National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
Cathy Abramson, Chairperson
HOUSE COMMITTEE ON NATURAL RESOURCES
Subcommittee on Indian and Alaska Native Affairs

Legislative Hearing on H.R. 3229; H.R. 4546; H.R. 4867; and S. 1603

Chairman Young, Ranking Member Hanabusa, and Members of the Committee, thank you for holding this important hearing on the proposed legislation. All of these proposed bills address issues of paramount importance to Indian Country and we sincerely appreciate the attention that this committee has given to the discussion of these key concerns. On behalf of the National Indian Health Board (NIHB)[1] and the 566 federally recognized Tribes we serve, I submit this testimony for the record, specifically addressing H.R. 3229 – Indian Health Service Advance Appropriations Act.

First, I would like to emphasize the importance of the Federal Trust responsibility, when it comes to the health of American Indian/Alaska Native (AI/AN) people. The United States assumed this responsibility in 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. To facilitate 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 toward fulfilling the federal promise to provide health care to Native people. In passing the Affordable Care Act, Congress also reauthorized and made permanent the Indian Health Care Improvement Act (IHCIA). In renewing 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."

Despite this responsibility, AI/ANs still experience greater health disparities than other races. For instance, the AI/AN life expectancy is 4.2 years less than the rate for the U.S. all races population. According to IHS data from 2006-2008, AI/AN people die at higher rates than other Americans from chronic liver disease and cirrhosis (368% higher), diabetes (177% higher), unintentional

[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.

injuries (138% higher), homicide (82% higher) and suicide (65% higher). Additionally, AI/ANs suffer from higher mortality rates from cervical cancer (1.2 times higher); pneumonia/influenza (1.4 times higher); and maternal deaths (1.4 times higher).

Sadly, these statistics have become all too familiar in our communities. IHS is currently funded at only 59 percent of total need. 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. Medicare spending per patient was over $12,000 and Medicaid spending was over $6,000/per person. Clearly, the federal government is not doing a good job of fulfilling its legal and moral obligations to Indian Country. Additionally, Medicare and Medicaid are mandatory spending accounts, meaning that the health delivery to these groups is known well in advance of the actual care needed.

This is why the NIHB strongly supports H.R. 3229 – The Indian Health Service Advance Appropriations Act and the Senate companion bill S. 1570. 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 2016 advance appropriations for the IHS were included in the FY 2015 appropriations bills, those advance appropriations would not be counted against the FY 2015 funding allocation but rather, against the FY 2016 allocation.[2]

While H.R. 3229 will not solve the severe lack of funding that the agency experiences, advance appropriations would allow IHS, Tribal, and urban (I/T/U) health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. This change in the appropriations schedule creates an opportunity for the federal government to come closer to meeting the trust obligation owed to Tribal governments and bring parity to federal health care system by bringing IHS in line with other federal health programs.

Funding Delays and Impact on Care

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). In FY 2014, there was a 108 day delay on the enactment but it was 140 days before the FY 2014 operating plan which allocates specific accounts was known. These delays make it very difficult for Tribal health providers and IHS to adequately address the health needs of AI/ANs. Even once appropriations is enacted, there is an administrative process of apportionment involving the Office of Management and Budget that causes delay in actually getting funding down to the local level. Advance appropriations will allow IHS and Tribal health professionals time to plan and tackle many other administrative hurdles, thereby improving access to care. Additionally, it will result in costs savings through lower administrative costs as significant staff time, at all levels, is required each time Congress decides to pass a continuing resolution.

Nothing underscores this need more clearly than the federal government shutdown at the start of FY 2014. Not only did this period prevent Tribal and IHS facilities from providing care, it came

[2] Advance appropriations ***differs from*** "forward funding," which allows funds to become available beginning late in the budget year and is carried into at least one following fiscal year. Forward funding is counted against the same budget year. Advance appropriations is counted only in the budget year for which the appropriated dollars will be spent.

at a time when programs were already operating with minimal budgets due to the draconian, and irresponsible FY 2013 across- the- board sequestration cuts. The two week government shutdown forced Tribally-run health programs to close their doors and deny care to thousands of AI/ANs. The Crow Nation furloughed 300 Tribal employees during this time. Others were only able to treat "life or limb" cases due to the lack of an operating budget. As a result, AI/AN population experienced additional suffering. In a testimony submitted to the Senate Committee on Indian Affairs, on November 14, 2013 the Chairwoman of the Mississippi Choctaw stated:

> *"…the uncertainty caused by the combination of sequestration and the government shutdown interrupted many hospital and health department operations. Final payments were slow to reach us with payments distributed erratically, even down to the last few days of September 2013. Such an unpredictable stream of income for a small reservation hospital in rural Mississippi that provides services to more than 10,000 eligible users limits the tribe's ability to plan for such services and execute the contracts that are necessary to operate our facility."*

Other Americans do not have to live with this reality. The First people of the United States should not be last in line when it comes to receiving their health care.

Even without events as extreme as a federal government shutdown, funding delays contribute to other health risks for AI/ANs. Sadly, it is often a saying in our communities, "Don't get sick after June 1" because this is often when dollars to treat patients through the Purchased/Referred Care program run out. However, if Tribal and IHS programs had advance appropriations, they could better plan their patients' care over a longer period of time. Currently, when funding becomes scarce, I/T/U medical professionals often prescribe treatments that address only symptoms, and not the disease. This 'Band-Aid' type of care contributes to a wide variety of other medical risks that are more costly and can be detrimental to the person over the long term. Advance appropriations would mean better ability to plan programmatic activity over several years, thereby leading to better health outcomes for AI/AN people and decreased long-term healthcare costs.

Funding delays also often impact recruitment and retention of IHS medical professionals. Many IHS and Tribal health facilities are located in remote, rural areas where staff recruitment is especially difficult. This is true throughout the rural United States, not just in Indian Country. However, it becomes impossibly difficult to recruit staff if it is not known whether a position will be funded in two months. Giving medical professionals attractive job opportunities that spans longer than a year benefits Tribal communities by providing stability for AI/ANs and the quality that comes with medical professionals familiar with their patients. Additionally, these professionals can provide a higher level of cultural competency which is learned over a sustained amount of time.

<u>Veterans Administration Advance Appropriations</u>

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 H.R. 3229 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.

Outside support and Unity in Indian Country

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. Attached to this testimony are 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. NIHB will continue to share these supportive documents with the committee as they are received.

It should also be noted that Tribes are ready and willing to engage with the government in advance consultation for the IHS budget should H.R. 3229 be enacted. The IHS Tribal Budget Formulation Workgroup already proposes its budget two years in advance, so this transition would not be difficult for Tribes. IHS officials have also stated publicly that they are engaged in conversations with the VHA on how this budgeting mechanism would work.

Conclusion

Medicare and Medicaid provide health care to millions of Americans, but these individuals do not have to worry on September 30 of each year if they will be treated on October 1 because they are considered "mandatory spending." The VHA provides care through discretionary spending, but still knows its budget a year in advance. Despite being founded on contractual treaty obligations and federal law, the requirement to fund the IHS is still discretionary. Our people must still wait on the whims of Congress before they can know if their health care is funded. Advance appropriations will be one important step forward toward improving the health of AI/ANs.

NIHB would like to again thank Chairman Young for introducing this important legislation and for holding this hearing on H.R. 3229. We urge the Subcommittee to markup and favorably report this critical bill as quickly as possible.

Thank you.