Congressional Talking Points for Indian Health

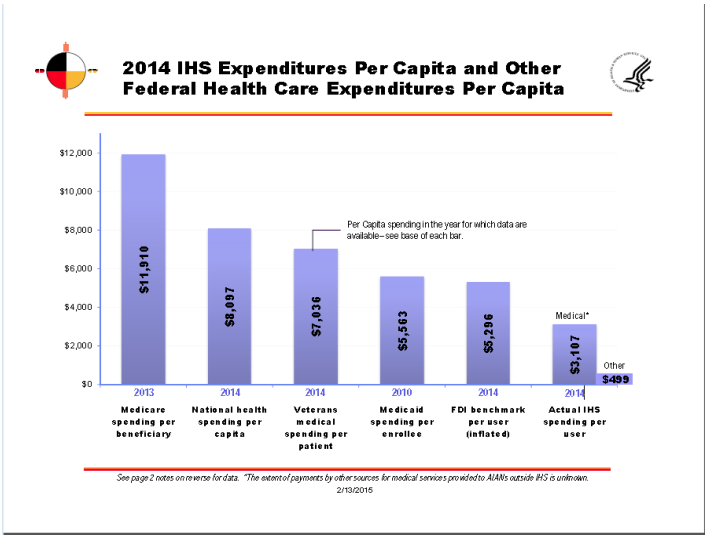
September 2015

National Indian Health Board

Increased funding for Indian Health

REQUEST: Fund the Indian Health Service at **$6.2 billion for FY 2017** and support IHS funding in requests to Interior Appropriations Subcommittee. Co-sponsor legislation that would exempt Indian Country from sequestration (H.R. 3063 and S.1497)

ISSUE: The administration has proposed $5.1 billion for FY 2016. This is a $460.6 million above the FY 2015 level. Overall, we believe that this request contains many provisions that will be beneficial for Tribes. The administration is eager to point out that that Indian Health Service funding has increased by 53%, or $1.8 billion, when comparing the FY 2008 Enacted budget to the FY 2016 proposed budget. However, this is a bit misleading. When considering staffing for new facilities, inflation, medical inflation, population growth, and Contract Support Cost obligations, the effective increase which would allow Tribes the resources necessary to actually improve health care, is minimal. This would explain why the reported net effect of these increases on the actual level of need, as calculated by IHS, is still hovering at a flat 56-59%. Tribes are asking that rather than comparing appropriations levels, that it be pointed out that the President's FY 2016 budget is proposed to be $5.1 billion compared to the Tribal Recommended full funding level of $28.7 billion. The proposed budget amount is actually 17% of the total needed to adequately fund the Tribal Health system in a manner which would bring parity with the rest of the nation.



When considering the level of funding appropriated to IHS, these statistics are not surprising. In 2014, the IHS per capita expenditures for patient health services were just $3,107 compared to $8,097 per person for health care spending nationally. The First People of this nation should not be last when it comes to health. Let's change that now.

TALKING POINTS

IHS Funding is fulfillment of the federal trust responsibility

- 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.
- For American Indians and Alaska Natives (AI/ANs), the federal budget is not just a fiscal document, but also a moral and ethical commitment. The budget request for Indian health care services reflects the extent to which the United States honors its promises of justice, health, and prosperity to Indian people.

Health Funding for Indian Country has been hurt by sequestration and government shutdown

- In FY 2013, sequestration cuts devastated Tribal communities throughout the United States. In a health care delivery system that has been chronically underfunded for decades, this was pure disaster for clinics across Indian Country.
- IHS should be fully exempt from sequestration in FY 2016 and beyond

National Indian Health Board

Special Diabetes Program for Indians

REQUEST: Renew the Special Diabetes Program for Indians at $200 million for 5 years and/or Support Permanent reauthorization of SDPI by September 30, 2017

ISSUE: The Special Diabetes Program for Indians (SDPI) will expire on September 30, 2017, unless Congress takes action. This program is usually renewed as part of the "Medicare Extenders" legislation. In 2015, the annual legislation which typically contained Medicare Extenders was permanently reauthorized. SDPI should be included in legislation between now and September 30, 2017. T

SDPI is changing the diabetes landscape in Indian Country. Today, the program supports 404 diabetes treatment and prevention programs in 35 states. Community-driven, culturally appreciate programs have led to significant advances in diabetes education, treatment and prevention. Failure to renew this program will mean worse health outcomes for American Indians and Alaska Natives and all the successes built by this program will be gone.

TALKING POINTS

SDPI is Saving Lives and Dollars

- Between 1995 and 2006, the incident rate of End-Stage Renal Disease (ESRD) in AI/AN people with diabetes fell by nearly 28 percent – a greater decline than any other racial or ethnic group.
- A reduction in new cases of ESRD would continue to decrease the number of patients needing dialysis, which means millions of dollars in savings for Medicare, the Indian Health Service, and other third party payers
- 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.

Bipartisan Support

- In late 2013, 75 percent of House members and 75 percent of the Senate signed a letter in support of SDPI

Community Transformation

- More than 80 percent of SDPI grant programs now use recommended public health strategies to provide diabetes prevention activities for AI/AN children and youth. This represents a 73% increase in primary prevention and a 56% increase in weight management activities targeting children and youth.
- Communities with SDPI-funded programs have seen a 57% increase in nutrition services, a 72% increase in community walking and running programs, and a 65% increase in adult weight management programs.

SDPI Improves Economic Conditions

- The SDPI's significant economic impact on Tribal communities throughout Indian Country has resulted in job creation opportunities that has brought skilled diabetes experts into Tribal communities and has helped to improve the economic infrastructure of Indian Country.
- In many areas, health jobs are limited, so SDPI is enabling these communities to increase employment and contributes to overall economic growth.

National Indian Health Board

Advance Appropriations for IHS

REQUEST: Ask your Representative to Co-sponsor H.R. 395 which if passed and signed into law, will allow Congress to appropriate funding for the Indian Health Service (IHS) a year in advance.

ISSUE: An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. This could greatly improve the delivery of care for IHS direct service Tribes as well as compacting Tribes. 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 Tribal health providers and IHS to adequately address the health needs of American Indians and Alaska Natives. Advance appropriations will allow IHS and Tribal health professionals time to plan and tackle many other administrative hurdles, thereby enriching access to care.

TALKING POINTS

Better stability in funding = better care

- The Indian Health Service is funded at only 59% of need, so any disruption in funding greatly hampers the ability of IHS, Tribes and Urban health systems to deliver necessary services due to lack of funds. Adopting advance appropriations for IHS would result in the ability of health administrators to continue treating patients without wondering if —or when— they will have the necessary funding.

Better recruitment and retention ability

- IHS and Tribal health professionals will know in advance how many positions they can hire or retain since staff often resign when funding is in doubt.

Parity between the Indian Health System and other Federal Health Providers

- In FY 2010, the Veterans Health Administration (VHA) achieved advance appropriations. IHS, also provides direct medical care to fulfill legal promises made by the federal government. The promises to American Indians and Alaska Natives were made in Treaties and executive orders, and have been repeatedly reaffirmed in Supreme Court cases and legislation. Altogether, these create a trust responsibility that runs from the federal government to the Tribes.
- Other federally-funded health programs such as Medicare and Medicaid are "mandatory" funding, meaning that these programs are automatically funded without annual appropriations, and without the uncertainty seen in other areas of the budget. While advanced appropriations for IHS does not create would reduce uncertainty for the Indian Health system

Significantly Improved program efficiency

- Funding disruptions create significant administrative costs for health programs. Advance appropriations would result in decreased costs to health programs by allowing long-term contracts with outside vendors and suppliers
- Better ability to plan programmatic activity over several years, thereby leading to better health outcomes

IHS Budget is stable over time, and could easily be predicted in advance

- With the exception of population growth and inflation, the IHS budget has remained stable over time
- Top Priorities of Purchased/referred care; Mental Health; Alcohol and Substance Abuse; Construction are consistent from year to year.

Medicare Like Rates for IHS and Tribes

REQUEST: Co-sponsor legislation that would enable the Indian Health Service and Tribes to purchase hundreds of thousands of additional services for American Indian and Alaska Native (AI/AN) patients annually, at no cost to the federal government. Legislation will be introduced soon.

ISSUE: Purchased/ Referred Care (PRC) (formerly Contract Health Services) programs operated by the Indian Health Service (IHS) and Tribes currently routinely pay full-billed charges for non-hospital care purchased for patients, including physician services. A 2013 Government Accountability Office (GAO) report revealed that this is up to 70% more than Medicare and other federal payers. This contributes in large part to the significant shortfalls the program experiences annually, leading to hundreds of thousands of denied and deferred services across Indian Country. The GAO report also found that that if the Indian Health System paid a "Medicare Like" rate for services purchased from non-hospital providers, IHS and Tribal PRC programs would save millions of dollars, resulting in an estimated 253,000 additional physician services annually.

The Native CARE Act (introduced as (H.R. 4843 in the 113th Congress) amends the Social Security Act to expand the Medicare-Like Rate cap beyond hospitals to cover all Medicare-participating providers and suppliers. It will ensure that AI/ANs have continued access to health care providers by making it a requirement for all Medicare-participating providers and suppliers, including physicians, to accept this rate of payment as payment in full as a condition participating in the Medicare program. This payment reform is achieved without additional cost to the federal government

TALKING POINTS

More Services for AI/AN People

AI/AN people continue to suffer disproportionately from a variety of illnesses, including heart disease, cancer, tuberculosis, and diabetes. On average, AI/AN life expectancy is 4.2 years less than the U.S. general population.

- Meanwhile, the Indian Health Service is funded at only 59% of need, with PRC programs frequently running out of funds prior to the end of the fiscal year (FY).
- In FY 2013, the IHS estimates it denied 147,000 necessary services due to lack of funds.
- By imposing a Medicare Like Rate cap on all payments to providers, IHS and Tribal PRC programs are projected to save millions of dollars annually, resulting in an estimated 253,000 additional services each year.

No Cost to the Federal Government

- In its evaluation of the Administration's legislative request to expand Medicare Like Rates, the Office of Management and Budget (OMB) projected that this change is budget neutral.

Parity between the Indian Health System and other Federal Payers

- Medicare, the Veterans' Administration, and the Department of Defense all pay vastly lowered rates for the care purchased on behalf of their patients.
- The Native CARE Act simply brings the Indian Health Service in line with the rates paid by other federal entities, a more efficient and effective use of federal dollars.

Continued Access to Care

- Since all Medicare participating providers and suppliers must accept the Medicare Like Rate from the Indian Health System under the Native CARE Act, AI/AN access to care is preserved.
- Because AI/ANs make up less than 2% of the total demand for care nationally, and because most providers and suppliers are currently accepting Medicare rates for many services, the proposed legislation is not likely to impact existing providers and suppliers in a significant way.

Tribal Exemption for the Affordable Care Act Employer Mandate

REQUEST: Co-sponsor the "Tribal Employment and Jobs Protection Act" (S.1771 and H.R. 3080) introduced by Senator Steve Daines (R-MT) and Representative Kristi Noem (R-SD), which would exempt Tribal employers from the Employer Mandate under the Affordable Care Act (ACA).

ISSUE: The Employer Shared Responsibility Rule, otherwise known as the Employer Mandate, states that all employers must offer health insurance to their employees or pay a penalty. Tribal governments are currently counted as large employers for application of this rule.

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/AN 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). Requiring Tribal employers to provide AI/ANs with such coverage anyway, and penalizing them if they do not, functionally invalidates the AI/AN exemption from the individual mandate by shifting the penalty from the individual to the Tribe itself.

TALKING POINTS

Individual Mandate exemption puts AI/ANs in conflict with the employer mandate

- Everyone is responsible for purchasing health insurance on the marketplace
- AI/ANs have an exemption from the individual mandate because of the trust responsibility that the federal government will provide health care (e.g. IHS access)

To encourage AI/AN enrollment in the marketplace, AI/AN have access to a number of tax credits that make purchasing insurance inexpensive

- Employer Mandate Conflicts with AI/AN special provisions because if an employer offers any insurance, even basic coverage, a person voids their ability to get special benefits and protections under the ACA Marketplace
- If the employer doesn't offer insurance, they will face a penalty, even if their employee is exempt from the individual mandate.
- Tribal government employees are often Tribal members

Many Tribal governments don't have the resources to purchase insurance for their employees

- Tribal governments often operate on the margins and are the *only* employer on a reservation
- If an AI/AN employee, with health insurance purchased for them by their employer (often times through federal funding), receives healthcare from the Indian Health Service, Tribes eventually end up paying the federal government to provide healthcare which is violation of their trust obligation
- 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.
- Unlike a private business, many tribal governments depend of federal resources to perform essential government functions like law enforcement, public health services, and education. They cannot just raise prices or taxes to compensate for the mandate.

Definition of Indian in the Affordable Care Act

REQUEST: Enact legislation that would streamline the Definition of Indian in the Affordable Care Act (ACA) to conform with definitions used by IHS and the Centers for Medicare & Medicaid Services

ISSUE: The Affordable Care Act (PL 111-148) contains several important provisions for Native Americans including permanent reauthorization of the Indian Health Care Improvement Act. However, certain portions of health care reform (aka "Obamacare") contain different definitions of "Indian" which led to conflicting interpretations of eligibility for benefits and requirements for coverage. These definitions are different than those used by IHS and the Centers for Medicare and Medicaid Services and require that an individual be a member of a federally recognized Tribe. On June 26, 2013 HHS announced a hardship exemption waiver that exempts AI/ANs who are not members of federally recognized from the tax penalty if they do not carry health coverage. Although this is a positive step, it only temporarily fixes 1 of 3 issues. It does not address the monthly enrollment benefit or cost-sharing.

TALKING POINTS

- Tribes, as sovereign nations, determine their membership requirements, which vary greatly across Indian Country, so many AI/AN individuals who, although there are eligible for IHS services, will not have afforded the benefits and protections due to AI/AN in the ACA for a variety of reasons.[1]

- This fix **will not** change who is eligible to receive IHS services, but will ensure that the benefits and protections in the law are given to those who it was intended.

- Without a fix, AI/ANs will be left out of benefits intended for them in the law, which will help to bring 3rd party revenue into an already underfunded IHS.

- Without a fix, the federal government will essentially create another class of "sometimes Indians" who are eligible for some benefits (e.g. IHS) but not others (those in the ACA)

- In the 113th Congress, Senator Mark Begich introduced legislation (S.1575) that would streamline the definitions in the law and make them consistent with definitions already used by the Indian Health Service and other government agencies.

- Because the amount of the effected population is so small, and the amount of participation in the health insurance marketplace is so low, the estimated cost for the fix is nominal.

- **Seeking a legislative or regulatory fix.**

- [1] Some examples include:
  - *Children born into Tribes that do not permit enrollment until age 18 would be determined ineligible as "Indians" under the ACA, although they would continue to be treated as such by IHS and by CMS for Medicaid.*
  - *California Indians who are entitled to IHS and Medicaid services as Indians will not be treated as Indian under the ACA.*
  - *In Alaska, many Alaska Natives who are too young to have enrolled in an Alaska Native Claims Settlement Act Corporations, which largely ended in the 1970s, continue to be eligible for IHS services but will be denied the special protections due Indians in the ACA, because they have not yet become shareholders which is mostly dependent on inheritance from a parent or grandparent who may still be living.*

Contract Support Costs

REQUEST: Enact Mandatory Appropriations for Contract Support Costs in FY 2017 as proposed in the FY 2016 Budget request for the Indian Health Service (IHS). For FY 2016, support Senate Appropriations language which creates a separate account for CSC.

ISSUE: 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. Due to this decision, Contract Support Costs were fully funded by Congress in FY 2014. However, in order to achieve this, cuts had to be made to other areas of the Indian Health Service Budget. Congress asked IHS and the Tribes to develop a long-term solution to funding CSC so that cuts do not have to be made for other programs.

On May 12, 2014, The National Indian Health Board passed a resolution that would require that CSC are appropriated as mandatory spending. In the FY 2016 Budget request to Congress, the IHS included a proposal to enact mandatory CSC for 3 years starting in FY 2017. The Appropriations Committees also took action on this in the draft FY 2016 bill. In both House and Senate legislation, CSC is fully funded in FY 2016. In the House, the appropriations language allows CSC to be used beyond FY 2016, but it is still part of the "services" budget meaning it could be taken from other accounts at IHS. The Senate Appropriations bill provides CSC as a separate appropriation, meaning that if a shortfall occurred, other IHS accounts would not be cut to pay CSC. The U.S. Treasury would have to find funding from elsewhere to cover these costs.

TALKING POINTS

CSC has been mandated to be funded by the Supreme Court, and therefore should be a mandatory allocation by Congress

- Now firmly established by U.S. Supreme Court precedent, the requirement to pay contract support costs under the Indian Self-Determination and Education Assistance Act is a binding legal obligation on the part of the federal government under substantive law – in other words, an *entitlement* –requiring full payment to contracting tribes and tribal organizations.
- Nevertheless, funding for contract support costs has historically been appropriated on a discretionary basis, leading to decades of implementation challenges and litigation that has twice put the question of the federal government's liability for unpaid contract support costs before the Supreme Court.
- It is time to square the appropriations process with the mandatory nature of contract support costs under substantive law and repeated judicial interpretations: funding for contract support costs must be appropriated on a mandatory basis.

Paying for CSC by cutting for other programs serving Tribes is a violation of the trust responsibility

- Like other federal contractors, Tribes are entitled to receive full funding of CSC. This has been ruled the case by the Supreme Court.
- Without CSC paid, funds are used from other areas of the budget to cover these costs, which is a violation of the federal trust responsibility