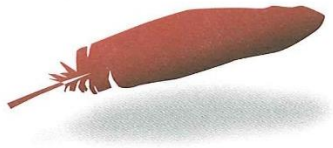
National Indian Health Board



MEMORANDUM: NIHB Analysis of FY 2024 Draft Appropriations Legislation
DATE: August 2, 2023

Overview

The House and Senate have each released their annual appropriations bills for the Indian Health Service (IHS) and other HHS accounts. The outlook on spending for FY 2024 is a tightening belt, with very low chances of breakout changes, including the addition of more funding for IHS. This fall, the National Indian Health Board (NIHB) will be advocating to oppose IHS rescissions, expand advance appropriations to all IHS accounts, and reclassify CSC and 105(*l*) mandatory payments as mandatory spending. Outreach to Congressional members back in their district during August recess and maintaining pressure into the fall will be critical to maximizing Tribal program investment.

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Political Context

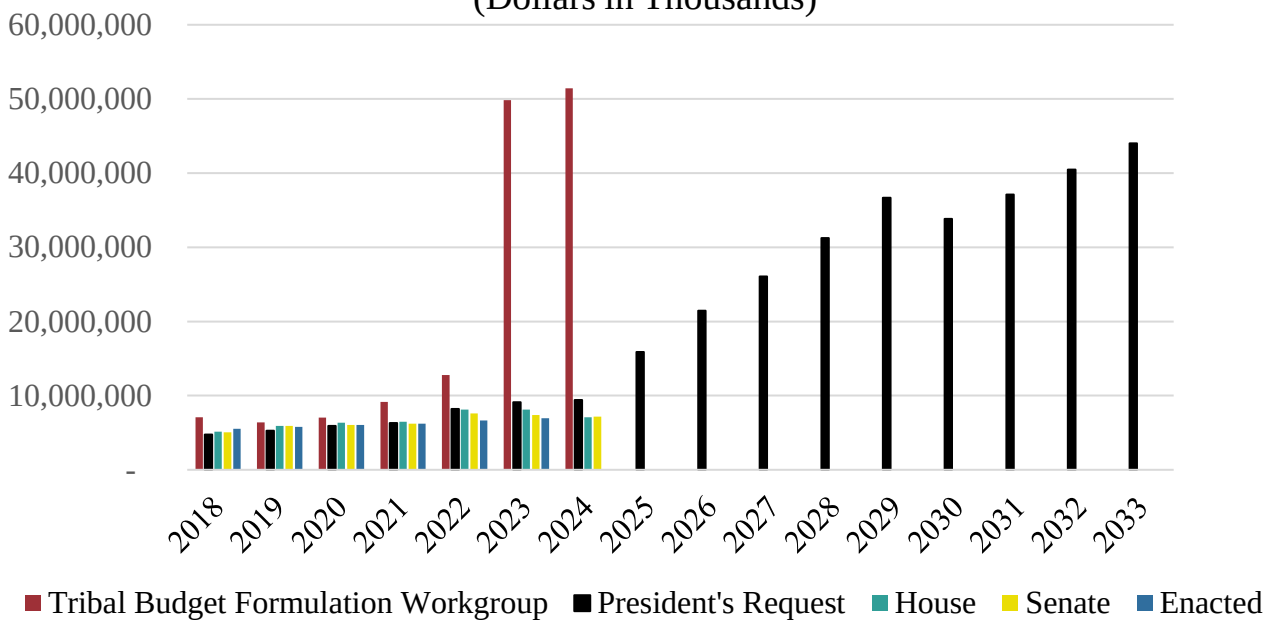
Last week, the Senate Appropriations Committee released and passed its FY 2024 Interior, Environment and Related Agencies Appropriations bill. This bill would fund the Indian Health Service (IHS) at about $7.2 billion, which is a small increase of $218.6 million over FY 2023. However, the Senate's bill also included a "rescission" of $350 million from IHS from the American Rescue Plan Act, sending IHS funds back to Treasury.

Earlier this summer, the House Appropriations Committee released its bill that would fund IHS at roughly $7.1 billion. The House and Senate bills both continue IHS advance appropriations, and the House proposal would expand the advance appropriation to every account except Contract Support Costs (CSC) and Section 105(*l*) Lease Agreements. Unfortunately, neither the House nor Senate bill included reclassification of Contract Support Costs and 105(*l*) leases as mandatory spending, which is a long-time request of Tribal nations, and a provision included in last year's Senate proposal.

The House and Senate have both introduced FY 2024 Labor, Health and Human Services (HHS), Education, and Related Agencies Appropriations bills. The House has released bill text, but a Committee report has not been released – which is the common source of appropriations detail. The Senate has released its accompanying report, and the bill largely continues the funding status quo for HHS's Tribal programs.

Overall, the change in party control of the House of Representatives has ushered in less spending on domestic programs, including U.S./Tribal relations, which corelates with lower spending outcomes in both the House and Senate appropriations bills, as detailed below. While each proposal is more in line with projections of past enacted amounts, the House and Senate take fundamentally different paths to achieve FY24 spending. Under detailed scrutiny, most of the annual increase is carried by just a handful of accounts – a systemic and repetitive practice that leaves some IHS programs losing purchasing power year after year, setting back an already chronically underfunded treaty and trust obligation to Tribal nations.[1]

Figure 1.1: IHS Proposals vs Enacted
(Dollars in Thousands)



Top-Line Comparison

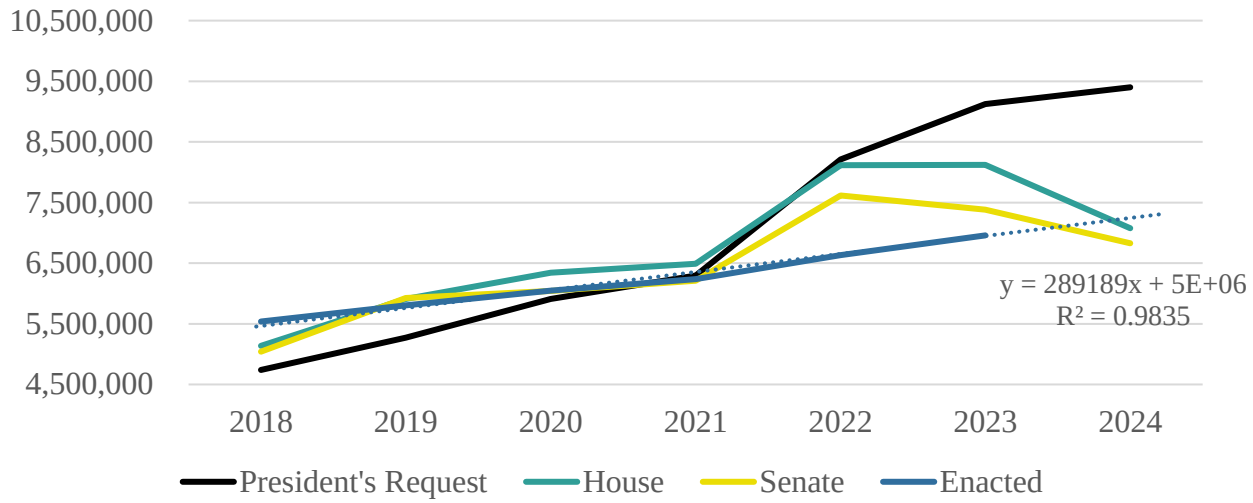
Congress continues to put forward amounts approximately seven times less than the amount collaboratively developed by the IHS National Tribal Budget Formulation Workgroup (NTBFW). In 2021, the NTBFW shifted to using the full Needs Based Budget (NBB) estimate for a given year instead of its phased in approach. The Workgroup stated that "accurate reporting of unmet obligations is necessary to show a clear picture of government performance in fulfilling its trust and treaty obligations."

President's IHS Mandatory Proposal

Figure 1.1 (above) includes the President's phased in approach to IHS mandatory funding. The President's proposal tells an important comparative story of one of the key parties to the annual budget and spending process. In addition to funding increases, the President's proposal includes changing the spending to mandatory in phases. This usually comes with changes that affect how accounts are reported and who has jurisdiction in Congress. For the purpose of this analysis, those proposed changes are controlled for easier dollar comparisons.

[1] U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (hereinafter "*Broken Promises*"), 65, available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf, accessed on: November 20, 2022.

Figure 1.2: Federal Proposals vs Enacted
(Dollars in Thousands)



Federal Comparison

When observing just Federal performance through 2024, we see the latest trends in greater detail. Since 2021, the enacted amount is coming in consistently lower than the House and the Senate bills. For FY 2024, the House and Senate have come in much closer to one another, and potentially more in line with, but a bit under, regular annual increases since 2018.

Since the Fiscal Responsibility Act of 2023 (P.L. 118-5) set caps on discretionary spending, the probability of breakout changes during negotiations this fall are relatively low. One change that may still be achievable is the reclassification of CSC and 105(*l*) lease payments as mandatory spending because no change to authorizing law is necessary and the payments are already mandatory obligations.[2] For this reason, a coalition of more than 23 partner organizations told Congress this change is good governance that makes sense.[3] The question of Congressional support for good governance is under constant study.

CSC and 105(l) Lease Agreements

Neither the House nor the Senate include a proposal to reclassify CSC and 105(*l*) lease agreements as mandatory. Last year, the Senate included a proposal to reclassify these accounts as mandatory that did not make it into the final negotiated agreement. The change in party control of the House included shifts in party and voting dynamics that drive resistance to new spending or the perceived lack of control associated with certain mandatory entitlement programs. NIHB believes that with

[2] The Appropriations Committees recognized as far back as 2014 that the mandatory nature of CSC obligations places the appropriators in an "untenable position." As they wrote in the Explanatory Statement that year, "[t]ypically obligations of this nature are addressed through mandatory spending, but in this case since they fall under discretionary spending, they have the potential to impact all other . . . equally important tribal programs." Similarly, appropriators stated in the FY 2021 Explanatory Statement for the Interior bill that 105(*l*) leases, as confirmed in the *Maniilaq* cases, appear to create an entitlement to compensation . . . that is typically not funded through discretionary appropriations. Tribal participation in ISDEAA programs has increased rapidly over the past decade, and Congress continues to struggle to meet CSC and Section 105(*l*) funding obligations through discretionary appropriations. In their Explanatory Statements, the Committees called on the agencies and Congress to find a sustainable solution including mandatory reclassification.

[3] https://www.nihb.org/resources/Tribal%20Org%20Letter%20to%20Appropriators%20on%20CSC%20and%20105.pdf

proper education and outreach, this account reclassification could be included in furtherance of improving transparency and accountability in the annual appropriations process – a bipartisan goal shared by both sides of the aisle in Congress.

Line-by-Line Comparison

In a line-by-line IHS comparison, the House generally proposes higher increases than the Senate, but it achieves this through a few key account changes (see Figure 1.3 below). In the House bill, its various funding increases come largely from consolidating the Indian Health Care Improvement Fund ($74.1 million) into the Hospitals and Health Clinics line item and from reducing funding for the Electronic Health Records line by $182.0 million (-83.6%). In the Senate bill, no single "Services" or "Facilities" account gets a large increase. For both versions, the majority of the increase goes to estimates for CSC and Section 105(l) lease payments. This means that annual increases are further consolidated into just a small handful of programs each year.

Rescissions

In the Senate bill, there is a section outside of the accounting and spending for IHS that rescinds funds provided to IHS pursuant to Sec. 11001 of the American Rescue Plan Act (P.L. 117-2). This amount was provided as supplemental funding to the IHS, so the rescission of these funds is accounted for differently in the Senate's appropriation bill. However, NIHB believes that inclusion of this rescission in the analysis paints a clearer picture of the "cost" of each bill for IHS accounts.

Advance Appropriations

In furtherance of the historic victory achieved by champions throughout Indian Country, both the House and Senate bills include FY 2025 advance appropriations for the IHS (see Figure 1.3 "FY 2025"). The House expands the advance appropriation to include every discretionary account at IHS except CSC and 105(*l*) lease payments, but flat funds every account from FY 2024 to FY 2025. The Senate's advance appropriation maintains the exclusion of Electronic Health Records, Health Care Facilities Construction, and Sanitation Facilities Construction but, otherwise, flat funds every account.

Both the House and Senate bills include adjustments to current year funding for the advance appropriations provided last year. This is a strong signal that there is bipartisan support to solidify and maintain advance appropriations, there are indications of support for covering more accounts in the IHS budget, and there will be opportunities for rational current-year adjustments in FY 2025.

Conclusion

Key to fall negotiations will be opposing IHS rescissions for punishing an already starved system, working to expand advance appropriations to all IHS accounts to maximize its efficiency and savings, and reclassifying CSC and 105(*l*) mandatory payments as mandatory spending. With Congress tightening the belt around domestic discretionary spending, framing the duty owed, the lives at stake, and the history of chronic underfunding will be a constant underpinning of comparative success in the next two funding cycles.

Stay engaged with NIHB and its partners throughout the fall, as we work to maximize U.S. spending for Indian Country. If you have any questions please contact Caitrin Shuy, NIHB Director of Government Relations, at cshuy@nihb.org, or Tyler Scribner, Director of Budget and Appropriations, at tscribner@nihb.org.

Figure 1.3: IHS Regular Appropriations within the Interior, Environment and Related Agencies Subcommittee

IHS Regular Appropriations (Dollars in Thousands)	FY 2023 Enacted	House				Senate			
		FY 2024	FY 2025	House vs Enacted		FY 2024	FY 2025	Senate vs Enacted	
Clinical Services									
Hospitals and Health Clinics	$ 2,503,025	$ 2,660,013	$ 2,660,013	$ 156,988	6.27%	$ 2,578,585	$ 2,578,585	$ 75,560	3.02%
Electronic Health Record System	$ 217,564	$ 35,572	$ 35,572	$ (181,992)	-83.65%	$ 217,564	$ -	$ -	0.00%
Dental Health	$ 248,098	$ 288,230	$ 288,230	$ 40,132	16.18%	$ 254,729	$ 254,729	$ 6,631	2.67%
Mental Health	$ 127,171	$ 130,864	$ 130,864	$ 3,693	2.90%	$ 130,155	$ 130,155	$ 2,984	2.35%
Alcohol and Substance Abuse	$ 266,440	$ 267,194	$ 267,194	$ 754	0.28%	$ 266,843	$ 266,843	$ 403	0.15%
Purchased/Referred Care	$ 996,755	$ 996,755	$ 996,755	$ -	0.00%	$ 997,755	$ 997,755	$ 1,000	0.10%
Indian Health Care Improvement Fund	$ 74,138	$ -	$ -	$ (74,138)	-100.00%	$ 74,138	$ -	$ -	0.00%
Subtotal, Clinical Services	**$ 4,433,191**	**$ 4,378,628**	**$ 4,378,628**	**$ (54,563)**	**-1.23%**	**$ 4,519,769**		**$ 86,578**	**1.95%**
Preventative Health									
Public Health Nursing	$ 110,782	$ 110,782	$ 110,782	$ -	0.00%	$ 111,626	$ 111,626	$ 844	0.76%
Health Education	$ 24,350	$ 24,350	$ 24,350	$ -	0.00%	$ 24,746	$ 24,746	$ 396	1.63%
Community Health Representatives	$ 65,212	$ 65,212	$ 65,212	$ -	0.00%	$ 65,212	$ 65,212	$ -	0.00%
Immunization (Alaska)	$ 2,183	$ 2,183	$ 2,183	$ -	0.00%	$ 2,183	$ 2,183	$ -	0.00%
Subtotal, Preventative Health	**$ 202,527**	**$ 202,527**	**$ 202,527**	**$ -**	**0.00%**	**$ 203,767**	**$ 203,767**	**$ 1,240**	**0.61%**
Other Services									
Urban Indian Health	$ 90,419	$ 115,156	$ 115,156	$ 24,737	27.36%	$ 92,419	$ 92,419	$ 2,000	2.21%
Indian Health Professions	$ 80,568	$ 94,324	$ 94,324	$ 13,756	17.07%	$ 82,568	$ 82,568	$ 2,000	2.48%
Tribal Management Grant Program	$ 2,986	$ 2,986	$ 2,986	$ -	0.00%	$ 2,986	$ 2,986	$ -	0.00%
Direct Operations	$ 103,805	$ 101,729	$ 101,729	$ (2,076)	-2.00%	$ 103,805	$ 103,805	$ -	0.00%
Self-Governance	$ 6,174	$ 6,174	$ 6,174	$ -	0.00%	$ 6,174	$ 6,174	$ -	0.00%
Subtotal, Other Services	**$ 283,952**	**$ 320,369**	**$ 320,369**	**$ 36,417**	**12.83%**	**$ 287,952**	**$ 287,952**	**$ 4,000**	**1.41%**
Indian Health Facilities									
Maintenance and Improvement	$ 170,595	$ 170,595	$ 170,595	$ -	0.00%	$ 170,595	$ 170,595	$ -	0.00%
Sanitation Facilities Construction	$ 196,167	$ 196,167	$ 196,167	$ -	0.00%	$ 196,167	$ -	$ -	0.00%
Health Care Facilities Construction	$ 260,896	$ 260,899	$ 260,899	$ 3	0.00%	$ 260,896	$ -	$ -	0.00%
Facilities and Environmental Health Support	$ 298,297	$ 306,176	$ 306,176	$ 7,879	2.64%	$ 305,133	$ 305,133	$ 6,836	2.29%
Equipment	$ 32,598	$ 42,862	$ 42,862	$ 10,264	31.49%	$ 32,598	$ 32,598	$ -	0.00%
Subtotal, Indian Health Facilities	**$ 958,553**	**$ 976,699**	**$ 976,699**	**$ 18,146**	**1.89%**	**$ 965,389**	**$ 508,326**	**$ 6,836**	**0.71%**
Rescission	**$ (29,388)**					**$ (350,000)**			
Contract support	**$ 969,000**	**$ 1,051,000**	**$ -**	**$ 82,000**	**8.46%**	**$ 1,051,000**	**$ -**	**$ 82,000**	**8.46%**
Tribal Sec. 105(l) leases	**$ 111,000**	**$ 149,000**	**$ -**	**$ 38,000**	**34.23%**	**$ 149,000**	**$ -**	**$ 38,000**	**34.23%**
Grand Total	**$ 6,928,835**	**$ 7,078,223**	**$ 5,878,223**	**$ 120,000**	**1.73%**	**$ 6,826,877**	**$ 5,228,112**	**$ 218,654**	**3.16%**