Northwest Portland Area Indian Health Board
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Testimony of Chairman Andrew Joseph, Jr.
The Northwest Portland Area Indian Health Board

Before:

House Appropriations Subcommittee on Interior, Environment, and Related Agencies
Public Witness Hearing
May 9, 2018

Good morning Chairman Calvert, Ranking Member McCollum, and Members of the Subcommittee. My name is Andy Joseph, Jr., and I serve on the Colville Business Council, as Co-Chair of the IHS National Tribal Budget Formulation Workgroup, and as Chairman of the Northwest Portland Area Indian Health Board. On behalf of the 43 Federally-recognized Tribes that the NPAIHB represents, I thank you for this opportunity to provide testimony on the President's proposed FY 2019 Indian Health Service (IHS) budget to the Subcommittee and to address the $368 million decrease (-7.6%) for services and facilities (excluding mandatory contract support costs), below FY 2018 enacted level.[1]

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 353,000 American Indian and Alaska Native (AI/AN) people reside in Idaho, Oregon, and Washington, representing 6.8% of the nation's AI/AN population. Over the past twenty-eight years, our Board has conducted a detailed analysis of the Indian Health Service (IHS) budget. Our analysis has been a resource for 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) declares our Nation's policy is to elevate the health status of the American Indian/Alaska Native (AI/AN or Indian) people to a level at parity with the general U.S. population. Over the last thirty-five years the IHS and Tribes have made great strides to improve the health status of Indian people through the development of preventative, primary care, and community-based public health services. Examples are seen in the reductions of certain health problems for AI/AN between 1972-1974 and 2007-2009: maternal mortality reduced by 19 percent, infant mortality rate reduced by 67 percent and age-adjusted death rate for all causes of death between 1972-1974 and 2007-2009 decreased 52 percent.[2] While Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that many diseases continue to impact Indian people. For example, national data for Indian people compared to the U.S. all races rates indicate they are 520 percent more likely to die from alcoholism, 450 percent greater to die from tuberculosis, 368 more likely to die from chronic liver disease and cirrhosis, 177 percent greater to die from diabetes complications, 60 percent greater to die from suicide, and 37 percent more likely to die from pneumonia and influenza.[3] These data document the fact that despite the considerable gains that

[1] NPAIHB analysis of President's FY 2019 budget excludes inclusion of mandatory Special Diabetes Program for Indians to discretionary funding as Northwest Tribes are in opposition to this proposed change.
[2] Trends in Indian Health, 2014 Edition, Indian Health Service, available at: https://www.ihs.gov/dps/publications/trends2014/.
[3] Ibid.

Tribes have made at addressing health disparities more must be done to ameliorate these health disparities.

Recommendation: Maintain Current Services and Commit to Full Funding in 12 Years

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 basic budget principle by Congress. Otherwise, unmet needs will never be addressed. 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, and population growth. Northwest Tribes appreciate that contract support costs are now fully funded.

In FY 2018, IHS received an overall increase of $498 million or 10% over FY 2017 enacted level. The President's request in FY 2019 proposes an overall decrease of $264 million (-4.8%) to IHS, or $368 million (-7.6%) for services and facilities (excluding contract support costs). Unfortunately, IHS and Tribal health programs will suffer consequences if IHS is not funded at FY 2018 levels with inflation, population growth and pay act increases. Any proposals to curtail discretionary spending will have a severe effect on IHS and Tribal programs if they are not adequately funded. Respectfully, we request that the Subcommittee recommend that IHS and Tribal health programs be exempt from any reductions in discretionary spending. This request should be honored in recognition of the trust and treaty obligations that the United States has to provide health care to Indian people. It is further compelling when one considers the severe health disparities that AI/AN people suffer.

Per Capita Spending Comparisons

The most significant trend in the financing of Indian health in nearly twenty years has been the stagnation of the IHS budget. With the exception of a few notable increases, 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 2016, Purchased and Referred Care Services (PRC) received level funding (a zero increase at our estimated loss of $46 million), and in FY 2017, we estimated that it would take at least $437 million to maintain current services. The final appropriation for FY 2017 for the IHS was a $150 million increase for services and facilities (excluding contract support costs), falling short by $287 million. This means that Tribes had to absorb unfunded inflation and population growth by cutting health services.[4]

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. It is estimated by the FDI, that the IHS system is funded at less than 60 percent of its total need.[5] The IHS Tribal Budget Formulation Workgroup has estimated this to be even higher when considering that full funding for IHS is projected at over $32 million.[6]

[4] NPAIHB Indian Health Service Budget: Analysis and Recommendations for FY 2016, FY 2017 and FY 2018, available at: http://www.npaihb.org/resource-lib/.
[5] Level of Need Workgroup Report, Indian Health Service, available: www.ihs.gov.
[6] IHS Tribal Budget Formulation Workgroup Recommendations, available at: https://www.nihb.org/legislative/budget_formulation.php

FY 2019 IHS Budget Recommendations

The NPAIHB recommends an increase of $268 million to cover inflation and population growth above FY 2018 enacted level for services and facilities (excluding contract support costs). In addition, NPAIHB strongly opposes the President's proposal to eliminate funding for Community Health Representatives (CHRs), Health Education, and Tribal Management Grants; and cuts to Indian Health Professions and Self-Governance funding (NPAIHB Resolution 18-03-08) as cuts to any of these programs would be devastating to Northwest Tribes. For example, CHRs provide critical services to our most vulnerable tribal members and loss of this funding would create a permanent loss of capacity and ability to care for those most in need in our communities; and prevention through Health Education funding is vital for young children to elders to entire communities and loss of this funding could reverse the progress that has been made in our communities. In addition, given the recruitment and retention issues of health care providers in many of our tribal communities, Northwest Tribes passed a resolution supporting an increase for IHS Indian Health Professions to fully fund scholarships for all qualified applicants to the IHS Scholarship Program and to support the Loan Repayment Program to fund all physicians, nurse practitioners, physician's assistants, nurses and other direct care practitioners (NPAIHB Resolution18-03-07). These programs must be funded in FY 2019 at FY 2018 levels and with inflation and population growth increases.

NPAIHB also opposes the President's FY 2019 budget request to move the Special Diabetes Program for Indians (SDPI) out of mandatory funding and into discretionary funding (NPAIHB resolution 18-03-06). There are 40 successful SDPI programs in the Northwest serving AI/ANs in the Portland Area with consistent positive clinical and community outcomes. A change from mandatory to discretionary could lessen SDPI as a priority compared to other IHS programs leading to decreased funding and program instability. For these reasons, NPAIHB supports continued mandatory funding for SDPI to uphold the trust responsibility and treaty obligations between the United States and Tribes. We also respectfully request that permanent authorization be considered with an increase to $250 million annually and with medical inflation rate increases thereafter.

NPAIHB also supports program increases of $300 million over FY 2018 levels: PRC/CHEF at $50 million (also, see #1 below); dental health at $20 million; mental health at $25 million; alcohol and substance abuse at $150 million to address the opioid crisis (also, see #2 below); sanitation facilities construction of $10 million; maintenance & improvement at $10 million; small ambulatory facilities at $25 million; and urban Indian health program at $10 million.

Lastly, we ask for fulfillment of the trust and treaty obligations of the United States to Tribes and respectfully urge Congress to fully fund IHS pursuant to the FY 2019 recommendation of the IHS Tribal Budget Formulation Workgroup (Workgroup). The Workgroup requested $32 billion phased in over 12 years with an initial budget increase of 33% to get IHS on the 12-year track for full funding.[7]

Additional Recommendations:

1. NPAIHB recommends that an additional $50 million be provided for Purchased and Referred Care (PRC). The PRC program is extremely important for Northwest Tribes since the Portland Area does not have any hospitals and must rely on the PRC program for all specialty

[7] Ibid.

and inpatient care. Other parts of the IHS system have access to hospitals for specialty and inpatient care. Because of this, the PRC program makes up over one-third of the Portland Area budget and when less than adequate inflation and population growth increases are provided, Northwest Tribes are forced to cut health services to absorb these mandatory costs. The level funding in FY 2016 of PRC diminished the purchasing power of Northwest Tribes. Those IHS areas that have inpatient care can absorb PRC funding shortfalls more easily than PRC dependent areas with their larger size staffing packages and infrastructure.[8]

2. NPAIHB supports the President's request of $150 million for FY 2019 for the IHS Tribal Opioid Prevention, Treatment, and Recovery Support (Tribal Opioid Support) from the $10 billion to HHS; however, there should be a multi-year commitment to address this crisis at $150 million with inflation and population growth increases. AI/ANs in the Portland Area (Idaho, Oregon, and Washington) are two times more likely to fatally overdose on prescription painkillers compared to non-Hispanic Whites in the region. Northwest Tribes have voiced the need for more direct funding and resources to address this crisis. Tribes need a comprehensive approach to address the epidemic; however, these funds must be available to all Tribes without the burden of a competitive grant process. Smaller Tribes are often at a disadvantage and cannot compete with larger Tribes with larger staff and lack resources to apply for grants so the application process must ensure that need is truly the focus. Funding must also be available to Tribal Epidemiology Centers for data and surveillance of the opioid crisis.

3. NPAIHB recommends phased in funding to add new Hepatitis C drugs to IHS formulary. It is estimated that there are at least 40,000 AI/AN people with a current Hepatitis C infection, according to the National Data Warehouse. Our Tribes support a "Treat All" policy. Under this policy, the cost of overall treatment for all AI/AN people with Hepatitis C will be $680 million -1.6 billion (depending on a price of $17,000 per treatment course), $50 million is programming (infrastructure/training/coordination). This policy would eventually accrue a lifetime cost of $0 (with 0 patients left untreated at a cost of $200,000/lifetime/individual) and provide $8 billion in cost savings (treatment of 40,000 patients at a cost savings of $200,000/lifetime/individual). The Veterans Administration has made these drugs available for veterans with Hepatitis C. IHS should be funded at $95 million in 2019, $180 million in 2020 and $170 million in 2021; projecting treatment of 1,500 people in 2019, 2,800 people in 2020 and 2,650 people in 2021, respectively.

We understand that our recommendations may seem excessive in the current fiscal environment, however when you consider the significant health needs of Indian Country they are realistic. We hope that you will be able to fund our recommendations and look forward to working with the Subcommittee on our request.

Thank you for this opportunity to provide our recommendations on the FY 2019 IHS budget. I invite you to visit Portland Area tribes to learn more about the utilization of IHS funding and health care needs in our Area. I am happy to respond to any questions from the Subcommittee.[9]

[8] Portland Area Facilities Advisory Committee has recommended construction of a demonstration Regional Specialty Care Referral Center, which would maximize the purchasing power of Northwest Tribes to provide specialty care. "Study to Develop Options for Access, Specialty Diagnostic Treatment and Ambulatory Surgery Services for Geographically Dispersed Populations," Interim PAFAC Report, Portland Area Indian Health Service, October 30, 2009, available at: http://www.npaihb.org/resource-lib/

[9] For more information, please contact Laura Platero, NPAIHB, at lplatero@npaihb.org or (503) 416-3276.