Abramson testifies to U.S. Senate Committee

Cathy Abramson, Director, Unit I

First, good luck to everyone in the primary election.

In lieu of a traditional report, I would like to share a presentation I made as the chairperson of the National Indian Health Board to the United States Senate Committee on Indian Affairs. If anyone would like to read the official written testimony, please see NIHB.com under the legislative tab.

"Good morning Chairman Calvert, Ranking Member Moran, and Members of the Committee, thank you for holding this important hearing on the FY 2015 budget. On behalf of the National Indian Health Board (NIHB) and the 566 federally recognized tribes we serve, I submit this testimony. My name is Cathy Abramson, and I am the chairperson for NIHB. I also serve as a councilwoman for the Sault Ste. Marie Tribe of Chippewa Indians.

First, I would like to thank this committee for the work that it has done to advance health care priorities for our people. In fact, due to the help of many members of this committee, we were able to change the mind of the Administration on Contract Support Costs. For this, and all you have done and continue to do for the First Peoples of this country – m'gwitch – or in other words, THANK YOU.

Despite important changes in health care funding that we have achieved over the last several years, we still experience many disparities. Devastating risks from historical trauma, poverty and a lack of adequate treatment resources continue to plague tribal communities. According to IHS data, 39 percent of our women experience intimate partner violence, the highest rate of any ethnic group in the United States. Dental health concerns also continue to affect AI/ANs at higher rates than other Americans. Our children have an average of six decayed teeth, when children in the U.S. all races population have only one. This has to stop.

America is too great a nation to stand by while we live with these realities. Enacting an FY2015 budget that does not aggressively tackle these issues would be tacit approval of the state of affairs in Indian Country.

When considering the level of funding appropriated to IHS, these statistics are not surprising. In 2013, the IHS per capita expenditures for patient health services were just $2,800 compared to almost $8,000 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.

For 2015 NIHB echoes the recommendations for the Tribal Budget Formulation Workgroup and recommends $5.3 billion for IHS overall. This request would allow the funding of current services and include program expansion increases in several key areas including purchased/referred care; hospitals and clinics; mental health and alcohol and substance abuse. These programs represent the core of IHS' work and areas of most critical need to our people. You will see in NIHB's written testimony greater detail about each priority.

We also ask that sequestration cuts from 2013 and 14 be fully restored. Congress did not provide enough funding to fund CSC and restore sequestration or provide increases in other crucial service areas. Some accounts even received cuts beyond the 2013 sequestration level in 2014. This combined with medical inflation and additional staffing costs, have not really allowed these budgets to move forward. We are once again losing ground in addressing health disparities suffered by our people. This cannot happen again.

I would also like to support several policy changes that will enable our IHS budget to be used in a better way.

1) First, NIHB strongly supports Medicare like rates for IHS. In 2003, Congress enacted legislation to require hospital providers to only pay Medicare rates when billing IHS through the purchased/referred care program, but nonhospital providers do not have this requirement. We echo the recommendation of the GAO, who said that reimbursements for all providers should be capped at Medicare like rates.

2) Second, advance appropriation for IHS would allow tribally operated and IHS programs to know what kind of funding they have a year in advance. This would mean that we could not only save on administrative costs, but would also be able to provide better care for our people.

3) Finally, we support the long-term renewal of the Special Diabetes Program for Indians at $200 million for 5 years. It is saving lives and taxpayer dollars and must be renewed to ensure our people get the care they deserve. Thank you again for this opportunity to testify before the committee today and for all the work you do to support Indian health. I am happy to answer any questions you might have."