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The Northwest Portland Area Indian Health Board

Before:

House Subcommittee on Interior, Environment, and Related Agencies
Public Witness Hearing

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Good morning Chairman Simpson, Ranking Member Moran, and members of the Subcommittee. On behalf of the 43 Federally-recognized Tribes that the Northwest Portland Area Indian Health Board represents, we thank you for this opportunity to provide testimony on the Indian Health Service (IHS) FY 2013 budget.

Established in 1972, NPAIHB is a P.L. 93-638 tribal organization that represents 43 federally recognized Tribes in the states of Idaho, Oregon, and Washington on health care issues. Over the past twenty-one years, our Board has conducted a detailed analysis of the Indian Health Service (IHS) budget. Our Annual IHS Budget Analysis and Recommendations report has become the authoritative Tribal document on the IHS budget. It is used by the Congress, the Administration, and national Indian health advocates to develop recommendations on the IHS budget. It is indeed an honor to present you with our recommendations.

Indian Health Disparities

The recent reauthorization of the Indian Health Care Improvement Act (IHCIA) includes a declaration of national Indian health policy. Congress declares 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 to provide all resources necessary to effect that policy.[1] Congress recognizes that it has a duty to elevate the health status of American Indian and Alaska Native (AI/AN) people to a parity with the general U.S. population and to provide the resources necessary to do so. Our recommendations are consistent with this policy declaration and we respectfully ask the Congress to fulfill this duty.

While Tribes have been successful at reducing the burden of certain health problems, there is strong evidence that other types of diseases are on the rise for Indian people. For example, national data for Indian people compared to the U.S. all races rates indicate they are 638 percent more likely to die from alcoholism, 400 percent greater to die from tuberculosis, 291 percent greater to die from diabetes complications, 91 percent greater to die from suicide, and 67 percent more likely to die from pneumonia and influenza.[2] In the Northwest, stagnation in the data indicates a growing gap between the AI/AN death rate and that of the general population. Evidence suggests that this gap might be widening in recent years. These data document the fact

[1] 25 USC § 1601
[2] FY 2000-2001 Regional Differences Report, Indian Health Service, available: www.ihs.gov.

that despite the considerable gains that Tribes have made at addressing health disparities, these gains are reversing themselves and the health of Indian people could be getting worse.[3]

Recommendation: Maintain Current Services

The fundamental budget principle for Northwest Tribes is that the basic health care program must be preserved by the President's budget request and Congress. Preserving the IHS base program by funding the current level of health services should be a fundamental budget principle of Congress. Otherwise, how can unmet needs ever be addressed if the existing program is not maintained? Current services estimates' calculate mandatory costs increases necessary to maintain the current level of care. These "mandatories" are unavoidable and include medical and general inflation, federal and tribal pay act increases, population growth, and contract support costs.

The IHS Congressional Justification reports that the President's budget provides a $115.9 million to support activities identified by the Tribes as budget priorities including increasing resources for the Contract Health Services (CHS) program; funding Contract Support Costs (CSC) shortfall; funding for health information technology activities, and; providing routine facility maintenance. The IHS explains that the overall increase is adequate to "sustain the Indian health system, expand access to care, and continue to improve oversight and accountability" despite the insignificant increase. How can you sustain the system or expand access to care if you do not fund inflation? NPAIHB projections indicate that an additional $287 million is needed to maintain the current levels of care.

Inflation and population growth alone using actual rates of medical inflation extrapolated from the Consumer Price Index (CPI) and IHS user population growth predict that at least $304 million will be needed to maintain current services. Compound this with the fact that nearly half of the proposed increase is for staffing and operation of six new facilities ($49 million), which will only leave $66 million to cover current services. Estimates developed by the IHS during the FY 2013 budget formulation process and used during Tribal Consultation to develop Tribal recommendations on the FY 2013 budget, estimate current services at $136.8 million for pay act costs, inflation and population growth. These are IHS estimates and not Tribal estimates, thus there should be no question about the validity of these projections.

FY 2013 Current Service Requirements
Dollars in Thousands

Mandatory Cost to Maintain Current Services	*Increase Needed*
CHS Inflation estimated at 5.5%; and Population Growth	$64,112
Health Services Account (not including CHS) inflation	$167,058
Contract Support Costs (unfunded)	$99,300
Population Growth (estimated at 1.6% of Health Services accounts)	$72,722
Total Mandatory Costs	$403,192

[3] Please note findings in, *The Health of Washington State: A Statewide Assessment of Health Status, Health Risks, and Health Care Services*, December 2007. Available: http://www.doh.wa.gov/hws/HWS2007.htm.

The Administration's proposal does not provide any funding increases for inflationary costs except for the CHS program. The $54 million increase for the CHS program is respectable but will fall short by $10 million to maintain current services. Aside from this request for CHS, there is absolutely no additional funding requested for inflation, population growth or civilian and Tribal pay cost increases. NPAIHB estimates that at least $213.4 million is needed to fund inflationary costs and an additional $90.4 million is needed to cover population growth. Add to this the accumulated past year's CSC shortfall of $99.3 million, means that there are at least $403million in mandatory costs that will have to be absorbed by IHS programs—most likely by cutting services to Indian people.

Per Capita Spending Comparisons

The most significant trend in the financing of Indian health over the past ten years has been the stagnation of the IHS budget. With exception of a notable increase of 9.2% in FY 2001 and last year's 14% increase, 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 2009, we estimated that it would take at least $513 million to maintain current services[4]. The final appropriation for the IHS was a $235 million increase, falling short by $278 million. This means that Tribes must absorb unfunded inflation and population growth by cutting health services. The IHS Federal Disparity Index (FDI) is often used to cite the level of funding for the Indian health system relative to its total need. The FDI compares actual health care costs for an IHS beneficiary to those costs of a beneficiary served in mainstream America. The FDI uses actuarial methods that control for age, sex, and health status to price health benefits for Indian people using the Federal Employee Health Benefits (FEHB) plan, which is then used to make per capita health expenditure comparisons. It is estimated by the FDI, that the IHS system is funded at less than 60 percent of its total need.[5]

FY 2013 IHS Budget Recommendations

NPAIHB recognizes that the following recommendations may seem unreasonable in the current fiscal environment. However when the significant health care needs of Indian people are considered, our recommendations are realistic. We all recognize that in this difficult budget environment, we all must make sacrifices for our Country. As the historic record on Indians will demonstrate, no one has sacrificed more than Native Americans. We hope you will recognize the significant health care needs of Indian Country by supporting the IHS budget.

1. NPAIHB recommends that the Subcommittee restore funding eliminated in the President's request for inflation, population growth and Tribal pay costs. Our estimates are based on budget worksheets provided and used by the IHS during FY 2013 National Budget Formulation Meetings. We recommend $13.4 million to cover Tribal pay costs; $60 million for inflation, and; $52.4 million for population growth.

[4] FY 2009 IHS Budget Analysis & Recommendations, Northwest Portland Area Indian Health Board, March 17, 2008; available: www.npaihb.org.
[5] Level of Need Workgroup Report, Indian Health Service, available: www.ihs.gov.

2. NPAIHB recommends that at least an additional $10 million be provided for the IHS Contract Health Service Program (CHS) to cover inflation and population growth. The CHS program is extremely important for Portland Area Tribes since we do not have any hospitals and rely on the CHS program for all specialty and inpatient care. Other parts of the IHS system have access to hospitals for specialty and inpatient care. Because of this, the CHS program makes up 34% of the Portland Area budget and when less than adequate inflation and population growth increases are provided, Portland Area tribes are forced to cut health services to absorb these mandatory costs.

3. We recommend that the Subcommittee provide an additional $99.3 million to fund past years' CSC shortfalls that are owed to Tribes under P.L. 93-638. The well-documented achievements of the Indian self-determination policies have consistently improved service delivery, increased service levels, and strengthened Tribal governments, institutions, and services for Indian people. Every Administration since 1975 has embraced this policy and Congress has repeatedly affirmed it through extensive amendments to strengthen the Self-Determination Act in 1988 and 1994.

4. The Portland Area has developed a new innovative approach to constructing health facilities in order to address the health needs of Tribes. Portland Tribes have conducted a pilot study to examine the feasibility of developing regional referral specialty care centers to improve health care access and quality of health care. The study concludes that regional referral specialty care centers are feasible, and recommended a demonstration project to validate the concept's viability through the collection of actual data. The pilot study recommended that the demonstration project be located in the Northwest quadrant of the Portland Area. This would serve 24,000 users from Tribal facilities within an hour's drive. We recommend that the Subcommittee include $10 million for the Portland Area to develop this demonstration project.

Thank you for this opportunity to provide our recommendations on the FY 2013 IHS budget. I am happy to respond to any questions from the Subcommittee.

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