ALASKA STATE LEGISLATURE
HOUSE SPECIAL COMMITTEE ON TRIBAL AFFAIRS
February 11, 2020
8:02 a.m.

MEMBERS PRESENT

Representative Tiffany Zulkosky, Chair
Representative Bryce Edgmon, Vice Chair
Representative John Lincoln
Representative Chuck Kopp
Representative Dan Ortiz
Representative Dave Talerico

MEMBERS ABSENT

Representative Sarah Vance

COMMITTEE CALENDAR

PRESENTATION: ALASKA TRIBAL HEALTH COMPACT BY NATASHA SINGH~ TANANA CHIEFS CONFERENCE

- HEARD

PREVIOUS COMMITTEE ACTION

No previous action to record

WITNESS REGISTER

NATASHA SINGH, General Counsel
Tanana Chief's Conference
Fairbanks, Alaska
POSITION STATEMENT: Offered a presentation on The Alaska Tribal Health Compact.

VERNE BOERNER, President and CEO
Alaska Native Health Board
Anchorage, Alaska
POSITION STATEMENT: Provided information and responded to questions during the presentation on The Alaska Tribal Health Compact.

ACTION NARRATIVE

8:02:25 AM

CHAIR TIFFANY ZULKOSKY called the House Special Committee on Tribal Affairs meeting to order at 8:02 a.m. Representatives Lincoln, Ortiz, Kopp, Talerico, and Edgmon were present at the call to order. Representative Vance arrived as the meeting was in progress.

PRESENTATION: ALASKA TRIBAL HEALTH COMPACT

8:03:04 AM

NATASHA SINGH, General Counsel, Tanana Chief's Conference, offered a presentation on The Alaska Tribal Health Compact (hereafter the ATHC or "the compact"). She thanked the committee for having been invited to educate the Alaska State Legislature on the history and opportunities in tribal compacting. Ms. Singh informed the committee that she is originally from Stevens Village, Alaska, but resides in Fairbanks, Alaska, where she raises her family and works for Tanana Chiefs Conference (TCC), a tribal health and social services consortium that provides services to Alaskans living in Interior villages and to tribal members living in Fairbanks.

MS. SINGH related that TCC is one of the 25 co-signers of the compact, which she stated is likely the most successful compact in the history of the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA). She explained the reason she said the ATHC is the most successful compact is because severe health disparities are being reversed for Alaska Native people in one of the most remote and rural areas of the country, and this is happening while the AHTC is suffering significant underfunding by the U.S. Congress.

MS. SINGH imparted to the committee that the Alaska Tribal Health System ("the system") is made possible because of the compact, an agreement between the federal government and the Alaska Tribal Health entities. She added that the compact is successful because tribal leaders are the decision-makers, planners, and strategists in the implementation of their own health care. She stressed that, rather than being race-based, this is a government-to-government relationship between the federal government and tribes. The reason for this, she explained, is that the compact is built on the Federal Trust Responsibility created through treaties signed with tribal governments.

MS. SINGH went on to say that before the compact, chronic underfunding, extremely rural nature of villages, and, most importantly, the absence of locally driven decision making resulted in a lack of quality provided by the Indian Health Service (IHS) [an agency of the US Department of Health and Human Services]. She added that Lower 48 tribes were also experiencing similar outcomes from IHS, so in 1988 Congress passed the ISDEAA amendments. Whereas the original ISDEAA provided the necessary authority for tribes to enter into agreements that carry out the responsibilities of the federal government, these 88 amendments addressed inflexible bureaucracy and federal inefficiencies, and increased the tribe's ability to redesign and tailor services to the specific needs of their communities.

MS. SINGH imparted to the committee that agencies and bureaucracies resist the implementation of self-determination, despite proven success, and legislative support is continually needed to fully implement the intent of the ISDEAA. She added that, soon after the amendments to the ISDEEA were passed, Alaska was offered an IHS demonstration project. Alaska tribes and health entities quickly joined together to create a multi-party compact consisting of all those that wanted to join, something that had never been done through IHS. With the support of the Alaska area IHS office and the determination of tribal leaders, the ATHC was created in 1994.

8:07:35 AM

MS. SINGH went on to say that compacting is just one choice the ISDEAA provides for self-determination; the other option being to assume operations of a federal program. Furthermore, she added that self-determination contracts require less in-depth planning to begin the tribal assumption of operations, but that those contracts also provide for less flexibility and local control over how a program is implemented.

MS. SINGH informed the committee that compacting on a federal level requires tribes to initiate a planning phase to assume operations of a federal program and to prove financial stability of the tribe. This longer process allows tribes to have more flexibility in how the programs are designed and implemented, and ultimately allows for more local control of funding and program outcomes. The true beauty of compacting, according to Ms. Singh, is the fact that tribal leaders have full authority to decide for themselves the best way to address their own health care needs. Ms. Singh emphasized that [in compacting] a

tribe is forced to be accountable for its own people. As such, TCC answers to its tribes continually throughout the year. The tribes, split into six sub-regions, are met with twice per year. Tribes are met with upon request in their own village or in Fairbanks, and all tribes are brought together to meet twice yearly.

MS. SINGH informed the committee that at all meetings tribes are able to take formal action, through resolutions or motions, to direct TCC. The tribes also contribute to and oversee implementation of TCC's strategic plan. The boss of the thousand employees at TCC is elected by the tribe and serves three-year terms: this is tribal accountability through self-determination. Through the ATHC, the health care information is owned by the tribe; therefore, practices can be changed, programs redesigned, and services, functions, and activities augmented to best fit regional needs. At a TCC meeting, she explained, if there is an issue with service delivery, tribes can explain their plan for redesign, and staff will move accordingly. If a program is not properly funded, the tribe is allowed the flexibility to reallocate funds and cobble together funding streams as the tribe sees fit. Ms. Singh mentioned that the state of Alaska could learn from this manner of conducting business.

MS. SINGH went on to say that the AHTC does have some strings attached: co-signers are obligated to provide an annual single organization-wide audit as prescribed by the Single Audit Act (SAA) of 1984. The secretary of the U.S. Department of Health and Human Services submits a report to the Senate Committee on Indian Affairs and the House Natural Resources Committee detailing the level of need that is underfunded. The boards at TCC are well educated in the audit process and take pride in the lack of findings, she added, and robust accounting divisions often include an internal auditor who triple-checks that the little money received from the federal government is spent properly. Ms. Singh let the committee know that currently there are over 25 diverse co-signers, and that financially the co-signers are also very different, ranging from small, community health aid programs under 60,000, to a large statewide medical center and environmental health program with over 2,000 employees. Co-signers, the IHS, and partners make up the ATHS, which is rooted in community and tribally driven.

8:12:17 AM

MS. SINGH informed the committee that the system consists of community clinics, sub-regional services, regional services, and statewide services and is interconnected through sophisticated patterns of referrals in its primary mission of improving the health status of Alaska Native people. As a co-signer, TCC relies on the "common" ATHC, a perpetual agreement that sets the general terms of the nation-to-nation relationship between the United States and the Alaska tribes as it relates to the implementation of health care services. All the co-signers under the compact speak with one voice when they negotiate; in order to do this, all final, common decisions affecting the ATHC, whether they regard resource distribution or others, are made through the consensus process with tribal representatives of the co-signer.

MS. SINGH added that once the co-signer agrees, a strict protocol of negotiation rules govern the annual negotiation process. The negotiations are a time when the parties are able to discuss, update, and make changes to four key documents: the ATHC itself, which is a perpetual document amended as needed, but not necessarily every year; the funding agreements, which can be multi-year or amended at each annual negotiation, and usually include a highly individualized scope of work as is common in other individual provisions; the funding tables, also known as "Appendix A" to the funding agreement, which provide the beginning funding amounts for each annual funding period, and in which funding allocations for each co-signer are re-calculated based on the approved Alaska tribal share distribution formula and co-signer selections for retained services and buy-back services from the IHS; and, last, the continuing services agreement, another sort of appendix to the funding agreement and an annual description of the scope and extent of services which will continue to be provided by the IHS office in Alaska.

8:15:18 AM

MS. SINGH said the negotiations have been built on a foundation of good faith, trust, and government-to-government relationship. The shared goals of negotiations, as well as the shared goals of the nations, according to Ms. Singh, include being prepared and sharing information early and often so parties are able to stay transparent and honest with each other, as the continued relationship between the parties is just as valuable as the outcome of the negotiations. When these rules are not enough for a successful negotiation, the ISDEAA provides for the backbone of the ATHC. With the ATHC's current language, IHS has

a clearer understanding of its legal mandates. When they do not have a clear understanding, the tribes will point them in the right direction. Because of ISDEAA, the ATHC, and the ATHS, Ms. Singh shared with the committee, smiles of children in rural Alaska are improving. Because of the dental health aid therapy program, children in rural Alaska are cavity-free.

MS. SINGH went on to say that these achievements by ATHS, made possible because of the compact, have been done without tribes and tribal health entities being required to waive their sovereign immunity. Tribes and co-signers of ATHC are deemed by ISDEEA to be a part of the public health services for purposes of coverage under the Federal Tort Claims Act (FTCA), including medical malpractice claims. Ms. Singh encouraged the Alaska Legislature to study the ISDEEA as a possible method for providing similar coverage for state compacters. Ms. Singh closed by stating that tribes are amazing entities when given the authority and trust to address their own issues.

8:18:08 AM

REPRESENTATIVE EDGMON asked Ms. Singh her thoughts on using the ISDEEA model with regard to public safety.

8:18:39 AM

MS. SINGH answered that it made sense, and referenced a report by twelfth Assistant Secretary of the Interior for Indian Affairs' Kevin Washburn, in which he determined that compacting and self-determination for public safety is the next logical step in tribal self-determination and it is how we can actually impact other social health barriers such as education and child protection.

8:19:46 AM

REPRESENTATIVE EDGMON followed up by asking whether the auditing process, with its different components of regional and sub-regional, is more involved than a normal auditing process in which there would be essentially one round.

8:20:22 AM

MS. SINGH replied that she wished she could take committee members through TCC's accounting division and administration so they could see the internal controls they have in place to protect the tribal resources and ensure that they are being used

in the proper way. She added that if it were not the federal government, the SAA, or the ISDEEA that required them to have such strict internal controls, it would be the tribe itself that would require them as such.

8:21:35 AM

CHAIR ZULKOSKY asked Ms. Singh to remind the committee what the four key documents are over which the co-signers negotiate.

8:21:52 AM

MS. SINGH replied that the compact is about 25 pages and lays out the fundamentals and what is being done for the ATHS. The actual funding agreement lays out exactly what services TCC provides to Interior Alaska, she continued, which is very different from what the Arctic Slope Native Association (ASNA) provides, because instead of having the ability to redesign programs, they lay out, in agreement form, what the services are. After all the tribes at negotiations compact the common documents, individual funding agreements are negotiated. Ms. Singh pointed out the importance of the funding tables' "Appendix A," which deals with the complex funding formulas tied to many different departments within the U.S. Department of Health and Human Services, which impact everyone differently throughout the state: TCC, she noted as an example, is one of the only regions that doesn't have a hospital.

8:24:15 AM

MS. SINGH informed the committee that TCC funding goes to Fairbanks Memorial Hospital, which serves the tribe. The funding "bucket," she continued, is very important to TCC. She added that often negotiations happen internally between tribes first, and it's a real awesome demonstration in self-determination in that tribes sit down and negotiate between themselves first, and sometimes with not much funding there isn't much disagreement over who gets the pennies, but when there is new funding available, complex negotiations take place. Ms. Singh related that the next step is to determine how funding will be distributed. Finally, there's the continuing service agreement: even though the tribes in Alaska have taken over 90 percent of the health care services, there are some residual services the Alaska area [IHS] still provides, and the continuing service agreement lays out what those are. She offered as an example the tribes' takeover of the Village Public Safety Officer Program (VPSO). There would still be some

administrative oversight that the state would provide, she acknowledged: on the IHS side is a chief medical officer who oversees the health aide certification and the manuals; that officer also sits on the board to ensure compliance on the federal side.

8:26:59 AM

REPRESENTATIVE KOPP said that he appreciated Ms. Singh's comments about compacting public safety, and that he thought the entire VPSO program budget was about $11 million dollars total within the Department of Public Safety (DPS). He asked Ms. Singh whether she knew the total value of the ATHC.

8:27:32 AM

MS. SINGH replied that she didn't know, but that the question could possibly be answered by Verne Boerner from the Alaska Native Health Board (ANHB), the next testifier, who would get into more details of economic impacts.

8:27:52 AM

REPRESENTATIVE KOPP posited that the total value of the ATHC is actually in the billions and that he was certain it could manage a $1 million dollar program.

8:28:15 AM

CHAIR ZULKOSKY said that Representative Kopp's point was well taken. She then asked Ms. Singh to revisit the portion of her statement regarding sovereign immunity with regard to the federal government's coverage of tribes and tribal consortiums' liabilities.

8:28:33 AM

MS. SINGH replied that ATHC employees are covered under the Federal Tort Claims Act (FTCA), a statute which provides tort coverage to federally employed medical providers. Because of this, she added, TCC does not need to waive their sovereign immunity. If an issue comes up and someone is questioning medical malpractice, TCC works with federal attorneys and investigators, who do a thorough review of the case file. Certain protocols must be abided by in order to keep tort coverage intact in these cases, and federal attorneys represent the tribal entities if a lawsuit arises. She added that in the

11 years she has been at TCC they have not reached this point. She then postulated that after a thorough review, the number of lawsuits would be remarkably low.

8:30:53 AM

CHAIR ZULKOSKY asked Ms. Singh to speak to the committee about the importance for Alaska tribes of keeping sovereign immunity intact and what it means in terms of recognition, and how that relationship has been able to be maintained through the ATHC.

8:31:27 AM

MS. SINGH related that, just like the state of Alaska wants to protect itself from being sued, the public interest in government is more important than a private interest in a lawsuit. Every time someone is sued, she added, it is because they have waived their sovereign immunity. It's the same with tribes: the government can't be totally torn down through an individual lawsuit. She provided the following example: there is a small grant from the state of Alaska for $100,000 for weatherization of homes. A request is made to waive immunity for all programs in order to receive said grant, and then something happens in the implementation of the grant and there is a liability lawsuit. According to Ms. Singh, it's not worth the risk, especially to a small village whose entire operation could shut down. She urged the committee to do away with the waiving of sovereign immunity in broad strokes because it's not worth it if it's for something much greater than what is being given.

8:35:09 AM

CHAIR ZULKOSKY checked that Ms. Singh was saying it came down to tribes being asked to waive a disproportionate amount of risk and responsibility for a value and return that's not providing such broad benefits to the communities that the tribes are serving.

8:35:41 AM

MS. SINGH agreed with the summary.

8:36:00 AM

VERNE BOERNER, President and CEO, Alaska Native Health Board, began by imparting to the committee that she lives in Anchorage

but that her heart and home were in Kiana, Alaska, and that she is Inupiaq and enrolled in a Native village of Kiana. Referencing Ms. Singh's presentation, Ms. Boerner mentioned the information the committee had been given regarding the work, relationships, and mechanisms of the compact, and let them know that she would provide impact information on how the compact has shaped the ATHS and its impact on the state of Alaska. The compact also had its twenty-fifth anniversary last year, showing the strength of the compact and the resilience of its member organizations to work for the betterment of all Alaska Natives and American Indians in Alaska. The compact has also strengthened the work of the ATHS, Ms. Boerner added. She imparted that Alaska tribes are unmatched nationally in the realization of the level of self-determination and self-governance.

MS. BOERNER, as Ms. Singh had pointed out, Ms. Boerner informed the committee that the 229 federally recognized tribes in Alaska operate via a single compact agreement while maintaining each tribe's and its respective tribal organization's right to exercise sovereignty and negotiate individual agreements. Ms. Boerner related that the compact's innovative system was created out of necessity to provide health care and public health services to now more than 177,000 Alaska Natives and American Indian people, and the entirety of the 229 federally recognized tribes. The ATHS, the largest health care system in the state and one of the largest in the country, is a vital part of many communities, for whom tribal health programs are the only access point of care, Ms. Boerner said, adding that many centers have become dually funded community health centers providing care to thousands of non-Alaska Natives and American Indians.

8:39:58 AM

MS. BOERNER explained that in 2012 a special relationship was forged with the Alaska Veterans Affairs (VA), extending the VA's footprint from six points of access to care to over 200, reaching across the entire state and providing access to care for Alaska veterans both Native and non-Native, many of whom had not had access to care in decades. Due to its service population and statewide reach, the ATHS represents a large part of Alaska's economy, Ms. Boerner pointed out. The ANHB commissioned an economic impact study in 2017 and found that the system was 5 percent of the entire Alaska economy. The health system is a larger sector of the economy than the retail trade, the construction industry, the professional business and technical service sector, all arts and entertainment, all

manufacturing, the information sector, utilities, and agriculture and forestry sectors.

MS. BOERNER relayed that he tribal health system generated 18,000 jobs for Alaskans and contributed a total economic output of $2.4 billion in the state, Ms. Boerner explained. This can be broken down into economic sectors, she continued: the ATHS spent approximately $63.4 million on travel and lodging alone in 2017; it also spent 64.6 million in capital expenditures that year, which is approximately one third of the proposed fiscal year 2021 (FY 21) state capital budget and was at the time about 50 percent of the FY 2018 capital budget. As a part of the APHS, the ATHS has served as a pillar for the state's economy and as a partner with the State of Alaska as it pursues policy and health care coverage. The system helps the State of Alaska provide adequate health care statewide in its most remote corners and is an active partner in the public and emergency health response system, Ms. Boerner imparted. This partnership has not only generated net economic impact for the state, but it has also helped produce massive savings to the state budget in the form of federal Medicaid offset.

8:43:04 AM

MS. BOERNER added that the ATHS has helped the state budget a total of $152 million dollars, Ms. Boerner explained. That includes savings of $72.6 million in FY 19 alone, she added. Currently the state expects to save $104 million through tribal health programs in FY 21. Because ANHB is Alaska-based, -owned, and -operated, the ATHS can work with the state to achieve these types of savings. The compact has made all of this possible through the realization of self-determination and self-governance of Alaska tribes, she reiterated. When governance is returned to the tribes and tribal leaders, they can make decisions which will produce the best outcomes for the people, something that is also true as a part of the Federal Trust Responsibility, which underpins the ATHC.

MS. BOERNER surmised that with nearly half the tribes in the United States [in Alaska], if the State of Alaska would embrace the sovereignty of the tribes as partners, much could be done to benefit from the Federal Trust Responsibility. The health board's partnership with the state is already yielding substantial savings for the state as a whole, and the tribes have proven to be good stewards of the board's resources. Tribes in Alaska have the largest businesses in the state, are the largest and best employer, and have designed national,

award-winning, and internationally recognized programs, said Ms. Boerner. She wrapped up by adding that the ATHS invests in Alaskans and in Alaska.

8:45:19 AM

REPRESENTATIVE EDGMON asked Ms. Boerner to speak about the compliance aspect with which the health care system is involved, with specific attention to the audits.

8:46:32 AM

MS. BOERNER replied that there are a number of different ways in which compliance issues are measured, and that many of the board's systems are dually funded and have multiple funding sources. The various funding sources also have different requirements, she added, so many board facilities are also community health centers which go through an accreditation process and have to meet reporting requirements in order to be become eligible to receive the funding. Some tribal health organizations have to do as many as six different types of audits and reporting in a year. Ms. Boerner said the board has been working with the federal government to try to streamline some of the reporting requirements, but the board's programs are well documented and reported on as far as compliance issues are concerned.

8:48:08 AM

REPRESENTATIVE EDGMON replied that, being a member of a tribe himself, he was intrigued that there are the normal channels of compliance through government regulators, but also the compliance of measuring up to what the people expect. He added that the latter level of compliance, informal as it might be, could easily be at the top of the list: being answerable to the people is a really important connection.

8:48:50 AM

MS. BOERNER answered Representative Edgmon that she agreed completely; the most stringent and selective compliance requirement does come through the people, and that is one of the beauties of self-determination and self-governance.

8:49:22 AM

CHAIR ZULKOSKY asked Ms. Boerner to speak to how cost savings are realized; not in terms of displacement of particular line items of state or federal spending, but how the compact has been able to improve outcomes as well as save dollars.

8:50:33 AM

MS. BOERNER stated that the numbers she gave are actual numbers of the portion that the federal government reimburses the state through the Medicaid program. For services provided to tribal members through the ATHS, the state is able to claim 100 percent of those costs and be reimbursed fully by the state. She imparted that there are also a number of other cost savings that come from developing a statewide system like the ATHS given the vastness of Alaska: being able to establish referral patterns and relationships and developing telehealth. The system as a whole is able to benefit from economies of scale, she added. One great example of the benefits and the savings to the state, she imparted, is the relationship with the Alaska VA, which started in 2012. Prior to 2012, veterans had six points of access to care in the state and they were largely centered in urban areas; much of the state was not covered and veterans were not able to access care.

MS. BOERNER explained that after the tribal share agreements were entered into, the VA extended its footprint all across the state to over 200 facilities and for the first time in decades veterans, Native and non-Native alike, were able to access care. The board was working with the VA to help encourage enrollment of benefits: there are an estimated 70,000 to 90,000 veterans in the state of Alaska and only about 35,000 of those have enrolled with the VA, Ms. Boerner shared. This is another economic driver in being able to provide these services within the state as opposed to sending veterans out of state for care, she added.

8:53:42 AM

REPRESENTATIVE LINCOLN asked Ms. Boerner to highlight any programs or technological innovations that took place within tribal health.

8:54:08 AM

MS. BOERNER replied that she would highlight the development of the community health aide program. She related that her own grandmother was one of the first-generation community health

aides in the state, and that that program has allowed community members to be trained and provide culturally relevant care to communities across the state, even in the smallest villages. The health aide program is currently being implemented in the Lower 48, she added, and is an evidence-based program that shows and demonstrates that community members are able to get access to care and interventions earlier. The model has been utilized in other parts of the world and was a precursor to the dental health aide therapist program that was implemented and designed in New Zealand following the community health aide program that was also brought home to Alaska.

MS. BOERNER said from this same model, the behavioral health aide program has also been developed. Alaska and the tribal health system have been leaders in developing telehealth across the nation, she went on to say, and partnerships with the Federal Communications Commission (FCC) extend access to care via telehealth visits, which save $850 per visit. Award-winning programs such as the Nuka System of Care (also known as "Nuka") have also been highlighted and implemented in the Lower 48 with other tribes. The National Health System (NHS) in the United Kingdom has also shown interest in Nuka.

8:58:18 AM

CHAIR ZULKOSKY asked Ms. Boerner to speak to the ground rules aspect when it came to establishing such a successful compact.

8:59:22 AM

MS. BOERNER replied that the agreements between the tribes are a product of many, many hours of work and negotiations between the tribes, and that ground rules come from a basis of consensus. Early on in the negotiations process, tribes would remain together into the wee hours of the morning and just have enough time to return to their lodgings and shower and come back to the table to continue the process, she explained. Putting the 229 tribes together in unison speaking with the federal government really lifts the voice together, she added.

9:01:45 AM

MS. SINGH advised that ground rules are important because process is important. Because TCC relies so heavily on the IHS to provide information and updates, it's very important that all deliver their summation in a timely manner, she explained. When

ground rules were developed, an improvement in process was seen, she added.

9:04:08 AM

REPRESENTATIVE LINCOLN said that if he remembered correctly, the federal government initially was going to contract with a limited number of tribal organizations in the state, but the tribal community throughout the state came together and said that rather than just work with one or two tribes they should all work together and use that one opportunity to grow that into one compact instead.

9:04:47 AM

MS. SINGH confirmed this and said TCC was offered by IHS one agreement in the state of Alaska. Even though a compact had never been done before, it made more sense than fighting over it. Being able to visit other IHS regions around the country and the challenges they face not being within a larger tribal system, she explained, confirmed that the decision by going with one compact was the right one, and that progress has come out of the unification.

9:06:41 AM

MS. BOERNER added that one other benefit to having the single compact is the fact that by having it, the board is able to create institutional memory. Ms. Boerner related anecdotally that a tribe in Arizona had made some inroads but not as swiftly as were made by the tribes in the compact due to the Arizona tribe's multiple changes in leadership. Institutional memory survives various changes in governance itself, she added.

9:08:19 AM

REPRESENTATIVE KOPP remarked that every tribe is able to do an individual compact under the law, but he wondered whether it had happened anywhere else.

9:10:10 AM

MS. BOERNER replied that there have been some great collaborative efforts throughout the Lower 48 but not a single compact. The Northwest Portland Area Indian Health Board (NPAIHB) has 46 federally recognized tribes in Washington, Oregon, and Idaho; they have created the NPAIHB and have been

able to put forward as a tribal organization a unified position on various health issues affecting those 46 federally recognized tribes, but it's not the same as in the compact, as each NPAIHB tribe enters into its own separate compact with the federal government, whereas the ATHC speaks as one voice.

9:11:47 AM

CHAIR ZULKOSKY summed up that effectively, Alaska is the only state in the nation with both the tribal representation and the economic impact, and the scopes have worked in the size and breadth and complexity of its type within the compact in the country.

9:12:10 AM

MS. BOERNER agreed with this summation.

9:12:57 AM

ADJOURNMENT

There being no further business before the committee, the House Special Committee on Tribal Affairs meeting was adjourned at 9:13 a.m.