for much needed funding to support Indian contract health services and health facility construction.
The Centers for Medicare & Medicaid Services’ Tribal Technical Advisory Group (CMS TTAG) held its third face-to-face meeting for 2008 in Washington D.C. on November 13 & 14, 2008 at the National Museum of the American Indian. The meeting was well attended, including a 100% TTAG representation as well as senior staff from CMS, including the Deputy Administrator Herb Kuhn, Robin King, Director, CMS Office of External Affairs; Jim Scanlon, Deputy Assistant Secretary for Planning and Evaluation (Science and Policy); and Sandra Bastinelli, Division of Medical Review & Education.

Mr. Kuhn gave the group updates on four issue areas that were identified in the previous meeting in July: the Tribal Affairs Group (TAG) Director vacancy, the CMS Tribal Consultation Policy, Medicaid Administrative Match (MAM) and Medicaid citizenship documentation.

- Thirty-eight applications were submitted for the Tribal Affairs Group Director position at CMS and he expressed his appreciation for the group’s willingness to assist in the hiring process.
- In regards to the CMS Tribal Consultation Policy, he recognized the concerns expressed by the TTAG and the desire to be involved earlier in the regulations process but added that more discussions need to take place at CMS.
- Four states have MAM plans under active review: Montana, California, Oklahoma and Washington. Mr. Kuhn was confident that the California plan will be finished. He recognizes that while progress has been made there is still considerable work to be done.
- Mr. Kuhn was appreciative of the recent letter sent by the TTAG Citizenship Documentation Subcommittee with recommendations on citizenship documentation requirements. He mentioned that if the Department of Homeland Security (DHS) has created model agreements regarding documentation then CMS might be able to develop model agreements that Tribes could use, which could help facilitate enrollment efforts. In addition, Mr. Kuhn pointed out that states are in need of additional technical assistance that would help alleviate confusion regarding the documentation process.

The agenda from the day and a half meeting was jam packed with several agenda items including a report from the CMS Tribal Affairs Group, a report on CMS Day at the NIHB Annual Consumer Conference, reports from the Strategic Plan, Data, Outreach and Education, Long Term Care and the Citizenship Documentation Subcommittees, and presentations on emerging issues at CMS. For more information on this meeting and the CMS TTAG please visit the NIHB website.

The next CMS TTAG meeting will be held February 26-27, 2009 in Washington, D.C. at the National Museum of American Indian.
The TCAC decided to reinstate the budget sub-committee to further evaluate the CDC budget. This sub-committee will work to influence allocations to Indian Country. A few of the TCAC recommendations offered to the CDC include: the establishment of Information Technology grants to create capacity building in Indian Country; revisions to the CDC policy regarding funding to tribes or tribal organizations; and coordination of a strong approach to combat obesity that resembles what was done for tobacco cessation.

The recommendations received at the Tribal consultation session will be reviewed and discussed by the TCAC and CDC. The Second Bi-Annual Tribal Consultation Session was a success. The next TCAC meeting will be in February, dates to be determined. Please look to the CDC and NIHB websites for dates of future meetings and next action steps.

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This report is prepared by the National Indian Health Board for distribution to Tribal Governments via the Area Health Boards. It is intended to provide timely information on current federal and national policy issues and current events relevant to American Indian and Alaska Native health care. The Washington Report is prepared by NIHB's Legislative Director, Kitty E. Marx, J.D. and edited by Executive Director, Stacy A. Bohlen. The Honorable H. Sally Smith, Chairman, National Indian Health Board.