Congressional Talking Points for Indian Health

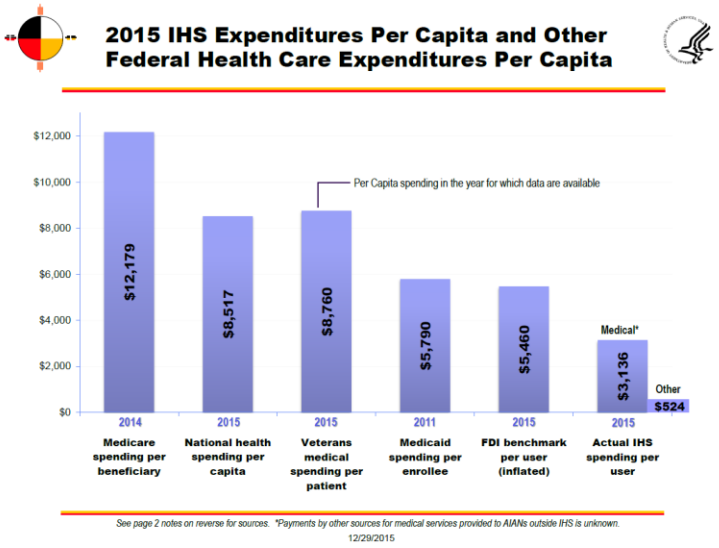
April 2016

National Indian Health Board

Increased funding for Indian Health Service

REQUEST: Fund the Indian Health Service (IHS) 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 $5.2 billion for FY 2017. 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 $5.2 billion compared to the Tribal Recommended full funding level of $30 billion. The proposed budget amount is actually just a fraction 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 2015, the IHS per capita expenditures for patient health services were just $3,136 compared to $8,760 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 2017 and beyond

National Indian Health Board

Increase Funding for Public Health Programs in Indian Country

Request: Create an American Indian and Alaska Native public health block grant administered through the Centers for Disease Control and Prevention (CDC) and create flagship funding for Tribal health departments for key public health issues in Indian Country at the CDC.

Issue: To facilitate upholding its trust responsibility to the Tribes, the federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to American Indians and Alaska Natives. Yet, IHS services are largely limited to direct patient care, leaving little, if any, funding available for public health initiatives such as disease prevention, education, research for disease, injury prevention, and promotion of healthy lifestyles. This means that Indian Country continues to lag far behind other communities in basic resources and services. Our communities are therefore more vulnerable to increased health risks and sickness.

As independent, sovereign nations, Tribal governments do not operate within the state regulatory structure, and often must compete with their own state governments for resources. Tribes are regularly left out of statewide public health plans and federal funding decisions for public health programs. Without a local tax base and little (if any) outside funding, Tribal communities are often the most in need of public health dollars. Tribes were ignored during the formulation of the US public health system, and it is now time to redress this wrong.

TALKING POINTS

Tribal Communities were not part of the creation of the U.S. Public Health System and must work to catch up to states and localities

- Tribes are often left out of state public health planning, and often have to compete with their own states for federal dollars

The Federal Trust Responsibility means that agencies should prioritize funding to Indian Country

- Competitive Grants do not fulfill the federal trust responsibility towards Indian Country. That has already been promised to tribes- exchanging compensation and benefits for Tribal land and peace.
- Tribes have no local tax base as states and cities do. That means, that federal cuts impact Indian Country even more because a larger share (e.g. almost 100%) of services revenue comes from the federal government.
- Many federal grants have little penetration into Indian Country because Tribes have difficulty meeting the service population requirements, match requirements, or are under resourced to even apply for the grants.

Without base funding, Tribes cobble together public health funding from a variety of federal, state, local, and private funding sources

- This leads to rampant unpredictability and inconsistency among Tribal public health initiatives.
- Tribal public health systems remain chronically underfunded, and unable to provide comprehensive services to their members, which results in increase risks from preventable and contagious diseases.

Special Diabetes Program for Indians

REQUEST: Support long-term renewal of the Special Diabetes Program for Indians (SDPI) funded at $200 million

ISSUE: SDPI is currently funded at $150 million/ year and 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.

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 2000 and 2011, the incident rate of End-Stage Renal Disease (ESRD) in AI/AN people with diabetes fell by **43 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 2014. 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.

Advance Appropriations for IHS

REQUEST: 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, IHS budget has remained consistent
- Top Priorities of Purchased/referred care; Mental Health; Alcohol and Substance Abuse; Construction are consistent from year to year.

National Indian Health Board

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.

National Indian Health Board

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. Senators should **co-sponsor S. 2114** introduced by Senator Lisa Murkowski (R-AK)

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.*

Allow for the Expansion of Dental Therapists in Tribal Communities

Request: Repeal restrictive language contained in the Indian Healthcare Improvement Act (IHCIA) (25 U.S.C. 1616l(d)) that prevents the use of Dental Therapists (DTs) in Tribal Communities without approval by a state legislature

Issue: Tribal communities suffer from some of the worst oral health disparities in the United States. AI/AN children have an average of 6 decayed teeth, while the same age group in the U.S. population overall has only one. For over a decade, Tribes in Alaska have successfully employed Dental Health Aide Therapists (DHATs), who have expanded oral health services to over 40,000 Alaska Natives. These safe and effective mid-level oral health providers deliver basic and routine services (i.e. cleanings, fillings, simple extractions, oral health education, sealants, etc.) to communities who do not have access to a regular dentist. However, when Congress passed the Indian Health Care Improvement Act in 2010, language was included that would limit the use of DHATs outside of Alaska within the Community Health Aide Program unless a state legislature approves. NIHB believes that this is a direct violation of the principle of Tribal sovereignty, and that Tribal governments, not state legislatures, should dictate who is able to deliver care in their community.

TALKING POINTS

The Language in the IHCIA is a direct violation of Tribal Sovereignty

- Tribes are sovereign nations, and as such, should be able to make their own decisions about who provides healthcare services in their communities.
- State legislatures should not have a say in these decisions for Tribes

Dental Therapists provide Safe and Effective Oral Health Services in Remote Locations where dentists are not available

- DTs practice in 54 countries, including the US, Canada, England, Australia, New Zealand and The Netherlands
- Under supervision of dentists, dental therapists can practice in remote settings where there is need for additional provider capacity
- Evidence shows care provided by dental therapists is high quality, cost effective and safe
    - 84.7% of the care DTs provide is preventative and routine
    - Malpractice Insurance is only $93 / year for a DT, because they are considered so safe

Dental Therapists are often community members who go back to work in their own communities

- A rigorous 2-year training program means that more AI/ANs will go into the practice
- DTs have the same amount (or more) clinical training as a dentist in the procedures that are within their scope of practice
- When a DT is on site, they can provide regular preventative care, which decreases the amount of dental emergencies, and allows a visiting dentist to focus on the toughest cases.

Medicare Like Rates for IHS and Tribes

REQUEST: 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.

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.