

National Indian Health Board



TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD OVERSIGHT HEARING ON INDIAN COUNTRY PRIORITIES FOR THE 114TH CONGRESS

**SENATE COMMITTEE ON INDIAN AFFAIRS
JANUARY 28, 2015, 2:30PM**

Chairman Barrasso, Vice Chairman Tester, and Members of the Committee, thank you for holding this important hearing on Indian Country Priorities for the 114th Congress, and for including the National Indian Health Board (NIHB)¹ in this important hearing to detail some of the top Indian health priorities for the next Congress. On behalf of the NIHB and the 566 federally-recognized Tribes we serve, I submit this testimony.

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and American Indians and Alaska Natives. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. The Snyder Act of 1921 (25 USC 13) legislatively affirmed this trust responsibility. As part of upholding its responsibility, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to AI/ANs. Since its creation in 1955, IHS has worked to fulfill the federal promise to provide health care to Native people.

In passing the Affordable Care Act (ACA), Congress also reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). As part of the IHCIA, Congress reaffirmed the duty of the federal government to American Indians and Alaska Natives, declaring that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians -- to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy."²

But despite these promises, our people continue to live sicker and die younger than other Americans. We experience significantly higher mortality rates from alcoholism, suicide, cancer, influenza and maternal deaths. Ninety percent of AI/AN children suffer from dental caries by the age of eight, compared with 50 percent for the same age in the US all races population. Our children ages 2 to 5 have an average of six decayed teeth, when children in the US all races population have only one. Devastating health risks from historical trauma, poverty and a lack of adequate treatment resources also continue to plague Tribal

¹ The National Health Board (NIHB) is a 501(c) 3 not for profit, charitable organization providing health care advocacy services, facilitating Tribal budget consultation and providing timely information and other services to all Tribal Governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their advocate. Because the NIHB serves all federally-recognized tribes, it is important that the work of the NIHB reflect the unity and diversity of Tribal values and opinions in an accurate, fair, and culturally-sensitive manner. The NIHB is governed by a Board of Directors consisting of representatives elected by the Tribes in each of the twelve IHS Areas. Each Area Health Board elects a representative and an alternate to sit on the NIHB Board of Directors.

² Indian Health Care Improvement Act, §103(2009).

communities. According to IHS data, 39 percent of AI/AN women experience intimate partner violence, which is the highest rate of any ethnic group in the United States.

America is too great a nation to stand idly by while AI/ANs live with these realities. The 114th Congress offers many opportunities to achieve real, meaningful change for Indian Country. Not moving to work on some of these issues would be tacit approval of the state of affairs in Indian Country. In the following testimony we will offer some legislative solutions but also suggestions for increases oversight over the Indian health system.

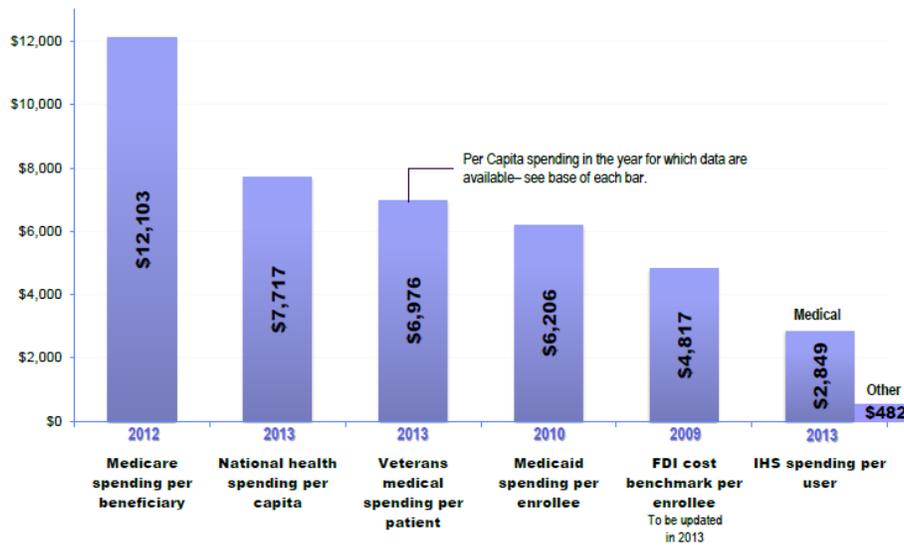
Legislative Opportunities

Mandatory Appropriations for the Indian Health Service

In 2013, the IHS per capita expenditures for patient health services were just \$2,849, compared to \$7,717 per person for health care spending nationally. Despite the historic increases that Congress has given to the IHS budget over the last several years, funding discrepancies unambiguously remain. Budgets have not even kept up with medical inflation, contract support cost needs, and sequestration cuts. We are never able to move forward. NIHB testified before the committee on upcoming budget priorities on March 26, 2014, and noted that for FY 2016 Tribes are requested \$5.4 billion for the IHS. Full funding would be \$28.7 billion and is practically achievable in a twelve year phase-in plan. We will continue to be engaged on the specifics of the Tribal health budget as Congress considers these appropriations in coming months.



2013 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



We realize that it is highly unlikely that Indian health will receive the funding it needs by continuing to chase ever dwindling discretionary dollars. Instead, the Indian Health Service should be treated like the obligation it is, and the Congress should move IHS funding to the mandatory side of the federal budget.

NIHB Testimony

Indian Country Priorities for the 114th Congress

As noted above, the requirement to provide funds for IHS has been long-established by over 200 years of American history. AI/ANs made sacrifices for this country that *require* the government to provide health care for our people, but with competing forces in the discretionary budget, the funds have never been realized to achieve this.

Moving IHS to the mandatory side of the federal budget would stabilize the IHS budget and ensure that the care that AI/ANs need is always guaranteed. For example, Indian Country would not have to wait months to know when it will get its funding for the next fiscal year. Tribes and the IHS facilities find it very difficult to plan and execute budgets by waiting for continuing resolutions (CRs). Additionally, the instability of the discretionary funding process continues to put the lives of AI/ANs at risk. Over the last several years we have been fortunate enough to have a supportive Congress and President when it comes to Indian health. However, that future is far from certain. Any change in government could reserve this trend and our people will suffer by not getting the surgeries, dental care, diabetes care or other treatments they need.

As we look toward FY 2016, we nervously await the possibility of across-the-board sequestration. As the Committee is well aware, the IHS budget lost \$220 million due to sequestration in FY 2013. Unlike mandatory programs, (or other direct health programs like the Veterans' Health Administration) IHS was subject to the full 5.1% sequester. Congress did specifically hold the IHS to 2 percent, but a quirk in the way the law was written caused sequestration to occur for IHS. The tragedy of sequestration in Indian Country was a clear denial of the federal trust responsibility to Tribes and our communities became, yet again, an unfortunate victim of unrelated political battles in Washington.

We implore you – do not let the same thing happen in FY 2016. **If sequestration cannot be avoided in FY 2016, this committee must show leadership in ensuring that the IHS is not subject to sequestration.** This exemption should be permanent, just as the federal trust responsibility to Indian Country. Even two percent is too much.

Support for Advance Appropriations for the Indian Health Service

Realizing that mandatory funding for the IHS could be a multi-year effort, NIHB reiterates its support for Advance Appropriations for the Indian Health Service. In the 113th Congress, Senator Lisa Murkowski (R-AK) introduced legislation to provide advance appropriations for the IHS and we hope to see continued action on this during the 114th Congress. An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. For example, if the FY 2017 advance appropriations for the IHS were included in the FY 2016 appropriations bills, those advance appropriations would not be counted against the FY 2016 funding allocation but rather, against the FY 2017 allocation. While this tactic will not solve the complex budget issues at IHS, it will be an important first-step in ensuring that AI/ANs receive the health care they deserve. Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs.

As we saw in the FY 2014 with the government-wide shutdown, failure to fund critical health care needs for AI/ANs was a thoughtless consequence of this unrelated political battle. Since FY 1998, there has been only **one year** (FY 2006) when the Interior, Environment, and Related Agencies budget, which contains the funding for IHS, has been enacted by the beginning of the fiscal year. The lateness in enacting

a final budget during that time ranges from 5 days (FY 2002) to 197 days (FY 2011). These delays make it very difficult for IHS/ Tribal/ or Urban (I/T/U) Indian health sites to adequately address the health needs of AI/ANs. Though IHS is a mandatory obligation that the government has made, it is still a discretionary program. That's the reality we live in. So we are asking this Congress to stand up for us and enact Advance Appropriations for the IHS – just as it did for several Veterans' Administration programs last December as part of the Consolidated and Further Continuing Appropriations Act of 2015 (P.L. 113-235).

In FY 2010, the Veterans Health Administration (VHA) achieved advance appropriations. IHS, like the VHA provides direct medical care to fulfill legal promises made by the federal government. In the 111th Congress, which ultimately enacted the advance appropriations for the VHA, the House bill (H.R. 1016) had 125 bi-partisan cosponsors. The Senate bill (S. 423) had 56 co-sponsors. Importantly, the Congressional Budget Office ruled at the time that the act “would not affect direct spending or revenues.”

IHS, like the VHA, provides direct care to patients as a result of contractual obligations made by the federal government. To NIHB and Tribes, enacting advance appropriations for IHS is a civil rights issue and a matter of equality. Like Veterans, Tribal communities have made sacrifices for this country, both historically and contemporarily. However, under the current funding mechanism, AI/ANs do not have the same stability in the care they are provided.

Continuing resolutions mean that Tribal health programs are left to make long-term decisions with only short-term money guaranteed. Often programs must determine whether and how they can enter into contracts with outside vendors and suppliers, plan programmatic activities, or maintain current personnel. In July 2014, Tim Schuerch, President/ CEO of the Maniilaq Association, an Alaska Native Corporation, testified before the House Natural Resources Subcommittee on American Indian and Alaska Native Affairs that continuing resolutions result in higher supply prices. For example, heating oil is a major expense for this provider, but it is cheaper if you buy in bulk in September, rather than buying in bits and pieces as continuing resolutions come out from Congress. In September, the oil can be pulled in by barge, but by November or December the oil must be flown in which dramatically increases the cost. Indian health budgets operate on the margins and CRs make this situation even worse. No private health provider would operate this way, and IHS/ Tribal/ or Urban (I/T/U) Indian health sites should not have to either.

Tribes and organizations across the country support advance appropriations for IHS. In June 2014, the American Medical Association's House of Delegates passed a resolution supporting Advance Appropriations for the Indian Health Service. NIHB has also submitted resolutions and letters from the National Indian Health Board, National Congress of American Indians; United South and Eastern Tribes; the California Rural Indian Health Board; Alaska Native Health Board; Midwest Alliance of Sovereign Tribes; the Northwest Portland Area Indian Health Board; the Oklahoma City Area Inter-Tribal Health Board; the Inter Tribal Council of the Five Civilized Tribes; and the Three Affiliated Tribes.

Advance appropriations will undoubtedly require significant changes in the way Congress and the Administration develop the IHS budget. But we believe that it will be worth it. The change will not cost any money, and it will not cede Congressional budget authority to the Administration. What Advance appropriations for IHS will do is put the Indian health system in a more stable position and thereby improve the continuity of care for Native Peoples.

Medicare Like Rates for Purchased/ Referred Care

One common-sense solution to enable IHS funds to go further is for Congress to enact legislation that would require that purchased/referred care (PRC) reimbursements to non-hospital providers are made at “Medicare Like Rates (MLR).” In 2003, Congress amended the Medicare law to authorize the Secretary of Health and Human Services to establish a rate cap on the amount hospitals may charge IHS and Tribal health programs for care purchased from hospitals under the PRC program. However, hospital services represent only a fraction of the services provided through the PRC system. The IHS PRC program may be the only federal government entity that does so. For example, neither the Veterans’ Administration nor the Department of Defense pay full billed charges for health care from outside providers.

On April 11, 2013, the Government Accountability Office (GAO) issued a report³ that concluded “Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS’s [PRC] program that is consistent with the rate paid by other federal agencies.” We agree: these savings would result in IHS being able to provide approximately 253,000 additional physician services annually and a program savings of over \$100 million. With discretionary budgets getting smaller and smaller we believe that this small change would bring parity to the IHS referral system with other health providers. In addition, it would help alleviate the approximately \$800 million shortfall that PRC sees each year.

In December 2014, the IHS issued a proposed rule that would require Medicare-Like Rate payments for non-hospital based services. Tribes are still formulating a specific response to this rule, but we believe the enactment of legislation will make this provision stronger and more effective. NIHB and Tribes encourage Congress to swiftly enact the legislative change to make PRC subject to Medicare Like Rates for all non-hospital providers and suppliers.

Employer Mandate in the Affordable Care Act

American Indians and Alaska Natives (AI/AN) are exempt from the Individual Mandate to purchase health insurance. This is in recognition of the fact that AI/ANs should not be forced to purchase healthcare that is obligated by the federal government’s trust responsibility and which is delivered through the Indian Health Service (IHS). However, Tribal employers (whose employees are often also Tribal members) are subject to the Employer Shared Responsibility Mandate, which says that employers, with 50 or more full-time employees or full time equivalent employees, must offer insurance to their employees or pay a tax penalty.

Applying the employer mandate to Tribal employers directly undercuts the ACA’s Indian-specific protections in three ways. First, it punishes Tribes for assisting AI/AN enrollment in the Marketplaces, despite the multiple ACA provisions designed specifically to encourage such activities. Second, it can disqualify AI/ANs from eligibility for premium tax credits in Marketplace plans, thus leaving them unaffordable. Third, it ignores the fact that AI/ANs are exempt from the individual mandate and forces Tribal employers to pay for AI/AN insurance plans as a proxy for the individual. None of these outcomes benefit Tribal employers, individual AI/ANs, or the federal government.

³ GAO-13-272: “Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services,” April 11, 2013.

The ACA contains several provisions designed to maximize AI/AN participation in Marketplace plans: for example, Indian-specific cost-sharing protections that help defray the cost of health coverage, special AI/AN enrollment periods, and the ability for Tribes to assist with Marketplace plan premium payments for Tribal members. Many Tribes and Tribal organizations have aggressively sought to facilitate AI/AN enrollment in Marketplace plans in order to take advantage of these protections. However, the employer mandate actively discourages AI/AN Marketplace participation, in direct contradiction to the provisions described above.

If a Tribe does offer employer coverage, AI/AN employees will almost certainly be personally responsible for paying premium costs, deductibles, co-payments, and co-insurance. Eligibility for IHS services acts as a natural disincentive for AI/AN enrollment in any insurance plan (employer sponsored or otherwise). Congress incentivized AI/AN Marketplace participation through the availability of premium tax credits. For AI/ANs, various types of Indian-specific income is excluded, thus leaving it comparatively easier for AI/ANs to qualify for subsidies and making many individual Marketplace plans significantly more affordable than employer sponsored coverage for AI/ANs. However, employees are automatically disqualified from tax credit eligibility upon receiving a qualifying offer of coverage from their employer. As a result, even if a Tribal Employer provides insurance that is less affordable or comprehensive than a plan available through the individual Marketplace, the mere offer of coverage eliminates the ability of AI/ANs to obtain tax credits from the Marketplace.

The employer mandate forces Tribes to divert funding necessary to sustain Tribal health programs, which by right should come from the federal government, and redirect it to the purchase of employee health insurance. In these circumstances, the employer mandate essentially results in Tribes funding the federal government: either they take their limited Tribal funding (some or all of which might be federal funding anyway) and pay it to the IRS in the form of a tax penalty, or they purchase insurance from private companies, which then pay IHS, after the insurance company keeps between 15-20% of the premium payments off the top. Tribal subsidization of the United States does not respect either the trust responsibility or the government-to-government relationship between Tribes and the United States.

Compliance with the employer mandate forces Tribes to either absorb the cost of employee health insurance or else pay non-compliance penalties of up to \$2,000 per year per full-time employee. Not only is this potentially devastating for Tribes that are already faced with significant financial hardships, but it fails to recognize the fundamental distinction between Tribal employers and private businesses.

Tribes are sovereign, governmental entities that are directly responsible for the health and welfare of their people, and are often the only major employers in Tribal territories. Forcing Tribes to pay millions of dollars in penalties – or, alternatively, to purchase costly insurance for Tribal member employees who are otherwise exempt from the individual mandate and eligible for IHS services – will not just affect Tribal business decisions concerning hiring or expansion, but will directly limit their ability to provide basic social, health, safety, and other governmental services on which their members and other reservation residents rely. Tribes cannot “pass on” the costs of compliance by raising prices on goods or services. Tribal governmental funding is a zero sum game, and any funding used to either comply with the mandate or pay the penalties will necessarily come from coffers used to provide what may be the only constituent services for hundreds of miles.

The ACA employer mandate creates a no-win situation for Tribal governments, forcing them to either pay for the cost of insurance for Tribal member employees who are otherwise exempt from having to obtain coverage, or pay a tax penalty in order to ensure that Tribal member employees qualify for the benefits and protections to which they are entitled. The mandate discourages Tribes from facilitating AI/AN Marketplace enrollment, requires Tribes to pay an individual mandate penalty by proxy on behalf of its AI/AN employees, and precludes AI/AN eligibility for tax credits. The mandate also acts as a federal directive that many AI/ANs pay for their health care in circumvention of the trust responsibility. Finally, the mandate is unaffordable for many Tribes, as Tribes will pay for both the penalties and the insurance payments with already-scarce resources that would be far better allocated towards funding direct Tribal services and programs. We therefore ask for a Tribal exemption to the Employer Mandate.

Definition of Indian in the Affordable Act

As NIHB testified previously, we urge Congress to enact a legislative “fix” for the Definition of Indian in the Affordable Care Act. The “Definitions of Indian” in the ACA are not consistent with the definitions already used by the Indian Health Service (IHS), Medicaid and the Children’s Health Insurance Plan (CHIP) for services provided to American Indians and Alaska Natives. The ACA definitions, which currently require that a person is a member of a federally recognized Tribe or an Alaska Native Claims Settlement Act (ANCSA) corporation, are narrower than those used by IHS, Medicaid and CHIP. This thereby excludes a sizeable population of AI/ANs that the ACA was intended to benefit and protect. Unless the definition of Indian in the ACA is adjusted to match other definitions used by IHS and CMS, many AI/ANs will not be able to receive the special protections and benefits intended for them in the law. This would essentially create a class of “sometimes Indians” who are eligible for IHS and other benefits but not those in the ACA. Both Congressional partners and the Administration have acknowledged that this was not the intent of the law, and we hope that this committee can take leadership on this issue in the 114th Congress.

Renewal of the Special Diabetes Program for Indians

As part of the Balanced Budget Act of 1997, Congress established the Special Diabetes Program for Indians (SDPI) to address the growing epidemic of Type 2 diabetes in American Indian and Alaska Native (AI/AN) communities. The Special Diabetes Program for Type 1 Diabetes (SDP) was established at the same time to address the serious limitations in Type 1 diabetes research resources. Together, these programs have become the nation’s most strategic, successful and comprehensive effort to combat diabetes. SDPI is transforming lives and changing the diabetes landscape in America.

According to the Centers for Disease Control and Prevention (CDC), AI/AN adults have the highest age-adjusted prevalence rate of diagnosed diabetes compared to other major racial and ethnic groups at 16.1 percent. By comparison, this is almost twice the rate for the total U.S. adult population. Some regions of Indian Country have diabetes rates as high as 33.5 percent, with specific communities having Type 2 diabetes reach a level as high as 60 percent.

But SDPI is working to overcome these challenges. Between 1995 and 2006, the incidence of End-Stage Renal Disease in AI/AN people with diabetes fell by nearly 28 percent – a greater decline than any other racial or ethnic group. ESRD costs Medicare over \$80,000 per patient per year. The average blood sugar level, as measured by the hemoglobin A1C test, decreased from 9.0 percent in 1996 to 8.1 percent in 2010. Every percentage drop in A1C results can reduce risk of eye, kidney, and nerve

complications by 40 percent. These positive preventative health outcomes help bend the medical cost curve and not only save lives but federal dollars.

Today, SDPI is funded at a level of \$150 million per year and supports 404 diabetes treatment and prevention programs in 35 states. With funding for this critical program set to expire on September 30, 2015, Tribes are requesting a renewal of this program of **\$200 million/ year for 5 years**. While we understand an increase in funds during this budgetary environment is difficult, SDPI has been level-funded since 2002. This represents an effective decrease. Calculating for inflation, \$150 million in 2002 would be about \$115 million in 2014 – or *23 percent less*. In order to keep the momentum of this important program alive, it is critical that Congress continue to invest in SDPI, which will save millions in preventative care over the long term. When taking into account additional Tribes that have gained federal recognition since 2002, the dollars are even scarcer.

NIHB wishes to express its gratitude for the work that members of this committee have done so far to support renewal of SDPI. With the deadline of September 30th in mind, I urge you to support a multi-year reauthorization of the SDPI by March 31st of this year. We have a critical opportunity to see the program renewed by March 31, when Congress must renew the “Medicare Extenders” as part of the “Sustainable Growth-Rate Fix.” This has typically been the legislative vehicle for SDPI renewals. Without an immediate, long-term reauthorization, critical infrastructure that the Tribes have built to address the diabetes epidemic in Indian Country has greatly contributed to the success of SDPI will be lost.

Oversight opportunities

In addition to considering the aforementioned legislative proposals, this committee has important oversight role for many of the issues and challenges affecting Indian Country. When it comes to health there are many challenges that merit some additional oversight for this committee, but we have chosen to highlight several of our top priorities for the purpose of this statement.

Implementation of the Affordable Care Act

The ACA recognizes the federal trust responsibility to provide healthcare for AI/ANs through its special provisions that outline protections for them. These special provisions include:

- Indian-specific cost-sharing protections that help defray the cost of health coverage
- Special AI/AN enrollment periods
- The ability for Tribes to assist with Marketplace plan premium payments for Tribal members
- An exemption for enrolled members in a federally recognized Tribe to the individual mandate to purchase insurance.

The Center for Consumer Information and Insurance Oversight (CCIIO) oversees the implementation of ACA provisions related to private health insurance and is charged with working to establish Health Insurance Marketplaces. These Health Insurance Marketplaces operate call centers and help desks to respond to consumer questions about the ACA. In addition, CCIIO has been tracking AI/AN enrollment in the Marketplace and to better facilitate our data tracking efforts, we have made repeated requests to CCIIO for this data and it has not been made available. Without this data, Indian Country has no clear understanding of what impact the ACA is having on AI/ANs.

The current call centers have proven to be inadequate at answering questions related to the special benefits and protections available to AI/ANs and have often caused greater confusion and application errors. There are still thousands of exemption applications that have yet to be processed with no discernible reason as to what the problems are. A large portion of those applications that have been processed, have been processed incorrectly and require prompt resolution so that AI/ANs can be issued exemption certificate numbers. These problems have all contributed to low enrollment, as many AI/AN are still confused about the benefits of the ACA and see no reason to sign up. We request that CMS provide their call center or help desk staff with better training on AI/ANs protections and provisions of the ACA. NIHB has also advocated for the creation of an AI/AN specific help desk where AI/AN callers would be redirected. This helpdesk would be better equipped to answer questions for AI/AN customers. In addition, an AI/AN call center would be more culturally sensitive and in certain cases, linguistically equipped to answer calls where the caller only speaks their native language. Our request for an AI/AN call center has gone unanswered at CMS, despite the fact that the Administration has developed call centers for other minority groups (like native Spanish speakers), who the federal government does not have a special trust responsibility towards. AI/ANs, not only speak languages other than English, but the law applies to them in a completely different way, thereby increasing the need for a native-specific call center.

For more than a year, NIHB and its partners in the Tribal Technical Advisory Group (TTAG) to CMS, have made repeated requests for access to current AI/AN enrollment data. Instead, the only data that has been made available has been data from 2011 and that data has been shown to be inaccurate and incomplete. Finally, in September of 2014, a formal letter was written to Marilyn Tavenner, Director of CMS, to request the data yet again. This time Technical Advisors to CMS and NIHB had a conference call with the data team from CCIIO. We were assured that our data request would be delivered in October. In October, we followed up with CMS and were told that the data request was taking longer than anticipated and would be available in December. We once again asked for the data in December and were told that in January it would be ready. Here we are today and we still do not have the data.

We therefore request that Congress intercede with CMS and CCIIO, fulfill its trust obligations in providing healthcare for AI/AN by providing better customer service and support for those AI/ANs looking for information about the Marketplace.

Implementation of the Indian Health Care Improvement Act

As noted above, when Congress passed the Affordable Care Act, it also permanently reauthorized the Indian Health Care Improvement Act (IHCIA). This law has meant that AI/ANs are receiving better and more coordinated care. IHCIA provides new authorities for Indian health care, however additional actions are needed to fully implement the Act. For example, *at least* an additional \$300 million is critically needed in order to begin to implement and fund the new priorities in IHCIA. Tribes fought for over 10 years to renew IHCIA and the Administration and Congress should act to fulfill the promise enacted by the 2010 law.

We believe that more needs to be done on behalf of the IHS and Congress to take advantage of these new authorities that would be more beneficial for their communities. The battle for IHCIA renewal was over ten years in the making. When this historic law was signed, Indian Country was elated by the promise of a new and more efficient health care delivery system for AI/AN people. However, four years later

many of the provisions of the Act remain unfunded or not implemented, and in many ways, represent yet another broken promise for Indian people.

Through the ACA, the American health care delivery system was revolutionized; meanwhile, the Indian health care system still waits for the full implementation of the IHCA, despite the fact that it was passed in the same law. For example, mainstream American health care increased focus on prevention as a priority and a treatment, and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs that is now standard practice. Reflecting these improvements in the IHCA was a critical aspect of the reauthorization effort. The time and resources paid off with the permanent reauthorization of IHCA. Highlights of what is contained in the IHCA Reauthorization include:

- Updates and modernizes health delivery services, such as cancer screenings, home and community based services and long-term care for the elderly and disabled.
- Establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.

All provisions of the IHCA are critical to advancing the health care of American Indian and Alaska Native people and should be implemented immediately. Additional funding will only beign to scratch the surface of implementing these new budget authorities. We believe that with proper Tribal consultation, and assistance from Congress, we can begin to see the reality of this important law.

Access to Quality Medical Providers

One of the significant barriers to achieving good care is a lack of good providers at IHS and Tribal facilities. Remote and rural locations; lower pay; lengthy hiring processes and ill-equipped IHS facilities all effect the ability for providers to be recruited and retained within the IHS system. IHS has an estimated 46% turnover rate for their physicians every year, which leads to significant issues when building trust between patients and physicians and enriching care.

One solution supported by the IHS and Tribes is making IHS scholarships and student loan repayments tax exempt. This would create parity between IHS and other federal health providers such as the National Health Service Corps. The President's FY 2015 budget recommendation for the Indian Health Service supported this approach noting, "The inability to fund 577 applicants who were not currently working for IHS is a significant challenge for the recruitment efforts of the agency." The Budget request also noted that "IHS, as a rural health care provider, has difficulty recruiting health care professionals. There are over 1,550 vacancies for health care professionals... across the IHS system."

But this is just one small solution to a very complex problem. We believe that oversight by the Committee on this topic could be a positive step toward increasing providers, and thus improving care, in Indian Country. Possible solutions could include streamlining the federal hiring process; additional incentives for physicians who stay with IHS or Tribal providers for multiple years, or providing greater flexibility for scholarship and loan reimbursements. It is vital that Congress and the Administration make serious investments in recruiting and retaining medial staff in Indian Country of the health of our people is ever to improve.

Public Health Infrastructure for Indian Country

Earlier in this testimony, we listed some of the health disparities for AI/ANs including alcoholism, substance abuse, obesity, diabetes, behavioral health and suicide. Many of the top health concerns for AI/ANs of these afflictions are preventable, chronic conditions. Small, targeted, investments in public health infrastructure are an important first step in combating some of these health discrepancies. Public health is the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. While health care systems like the Indian Health Service cater to the individual patient, public health seeks to serve whole communities.

The health disparities experienced in Indian Country are often the areas of health that benefit the most from a public health approach. For example, chronic/preventable diseases like diabetes, heart disease, and chronic lower respiratory disease are some of the leading causes of death for AI/AN people. A 2011 study published in *Health Affairs* found that increased spending by local public health departments can save lives currently lost to many of these and other preventable illnesses. The study found that a 10% increase in spending translated to a 3.2% decrease in cardiovascular disease mortality. The additional cost to local health departments, on average, was \$312,274 a year for prevention strategies. In comparison, achieving the same mortality reduction using treatment costs an estimated \$5.5 million.

However, in Indian Country, public health support is virtually non-existent. While much of the U.S. population has access to government-sponsored, accredited, health departments, behavioral health facilities or alcohol and substance abuse treatment facilities, these facilities rare in Indian Country. Combine this with high rates of poverty, widespread historical trauma, and adverse childhood experiences (See text box), and the problems seem insurmountable.

However, we believe that a focused, multi-jurisdictional approach could help combat some of these difficult problems in Indian Country. In November 2014, a report by the Attorney General’s Advisory Committee on American Indian and Alaska Native Children Exposed to Violence⁴ found that “AI/AN children experience posttraumatic stress disorder at the same rate as veterans returning from Iraq and

ADVERSE CHILDHOOD EXPERIENCES

The association between ACE (Adverse Childhood Experiences) and unhealthy adult lifestyles has been well documented. Adolescents with a history of multiple risk factors are more likely to initiate drinking alcohol at a younger age and are more likely to use alcohol as a means of coping with stress than for social reasons. The adoption of unhealthy lifestyles as a coping mechanism might also explain why higher ACE exposures are associated with tobacco use, illicit drug abuse, obesity, and promiscuity as well as why the risk of pathologic gambling is increased in adults who were maltreated as children.

Adolescents and adults who manifest higher rates of risk-taking behaviors are also more likely to have trouble maintaining supportive social networks and are at higher risk of school failure, gang membership, unemployment, poverty, homelessness, violent crime, incarceration, and becoming single parents. Furthermore, adults in this high-risk group who become parents themselves are less likely to be able to provide the kind of stable and supportive relationships that are needed to protect their children from the damages of toxic stress. This intergenerational cycle of significant adversity, with its predictable repetition of limited educational achievement and poor health is mediated at least in part by the social inequalities and disrupted social networks that contribute to fragile families and parenting difficulties.”

Shonkoff, Jack P., et al. "The Lifelong Effects of Early Childhood Adversity and Toxic Stress." *Pediatrics* 129.1 (2012): e232-e246.

⁴ “Ending Violence So Children can Thrive,” Attorney General’s Advisory Committee on American Indian and Alaska Native Children Exposed to Violence, November 2014. Accessed at: <http://www.justice.gov/sites/default/files/defendingchildhood/pages/attachments/2014/11/18/finalaianreport.pdf>

Afghanistan and triple the rate of the general population.” This troubling statistic calls for coordination between state and Tribal governments, the Department of Justice, Department of the Interior IHS, and other federal health programs. Without this important coordinated approach, our children will continue to live in a cycle of poverty, trauma, alcoholism and substance abuse.

In the 114th Congress, we strongly encourage the Committee to take a serious look at public health infrastructure and coordination in Indian Country. We believe that small investments will result serious improvements for the health of AI/ANs.

Contract Support Costs

Contract support costs (CSC) are the funds that Tribes and Tribal organizations receive from the government to manage health and other programs that were previously operated by the federal government. For many years, Congress did not appropriate enough funds to fully pay CSC. In 2012, the Supreme Court ruled that the government must pay contract support costs for Tribes even if Congress has not appropriated the funds. In FY 2014, Congress provided a partial pathway forward to fully fund FY 2014 CSC costs by removing budget-line caps and providing a lump-sum payment to the agency. However, the fluid nature of how CSC funding is accessed throughout the year means the true annual cost cannot be known until the end of the fiscal year. Therefore, Congress made the best decision possible with the information available at the time: but by the end of the fiscal year that reality has changed. IHS ended up cutting \$25 million from the IHS budget to pay for the short-funded CSC need. While most of this shortfall was restored by Congress in the FY 2015 appropriations law, this was at the expense of increases for medical inflation in the IHS budget. Congress has asked Tribes and the Administration to develop a long-term solution to funding CSC so that cuts do not have to be made from other programs.

It was clearly not the intent of the Supreme Court for Tribes to cover CSC out of their own budgets, but unless real, long-term solutions are implemented by Congress and the Administration, CSC will continue to have an unpredictable effect on direct services in IHS budget. NIHB and Tribes have recommended that Congress consider enacting mandatory appropriations for CSC in order to avoid balancing the IHS budget on the backs of other Tribal health programs. This and other solutions should be considered as part of CSC reform. This could include provisions relating to agency-wide consistency on CSC negotiations; revised timelines for CSC re-negotiations; and other standardized rates and categories.

In the 114th Congress, we encourage the committee to continue to work with IHS and Tribes in order to find a stable, long-term solution for CSC funding. One that will hold both self-governance and direct service Tribes harmless and also respects and promotes Tribal self-determination and honors the federal government's trust responsibilities and obligations.

Conclusion

Thank you for the opportunity to offer this testimony for Indian Country Health priorities in the 114th Congress. We express support for the work that this Committee has previously done to support the First Peoples of this Country and look forward to working together in a bipartisan way over the next two years. To reiterate, our top legislative concerns remain:

- 1) Achieving increased appropriations and mandatory funding for the IHS
- 2) Advance Appropriations for the IHS

- 3) Legislation to enacted to provide Medicare Like Rates for Non-hospital providers and suppliers
- 4) Tribal exemption for the Employer Mandate in the ACA
- 5) Streamlining the Definitions of Indian in the Affordable Care Act
- 6) Long-term renewal of the Special Diabetes Program for Indians

The 114th Congress also presents many oversight opportunities for the Committee that could go a long way toward improving the health of AI/ANs. Some of the potential topics could include:

- 1) Implementation of the Affordable Care Act
- 2) Implementation of the Indian Health Care Improvement Act
- 3) Access to Quality Medical Providers
- 4) Public Health Infrastructure for Indian Country
- 5) Contract Support Costs

NIHB stands ready and willing to serve as a resource for the committee as you work toward bipartisan solutions to improve the lives of AI/ANs in the 114th Congress. Together, we can achieve great things for Indian Country and we look forward to working with you.