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{ REPORT  
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### INDIAN HEALTH CARE IMPROVEMENT TECHNICAL CORRECTIONS ACT OF 1996

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JULY 31, 1996.—Ordered to be printed

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

### REPORT

[To accompany S. 1869]

The Committee on Indian Affairs, to which was referred the bill (S. 1869) the Indian Health Care Improvement Technical Corrections Act of 1996, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

#### PURPOSES

The purpose of S. 1869 is to amend the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.) by making technical corrections to certain provisions of the Act and reauthorizing several Indian health care demonstration programs.

#### BACKGROUND ON THE INDIAN HEALTH CARE IMPROVEMENT ACT

Through numerous treaties, statutes, regulations, and case law, the United States has established a fundamental trust obligation to ensure that comprehensive health care is provided to American Indians and Alaska Natives. The Congress enacted the Indian Health Care Improvement Act in 1976 in an effort to raise the health status of American Indians and Alaska Natives to a level comparable to the national population. While the health status of Indian people has generally improved since its enactment, it still lags behind far behind any other segment of the American population. Health crises in every possible problem area continue to afflict many reservation communities at alarming rates. The mortality rate for diabetes exceeds the national average by 139 percent. American Indians are four times more likely to die from alcoholism

than other Americans. The incidence rate for Fetal Alcohol Syndrome is six times the national average. The mortality rate for tuberculosis among Native Americans exceeds the national average by 400 percent.

In 1992, the Congress amended the Indian Health Care Improvement Act to set out 59 health status objectives to improve the health status of American Indians and Alaska Natives by the year 2000. These health status objectives were intended to measure improvements in the health status of American Indians and Alaska Natives. The objectives were derived from the report of the U.S. Department of Health and Human Services, entitled "Healthy People 2000: National Health Promotion and Disease Prevention Objectives." In the Indian Health Amendments of 1992, the Congress extended the authorizations of most of the programs administered by the Indian Health Service (IHS) through the year 2000, at which time the IHS is required to report its progress to the Congress in meeting these 59 health status objectives.

S. 1869, THE INDIAN HEALTH CARE IMPROVEMENT TECHNICAL  
CORRECTIONS ACT OF 1996

S. 1869 makes technical amendments to certain provisions of the Indian Health Care Improvement Act (IHCA) and reauthorizes several Indian health care demonstration programs through the year 2000.

S. 1869 will clarify certain provisions in order to allow greater flexibility to the IHS in administering IHS scholarships and programs. The bill modifies the definition of Health Profession in Section 4(n) to include "allopathic medicine" in order to provide more flexibility to the IHS in awarding scholarship assistance to individuals enrolled in health degree professions. Prior to the 1992 amendments, individuals studying disciplines such as allopathic medicine were eligible to receive IHS assistance. Because the 1992 Amendments omitted this reference, many individuals were denied eligibility for scholarship assistance. These amendments would restore their eligibility for scholarship funds and fulfill the Act's intent.

The bill also clarifies certain provisions under Section 104(b), the Indian Health Professions Scholarship, to clarify the authority of the Secretary of the Department of Health and Human Services to waive or defer service or payment obligations of Indian health professionals under specified circumstances. Many requirements for a degree in the health professions include an internship, residency, or other advanced clinical program. The bill would clarify the authority of the Secretary to defer a scholarship recipient's service or repayment obligation until the recipient has completed his or her education program.

The bill also amends Section 206, regarding reimbursement from certain third parties for the costs of health services, to clarify the notice provisions for individuals in collection actions brought by the IHS or tribal health care provider. It also clarifies what costs are recoverable in such an action and that the IHS and tribal provider shall have the right to recover against an insurance company or employee benefit plan.

In addition, the bill extends the authorization for four health care demonstration projects and one grant program established as model programs under the Act through the year 2000. The program authorizations for these programs are due to expire.

The California Contract Health Services Demonstration Program authorizes the California Rural Indian Health Board to act as a contract care intermediary to improve the accessibility of health services to California Indians. The project is intended to cover the high-cost contract care cases over \$1,000 and up to the threshold participation level of the Catastrophic Health Emergency Fund. The program has successfully enabled tribal programs to provide in-patient services and prevent high-cost cases from devastating many small tribal health programs in California. Around 41 percent of the California tribes participate in this program.

The Medicare/Medicaid Demonstration Program allows four tribal health contract operators to directly bill and collect Medicare/Medicaid payments rather than operate through the current system of channeling payments through the IHS. The four participating Indian tribes include Mississippi Band of Choctaw Indians, Bristol Bay Area Health Corporation of Alaska, Choctaw Tribe of Oklahoma and South East Alaska Regional Health Consortium. The Medicare/Medicaid Demonstration Program has been a highly successful program for the participating tribes and the IHS, who have reported significantly increased collections for Medicare/Medicaid services and greater efficiency in the billing/payments process.

The bill expands the Medicare/Medicaid Demonstration Program from four participants to no more than twelve participants. The Committee intends that in determining the number of eligible participants for this program, all of the co-signers and signatory tribes to the Alaska Tribal Health Compact between certain Alaska Native tribes and the United States of America shall be deemed one participant. This is consistent with Title III of Public Law 93-638, as amended, which authorized this compact.

The Home and Community Based Care Demonstration Program authorizes Indian tribes to enter into contracts to establish demonstration projects for the delivery of home and community based services to functionally-disabled Indians. The Substance Abuse Counselor Education Demonstration Project authorizes the IHS to enter into contracts with, or make grants to, colleges, universities and tribally-controlled community colleges to develop educational curricula for substance abuse counseling. Although funding has not been provided to implement this project, the IHS has taken steps to enhance counselor certification efforts, including providing training at tribally-controlled Indian community colleges.

The Gallup Alcohol and Substance Abuse Treatment Program has funded residential treatment for alcohol and substance abuse at the Navajo Adult Rehabilitation Demonstration Project. The grant program has also funded a protective custody program for alcohol abuse offenders at the Gallup Crisis Center. These programs are unique to the Navajo Nation area and provide valuable services as a community-based outpatient program.

## LEGISLATIVE HISTORY

S. 1869 was introduced by Senator McCain, for himself and Senators Kassebaum, Murkowski, Stevens and Simon on June 13, 1996 and was referred to the Committee on Indian Affairs.

## COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

In an open business session on July 18, 1996, the Committee on Indian Affairs ordered the bill reported without amendment with the recommendation that the Senate do pass the bill as reported.

## SECTION-BY-SECTION ANALYSIS

Section 1(a) sets forth the short title of the Act.

Section 1(b) provides that wherever a section or other provision is amended or repealed in this Act, such amendment shall be considered made to the referenced section or provision of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

Section 2(a) amends Section 4(n) of the Indian Health Care Improvement Act to modify the definition of "Health Profession" to specify that "allopathic medicine" shall be added as an eligible degree program for individuals who qualify for scholarships and loan repayment programs. This section also modifies the definition by striking the current language of "and allied health professions" and inserting "an allied health profession, or any other health profession" to allow the IHS additional flexibility to determine eligibility for scholarships and loan repayments for individuals enrolled in health professions not specified under this section.

Section 2(b) amends Section 104(b) of the Indian Health Care Improvement Act to add a new provision that clarifies that an individual serving in an academic setting that is funded under sections 102, 112, or 114 of the Act who is responsible for the recruitment and training of Indian Health Professionals shall be considered to be meeting their service obligations under section 338A of the Public Health Service Act. This provision will allow an individual to meet their service obligation to the IHS by working at a university or other academic setting which is responsible for recruiting and training American Indians in the health professions. This is also intended to clarify that the Secretary may defer an individual's service obligation during the term of an internship, residency or other advanced clinical program. Section 104(b) is further amended by adding new subsections to address unique circumstances under which the Secretary is authorized to waive or suspend service or payment obligations due to death or the Secretary's determination that it would cause extreme hardship or that to enforce such a requirement would be unconscionable. An additional subsection is added to clarify the terms under which an individual's payment obligation may be discharged in a bankruptcy proceeding.

Section 2(c) amends Section 206 of the Indian Health Care Improvement Act to clarify the notice provisions for individuals in collection actions for services provided by IHS or tribal health facilities and recoverable costs in such a collection action and the right of the United States and Indian tribes to recover against an insurance company or employee benefit plan.

Section 2(d) amends Section 211(g) of the Indian Health Care Improvement Act to extend the authorization for the California Contract Health Services Demonstration Program until the year 2000.

Section 2(e) amends Section 405(c) of the Indian Health Care Improvement Act to provide that applicants for the Medicare and Medicaid Demonstration Program must be accredited by the Joint Commission on Accreditation of Hospitals within one year of submission of an application. Section 405(c) is amended to increase the number of eligible tribal health facilities from four to twelve. The authorization for the Medicare and Medicaid Demonstration Program is extended through the fiscal year 2000.

Section 2(f) amends Section 706(d) of the Indian Health Care Improvement Act to strike out 706(d) in its entirety and add a new subsection that will extend the authorization for the Gallup Alcohol and Substance Abuse Treatment Center through the fiscal year 2000.

Section 2(g) amends Section 711(h) of the Indian Health Care Improvement Act to extend the authorization for the Substance Abuse Counselor Education Demonstration Program through the fiscal year 2000.

Section 2(h) amends Section 821(I) of the Indian Health Care Improvement Act to extend the authorization for the Home and Community-Based Care Demonstration Program through the fiscal year 2000.

#### COST AND BUDGETARY CONSIDERATIONS

The cost estimate for S. 1869 as calculated by the Congressional Budget Office is set forth below:

U.S. CONGRESS,  
CONGRESSIONAL BUDGET OFFICE,  
*Washington, DC, July 26, 1996.*

Hon. JOHN MCCAIN,  
*Chairman, Committee on Indian Affairs,  
U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 1869, the Indian Health Care Improvement Technical Corrections Act of 1996.

Enactment of S. 1869 would not affect direct spending or receipts. Therefore, pay-as-you-go procedures would not apply to the bill.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director.*

#### CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: S. 1869.
2. Bill title: The Indian Health Care Improvement Technical Corrections Act of 1996.
3. Bill status: As ordered reported by the Senate Committee on Indian Affairs on July 18, 1996.

4. Bill purpose: S. 1869 would reauthorize five Indian Health Service (IHS) programs and would make amendments to the Indian Health Professions Scholarship program. Also, for the purposes of the Indian Health Care Improvement Act, the bill would expand the definition of health professions.

5. Estimated cost to the Federal Government: Assuming appropriation of the necessary funds, CBO estimates that the federal government would spend \$25 million over the fiscal year 1997–2002 period to implement the provisions of S. 1869. The following table summarizes the estimated authorizations and outlays that would result from S. 1869 under two different sets of assumptions. The first set of assumptions adjusts the estimated amounts for projected inflation after 1996. The second set of assumptions makes no allowance for projected inflation.

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
WITH ADJUSTMENTS FOR INFLATION						
Authorizations of appropriations under current law:						
Estimated authorization .....	( <sup>1</sup> )					
Estimated outlays .....	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )			
Proposed changes:						
Estimated authorization .....	6	6	6	7		
Estimated outlays .....	5	6	6	7	2	( <sup>1</sup> )
Authorizations of appropriations under proposal:						
Estimated authorization .....	6	6	6	7		
Estimated outlays .....	6	6	6	7	2	( <sup>1</sup> )
WITHOUT ADJUSTMENTS FOR INFLATION						
Authorization of appropriations under current law:						
Estimated authorization .....	( <sup>1</sup> )					
Estimated outlays .....	( <sup>1</sup> )	( <sup>1</sup> )	( <sup>1</sup> )			
Proposed changes:						
Estimated authorization .....	6	6	6	6		
Estimated outlays .....	5	6	6	6	1	( <sup>1</sup> )
Authorizations of appropriations under proposal:						
Estimated authorization .....	6	6	6	6		
Estimated outlays .....	5	6	6	6	1	( <sup>1</sup> )

<sup>1</sup> Less than \$500,000.

The costs of this bill fall within budget function 550.

6. Basis of the estimate: S. 1869 would reauthorize five IHS programs through fiscal year 2000. Reauthorization of the California Contract Health Services Demonstration program would cost approximately \$1 million through fiscal year 2000. This program assesses the effect of the use of contract care intermediaries on California Indians' access to medical services. Under this demonstration program, the federal government reimburses the California Rural Indian Health Board for the provision of high-cost contract care that does not meet the threshold cost requirement for coverage under the Catastrophic Health Emergency Funds.

The Medicare and Medicaid Direct Billing Demonstration Program would be reauthorized under S. 1869. This program permits four participating facilities to bill directly, and receive reimbursements from, third-party payers for services rendered. These entities also entitled to the Medicare and Medicaid reimbursement rates that the IHS has negotiated with the Health Care Financing Administration. Qualifying participants are hospitals or clinics operating under the Indian Self-Determination Act by tribes, tribal orga-

nizations or Alaska Native health organizations. Facilities that do not participate in this program can operate as Federally-Qualified Health Centers (FQHCs) or can choose to file claims through the IHS. Because it enables participants to bill directly for services rendered, rather than working through the IHS, the demonstration program may reduce IHS administrative costs slightly.

The proposal would also reauthorize two substance abuse grant programs. Reauthorization of the Gallup Alcohol and Substance Abuse Treatment Center grant program would require \$1.24 million in appropriations over the 1997–2000 period. This program gives grants to the Navajo Nation for residential alcohol and substance abuse treatment for adults and adolescents. The Substance Abuse Counselor Education Demonstration Program would also be reauthorized at a cost of \$1 million over the 1997–2000 period. Through this program, which currently is unfunded, the IHS would provide grants to tribally-controlled community colleges and vocational institutions for the development of substance abuse counseling educational curricula.

Finally, the bill would reauthorize the Home and Community-Based Care Demonstration Program, which is currently unfunded. Under this program, the IHS would make grants to Indian tribes or tribal organizations to establish demonstration programs of home and community-based services for functionally disabled Indians. Grant recipients would be required to have a contract under the Indian Self-Determination Act. The number of demonstration programs that could be funded would be capped at 24. Based on the budget request of the INS for fiscal year 1997, CBO estimates that the cost of reauthorizing this program would be \$22 million through fiscal year 2000.

S. 1869 would also make several technical amendments to the Indian Health Care Improvement Act. The bill would expand the definition of a health profession to include allopathic medicine and any other health profession. This change would allow practitioners of allopathic medicine and other health professionals access to the benefits accorded under the act. According to the Indian Health Service, this expansion would involve no additional cost to the federal government. For example, recipients of Health Professions Scholarships do not declare their specialty until they have completed their training and their scholarship has ended. Thus, the change in the definition of health professions would not increase the number of individuals participating in this program and would not increase the federal government's costs.

The bill would also relieve recipients of Indian Health Professions Scholarships of their service or payment obligation under certain circumstances. A recipient's obligation would be canceled upon his death, and the Secretary could waive or suspend the obligation if she determined that fulfillment would cause the recipient undue hardship. The obligation could be discharged under Chapter 11 bankruptcy only if the discharge were granted five or more years after the first payment was due and if the bankruptcy court determined that it would be unconscionable not to discharge the obligation. Because the scholarship program is currently governed by the Public Health Service Act, which also permits these waivers, these provisions would not increase the costs of the federal government.

Finally, S. 1869 would affect reimbursement of the federal government, tribes and tribal organizations by third-party payers. Tribes, tribal organizations and the federal government could be reimbursed for reasonable charges incurred in providing health services. Current law only allows the recovery of reasonable expenses incurred. According to the Indian Health Service, this provision would not result in any additional costs to the federal government. Under the proposal, the federal government, tribal organizations and tribes could also recover damages against the fiduciaries of employee benefit plans or insurance companies that are third-party providers and that fail to give reasonable assurances that they can sufficiently cover the benefits owed. CBO is unable to determine the precise amount of these offsetting collections at this time.

7. Pay-as-you-go considerations: None.

8. Estimated cost to State and local governments: This bill contains no intergovernmental mandates as defined in P.L. 104-4 and would impose no costs on state, local or tribal governments.

The bill would reauthorize appropriations for three programs that provide grant money to tribal governments and organizations for the provision of health care services and training. Assuming that the amounts authorized are appropriated, CBO estimates that tribal governments and organizations would receive about \$6 million annually through fiscal year 2000. In addition, the bill would reauthorize appropriations for a demonstration program under which the California Rural Indian Health Board, a nonprofit organization, provides health care to Indians in California. If the amounts authorized are appropriated, CBO estimates that the Board would receive about \$250,000 annually through fiscal year 2000.

The bill would also extend the life of another demonstration program by four years. Under this program, tribally operated health facilities, which are chosen by the Secretary of Health and Human Services, are allowed to directly bill and receive payments for health services provided under the Medicare and Medicaid programs. The bill would also expand the program from four to twelve facilities. The facilities that are currently participating are reporting that the program has had a favorable impact on their budgets by increasing the efficiency and decreasing the turn-around time of the billing and payment process. When the demonstration program ends, bills and payments will be channeled through the IHS.

Finally, the bill would clarify that tribal governments and organizations can collect from third party payers of health care services the reasonable charges billed, rather than the reasonable expenses incurred. Tribal governments and organizations have reported that some third-party payers have refused to pay for overhead and administrative costs billed to them. To the extent that this refusal to pay occurs, the clarification would expand offsetting collections by tribal governments and organizations.

9. Estimated impact on the private sector: S. 1869 does not include any private sector mandates as defined in P.L. 104-4.

10. Estimate comparison: None.

11. Previous CBO estimate: None.

12. Estimate prepared by: Federal Cost Estimate: Anne Hunt; State and Local Cost Estimate: John Patterson; and Private Sector Mandate Estimate: Julia Matson.

13. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

#### REGULATORY IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires 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 passing S. 1869 will create minimal regulatory or paperwork impacts.

#### EXECUTIVE COMMUNICATIONS

The Committee received the following executive communication from the Honorable Donna E. Shalala, Secretary of the U.S. Department of Health and Human Services, regarding S. 1869:

THE SECRETARY OF HEALTH AND HUMAN SERVICES,  
*Washington, DC, July 17, 1996.*

Hon. JOHN MCCAIN,  
*Chairman, Committee on Indian Affairs,  
U.S. Senate, Washington, DC.*

DEAR MR. CHAIRMAN: This is in response to your request for a report on S. 1869, the Indian Health Care Improvement Technical Corrections Act of 1996.

In summary, we support S. 1869, as the bill would authorize the continuation through fiscal year 2000 of five tribal health care demonstration programs that are making progress, and that may provide models for other initiatives elsewhere among Indian communities. We also recommend a minor change to provisions in the bill concerning collections from third party payers.

S. 1869 would extend through fiscal year 2000 the authorities for five Indian health care demonstration programs: the California health services demonstration program, the Medicare and Medicaid demonstration program, the Gallop alcohol and substance abuse treatment center demonstration program, the substance abuse counselor education demonstration program, and the home and community-based care demonstration program. S. 1869 would also enact a number of minor and technical provisions, including a provision that, in relation to third party payer collections, would change the term "expenses" to "charges".

The five demonstration programs are making progress in enhancing and expanding services for Indians and may serve as models for other tribes. We support continuing these demonstrations.

We recommend, however, that the term "expenses" (in relation to collections from third party payers) be retained. Because Indian health programs do not bill their patients, the use of the term "charges" would not seem to be helpful in the context of Indian health services.

We therefore recommend that bill be favorably considered, with the minor change suggested above for third party collections.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

DONNA E. SHALALA.

#### CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states that the enactment of S. 1869 will result in the following changes in 25 U.S.C. 1603(n), 25 U.S.C. 1613a(b)(3), 25 U.S.C. 1613a(b)(4), 25 U.S.C. 1613a(b)(5), 25 U.S.C. 1621e, 25 U.S.C. 1621j(g), 42 U.S.C. 1395qq note, 25 U.S.C. 1665e(d), 25 U.S.C. 1665j(h), and 25 U.S.C. 1680k(i), with existing language which is to be deleted in black brackets and the new language to be added in italic:

#### 25 U.S.C. 1603(n)

(n) "Health Profession" means *allopathic* medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychiatry, osteopathy, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, **and allied health professions** *an allied health profession, or any other health profession.*

\* \* \* \* \*

#### 25 U.S.C. 1613a(b)(3)

(3)(A) **【The active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) shall be met by a recipient of an Indian Health Scholarship by service】** *The active duty service obligation under a written contract with the Secretary under section 338A of the Public Health Service Act (42 U.S.C. 2541) that an individual has entered into under that section shall, if that individual is a recipient of an Indian Health Scholarship, be met in full-time practice, by service—*

(iii) in a program assisted under title V of this Act; **【or】**

(iv) in the private practice of the applicable profession if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, 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**【.】**; *or*

(v) *in an academic setting (including a program that receives funding under section 102, 112, or 114, or any other academic setting that the Secretary, acting through the Service, determines to be appropriate for the purposes of this clause) in which the major duties and responsibilities of the recipient are the recruitment and training of Indian health professionals in the discipline of that recipient in a manner consistent with the purpose of this title, as specified in section 101.*

*(B) At the request of any individual who has entered into a contract referred to in subparagraph (A) and who receives a degree in medicine (including osteopathic or allopathic medicine), dentistry, optometry, podiatry, or pharmacy, the Secretary shall defer the active duty service obligation of that individual under that contract, in order that such individual may complete any internship, residency, or other advanced clinical training that is required for the practice of that health profession, for an appropriate period (in years, as determined by the Secretary), subject to the following conditions:*

*(i) No period of internship, residency, or other advanced clinical training shall be counted as satisfying any period of obligated service that is required under this section.*

*(ii) The active duty service obligation of that individual shall commence not later than 90 days after the completion of that advanced clinical training (or by a date specified by the Secretary).*

*(iii) The active duty service obligation will be served in the health profession of that individual, in a manner consistent with clauses (i) through (v) of subparagraph (A).*

**[B]** *(C) A recipient of an Indian Health Scholarship may, at the election of the recipient, meet the active duty service obligation prescribed under Section 338C of the Public Health Service Act (42 U.S.C. 254m) by service in a program specified in subparagraph (A) described in subparagraph (A) by service in a program specified in that subparagraph that—*

*(i) is located on the reservation of the tribe in which the recipient is enrolled; or*

*(ii) serves the tribe in which the recipient is enrolled.*

**[C]** *(D) [Subject to subparagraph (B),] Subject to subparagraph (C), the Secretary, in making assignments of Indian Health Scholarship recipients required to meet the active duty service obligation prescribed under section 338C of the Public Health Service Act (42 U.S.C. 254m) described in subparagraph (A), shall give priority to assigning individuals to service in those programs specified in subparagraph (A) that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.*

\* \* \* \* \*

25 U.S.C. 1613a(b)(4)

**[(B) the period of obligated service specified in section 338A(f)(1)(B)(iv) of the Public Health Service Act (42 U.S.C. 254m(f)(1)(B)(iv)) shall be equal to the greater of—] (B) the period of obligated service described in paragraph (3)(A) shall be equal to the greater of—**

**(C) the amount of the monthly stipend specified in section 338A(g)(1)(B) of the Public Health Service Act [(42 U.S.C. 254m(g)(1)(B))] (42 U.S.C. 2541(g)(1)(B))**

\* \* \* \* \*

## 25 U.S.C. 1613a(b)(5)

(C) Upon the death of an individual who receives an Indian Health Scholarship, any obligation of that individual for service or payment that relates to that scholarship shall be canceled.

(D) The Secretary shall provide for the partial or total waiver or suspension of any obligation of service or payment of a recipient of an Indian Health Scholarship if the Secretary determines that—

(i) it is not possible for the recipient to meet that obligation or make that payment;

(ii) requiring that recipient to meet that obligation or make that payment would result in extreme hardship to the recipient; or

(iii) the enforcement of the requirement to meet the obligation or make the payment would be unconscionable.

(E) Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

(F) Notwithstanding any other provision of law, with respect to a recipient of an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is granted after the expiration of the 5-year period beginning on the initial date on which that payment is due, and only if the bankruptcy court finds that the nondischarge of the obligation would be unconscionable.

\* \* \* \* \*

## 25 U.S.C. 1621e

[(a) Except as provided] (a) *RIGHT OF RECOVERY*.—*Except as provided* in subsection (f), the United States, an Indian tribe, or a tribal organization shall have the right to recover [the reasonable expenses incurred] *the reasonable charges billed* by the Secretary, an Indian tribe, or a tribal organization [in providing] *for providing* health services, through the Service, an Indian tribe, or a tribal organization, to any individual to the same extent that such individual or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification [for such expenses] *for such charges* if—

(2) such individual had been required to pay [such expenses] *such charges* and did pay [such expenses] *such charges*.

[(b) Subsection (a)] (b) *RECOVERY AGAINST STATE WITH WORKERS' COMPENSATION LAWS OR NO-FAULT AUTOMOBILE ACCIDENT INSURANCE PROGRAM*.—*Subsection (a)* shall provide a right of recovery against any State only if the injury, illness, or disability, for which health services were provided is covered under—

[(c) No law] (c) *PROHIBITION OF STATE LAW OR CONTRACT PROVISION IMPEDIMENT TO RIGHT OF RECOVERY*.—*No law* of any State, or of any political subdivision of a State, and no provision of any contract entered into or renewed after the date of enactment of the Indian Health Care Amendments of 1988, shall prevent or hinder

the right of recovery of the United States, an Indian tribe, or a tribal organization under section (a).

[(d) No action] (d) *RIGHT TO DAMAGES.*—No action taken by the United States, an Indian Tribe, or a tribal organization to enforce the right of recovery provided under subsection (a) shall affect the right of any person to any damages (other than damages for the cost of health services provided by the Secretary through the Service).

[(e) The United States] (e) *INTERVENTION OR SEPARATE CIVIL ACTION.*—The United States, an Indian tribe, or a tribal organization may enforce the right of recovery provided under subsection (a) by—

[(2) instituting a separate civil action, after providing to such individual, or to the representative or heirs of such individual, notice of the intention of the United States, an Indian tribe, or a tribal organization to institute a separate civil action.] (2) *while making all reasonable efforts to provide notice of the action to the individual to whom health services are provided prior to the filing of the action, instituting a civil action.*

[(f) The United States] (f) *SERVICES COVERED UNDER A SELF-INSURANCE PLAN.*—The United States shall not have a right of recovery under this section if the illness, injury, or disability for which health services were provided is covered under a self-insurance plan funded by an Indian tribe or tribal organization.

(g) *COSTS OF ACTION.*—In any action brought to enforce this section, the court shall award any prevailing plaintiff costs, including attorneys’ fees that were reasonably incurred in that action.

(h) *RIGHT OF RECOVERY FOR FAILURE TO PROVIDE REASONABLE ASSURANCES.*—The United States, an Indian tribe, or a tribal organization shall have the right to recover damages against any fiduciary of an insurance company or employee benefit plan that is a provider referred to in subsection (a) who—

(1) *fails to provide reasonable assurances that such insurance company or employee benefit plan has funds that are sufficient to pay all benefits owed by that insurance company or employee benefit plan in its capacity as such a provider; or*

(2) *otherwise hinders or prevents recovery under subsection (a), including hindering the pursuit of any claim for a remedy that may be asserted by a beneficiary or participant covered under subsection (a) under any other applicable Federal or State law.*

\* \* \* \* \*

25 U.S.C. 1621j(g)

(g) There are authorized to be appropriated for each of the fiscal years [1993, 1994, 1995, 1996, and 1997] 1996 through 2000 such sums as may be necessary to carry out the purposes of this section.

\* \* \* \* \*

25 U.S.C. 1645(c)

(1)(D) the facility is accredited by the Joint Commission on Accreditation of Hospitals, or has submitted a plan, which has been

approved by the Secretary, for achieving such accreditation [prior to October 1, 1990] *on or before the date which is 1 year after the date of submission of the plan.*

(2) From among the qualified applicants, the Secretary shall [prior to October 1, 1989, select no more than 4] *select no more than 12 facilities to participate in the demonstration program described in subsection (a). The demonstration program described in subsection (a) shall begin by no later than October 1, 1991, and end on [September 30, 1996] September 30, 2000.*

\* \* \* \* \*

25 U.S.C. 1665e(d)

[(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated—

(1) to carry out the purposes of subsection (b)(1) of this section—

- (A) \$400,000 for fiscal year 1993;
- (B) \$400,000 for fiscal year 1994; and
- (C) \$500,000 for fiscal year 1995;

(2) to carry out the purposes of subsection (b)(2) of this section—

- (A) \$100,000 for fiscal year 1993;
- (B) \$125,000 for fiscal year 1994; and
- (C) \$150,000 for fiscal year 1995;

(3) to carry out the purposes of subsection (b)(3) of this section—

- (A) \$75,000 for fiscal year 1993;
- (B) \$85,000 for fiscal year 1994; and
- (C) \$100,000 for fiscal year 1995;

(4) to carry out the purposes of subsection (b)(4) of this section, \$150,000 for each of fiscal years 1993, 1994, and 1995; and

(5) to carry out the purposes of subsection (b)(5) of this section—

- (A) \$75,000 for fiscal year 1993;
- (B) \$90,000 for fiscal year 1994; and
- (C) \$100,000 for fiscal year 1995.]

*(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, for each of fiscal years 1996 through 2000, such sums as may be necessary to carry out subsection (b).*

\* \* \* \* \*

25 U.S.C. 1665j(h)

[There are authorized to be appropriated for each for the fiscal years 1993, 1994, 1995, 1996, and 1997] *1996 through 2000, such sums as may be necessary to carry out the purposes of this section. Such sums shall remain available until expended.*

\* \* \* \* \*

25 U.S.C. 1680k(i)

(i) ~~There are authorized to be appropriated for each of the fiscal years 1993, 1994, 1995, 1996, and 1997~~ *1996 through 2000*, such sums as may be necessary to carry out the purposes of this section. Such sums shall remain available until expended.

