



# NPAIHB POLICY BRIEF

## President's FY 2007 IHS Budget Request

PREPARED BY: NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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### **The President's FY 2007 Budget is detrimental for Indian health programs and not enough to Maintain Current Services**

Portland, OR —The President's FY 2007 budget provides \$3.17 billion for the Indian Health Service (IHS), an increase of \$125 million over the FY 2006 final enacted level. Initial estimates by the Northwest Portland Area Indian Health Board (NPAIHB) indicate that it will take at least \$418.8 million to maintain current services in FY 2007. Since 1993, the IHS has absorbed approximately \$2.5 billion in mandatory cost increases. The FY 2007 increase of \$125 million will leave another \$294 million in unfunded mandatory costs. This lost purchasing power has resulted in a diminishment of medical services to American Indians/Alaska Natives (AI/AN) putting their health and lives at risk.

#### **IHS FY 2006 Update**—*budget falls short again*

H.R. 2361 the Consolidated Appropriations Act of 2005 initially provided \$3.09 billion for the IHS, however, there were two rescissions that significantly affected the final outcome. The Interior bill required an across-the-board (Section 439) cut of .476%, while the Department of Defense appropriations bill required a 1% across-the-board cut (Section 3801) to almost all "discretionary" programs, including both defense and domestic programs. The medical care programs for the Veterans Administration were exempt from the cut. The FY 2006 rescissions equate to a net loss of \$46 million to the IHS budget (44% of the approved increase). What was once a \$106 million increase for Indian health programs, has been whittled down to \$60 million. It is not understandable why IHS health programs are not exempt from across-the-board reductions like Veterans Administration (VA) programs, which have the same costs of delivering health care.

<b>IHS FY 2006 Budget Summary of Action Taken (Dollars in Thousands)</b>	
<b>Action Taken</b>	<b>FY 2005</b>
Approved by Interior Approp. Committee	\$ 3,090,783
Section 501 Rescission (.594%)	\$ (14,712)
Section 122 Rescission (.80%)	\$ (24,073)
<b>Final FY 2004 IHS Budget</b>	<b>\$ 2,985,066</b>

Last year, NPAIHB estimated that it would take \$371 million to maintain current services in FY 2006. Anything less ultimately means a cut in health care services provided to American Indian and Alaska Native people. There is simply no way for Tribes to acquire additional resources to cover the costs of maintaining current services without reducing the current levels of care or cutting other programs like education, social services, law enforcement, or economic development programs. The FY 2006 IHS appropriation falls short by \$308 million.

**Current Services Budget: Maintaining the existing Health Program and the President’s Proposed FY 2007 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, staff for recently constructed facilities, and population growth. The Northwest Portland Area Indian Health Board estimates the FY 2007 current services need to be approximately \$418.8 million. This year’s FY 2007 IHS budget request increase of \$125 million is far short of funding this need.

FY 2007 Mandatory Cost Increases

There are a number of ways to compute current services. The Indian Health Service usually estimates pay cost increases and reports this as separate from inflation. The reason for this has less to do with budget presentation and more from the simple fact that since Congress passes a pay act each year. These are costs that are very precisely computed for federal employees. The Indian Health Service has also added reasonable tribal pay estimates and also reports these. Since the President signs the pay act each year, it is the one cost most often funded in the President’s budget request since it would be very inconsistent to do otherwise.

<b>Mandatory Cost Increases (Current Services)</b>	
<i>Mandatory Cost</i>	<i>Increase needed to maintain current services (1,000s)</i>
CHS inflation estimated at 12.5%	\$ 64,662
Health Services Account (not including CHS) inflation estimated at 7.9%	\$161,068
Contract Support Costs (unfunded)	\$150,000
Population Growth (estimated at 1.6% of Health Services accounts)	\$ 43,074
<b>Total Mandatory Costs</b>	<b>\$418,804<sup>1</sup></b>

The recommendations presented here apply a 7.9% inflation adjustment in FY 2007 for the health services accounts. This inflation rate is consistent with the 8.3% inflation rate used by the Congressional Budget Office to estimate growth in the Medicaid program.<sup>2</sup> These inflation estimates are added to the FY 2006 budget to determine the amount needed to maintain current services. The Contract Health Service (CHS) account has a separate adjustment of 12.5% since it is subject to a greater degree of the medical inflation associated with purchasing specialty care. The Urban program line item is also estimated at 12.5% due to the same inflation factors as CHS and in part due to the lack of any real increases in past years. Estimates for Contract Support Costs (CSC) use the IHS yearly CSC Shortfall report. Finally, the facilities account estimate uses a 4% adjustment factor for the much lower inflation rate for facilities activities. Finally, 1.6% rate of growth (same as the IHS rate) is used to estimate population growth.

**Urban Indian Health Programs cut 100%**

While the Administration will reason that the President’s budget provides a good increase for the IHS programs (4%) compared with other federal agencies, it does so at the expense of urban health programs. The President eliminates funding of \$34 million to the urban Indian health program and redistributes the savings to other program line items. In effect the President’s budget only makes available \$91.7 million for programs in FY 2007 and could actually increase costs for Indian health programs and Tribal

<sup>1</sup> Please Note: The recommended increases presented here are subject to review by 43 Northwest Tribes at their Annual All Tribes Meeting scheduled for March 14, 2006 where Tribal Leaders, Health Directors, and NPAIHB Delegates will provide final recommendations for mandatory cost increases.

<sup>2</sup> “The Budget & Economic Outlook: Fiscal Years 2007 to 2016,” Congressional Budget Office, available online: [www.cbo.gov](http://www.cbo.gov).

administration. It just does not make sense to cut the health services for AI/AN residing in 41 sites throughout the nation. In FY 2006, these urban health programs provided over 700,000 health services to 1.3 million AI/AN residing in urban areas.

Many of these Indian people are in transition from reservations to cities where they receive educational and training opportunities. These people will now go without receiving health services or return to reservations for health care. The IHS congressional justification indicates that urban Indians—unlike other Indian people that live in isolated rural areas—have access to health services under Medicaid and other Federal, State and local health care programs, on the same basis as other Americans. Indian people are not able to navigate the social or community health center system in an urban setting for a variety of reasons; receiving care from a culturally competent provider being one of them. When these Indian people return to reservations to receive health services they could actually cost the federal and state governments and tribal health programs more money to treat. This will also be the same situation when they present at a local community health center. Many will have gone without services for some time and be in a greater need of care. They will require more services than if they had been treated sooner and this will cost more. They may also enroll in other social service programs that will cost the Tribes and state programs more money. Access to services from the Community Health Centers Program, administered by the Health Resources Services Administration (HRSA), will simply not be an option for urban Indians. Furthermore, many urban Indian health providers have been designated as community health centers and leveraged IHS resources to develop the capacity of their program. They not only provide IHS services, but other services funded by SAMHSA, CDC, HRSA, states, and the private sector. These services are not just provided to AI/AN people, but to the overall community. By cutting urban programs, the Administration has compromised these other services and the very safety net that it indicates Indian people will be able to rely on.

The elimination of the urban health programs does not make sense when Secretary Leavitt's 500 Day Plan outlines priorities and two objectives for HHS are to *Eliminate Racial and Ethnic Health Disparities* and *Increase Access to Health Service for AI/AN*. The proposal to eliminate the urban health will contribute to worsening the health disparities of Indian people and decrease access to health services.

### ***FY 2007 Budget is Contrary to Tribal Consultation--fails to preserve basic health programs of the Indian Health Service***

The Administration indicates that the IHS budget is indicative of Tribal Consultation and reflects Tribal priorities across Indian Country. These priorities are to maintain current services and fund pay costs, population growth, and inflation within the context of the **overall** IHS program. Tribal leader recommendations were to fund the components of pay costs, inflation, and population growth within the overall program; and not fund them by cutting the urban Indian health program.

The President's budget makes a reduction for Health Facilities construction at \$20.1 million. Northwest Tribes believe this to be good budgeting practice until the IHS completes its revision of the Health Facilities Construction Priority System. This will allow the facilities construction needs of Indian Country to be re-prioritized with current data and reflect the true health facility needs of Indian people.

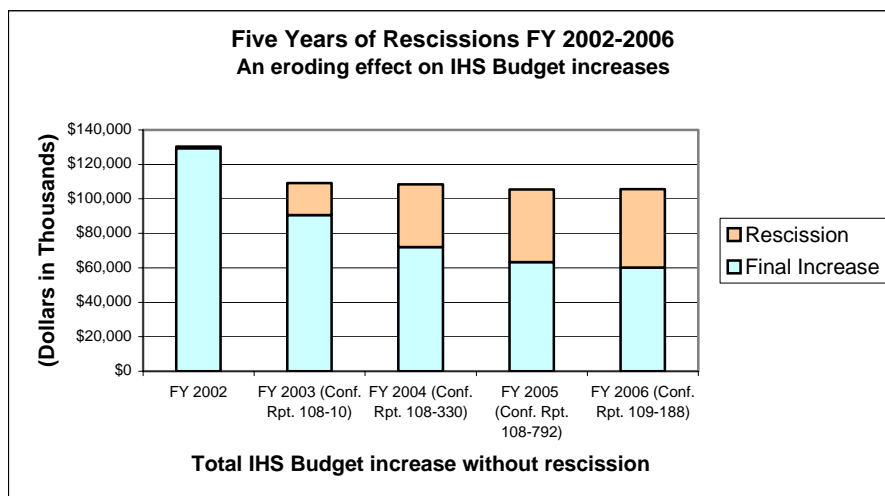
The President's budget falls short of preserving the existing IHS programs. Tribes and IHS are focused on preserving the basic health care program funded by this budget. Preserving the purchasing power of the base program should be the President's first budget principle, not an afterthought. How can unmet needs ever be addressed if the existing program is not maintained? Tribes have one overriding concern that is crucial to this discussion. There must be a trusting relationship between Tribes who are concerned about improving their health status, the Administration that is charged with that responsibility, and the Congress who holds the purse strings. Tribes, IHS, and Congress must continue to focus on the goals and

objectives of the IHS program and assure that the necessary resources are available to continue to make improvements in health status. If the Administration is serious about addressing health disparities it must improve its commitment to adequate funding for the Indian Health Service.

### Rescissions have a growing effect on IHS Budget

Unfortunately for Indian health programs, the FY 2006 Defense conference report included a 1% across the board cut for all FY 2006 discretionary spending. The Veterans Administration programs will be exempt from the cut. Earlier last year, the FY 2006 Interior appropriations bill adopted a .476% across the board reduction that resulted in a \$14.7 million loss to the IHS budget. The effect of the second cut to the IHS budget was a loss of an additional \$30.8 million. This year IHS will lose a total of \$45.5 million due to rescissions (44% of its approved increase) in this fiscal year.

Rescissions have had a growing effect on Indian health programs over the last five years. The reductions as a percentage of the approved IHS budget are growing at a disproportionate rate. Five years ago, the rescissions were a mere one percent of the approved IHS budget increase. In FY 2006, the rescissions will eat up almost half of the approved IHS budget



increase. It is not understandable why IHS health programs are exempt from across-the-board reductions like Veterans Administration (VA) programs. IHS health programs are subject to the same rates of medical inflation that VA programs are and should be given the same consideration. If the Administration and Congress are serious about addressing Indian health disparities, it must restore past year's rescissions and exempt them from future cuts.

### Restored Services will again be cut due to inadequate funding

There is strong evidence that current services will again be cut due to inadequate funding. After the 10% increase approved in FY 2001, the IHS and Tribal health programs were able to restore some services and enhance their health care programs. In FY 2001, the number of service denials declined for the first time since 1993. In FY 2001 the IHS deferred payment authorization for 111,620 recommended cases (a new high) and denied care to 22,030 for cases that it determined not to be within medical priorities. These reported amounts **understate** the actual unmet need since many Tribes no longer report deferred services because of the expense involved in reporting. More compelling is that many IHS users do not even report to IHS facilities because they know they will be denied services due to funding shortfalls. The following table compares the President's FY 2007 budget request with the NPAIHB current services estimates for the IHS. □

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**Table 1. Comparing President's FY 2007 Request to Current Services Budget**

	Enacted	President's	Change over	Increase Needed	Current	(President's	
	FY 2006	Request 07	FY 2006	for Inflation	Services	is Less)	
<b>CLINICAL SERVICES:</b>							
	<i>28-Dec-05</i>	<i>6-Feb-06</i>					
Hospitals & Clinics	\$1,339,539	\$1,429,772	\$90,233	\$105,824	\$1,445,363	-\$15,591	
Dental Health	\$117,731	\$126,957	\$9,226	\$9,301	\$127,032	-\$75	
Mental Health	\$58,455	\$61,695	\$3,240	\$4,618	\$63,073	-\$1,378	
Alcohol Substance Abuse	\$143,198	\$150,634	\$7,436	\$11,313	\$154,511	-\$3,877	
Contract Health Services	\$517,297	\$554,259	\$36,962	\$64,662	\$581,959	-\$27,700	
<i>Sub-total, Clinical Services</i>	<i>\$2,176,220</i>	<i>\$2,323,317</i>	<i>\$147,097</i>	<i>\$195,717</i>	<i>\$2,371,937</i>	<i>-\$48,620</i>	
<b>PREVENTIVE HEALTH:</b>							
Public Health Nursing	\$48,959	\$53,043	\$4,084	\$3,868	\$52,827	\$216	
Health Education	\$13,584	\$14,490	\$906	\$1,073	\$14,657	-\$167	
CHRs	\$52,946	\$55,790	\$2,844	\$4,183	\$57,129	-\$1,339	
AK Immunization	\$1,621	\$1,708	\$87	\$128	\$1,749	-\$41	
<i>Sub-total, Preventive Health</i>	<i>\$117,110</i>	<i>\$125,031</i>	<i>\$7,921</i>	<i>\$9,252</i>	<i>\$126,362</i>	<i>-\$1,331</i>	
Urban Health	\$32,744	\$0	-\$32,744	\$4,093	\$36,837	-\$36,837	
Health Professions	\$31,040	\$31,697	\$657	\$1,242	\$1,242	-\$585	
Tribal Management	\$2,394	\$2,488	\$94	\$96	\$2,490	-\$2	
Direct Operations	\$62,194	\$63,804	\$1,610	\$2,488	\$64,682	-\$878	
Self Governance	\$5,667	\$5,847	\$180	\$227	\$5,894	-\$47	
Contract Support Costs	\$264,730	\$270,316	\$5,586	\$10,589 <sup>1</sup>	\$275,319	-\$5,003	
<i>Total, SERVICES</i>	<i>\$2,692,099</i>	<i>\$2,822,500</i>	<i>\$130,401</i>	<i>\$213,114<sup>2</sup></i>	<i>\$2,884,762</i>	<i>-\$93,302</i>	
<b>FACILITIES:</b>							
Maintenance & Improvement	\$51,633	\$52,668	\$1,035	\$2,065	\$53,698	-\$1,030	
Sanitation Facilities	\$92,143	\$94,003	\$1,860	\$3,686	\$95,829	-\$1,826	
Health Care Facilities Construction	\$37,779	\$17,664	-\$20,115	\$0 <sup>3</sup>	\$17,664	\$0	
Facil & Env Hlth Support	\$150,709	\$161,333	\$10,624	\$6,028	\$156,737	\$4,596	
Equipment	\$20,947	\$21,619	\$672	\$838	\$21,785	-\$166	
<i>Total, FACILITIES</i>	<i>\$353,211</i>	<i>\$347,287</i>	<i>-\$5,924</i>	<i>\$12,617</i>	<i>\$345,713</i>	<i>\$1,574</i>	
<b>TOTAL, IHS</b>	<b>\$3,045,310</b>	<b>\$3,169,787</b>	<b>\$124,477</b>	<b>\$225,731</b>	<b>\$3,230,475</b>	<b>-\$91,728</b>	
<b>Other Increases Required for Current Services:</b>							
				Population Growth	\$43,074	\$43,074	\$43,074
				Contract Support Cost	\$150,000	\$150,000	\$150,000
				Program Enhancements	\$0	\$204,000	\$0
				Subtotal Pop.Growth/CSC/Enhancements	\$193,074	\$397,074	\$193,074
<b>Totals</b>	<b>\$3,045,310</b>	<b>\$3,169,787</b>	<b>\$124,477</b>	<b>\$418,804</b>	<b>\$622,804</b>	<b>-\$294,327</b>	
<b>% increase</b>			<b>4.09%</b>	<b>13.8%</b>	<b>20.5%</b>		

<sup>1</sup> Contract Support Costs (CSC) are calculated for inflation at 4%, however are not factored into the total for "Increase for Inflation" column. Rather, the CSC estimate of \$150 million is used to determine the total increase required for CSC inflation. (Source: Indian Health Service, Office of Tribal Activities)

<sup>2</sup> Does not include \$10,589 CSC increase (see footnote above)

<sup>3</sup> The President cut the Health Facilities construction line item by \$20.1 million; this is sound budgeting practice until the IHS completes its revision of the Health Facilities Construction Priority System. This will allow the facilities construction needs of Indian Country to be re-prioritized with current data and reflect the true health facility needs of all Indian people