The Way Indian Health is Funded Puts the Health of American Indians and Alaska Natives at Risk

The provision of health care to American Indians and Alaska Natives (AI/ANs) is a treaty right/trust obligation of the United States and the trustee is Congress. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace. Congress has consistently legislatively affirmed this responsibility.[1]

American Indians & Alaska Natives Experience Significant Health Disparities

To facilitate upholding its trust responsibility, the Federal government created the Indian Health Service (IHS) and tasked the agency with providing health services to AI/ANs. Today, the IHS serves approximately 2.2 million AI/ANs.

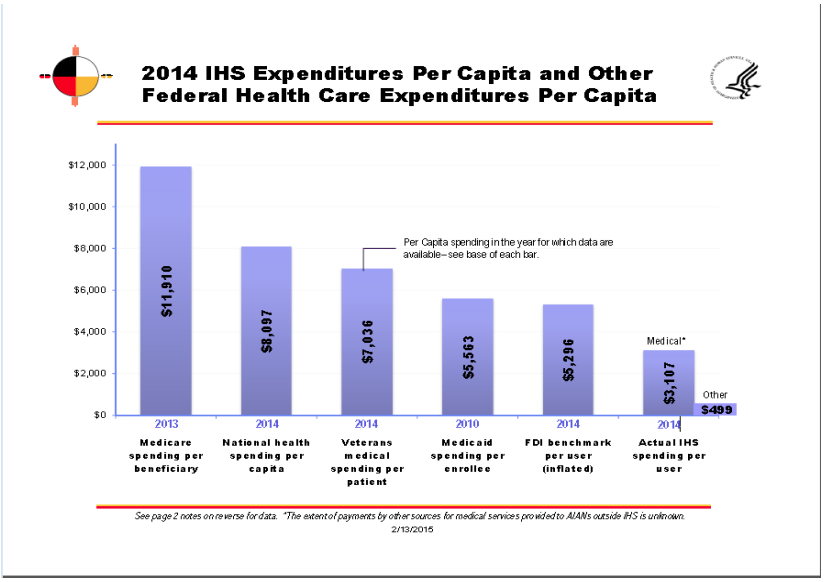
- To bring health care funding for AI/ANs in parity with mainstream care provided to others, the true IHS budget need is approximately $29.96 billion vs. enacted 2015 IHS budget of $4.6 billion.

- Health status and living conditions are still among the worst in the United States:
  - 40% of AI/ANs living on reservations live in poverty; 20.5% lack a complete kitchen 24.8% lack complete plumbing; 18.9% lack a telephone; 7.8% live in overcrowded conditions
  - ***Eight of the 10 poorest counties*** in the United States are in Indian Country.
  - ***Life expectancy 4.2 years lower than the rest of the United States*** with some Tribes reporting an average age of death @ 50 years old.

- Higher rates of mortality due to:
  - Alcoholism 552% higher
  - Diabetes 182% higher
  - Unintentional Injuries 138 % higher
  - Suicide 74% higher

- Much care is rationed to "life or limb only" meaning that usually only symptomatic treatment is given leading to long-term pain management, worse health outcomes, and increased costs to the Indian health delivery system.

IHS Funding is not at parity with other Federal programs[2]



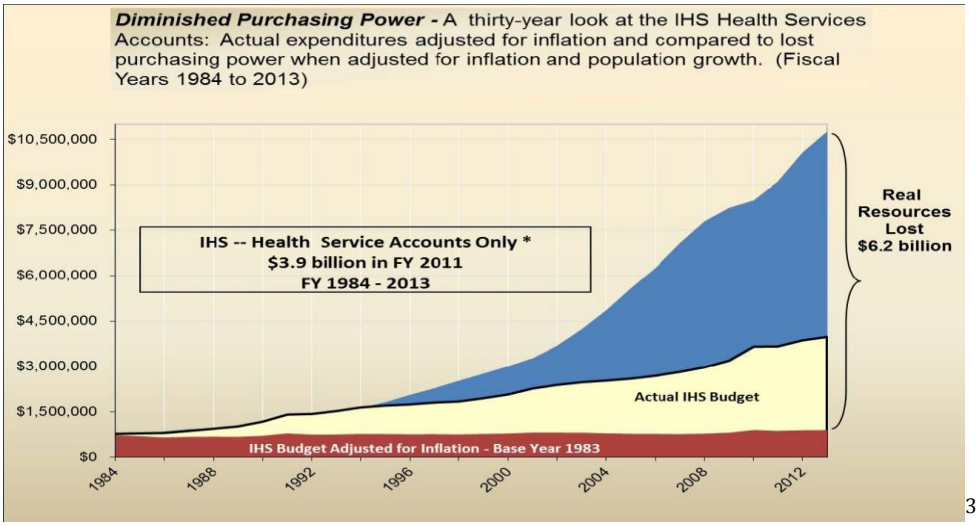
[1] See: The Snyder Act of 1921 (25 USC 13); Indian Health Care Improvement Act of 1976 (25 USC 1601); Patient Protection and Affordable Care Act (P.L. 111-148)

[2] Source: Indian Health Service, February 2014

Discretionary Appropriations vs. Mandatory Appropriations Impact (Mandatory Health programs include Medicare, Medicaid, CHIP and some Veterans Health Programs)

Despite the fact that provision of health to AI/ANs is a legal trust obligation of the Federal government, IHS is still funded on the discretionary side of the Budget. Meaning that the budget:

- Does not increase with inflation or population
- Does not increase with new technologies
- Purchasing power decreases each year
- Subject to sequestration under the Budget Control Act of 2011



[3]

We Need Your Support on these Current Initiatives:[4]

- Advance Appropriations for the Indian Health Service – by enabling IHS to receive its budget a year ahead of time, it would allow the Agency and Tribes to better plan long term costs and would result in more efficient care in addition to an improved continuum of services for AI/ANs. It would not have a cost to the federal government.

- Medicare-Like Rates for Purchased / Referred Care – In a 2013 report,[5] the Government Accountability Office (GAO) concluded "Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS's [PRC] program that is consistent with the rate paid by other federal agencies." This would allow limited IHS discretionary dollars to be used more effectively and efficiently and provide savings around $100 million annually.

- Long-term renewal of the Special Diabetes Program for Indians (SDPI) – 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. Long-term renewal will ensure that these gains will be sustained and that the program will have the stability it needs.

[3] (Source: National Indian Health Board 2012, chart updated by Jim Roberts, 2014)

[4] For more information please visit: http://nihb.org/legislative/legislative.php

[5] GAO-13-272: "Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services," April 11, 2013.