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The Northwest Portland Area Indian Health Board

Before:

House Subcommittee on Interior, Environment, and Related Agencies
Public Witness Hearing

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Established in 1972, NPAIHB is a P.L. 93-638 tribal organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health care issues. Over the past twenty-one years, our Board has conducted a detailed analysis of the Indian Health Service (IHS) budget. It is used by the Congress, the Administration, and national Indian health advocates to develop recommendations on the IHS budget. It is indeed an honor to present you with our recommendations.

Indian Health Disparities

The Indian Health Care Improvement Act (IHCIA) includes a declaration of national Indian health policy for the Congress and this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians, to ensure that the highest possible health status for Indians is achieved and to provide all resources necessary to effect this policy.[1] This declaration recognizes that Congress has a duty to elevate the health status of American Indian and Alaska Native (AI/AN) people to parity with the general U.S. population and to provide the resources necessary to do so.

While there has been success at reducing the burden of certain health disparities, evidence continues to document that other types of diseases are on the rise for Indian people.[2] An analysis of Medicaid data in Washington State indicates that infant mortality among AI/ANs was twice the rate for the Medicaid population as a whole. Compared to the rest of the world, the AI/AN infant mortality rate was higher in Washington State than in Poland, Slovakia, Estonia, Malaysia, Thailand, and Sri Lanka. Contributing factors included deaths due to Sudden Infant Death Syndrome (SIDS) at a rate 3 times higher among Indians compared to the total Medicaid population, deaths due to injuries at a rate 5 times higher among Indians, and a rate of deaths from complications of pregnancy and delivery 50 percent higher than the total Medicaid population.

Medicaid data from Washington State also provided an analysis of the risk factors that lead to poor pregnancy outcomes. Compared to all pregnant women on Medicaid, Indian pregnant women were 2.7 times more likely to have a mental health diagnosis, 3.3 times the rate of alcohol and substance abuse, a 70 percent higher rate of smoking, and a 30 percent higher rate of obesity. According to the most recent reports from IHS, AI/ANs die at higher rates than other Americans from tuberculosis (500 percent higher), alcoholism (514 percent higher), diabetes

[1] 25 USC § 1601
[2] Please note findings in, *The Health of Washington State: A Statewide Assessment of Health Status, Health Risks, and Health Care Services*, December 2007. Available: http://www.doh.wa.gov/hws/HWS2007.htm.

(177 percent higher), unintentional injuries (140 percent higher), homicide (92 percent higher) and suicide (82 percent higher).[3] A number of factors contribute to persistent disparities in AI/AN health status. AI/ANs have the highest rates of poverty in America, accompanied by high unemployment rates, lower education levels, poor housing, lack of transportation and geographic isolation. All of these factors contribute to insufficient access to health services.

Most important for this Subcommittee, is that historic and persistent under-funding of the Indian healthcare system has resulted in problems with access to care, and has limited the ability of the Indian healthcare system to provide the full range of medications and services that would prevent or reduce the complications of health disparities. This is why our recommendations are so important to the work of this Subcommittee.

Per Capita Spending Comparisons

The most significant trend in the financing of Indian health over the past ten years has been the stagnation of the IHS budget. With exception of a notable increase of 9.2% in FY 2001 and last year's 14% increase, the IHS budget has not received adequate increases to maintain the costs of current services (inflation, population growth, and pay act increases). The consequence of this is that the IHS budget is diminished and its purchasing power has continually been eroded over the years. As an example, in FY 2011, we estimated that it would take at least $474 million to maintain current services[4]. The final appropriation for the IHS was a mere $16.5 million increase, falling short by $454 million. This meant that Tribes had to absorb unfunded inflation and population growth by cutting health services. The IHS Federal Disparity Index (FDI) is often used to cite the level of funding for the Indian health system relative to its total need. The FDI compares actual health care costs for an IHS beneficiary to those costs of a beneficiary served in mainstream America. The FDI uses actuarial methods that control for age, sex, and health status to price health benefits for Indian people using the Federal Employee Health Benefits (FEHB) plan, which is then used to make per capita health expenditure comparisons. It is estimated by the FDI, that the IHS system is funded at less than 60 percent of its total need.[5] The Tribal Needs Based Budget estimates that $26 billion would fully fund the health care needs of Indian people through the IHS budget.

Recommendation No. 1: NPAIHB recommends that Congress restore the $228 million sequestration to the IHS appropriation in FY 2014.

The Budget Control Act of 2011 (BCA) established procedures designed to reduce the federal budget deficit. The BCA triggers a sequestration of discretionary and mandatory spending since the Joint Select Committee on Deficit Reduction and Congress failed to enact legislation to reduce the deficit. This has triggered automatic spending reductions, which include a sequestration of discretionary spending through FY 2021. The BCA includes references to requirements in the Balanced Budget and Emergency Control Act of 1985 (BBECA or P.L. 99-177), at Section 256, "Exceptions, Limitations, and Special Rules," which establishes limitations

[3] Website http://www.ihs.gov/Public Affairs/IHSBrochure/Disparities.asp. AI/AN data from 2004-2006 are compared with U.S. All Races data for 2005.
[4] FY 2011 IHS Budget Analysis & Recommendations, Northwest Portland Area Indian Health Board, March 12, 2010; available: www.npaihb.org.
[5] Level of Need Workgroup Report, Indian Health Service, available: www.ihs.gov.

on the amount of funds that can be sequestered for certain programs (Subsection 256(k)). This section stipulates that IHS health services and facilities funds can be sequestered at no more than 2 percent.

However when the sequestration was carried out, OMB and Congress both interpreted that the IHS appropriation was subject to a full sequestration and that Subsection 256(k) did not apply. This resulted in a $228 million reduction to the IHS appropriation. Both the Administration and Congress have indicated that they believed the IHS appropriation was protected from a full sequestration and could only be reduced by the 2 percent cap contained in Subsection 256(k).

It is the position of Northwest Tribes that this was a drafting error and unintended consequence. Other federal health care programs were protected up to a 2 percent sequestration in accordance with Subsection 256(k). It does not make sense to have a similar protection not apply to the IHS appropriation. IHS also provides expensive and vital health care services. Most importantly, we emphasize that while deficit reduction may be targeted at discretionary spending and recognize that the IHS appropriation falls into this funding classification however, IHS funding is not "discretionary" by its mere nature. This funding is provided in recognition of the United States federal trust responsibility to fulfill treaty obligations. To sequester this funding abrogates Congress' legal and moral responsibility under the federal trust relationship.

Recommendation No. 2: Maintain Current Services by Funding Inflation & Population Growth

The fundamental budget principle for Northwest Tribes is that the basic health care program must be preserved by the President's budget request and Congress. Preserving the IHS base program by funding the current level of health services should be a fundamental budget principle of Congress. Otherwise, how can unmet needs ever be addressed if the existing program is not maintained? Current services estimates' calculate mandatory costs increases necessary to maintain the current level of care. These "mandatories" are unavoidable and include medical and general inflation, federal and tribal pay act increases, population growth, and contract support costs.

Inflation and population growth alone using actual rates of medical inflation extrapolated from the Consumer Price Index (CPI) and IHS user population growth predict that at least $302 million will be needed to maintain current services in FY 2014. Compound this with the fact that $77 million of the President's proposed $124 million increase is directed at staffing ten new facilities, will only leave $47 million to cover current services. The President's request will fall short by $255 million.

Recommendation No. 3: Fully fund IHS Contract Support Costs

NPAIHB recommends that Congress fully fund IHS CSC in FY 2014. The choice of tribes to operate their own health care systems and their ability to be successful in this endeavor depends upon the availability of CSC funding to cover fixed costs. Without full funding, tribes are forced to reduce direct services in order to cover the CSC shortfall. Adequate CSC funding assures that tribes, under the authority of their Self-Determination Act contracts and Self-Governance compacts with IHS, have the resources necessary to administer and deliver the highest quality health care services to their members without sacrificing program services and funding. Most

importantly, full funding of contract support costs is a contract obligation that the federal government must honor by law. The total amount required to fully cover contract support cost requirements in FY 2014 was estimated to be $617 million in December of 2012 by the National Tribal Contract Support Costs Coalition."

NPAIHB also notes that the IHS FY 2014 Congressional Justification proposes damaging language on contract support costs that is intended to cap contract support cost (CSC) payments to Tribes and tribal organizations. This is a radical and unfortunate reaction to a recent court decision. The proposed language by the Administration is intended to block Tribes and tribal organizations from pursuing any contract claims for underpayments which occur next year. The proposal makes reference to a "table" that has been submitted to the appropriations committees showing each Tribe's and tribal organization's capped amount of CSC for 2014. The tables have not been disclosed with Tribe nor included any form of Tribal consultation. This proposed policy is inconsistent with the President's Executive Order on Tribal Consultation and in violation of the IHS own Tribal Consultation policy.

Thus, we respectfully request that the Subcommittee reject the recommended changes by IHS until the Agency and Administration have consulted with Tribes about the proposed changes. We further recommend that the Subcommittee coordinate with House Resources Subcommittee on Indian and Alaska Native Affair to convene an oversight hearing on contract support cost issues to address future CSC funding issues in light of the recent *Ramah* decision.

Recommendation No. 4: Halt facilities construction as a deficit reduction strategy

The NPAIHB recommends that the Subcommittee place a moratorium on facilities construction funding including staffing packages for new constructed facilities. The Subcommittee must recognize that when new facilities are constructed it carries a liability for a staffing package that must be funded annually. The inequity of facilities construction funding is that it provides a disproportionate share of funding to a few select Tribal communities. The significance of facilities funding, both for construction and staffing new facilities, is that it removes funds necessary to maintain current services (pay costs, inflation, and population growth) from the IHS budget increase. While Congress undergoes deficit reduction and the Administration sequestration, it is not appropriate to take valuable health care resources to build and staff new facilities at a select few Tribal communities while health services must be reduced to absorb budget cuts. It is more appropriate to maintain the current health care program by directing this funding to fund inflation and population growth in all health care programs.

Thank you for this opportunity to provide our recommendations on the FY 2014 IHS budget. I am happy to respond to any questions from the Subcommittee.

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