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Before:

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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. The Act states that in fulfillment of the United States' special trust responsibilities and legal obligations to Indians—and to ensure the highest possible health status for Indians is achieved—that the Nation will 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 chronic liver disease and cirrhosis (368% higher), diabetes mellitus (177% higher),

[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.

unintentional injuries (138% higher), assault/homicide (82% higher), intentional self-harm/suicide (65% higher), and chronic lower respiratory diseases (59% 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.

Per Capita Spending Comparisons

Most important for this Subcommittee, is that chronic under-funding of the Indian healthcare system relative to its total needs has resulted in problems with access to care and 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. With exception in FY 2001 and FY 2010, the IHS budget has never 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, NPAIHB 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 provide adequate increases to restore the $227 million lost because of 2013 sequestration and rescission.

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 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.

[3] "Mortality Disparity Rates: AI/AN in the IHS Service Area, 2006-2008 and US All Races Data for 2007," available at: http://www.ihs.gov/Public Affairs/IHSBrochure/Disparities.asp, accessed March 15, 2014.
[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.

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 $223 million for Inflation, Pay Costs, and 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 $223 million will be needed to maintain current services in FY 2015. The President's proposed increase for current services is only $65 million. The budget falls short by over $158 million to fund current services. The impact of phasing in new health facilities continues to have a negative effect on the ability to maintain current services. The FY 2015 budget will take $70 million of the President's proposed $199 million increase. The Mental Health account will actually lose funding due to the impact of phasing in new facility staff and funding new tribes.

Recommendation No. 3: Continue to fund and require the Administration to fully fund IHS Contract Support Cost payments to Tribes.

NPAIHB commends the work of the Subcommittee to assist Tribes to get the Administration to fully fund CSC payments to Tribes. Thank you for your help on this very important matter. CSC funds assist us to administer programs, provide jobs and services in our communities. When CSC requirements are not funded, Tribes are forced to absorb these costs by cutting services or using their own resources that displace funds for other program purposes. The policy requiring the Administration to fully fund CSC is only one year old and Tribes are cautious that this will be permanent and that the Administration will pursue a statutory change to obviate this

requirement. We urge the Committee to make sure that the Administration obeys the law and continues to pay full CSC payments.

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

The NPAIHB recommends that the Subcommittee place a moratorium on facilities construction i 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.

Recommendation No. 5: If funded change the IHS facilities funding priorities of the Opportunity, Growth, and Security Initiative.

The FY 2015 budget includes a request for an additional $200 million for projects on the IHS Health Care Facilities Construction (HCFC) priority list. Portland Area Tribes support the additional funding for facilities related projects however do not support that Congress nor the Administration provide this funding for HCFC priority list projects. The President's FY 2015 budget is titled "Opportunity for All" and it discusses how "inequalities in America have deepened" and because of this "upward mobility stalled." These inequities are the exact reason why funding should not be put into a facilities construction process that will only benefit two or three construction projects. Rather funding should be provided into programs and services that will promote economic growth and opportunity for all of Indian Country.

The controversy and unfairness of the IHS facility construction program are well documented by many tribes. The American Recovery and Reinvestment Act (ARRA) of 2009 provided $500 million in economic stimulus for Indian Country. Unfortunately, almost one-half ($227 million) of the funds were provided to only two projects on Priority System. Tribes objected to this decision by IHS and complained at hearings before this Subcommittee. Important to note about the ARRA funding is that $100 million was allocated to maintenance and improvement projects. The result of this was that funding spread equally across all twelve IHS Areas and a sizeable number of tribes in the United States benefitted and received funding from this allocation.

If Congress provides the $200 million for facilities related projects, NPAIHB recommends that HHS and IHS direct the funding to reduce the Backlog of Essential Maintenance, Alteration and Repair (BEMAR). This need is currently estimated at over $462 million for all IHS and reporting Tribal facilities.

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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