NPAIHB POLICY BRIEF

Brief Analysis of President's FY 2011 IHS Budget

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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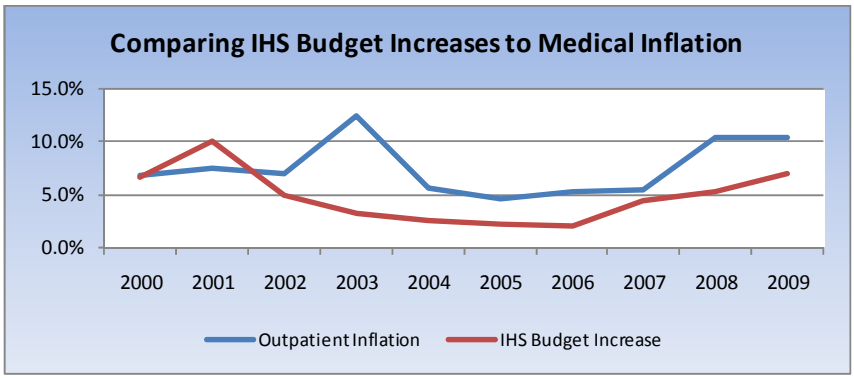
President Obama proposes $354.1 million increase for Indian Health Service programs

Portland, OR — The President's released the details of his FY 2011 spending plan, which poses to "improve health outcomes for American Indian and Alaska Native communities and supporting the provision of health care for American Indians and Alaska Natives (AI/AN)." The President's request includes $4.4 billion for the Indian Health Service (IHS) budget to support and expand the provisions of health care services and public health for AI/ANs. This marks the second year of remarkable support by the Obama Administration to fund Indian health programs. Last year's enacted FY 2010 budget included a $471.3 million increase (13.2%) increase for the IHS that began with a generous President's request. This year's FY 2011 President's request for the IHS includes a $354.1 million increase (8.7%) and will come close to maintaining current services. The Northwest Portland Area Indian Health Board estimates and recommends that an additional $111 million will be provided to maintain current services for the Indian Health Service (IHS).



Despite last year's positive increase, and the President's generous request for FY 2011, there continues to be a tremendous unfunded need for IHS and Tribal health programs. This unmet needs stems from years of chronic underfunding that has plagued the IHS and Tribal health programs. It has resulted in over $6 billion in lost purchasing power due to unfunded inflation and population growth.[1] Tribes understand that this Country is in a deep recession and that it is going to take a strong commitment to fiscal responsibility to turn the U.S. economy around. This has already begun with a freeze on non-security discretionary spending. As with the rest of America, Indian country is also dealing with the effects of the recession and in fact the economic crisis has been detrimental on Tribal communities. The economic conditions in Indian Country are among the worst found anywhere in the United States. Tribal communities do not have the same economic infrastructure or capital needed to create job opportunities and stimulate economies as the rest of the country. *Investing in Indian health programs is vital for job creation and economic growth.* On many reservations the IHS and Tribal health system is the major employer and these programs must be sustained.

[1] "NPAIHB FY 2010 Budget Analysis and Recommendations", (p. 6-7), June 10, 2009.

Current Services Budget: Maintaining the existing Health Program and the President's Proposed FY 2011 IHS Budget

Current services estimates' calculate mandatory costs increases necessary to maintain the current level of services. These *mandatories* are unavoidable and include medical and general inflation, pay costs, population growth, and contract support costs. The Northwest Portland Area Indian Health Board estimates the FY 2011 current services need to be approximately $465.4 million. This year's President's request includes a $354.1 million increase for the IHS budget. This means the President's request will fall short by $111 million and Tribes will have to work with the Congress to request that this funding be provided.

FY 2010 Current Service Requirements
(Dollars in Thousands)

Mandatory Cost to Maintain Current Services	*Increase needed*
CHS inflation estimated at 8.2%; and Population Growth	$ 80,273
Health Services Account Inflation	$ 178,613
Contract Support Costs (unfunded)	$ 146,100
Population Growth (estimated at 2%)	$ 60,444
Total Mandatory Costs	**$ 465,430**

It is important to underscore the President's support to Indian health programs and to promote Indian Self-Determination and Self-Governance by providing adequate funding. Tribes understand fully that this Country is in a deep recession and is going to take a commitment to fiscal responsibility to turn the U.S. economy around. Likewise, Indian country is also dealing with the effects of the recession and in fact the economic crisis is more detrimental on Tribal communities than the rest of the country. The economic conditions in Indian Country are among the worst found anywhere in the United States. Tribal communities do not have the same economic infrastructure or capital needed to create job opportunities and stimulate economies as the rest of the country. *Investing in Indian health programs is vital for job creation and economic growth*. On many reservations the IHS and Tribal health system is the major employer and these programs must be sustained.

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FY 2010 Mandatory Cost Increases

The fundamental budget principle of Northwest Tribes has always focused on preserving the basic health care program funded by the IHS budget. Preserving the purchasing power of the IHS base program should be the first budget principle, not an afterthought, by any Administration. 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 services. These *"mandatories"* are unavoidable and include medical and general inflation, federal and tribal pay act increases, population growth, and administrative costs (contract support costs). The 13% increase received in FY 2010 was the highest budget increase received since 1991, and will allow Tribes to reduce denied and deferred care in Contract Health Service program, as well as provide other needed services in health programs.

NPAIHB estimates the current services need in FY 2011 to be $465.4 million. This is the minimum amount necessary to fund inflation, pay cost increases, population growth, and fully fund contract support costs. President Obama and Congress must continue to build on their commitment to address AI/AN health disparities by providing an additional $111 million more than the Administration has requested for the Indian Health Service appropriation.

The recommendations presented here extrapolate medical related components of the Consumer Price Index (CPI) as they relate to IHS budget account activity. For example, inflation for the Hospital and Clinic Services is measured using the Hospital and Related Services component of the CPI; which only measures inpatient and outpatient hospital related care. Similarly, inflation for Dental Services is measured using the CPI component for Dental care services. Hospital outpatient

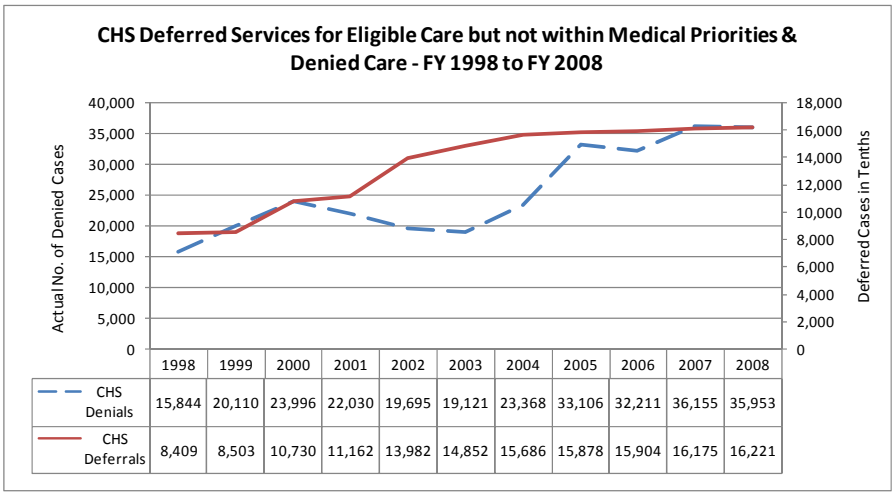
inflation is used for the CHS program, since many CHS services are purchased from hospitals or other private health providers. Footnotes are included in the attached spreadsheet to indicate which CPI components have been used to measure inflation for budget sub-sub activity. A reference to locate that measure is included in the footnote. Extrapolating CPI medical component indices is a standard economic forecasting method that allows accurate and defensible estimates to be developed. Whereas, the Office of Management and Budget routinely applies non-medical related inflation rates to the IHS budget, which underestimate the true funding need for health care programs.

The Urban program line item is estimated using the CPI chained index for Medical Care Services and includes prescription drugs, non-prescription and medical supplies, physician services, dental services, eyeglasses and eye care, and services by other medical professionals. Estimates for Contract Support Costs (CSC) use the IHS yearly CSC Shortfall report amount. The facilities account uses the general CPI index to measure inflation. Finally, 2.1% rate of growth (same as the IHS rate) is used to estimate population growth.

Recommendation: Congress must provide an additional $111 million over the President's request to fund mandatory costs and maintain current services. The President and Congress must use real medical inflation projections when recommending funding for the IHS budget.

CHS Denied and Deferred Services will rise due to inadequate funding

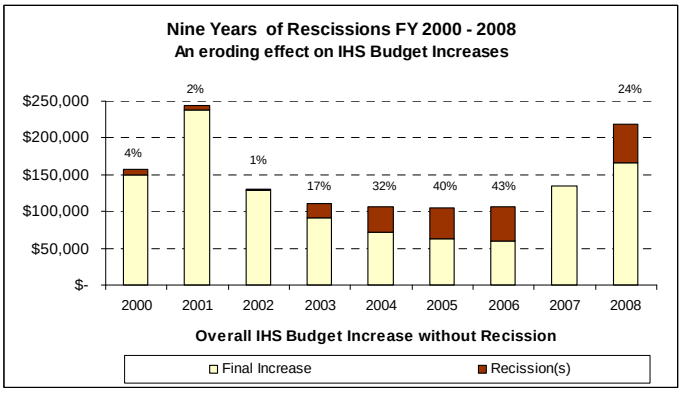
There is strong evidence that Contract Health Services (CHS) services will be cut due to inadequate funding. In FY 2001, the denied services in the CHS program fell for the first time in over five years. Denied services are those cases that are within the medical priorities for care, however there simply is not enough funding to cover the case. Thus, the patient must go without receiving care. Deferred services are those cases that are not within the medical priorities since there is not enough CHS funding and are left untreated. In FY 2001, a significant increase for the CHS program allowed some services to be restored. In 2001, the number of CHS denials declined for the first time since 1993. In FY 2008, the IHS deferred payment for 158,784 recommended cases totaling $152 million. From 2003 to 2008, CHS denials have increased 88% from 19,121 to 35,953. This is the highest amount that deferred payments in the CHS program have ever been. For the first time in five years these numbers dropped, however these reported amounts **understate** the actual unmet need since many tribes no longer report denied or deferred services because of the expense involved in reporting. More disturbing is that many IHS users do not even visit IHS facilities because they know they will be denied services due to funding shortfalls.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
CHS Denials	15,844	20,110	23,996	22,030	19,695	19,121	23,368	33,106	32,211	36,155	35,953
CHS Deferrals	8,409	8,503	10,730	11,162	13,982	14,852	15,686	15,878	15,904	16,175	16,221

Recommendation: Congress should provide an additional $3.2 million increase for the CHS program in order to fund completely the requirements of inflation and population growth.

Rescissions continue to effect on the IHS Budget



Rescissions have had a growing effect on Indian health programs over the last six years. The reductions as a percentage of the approved IHS budget are growing at a disproportionate rate. In FY 2007, the IHS did not have a rescission because Congress passed a year long continuing resolution. Beginning six years ago, rescissions were a mere one percent of the approved IHS budget increase. Three years ago, the rescissions cut into almost half of the approved IHS budget increase. Why aren't IHS health programs exempt from across-the-board reductions like the Veterans Administration (VA) programs? IHS health programs are subject to the same rates of medical inflation that VA programs are and are deserving of the same consideration. If the Administration and Congress are resolved to address Indian health disparities, they must restore past year's rescissions and exempt them from future cuts.

FY 2011 Budget Recommendations

The Indian health system has made great strides to improve the health status of American Indian people. The President and Congress must continue to work to restore the funding that has been lost under the previous Administration or the gains in health status will be reversed and AI/AN health disparities will continue to grow. The current economic conditions are also affecting the Indian health system, which has seen a rise in the demand for health service and more individuals without third party coverage like Medicaid or private insurance. This means the IHS and Tribes cannot bill for third party collections that were once used to replenish IHS resources and expand services to other Tribal members. IHS and Tribes must now do even more with less. NPAIHB makes the following recommendations:

1. Congress must provide at least $111 million more than the President's request to fund mandatory costs associated with maintaining current services.
2. The President and Congress should restore the $711 million in lost purchasing power to the IHS Contract Health Service program by providing adequate increases over the next two fiscal years.
3. It is recommended that Congress provide the IHS with a special appropriation to phase-in staffing at the two new facilities funded by the American Investment and Recovery Act in FY 2011 and FY 2012.
4. The IHS budget should be exempt from across the board cuts

The Congress must continue to preserve the basic health program that was funded in FY 2010 by providing an increase of at least $465.4 million to the IHS budget. This recommendation is based on true inflationary rates developed using the CPI's medical components. Anything less than $465 will leave IHS and Tribal programs with no alternative but to cut health services to Indian people. There simply is no other way for Tribes to absorb these mandatory costs.

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NPAIHB Policy Brief is a publication of the Northwest Portland Area Indian Health Board, 527 S.W. Hall, Suite 300, Portland, OR 97140. For more information visit www.npaihb.org or contact Jim Roberts, Policy Analyst, at (503) 228-4185 or by email jroberts@npaihb.org.

Indian Health Service Budget

Comparing Final FY 2010 to FY 2011 Current Services Estimates

(Dollars in Thousands)

	A	B	C	D	E (D x A)	F (2.1% x A)	G (E + G)
				CURRENT SERVICES ESTIMATES			
Sub Sub Activity	**FY 2010 Final**	**President's FY 2011 Request?**	**Change**	**CPI Medical Care**	**Increase needed for Inflation**	**Increase needed for Pop. Growth**	**NPAIHB ESTIMATE FOR CURRENT SERVICES**
SERVICES:							
Hospitals & Health Clinics	1,754,383	1,893,292	138,909	7.1% [a]	$ 124,561	$ 36,842	$ 161,403
Dental Services	152,634	161,262	8,628	3.2% [b]	$ 4,884	$ 3,205	$ 8,090
Mental Health	72,786	77,076	4,290	3.8% [c]	$ 2,766	$ 1,529	$ 4,294
Alcohol & Substance Abuse	194,409	205,770	11,361	3.8% [c]	$ 7,388	$ 4,083	$ 11,470
Contract Health Services	779,347	862,765	83,418	8.2% [d]	$ 63,906	$ 16,366	$ 80,273
Total, Clinical Services	*2,953,559*	*3,200,165*	*246,606*		*$ 203,505*	*$ 62,025*	*$ 265,530*
PREVENTIVE HEALTH:							
Public Health Nursing	64,071	67,571	3,500	3.8% [c]	$ 2,435	$ 1,345	$ 3,780
Health Education	16,682	17,489	807	3.8% [c]	$ 634	$ 350	$ 984
Comm. Health Reps	61,628	63,991	2,363	3.8% [c]	$ 2,342	$ 1,294	$ 3,636
Immunization AK	1,934	2,009	75	3.8% [c]	$ 73	$ 41	$ 114
Total, Preventative Health	*144,315*	*151,060*	*6,745*		*$ 5,484*	*$ 3,031*	*$ 8,515*
OTHER SERVICES:							
Urban Health	43,139	45,502	2,363	8.2% [d]	$ 3,537	$ 906	$ 4,443
Indian Health Professions	40,743	41,413	670	3.4% [e]	$ 1,385	$ 856	$ 2,241
Tribal Management	2,586	2,669	83	3.4% [e]	$ 88	$ 54	$ 142
Direct Operation	68,720	69,845	1,125	3.4% [e]	$ 2,336	$ 1,443	$ 3,780
Self Governance	6,066	6,201	135	3.4% [e]	$ 206	$ 127	$ 334
Contract Support Costs	398,490	444,332	45,842	3.4% [e]	$ 13,549	$ 8,368	$ 21,917
Total, Other Services	*559,744*	*609,962*	*50,218*		*$ 21,102*	*$ 11,755*	*$ 32,857*
TOTAL, SERVICES	*3,657,618*	*3,961,187*	*303,569*		*$ 230,091*	*$ 76,810*	*$ 306,901*
FACILITIES:							
Maintenance & Improvement	53,915	55,523	1,608	3.4% [e]	$ 1,833	$ -	$ 1,833
Sanitation Facilities Construction	95,857	97,710	1,853	3.4% [e]	$ 3,259	$ -	$ 3,259
Hlth Care Facilities Construction	29,234	66,192	36,958	3.4%	$ -	$ -	$ -
Facil. & Envir. Hlth Supp	193,087	202,106	9,019	3.4% [e]	$ 6,565	$ -	$ 6,565
Equipment	22,664	23,711	1,047	3.4% [e]	$ 771	$ -	$ 771
Total, Facilities	*394,757*	*445,242*	*50,485*		*$ 12,428*	*$ -*	*$ 12,428*
TOTAL, IHS	**4,052,375**	**4,406,429**	**354,054**		**$ 242,519**	**$ 76,810**	**$ 319,329**

Summary of Costs to maintain Current Services:

Contract Support Costs Shortfall Amount: [f]	$ 146,100	
Inflation & Population Growth:	$ 319,329	
Program Enhancements (see p. 18):	$ -	0%
Total Current Services Budget:	**$ 465,429**	11%

Inflation Rates Calculated as follows:

[a] Hospital & Clinics inflation calculated using CPI Series CUSR0000SEMD: Hospital & Related Services (inpatient and outpatient related costs).

[b] Dental inflation calculated using CPI Series CUSR0000SEMC02: Dental Services.

[c] Inflation calculated using CPI Series CUSR0000SEMC04 Medcial Care Inflation (Other medical care professionals).

[d] CHS & Urban Health inflation calculated using CPI Series CUSR0000SS5703: Hospital Outpatient Services.

[e] Inflation calculated using CPI Series SUUR0000SA0: Chained Medical Care Index all goods and services.

[f] Source: *FY 2009 IHS Contract Support Costs Shortfall Report* - amount required to address past year's CSC funding shortfall and growth for new and expanded Self-Determiniation and Self-Governance agreements.