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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 the recommendations from our "Twenty-second Annual Budget Analysis and Recommendations Report.'

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. 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), 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

[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.
[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.

housing, lack of transportation and geographic isolation. All of these factors contribute to insufficient access to health services.

Per Capita Spending Comparisons

The 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. The consequence of this is that the IHS budget is diminished and its purchasing power has continually been eroded over the years. 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.[4]

Analysis of the President's FY 2016 IHS Budget Request

The President's proposed increase of $461 million is a respectful increase. The request will go a long way to restore the $217 million that was lost in FY 2013 budget sequester. Unfortunately the distribution of the increase among the sub-sub accounts will not allow enough funding for inflation, population growth, or contract support cost requirements. Northwest Tribes caution the Committee to not be duped by the Trojan horse (a substantial budget increase) and lose sight of the real issue in this budget request—and that is the allocation of the $461 million among the sub-sub accounts. NPAIHB estimates that it will take $297.2 million to fund inflation and population costs for IHS programs. While there is adequate funding to provide for inflation and population growth in the President's budget, the Administration only requests $147.3 million for these costs. This means that after $313 million is funded for proposed program expansion, Tribes will have to absorb over $149 million in unfunded inflation and population growth. This will result in Tribes cutting services to absorb these costs.

Recommendation No. 1: Maintain Current Services by funding $297 million for Inflation, Pay Costs, and Population Growth

Portland Area Tribes recommend that the $100 million increase requested for health facilities construction be reallocated to cover the true costs of current services. 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.

[4] Level of Need Workgroup Report, Indian Health Service, available: www.ihs.gov.

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 $297 million will be needed to maintain current services in FY 2016. The President's proposed increase for current services is only $147 million. The budget falls short by over $150 million to fund current services. Yet there are adequate resources within the President's request to do so. The impact of building new health facilities and staffing continue to have a negative effect on the ability to maintain current services. The facilities costs in the President's FY 2016 budget will take over 44% of the proposed $461 million increase. It calls the question, "why do we build and fund new facilities when we cannot take care of the programs we have?" We recommend that Congress redirect these resources to help maintain the current health care program.

Recommendation No. 2: If Congress funds health facilities construction it should do so to maximize taxpayer resources and provide equal opportunities for Tribes to participate in the facilities construction program.

Ideally, the Subcommittee should place a moratorium on IHS facilities construction process 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 on a recurring basis. 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. It has been over 15 years since the Interior Appropriations Committee directed the IHS to revamp its facilities construction priority system. However the IHS has ignored this request and never provided an updated facilities construction priority system. The Agency has ignored Congress on this issue. We urge the Subcommittee to request the IHS to release its revised priority system and to request funding so that all Tribes have some opportunity to apply for facilities construction resources.

We recommend that the Subcommittee include $20 million in FY 2016 for the Small Ambulatory Program.

We recommend that the Subcommittee include $20 million for an Area Distribution Fund in FY 2016.

Recommendation No. 3: Provide the Purchased and Referred Care (PRC) program an increase of $100 million.

The Subcommittee's support to the PRC program over the last four years has been generous and is without a doubt of historic significance in its potential to make a positive impact on the health of AI/AN people. Past year's increases have had a very positive impact for Portland Area PRC programs. PRC is the most important budget line item for Northwest Tribes. In FY 2013, there were over 73,000 deferred services that were within the PRC medical priorities but had to be deferred due to insufficient PRC funding. These deferred services are estimated to cost over $322 million. In addition, there were over 42,000 denied services (estimated to be $186 million) because they were not within the PRC medical priorities. Clearly additional resources are needed for the PRC program. NPAIHB recommends an increase of $100 million in FY 2016 for the PRC program.

Recommendation No. 4: We recommend the Subcommittee continue to require the IHS to fully fund contract support costs (CSC) and work with Tribes and the Administration to authorize CSC payments on a mandatory basis.

NPAIHB acknowledges and thanks the Subcommittee to work for its with Tribes to get the Administration to fully pay CSC payments on Indian Self-Determination contracts and compacts. CSC funds assist us to administer programs and 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 President's budget request includes a proposal that Congress establish a mandatory appropriation for contract support costs. The proposal requests a three-year mandatory appropriation at stated dollar amounts for IHS with up to 2% of the sums so designated to be available for IHS' administrative activities. The President's Budget also proposes that this measure go into effect beginning in FY 2017. NPAIHB wants to notify the Subcommittee that our Portland Area Tribes are very supportive of the Administration's proposal with exception of the 2% set-aside for IHS' administrative activities. We believe there are alternatives for the IHS to cover these administrative costs.

Until the IHS, Tribes, and the Congress can finalize the details of the Administration's proposal to authorize CSC payments on a mandatory basis, we request the Subcommittee to continue to require the Administration to obey the law and continue to pay full CSC payments in FY 2016 consistent with recent Supreme Court decisions and congressional action.

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