TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
PRESENTED BY CATHY ABRAMSON, CHAIRPERSON

THE PRESIDENT'S FISCAL YEAR 2014 BUDGET FOR TRIBAL PROGRAMS

SENATE COMMITTEE ON INDIAN AFFAIRS

APRIL 24, 2013

Chairwoman Cantwell, Vice Chairman Barrasso, and Members of the Committee, thank you for holding today's important hearing on the President's FY 2014 budget. My name is Cathy Abramson, and I serve as the Chairperson for the National Indian Health Board (NIHB) and as a Tribal councilperson for the Sault Ste. Marie Tribe of Chippewa Indians. The NIHB, in service to the 566 federally recognized Tribes, offers the following written comments regarding the President's FY 2014 Budget request for the Indian Health Service (IHS).

First, I would like to thank Congress for the increases to Indian Health it has provided. In the last three years, the IHS has received an increase of 29 percent which is enabling Indian Country to live with better health outcomes. As you may know, American Indian/ Alaska Native (AI/AN) populations suffer disproportionally from a variety of health disparities including diabetes, heart disease, tuberculosis, alcoholism and suicide. It is the commitments that this Congress has made to improving Indian Health in the last several years that are starting to turn these figures around.

It is critical that even in a time of tough fiscal choices that Congress continue to prioritize Indian Health. This is not only a human issue, but the fulfillment of the federal trust reasonability reinforced by 200 years of legislation, treaty agreements and case law. Furthermore, the dramatic cuts affecting IHS due to the federal sequestration process and rescissions will put the health of AI/AN people at risk and create a health care crisis across Indian Country. NIHB asks you to restore the $240 million in funding already lost due to sequestration and rescissions and create a permanent legislative exemption for IHS from sequestration.

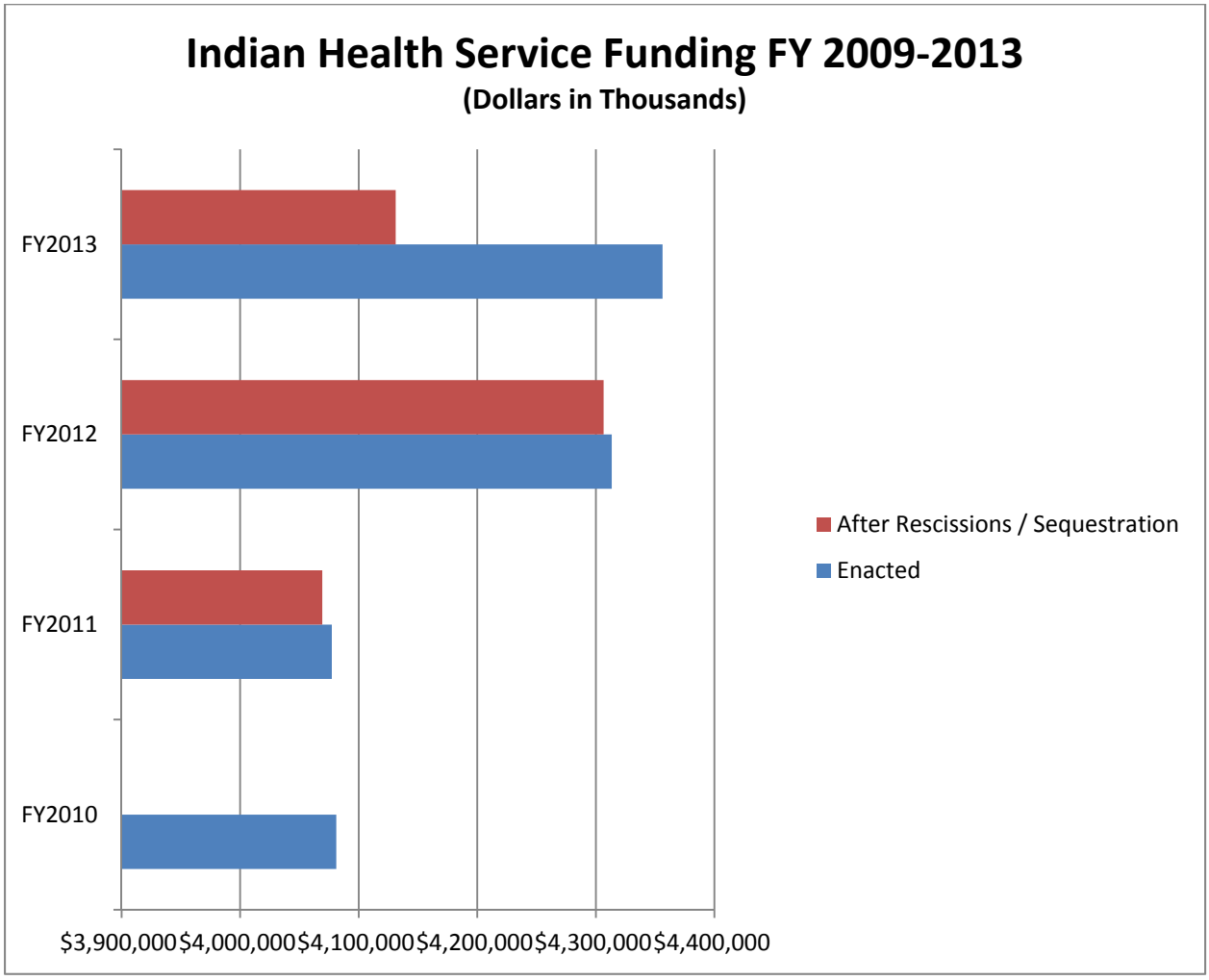
NIHB appreciates the President's budget request of $4.4 billion for IHS, but believes that this figure could go much further. To fulfill the total need in Indian Country, appropriations for the IHS would be $26.1 billion. However, due to the difficult fiscal environment, NIHB supports the recommendation of the National Tribal Budget Formulation Workgroup and requests IHS to be funded at $5.3 billion.

Sequestration and the 2 percent Continuing Resolution Recession

On March 1, 2013, IHS became subject the federal sequestration process. As discussed in an oversight hearing on Indian Health before the House Appropriations Subcommittee on Interior Environment, and Related Agencies on March 20, 2013, NIHB and the Tribal community believe that this is a grave oversight that will drastically affect the lives of every AI/AN. Although the American Taxpayer Relief Act reduced the level of the sequester reduction for the IHS from 8.2 percent to 5.1 percent, these cuts must be achieved over seven months instead of twelve, making the effective percentage of reductions approximately 9 percent. The amount

reduced out of the IHS budget through the sequester is $220 million. Additionally the 2 percent rescission enacted by the recently-passed Consolidated and Further Continuing Appropriations Act (P.L. 113-06) further reduces the IHS budget in the amount of $8 million for a total cut of $228 million from the IHS' FY 2013 budget. For FY 2013, combined with government rescissions since FY 2011, means that the IHS has lost *$240 million* in the last three years alone.

The chart below depicts the actual amount of enacted funding for IHS since FY 2010 compared with the funding eliminated through rescissions and sequestration:



As you can see, the increases in IHS that have been made over the last several years have been almost completely erased when accounting for rescissions and sequestration. When accounting for medical inflation rates of between 5 and 7 percent, and population growth of the AI/AN community the IHS is actually operating with slightly less money than it did before FY 2009. In order to reverse the health disparities of AI/AN people, it is critical that not only Congress continue to make increases in IHS funding, but that they restore funding that has been taken away from the IHS through rescissions and sequestration.

Health care provided through the Indian Health Service is not just another discretionary program. These services for AI/ANs are the fulfillment of a federal trust responsibility. Unlike other federal program cuts, the reductions to IHS are not about forcing government to run more efficiently. The sequestration cuts are literally a matter of life and death for AI/AN people and a deliberate abrogation of federal trust reasonability. Other medical service programs such as Medicaid, Medicare, the Children's Health Insurance Program, and medical care for Veterans have been exempt from the full sequester. NIHB strongly believes that the IHS should have the same exemption.

Overall, the White House predicted that the cuts will mean 3,000 fewer inpatient admissions and 804,000 fewer outpatient visits each year, though detailed budget numbers have not been released. The vast majority of programs treating Native Americans, especially those treating the sickest, most needy peoples will cut service. Alaska Native Tribal Health Consortium announced that it will discontinue its Community Health Aid training program as a result of the sequester and they will close the Bill Brady Healing Center that provides alcohol and drug treatment to Native Alaskans.

Seventy-three percent of Direct Services in the Aberdeen Area are implemented by IHS facilities. The automatic cuts will have a greater impact in our region. Already, examples from this area speak volumes of the automatic cuts. The Pine Ridge reservation's behavioral health staff has told NIHB that it will likely have severely cut back behavioral health services, which will be devastating in a community that suffers regularly with suicide, alcoholism and other substance abuse issues. There have been 100 suicide attempts in 110 days on Pine Ridge. Last year there were 563 suicide attempts on this reservation alone. Because of sequestration they will not be able to hire two mental health service providers. As one Tribal health official told NIHB, "We just can't take any more cuts." For example, Contract Health Services alone translates to 4,300 fewer approved referrals and 1,700 increase in denials. The proposed cuts will literally deny 6,000 fewer Tribal members ability to receive Priority 1 (Life or limb) services. This is Life or Death.

Across Indian Country, Tribal leaders and health administrators are facing tough decisions on how to make cuts, but they should not have to.

NIHB thanks those on this Committee that have publicly recognized the unjust nature of these cuts. ***Therefore, NIHB asks you to work with your colleagues in Congress to restore the $240 million in IHS funding eliminated due to sequestration and rescissions since FY 2011 and enact legislation that permanently exempts the Indian Health Service from sequestration.*** Now is not the time to completely erase the positive gains made by IHS in the last several years.

Contract Support Costs (CSC)

In June 2012, the Supreme Court issued a ruling in *Salazar vs. Ramah Navajo Chapter* that held that the U.S. Government must pay each Tribe's contract support costs even if the full amount to fund this has not been appropriated by Congress. As a result, the Administration has proposed an overhaul of the current Contract Support Cost system. The FY 2014 Budget recommends that

the government enter into individual contracts with each Tribe for CSC funds that each Tribe will receive. NIHB stands with the Tribes in opposing this unilateral policy change. The Administration has proposed this change without thorough and specifically focused consultation from Indian Country, which is a violation of a several federal laws and guidelines. While NIHB supports the overall elimination of statutory caps on CSC, this change should only be undertaken with a full comprehensive study by Congress, the IHS, and Tribal advisors. The Administration's proposal is destructive to Tribal self-governance and NIHB calls for extensive Tribal consultation on CSC. ***NIHB requests no major policy changes regarding CSC occur without Tribal consultation and a study process jointly undertaken by the Indian Health Service, the Bureau of Indian Affairs, and tribal leaders, informed by a joint technical working group***.

FY 2014 Budget requests an increase of $5.8 million (1.3 percent) for CSC in the total amount of $477,205,000 for FY 2014. In addition, the Budget requests $500,000 for CSC associated with new or expanded compacts or contracts. NIHB agrees that it is critical to increase funding for CSC. This funding enables Tribes to receive the essential infrastructure support needed to administer federal programs. Without full funding, Tribes are forced to redirect funds and reduce services in order to cover these costs. This is especially devastating for AI/ANs during a time of difficult budget reductions. CSCs are a critical part of health care delivery for AI/AN people and an affirmation of Tribal self-governance. Without funding this line at the full amount, Congress is abrogating this right to Tribal self-governance, and severely impacting health outcomes for AI/AN people. Therefore, NIHB asks that CSCs are increased by $109.2 million from FY2012 levels, as recommended by the National Tribal Budget Formulation Workgroup.

Purchased/Referred Care (formerly known as Contract Health Services)

The Purchased/Referred Care (PRC) Program (formerly known as the Contract Health Service Program) allows IHS to purchase health care from outside providers when no IHS-funded direct care service is available. NIHB is deeply appreciative of the dramatic increase in funding this program has seen in the last several years. Since FY 2005, funding for CHC has increased from $498 million to $845 million, or 69 percent. The FY 2014 Administration Budget requests funding of $879 million, an increase of $35 million, or 4 percent, over FY 2012.

However, this increase in funding does not adequately address the rate of medical inflation, nor does it provide adequate funding to meet the needs of the program. Adjusting funding for medical inflationary costs helps maintain the current level of services and offsets the rising cost in providing health care. The increase of $35 million is the calculated need based on a 3.7 percent medical inflation rate. However, according to the Consumer Price Index, inpatient hospital care is at 7 percent and outpatient hospital care is at 5 percent. PRC is grossly underfunded and IHS cannot purchase the care it needs. Currently, most IHS programs and Tribal health programs are only recommending the most desperate cases to be treated by PRC (e.g. "life or limb" situations) and less urgent or preventative care patients are deferred. As a result, Indian patients are left with untreated and often painful and preventable conditions that, if treated early, would result in better health outcomes at a lower cost. This is not a fulfillment of the federal Tribal trust obligation, but an outright denial of services to a large portion of the AI/AN population.

For PRC, NIHB requests a $171 million increase over the FY 2012 for a total amount of $1.01 billion. NIHB feels that this amount will allow IHS recipients to receive modest gains in access to care. For FY 2011, the estimate of PRC unmet need was over $800 million and with health care costs rising, this figure is only expected to grow. Without increases to this program or significant reform AI/ANs will continue to live shorter and die sicker than other Americans.

A Government Accountability Office (GAO) study released on April 11, 2013 also noted that IHS losing a lot of funding for PRC by failing to negotiate lower payment rates with nonhospital providers as Medicare and private insurance do. GAO recommends that Congress consider capping rates for nonhospital providers like other federal programs. While NIHB feels that this could enable IHS to provide more services for the amount appropriated by Congress, NIHB expresses concerns about access to care. While GAO did not express immediate concerns about patient access under payment caps, some rural areas served by IHS may only have one specialist or provider. To risk excluding patients from care through payment caps, would again, put the health of AI/ANs at risk. Because the GAO study was relatively limited in scope, NIHB recommends that Congress thoroughly study any issues resulting from access to care before enacting legislation that would cap PRC rates to nonhospital providers.

Definition of Indian in the Affordable Care Act

AI/ANs must be able to access the new benefits offered under the Affordable Care Act (ACA) (P.L. 111-148). The ACA contains numerous favorable procedural rules, cost-sharing protections, and mandatory enrollment exemptions that apply specifically to AI/ANs.

However, the Act references several different definitions of the word "Indian." Though HHS has officially stated that these definitions are "operationally" similar but not exactly the same, it is expected that AI/ANs will experience many administrative setbacks before they can fully access ACA programs. This will create enormous potential for confusion and inefficiency in the implementation of the ACA. One consequence will be that certain AI/ANs would face tax penalties for not enrolling in an Exchange though they are already receiving health care from the IHS or a Tribally-administered program.

Officials and HHS have stated that there must be a legislative fix. The NIHB recommends that the definition of "Indian" adopted by the Centers for Medicare & Medicaid Services (CMS) (at C.F.R. § 447.50 and effective on July 2, 2010) in its implementation of the Medicaid cost-sharing protections should be adopted uniformly in its implementation of the ACA for both the health insurance marketplace plans and the Medicaid expansion.

Special Diabetes Program for Indians (SDPI)

The Special Diabetes Program for Indians (SDPI) is a mandatory spending program which provides grants for diabetes treatment and prevention services to 404 IHS, Tribal and Urban health system programs. Currently this program is authorized at $150 million per year through September 30, 2014. The SDPI program is subject to a 2 percent sequestration cut as of March 1, 2013. This translates into a $3 million budget reduction for SDPI and will force SDPI grantees to make difficult choices on how to use SDPI funding to address the primary, secondary and tertiary prevention of diabetes in American Indian and Alaska Native (AI/AN) communities.

SDPI is making a real difference in the lives of people who must manage diabetes on a daily basis. As a result of intensive SDPI program data collection analysis, we are able to demonstrate remarkable outcomes from SDPI programs, including: a decrease in the average blood sugar level from 9.0 percent in 1996 to 8.1 percent in 2010; and a 56 percent increase in weight management activities targeting children and youth. Additionally, end stage renal disease (ESRD) has decreased by 27.7 percent between 1995 and 2006 – the lowest for any other ethnic group. Because this program is outcome driven, and focuses on individual grants which enable health professionals to tailor program activities to specific communities and cultural sensitivities, the success of SDPI is only expected to grow.

SPDI is also saving money for IHS and Tribal programs. The cost to treat someone with diabetes is 2.3 times higher than a non-diabetes patient. By engaging in interventions to prevent this disease, costs for health care services also plummet and providing savings for other government programs such as Medicare, and Medicaid. NIHB requests that Congress continue to support reauthorization of SDPI.

Advanced funding to Indian Health Service Budget

Since FY 1998, appropriated funds for medical services and facilities through IHS have not been provided before the commencement of the new fiscal year, causing IHS and Tribal providers great challenges in planning and managing care for AI/ANs.

The lateness in enacting a final budget ranges from five days (FY 2002) to 197 days (FY 2011). Even after the enactment of an appropriations bill, there is an apportionment process involving OMB and then a process within IHS allocation of funds to IHS Area offices. In FY 2010, the Veterans Administration (VA) medical care programs achieved advance appropriations. The fact that Congress has implemented advance appropriations for the VA medical programs provides a compelling argument for Tribes and Tribal Organizations to be given equivalent status with regard to IHS funding. Both systems provide direct medical care and both are the result of federal policies. Just as the veterans groups were alarmed at the impact of delayed funding upon the provision of health care to veterans and the ability of VA to properly plan and manage its resources, Tribes and Tribal Organizations have those concerns about the IHS health system. If IHS funding was on an advance appropriations cycle, Tribal health care providers, as well as the IHS, would know the funding a year earlier and would not be subject to continuing resolutions.

Delayed funding significantly hampers Tribal and IHS health care providers' budgeting, recruitment, retention, provision of services, facility maintenance, and construction efforts. Advanced funding enable IHS and Tribal leaders to make decisions on health care for AI/ANs well in advance, and contribute to greater health outcomes. As a result of these greater efficiencies created by advanced funding, IHS have a cost-savings that would allow the agency to redirect much needed funding into other areas, and build up the overall health of AI/AN patients. Providing sufficient, timely and predictable funding is needed to ensure the federal government meets its obligation to provide health care for AI/ANs.

Other Programs

FY 2014 Budget requests $196,405,000 for the Alcohol and Substance Abuse, which is an increase of $2,108,000 over the FY 2012 enacted level. NIHB supports this increase but believes that federal funding for this program should be $203.7 million. This funding supports integrated behavioral support to reduce substance abuse in Indian Country, which is one of the most critical health epidemics for AI/ANs.

In a related matter, the FY 2014 Budget request for Mental Health is $79.9 million, an increase of $185,000 for pay costs and $4.1 million for mental health staffing at newly constructed healthcare facilities. AI/ANs are at higher risk for certain mental health disorders than other racial or ethnic groups. More funding is needed to increase the incidence of suicidal behavior reporting by health care (or mental health) professionals. NIHB requests $121 million (or an increase of $45.8 million over the FY 2012 enacted level) for FY 2014.

Conclusion

In closing, I would like to reiterate my deep appreciation for this Congress' commitment to Indian Health in last several years. With your help, Tribes and IHS have been able to make great strides in Indian Health and these increases will help to ensure that AI/ANs remain a healthy and vibrant people for generations to come.

There is still much work to be done. NIHB recommends that Congress work to restore previous cuts to the IHS by federal budget rescissions and sequestration and establish permanent legislative exemption for IHS from the sequestration process. Cuts of this magnitude will only result in increased disease and sickness for AI/ANs. NIHB also appreciates the President's request for increased funding in these difficult fiscal times. However, in order to address these great inequalities and fulfill the federal government's trust obligation to native communities, FY 2014 appropriations for IHS should be at $5.3 billion.

Thank you again for this opportunity to testify regarding the FY 2014 IHS budget. I look forward to answering your questions.