

A PROMISE KEPT: HONORING OUR TRUST AND INVESTING IN OUR FUTURE TODAY

THE NATIONAL TRIBAL BUDGET FORMULATION WORKGROUP'S RECOMMENDATIONS ON THE INDIAN HEALTH SERVICE FISCAL YEAR 2016 BUDGET

- RECOMMENDATIONS IN BRIEF¹ -
March 7, 2014

INTRODUCTION

Throughout his Administration, President Obama has demonstrated an understanding of the unique government-to-government relationship between the United States and sovereign Tribal Nations, striving to fulfill his promise to adequately fund the Indian Health Service (IHS). Under this Administration, the IHS has seen its first year-over-year budget increases in decades with a historical increase of 24% during the past six years. However, funding for Indian health care services and programs still falls significantly short of what is required for parity between Indian health and other federal healthcare programs.

In FY 2014, for example, IHS received an increase of \$304 million over FY 2013 enacted levels. Most of this increase was designated to fully fund contract support costs (CSC), as well as new staffing packages, at the direction of Congress. While Tribes are appreciative of these important account increases, the agency was forced to cut an additional \$10 million from the overall IHS budget. This means, that funds were not available to restore sequestration cuts from FY 2013 and adjust for inflationary increases and population growth. Tribes are insisting this year that the Department and Congress fully restore the draconian FY 2013 sequestration cuts and provide funding to maintain current services, as well as provide a meaningful increase in the services line item. This means that Tribes request that for FY 2016, the Administration:

"The United States has a duty to uphold its trust responsibilities to Native people in good times and in challenging times. Yet... there is a large gulf between promises made and promises kept."

Senator Brian Schatz, November 14, 2013

1. Phase In Full Funding of IHS - Total Tribal Needs Budget of \$28.7 Billion Over 12 Years
2. Present a 17.58% increase in the overall IHS budget from the FY 2014 President's Budget request planning base*
3. Restore Cuts/Shortfalls in FY2013-15 resulting from sequestration, inadequate increases to cover Congressionally mandated budget categories, and no provision for inflation for Continuing Services & Binding Obligations
4. Advocate that Tribes and Tribal programs be permanently exempted from sequestration
5. Provide an additional \$300 million to implement the provisions authorized in the Indian Health Care Improvement Act (IHCA)

*includes placeholder estimates for CSC, Staffing for new facilities & new Tribes

¹ The Recommendations in Brief is a summary document highlighting the National Tribal Budget Formulation Workgroup's for the IHS FY 2016 budget and is being presented at the United States Department of Health and Human Services Annual Tribal Budget Consultation on March 7, 2014. A full written recommendation report will be released in May 2014.

As the President's second term draws to a close, his administration has the historic opportunity *to not only reduce, but also eliminate* the vast chasm between the health conditions of Native peoples and other Americans. The target for the IHS budget of **\$28.7 billion** over twelve years contained in this brief offers a path forward and clear direction, countering those who argue this cannot be done. In defying this cynicism, we are reminded of the timeless wisdom of Abraham Lincoln, where we "...*determine the thing that must and shall be done, and then we find the way.*"

This administration, in partnership with Tribes, can truly be the change that moves health care in Indian Country toward a brighter future. Nothing can undo the damage done in the past, but we can use the lessons to guide our future. Together, we can ensure our children have the opportunity to have healthy and productive lives and that our elders leave this life with dignity.

A PROMISE KEPT...

To Indian people, the federal budget is not just a fiscal document, but also a moral and ethical commitment. The budget request for Indian health care services reflects the extent to which the United States honors its promises of justice, health, and prosperity to Indian people. For Tribes to recommend a budget that falls short of providing even the most basic of health care services to all our people is no different from deciding which member of your family will be able to get life-saving treatment.

Washington must not continue to neglect or ignore its trust responsibility to Tribal Nations. Instead, Congress and this Administration must begin a new era of honoring its promise to Indian Country. These are not duties to be grudgingly accepted, but must be embraced in a way that defines the character of this great nation. It is a matter of honor.

HONORING OUR PAST...

The provision of federal health care services to American Indians and Alaska Natives is the direct result of treaties between the United States and Tribes and subsequently reaffirmed by Executive Orders, Congressional actions and two centuries of Supreme Court case law. Through the cession of lands and the execution of treaties, the federal government took on a trust responsibility to provide for the health and welfare of Indian peoples. This federal trust responsibility is the foundation for the provision of federally funded health care to all members of the 566 federally recognized Indian Tribes, bands, and Alaska Native villages in the United States.

...INVESTING IN OUR FUTURE

Although the Indian health care system has made significant improvements in mortality and morbidity rates for AI/ANs, serious health disparities persist. More must be done to finally end long-standing inequities in health status for First Americans. The health of AI/ANs, while improving in some areas, is still grave, with the AI/AN life expectancy that is 4.1 years less than the rate for the U.S. all races population. According to IHS data, AI/AN people die at higher rates than other Americans from alcoholism (552% higher), diabetes (182% higher), unintentional injuries (138% higher), homicide (83% higher) and suicide (74% higher). Additionally, AI/ANs suffer from higher mortality rates from cervical cancer (1.2 times higher); pneumonia/influenza (1.4 times higher); and maternal deaths (1.4 times higher).

"After I became President, I said that given the painful chapters and broken promises in our shared history, I'd make sure this country kept its promises to you."

*President Barack Obama
White House Tribal Nations Summit
November 2013*

The Indian health care delivery system, in addition to significant health disparities, also faces significant funding disparities, notably in per capita spending between the IHS and other federal health care programs.

In 2013, the IHS per capita expenditures for patient health services were just \$2,849, compared to \$7,717 per person for health care spending nationally. Compared to IHS calculations of expected cost for a blend of Federal Employee Health Benefits, average IHS per user spending in 2013 was only 59% of

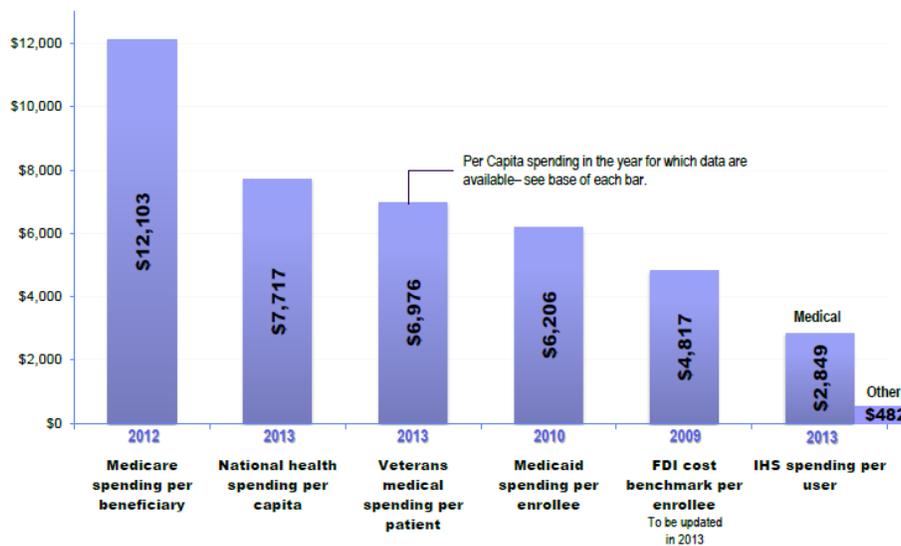
“We shall continue to fulfill the federal trust responsibility for the physical and financial resources we hold in trust for the tribes and their members. The fulfillment of this unique responsibility will be accomplished in accordance with the highest standards”

*President Ronald Reagan
1983 Statement on Indian Policy*

calculated full costs. The actual percentage varies between IHS areas, with some funded at much less than 59% of need. New health care insurance opportunities beginning in 2014 and expanded Medicaid in some states may expand health care resources available to American Indians and Alaska Natives. But these new opportunities are still no substitute for the fulfillment of the federal trust responsibility, and the budget gap will still remain. It will be some time before reliable data is available to determine the impact of these changes on American Indians and Alaska Natives.



2013 IHS Expenditures Per Capita and Other Federal Health Care Expenditures Per Capita



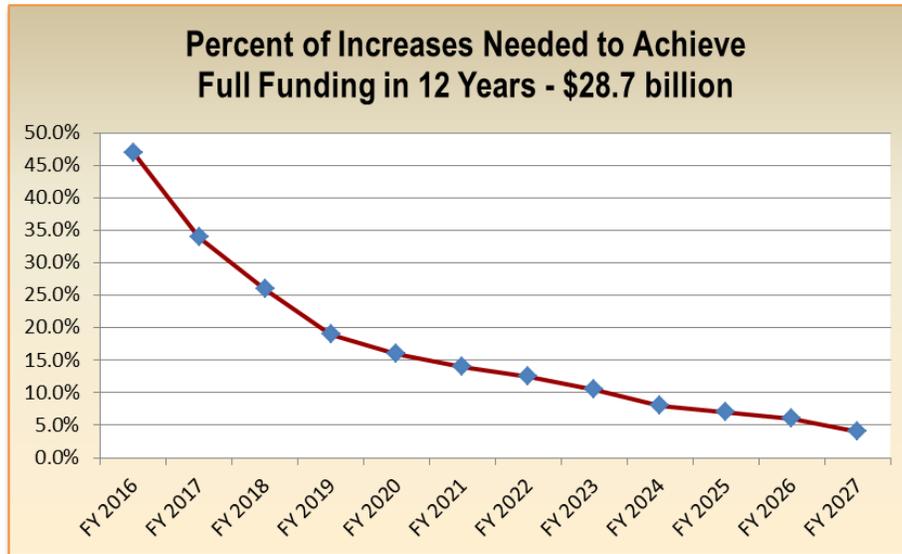
FY 2016 TRIBAL BUDGET RECOMMENDATIONS AND PRIORITIES

❖ 1st Recommendation: Phase In Full Funding of IHS - Total Needs Based Budget of \$28.7 Billion Over 12 Years

Early in 2003, the Workgroup met to develop the national Tribal budget recommendations for FY 2005. Tribal leaders were disheartened that the planning base for the IHS budget was \$2.85 billion, less than 15% of the total funding required to meet the health care needs for AI/ANs. This level of funding was not even sufficient to maintain current services in the face of inflation and increases in the Indian population. Tribal leaders warned that continued under-funding would thwart the Tribes and IHS's efforts to address the serious health disparities experienced by our AI/AN people. To address this shortfall, IHS, Tribal and Urban programs worked together to develop for the first time a true Needs Based Budget (NBB) and for FY 2005, proposed a IHS NBB totaling \$19.5 billion. This includes amounts for personal health services, wrap-around community health services and facility capital investments.

That Workgroup proposed a 10-year phase-in plan, with substantial increases in the first two years and more moderate increases in the following years even though the Workgroup understood that meeting the NBB of \$19.5 billion in one fiscal year was unlikely, due to the importance of balancing the Federal budget and other national priorities. Furthermore, IHS and Tribal health programs lacked the health infrastructure to accommodate such a large program expansion at one time. The most significant aspect of the 10-year plan was that it would require a multi-year commitment by Congress and Administration to improve the health status of AI/ANs.

That was 10 years ago. In the intervening years and with failure to produce necessary funding to fulfill this 10-year plan, the health disparities between AI/ANs and other populations continued to widen, and the cost and amount of time required to close the funding disparity gap has grown. The NBB has been updated every year, using the most current available population and per capita health care cost information. The *IHS need-based funding aggregate cost estimate for FY 2016* is now **\$28.7 billion**, based on the FY 2013 estimate of 2.7 million eligible AI/ANs served by IHS, Tribal and Urban health programs. With the lack of adequate increases over the years, the phase-in of the NBB at \$28.7 billion would need to occur over the next 12 years.



❖ **2nd Recommendation: Present a 17.58% Increase in the Overall IHS Budget from the FY 2014 President’s Budget Request Planning Base**

While the Workgroup’s and Tribes’ primary recommendation remains full funding of the IHS NBB, Tribes in each Area were asked to prepare budget recommendations at specific funding levels. Taking the Area recommendations, the Workgroup recommends an increase of **17.58** or **\$779 million** over the FY 2014 President’s proposed IHS Budget. This includes **\$188.9 million** for *Current Services*, **\$191.3 million** for *Binding Agreements* with Tribes and **\$336.6 million** in *Program Increases Expansion*. Current Services and other Binding Agreements provide the base for program increases designed to expand services. These base costs, which are necessary in order to maintain the status quo, must be accurately estimated and fully funded before any real program expansion can begin. The Program Expansion Increases are the additional funding needed to address critical health services and new facility authorities aimed at slowing the growing health disparity rates in Tribal communities.

| INDIAN HEALTH SERVICE FY 2016 Budget Process Summary of Area Budget Recommendations <u>+17.58% Level National Recommendations</u> |
|--|
| Planning Base for FY 2016 FY 2014 President’s Budget of \$4,430,637,000 x 17% = +\$753,875,000 |
| Current Services: +\$188,874,000 All 12 Areas recommended funding for Federal and Tribal pay, inflation (medical and non-medical) and population growth |
| Binding Agreements: +\$193,988,000 <ul style="list-style-type: none"> • Contract Support Costs for New and Expanded Programs: +\$42,593,000 • Health Care Facilities Construction Projects: +\$75,000,000 |

- Staffing Costs for New Facilities: +\$62,500,000

Addition:

- New Tribes - +\$13,895,000

Program Expansion – Top 5: +\$336,563,000

1. Purchased/Referred Care (CHS): +\$145,402,000
2. Hospitals & Health Clinics: +\$98,339,000
3. Mental Health: +\$42,317,000
4. Alcohol/Substance Abuse: +\$34,524,000
5. Health Care Facilities–Other Authorities: +\$15,981,000

Other Budget Recommendation: +\$59,687,000

6. Urban: +\$15,000,000
7. Maintenance & Improvement: +\$11,906,000
8. Sanitation Facilities Construction: +\$10,833,000
9. Dental: +\$9,162,000
10. Equipment: +\$5,000
11. Health Education: +\$4,453,000
12. Community Health Representatives: +\$2,500,000
13. Indian Health Professions: +\$833,000

Program Expansion Increases

Additional *Program Expansion Increases* totaling \$ **349.9 million** are needed to address the ever-widening AI/AN health disparity and funding gap. With major setbacks brought on by the FY 2013 Sequestration in mind, all 12 IHS Areas identified the Purchased/Referred Care and Hospitals & Clinics (H&C) line items for increased funding. H&C includes funding for the Indian Health Care Improvement Fund, Health Information Technology, and Long Term Care, as well as general H&C increases. Top Tribal priorities are reflected by the critical line item increases listed below.

- Increase funding for *Purchased/Referred Care (PRC)* by \$ **145.4 million**.
- Increase funding for *H&C* by \$ **98.3 million**.
- Increase funding for *Mental Health* by \$ **42.3 million** to address resource deficiencies at behavioral health programs that are providing outpatient and emergency crises services and community based prevention programs.
- Increase funding for *Alcohol & Substance Abuse Services* by \$ **34.5 million**.
- Increase funding for new *Health Care Facilities & Other authorities* by \$ **16 million**.

If the requested Program Expansion increases are not funded, AI/ANs will continue to live sicker and die younger than other American citizens do and will continue to drain existing available resources for costly urgent, emergent and chronic care at higher rates than other populations. The prospect of a better future, the dream of healthy communities, and equal opportunities for improving the health status of all AI/ANs will remain out of reach for most Tribal Nations.

❖ 3rd Recommendation: Restore Cuts/Shortfalls in FY2013-15

Full Funding of Current Services

This recommendation addresses restoration of the FY 2013 sequestration cuts, and the cuts/shortfalls which resulted from inadequate funding to cover Congressional mandates in FY2014 & FY2015 above

and beyond those needed to keep up with inflation and population growth. Current Services are fixed costs that are necessary to maintain services at the same level as the previous year. This means that the draconian cuts made to Tribal health programs through automatic sequestration cuts in FY 2013 must be restored. Many Tribes were forced to subsidize the federal trust responsibility in FY 2013, and those that could not cut programs and services. If increased funding is not appropriated to cover these fixed costs, programs will have to absorb these mandatory cost increases within their existing programs by reducing services or by investing other Tribal resources reserved for education, elder services or other important Tribal programs. We recommend full funding for Current Services at an estimated an increase of **\$188.9 million**.

The FY 2015 President's Budget requested an additional \$2.5 million for federal and Tribal employees. Civil service employees have access to bonus and performance pay as incentives to recruit or retain staff, while Tribes do not. In this competitive health workforce market, Tribal employees should have access to some form of incentive pay during a recession and difficult budget times to encourage staff retention similar to commissioned corps and civil service employees. The Workgroup feels strongly that not only commissioned officers, but also Tribal and federal IHS employees, should be exempt from any federal employee pay freeze that may be imposed in FY 2015 or 2016. The FY 2016 Tribal budget request includes an additional **\$14.9 million** for Federal Pay Costs and **\$20.1 million** for Tribal Pay Costs.

The Current Services request also includes **\$16.3 million** for Non-Medical Inflation and \$66.5 for Medical Inflation above the \$34 million included in the FY 2015 President's Budget. Tribes proposed this to address a 1.5% non-medical inflation rate and a 3.6% medical inflation rate identified by the Office of Management and Budget and aimed primarily at increases in Contract Health Services (CHS) costs.

However, the actual inflation rate for different components of the IHS health care delivery system is much greater. As a component of the Consumer Price Index (CPI), inpatient hospital care is currently at 4.3%ⁱ and outpatient hospital care is at 3.8%.ⁱⁱ The Workgroup asserts that the rates of inflation applied to Hospitals & Clinics, Dental Health, Mental Health, and CHS in developing the IHS budget should correspond to the appropriate components in the CPI. Otherwise, the estimates developed by IHS underestimate the true level of funding needed to maintain current services.

Another **\$77.1 million** is requested for Population Growth to fund the increased need arising from the growth in the AI/AN population, which in recent years has been growing at an average rate of 1.9% annually.

Funding for Binding Agreements

We recommend **\$194 million** to meet the fiscal requirements of existing Binding Agreements with Tribes. Appropriated funding must be sufficient for the IHS to meet its binding obligations made with Tribes and Tribal organizations. This funding is critical to support the commitments for Contract Support Costs (CSC), Health Care Facility Construction (HCFC), and staffing for new facilities through annual funding agreements.

Specifically, the Workgroup recommends **\$62.5 million** for Staffing and Operating Costs for New and Replacement Facilities. This funding allows the IHS and Tribes to provide the necessary services associated with operating these facilities. In the case of Joint Venture projects, Tribes have taken on great risk in financing the construction of new or replacement facilities. This risk is taken with a commitment from the IHS to fund necessary staffing and operating costs upon completion of facility construction.

Failure to fund staffing and operating costs in a sufficient and timely manner leaves Tribes without the means to safely operate these facilities, compromising their ability to service loan agreements while jeopardizing the health and safety of entire communities.

The HCFC program plays an essential role in ensuring access to comprehensive health care for the most vulnerable AI/AN populations. These facilities investments lead to more effective care, improved health outcomes and reductions in overall health care delivery costs. We recommend **\$75.0 million** in FY 2016 funding to support projects currently on the HCFC program.

Funding for Newly Recognized/Restored Tribes

The Workgroup elected to include funding for six newly recognized/restored Tribes within the category of binding obligations, over and above the increased funding mark of 17.58%. Federal recognition obligates the government to provide for the health and welfare of Tribal nations. Yet, four Tribes in the California Area and two Tribes in the Nashville Area are forced to operate without the appropriated funds for health care services to which they are legally entitled. In some cases, this has gone on for several years, in spite of previous requests for funding from the IHS. While other Tribes have access to their full apportionment of IHS funds, these Tribes have only “bridge” funding through the PRC program or no funding at all. This Administration and Congress must deliver on the promise made to these “new” Tribes and provide new appropriations that will allow for parity with other Indian health programs nationally. We urge the Administration to request new appropriations in the following amounts:

California Area

- Tejon Indian Tribe (Restored Federal Recognition)
- Wilton Rancheria (Restored Federal Recognition)
- Koi Nation of Northern California (New Federally Recognized Tribe)
- Smith River (Unserved Tribal Population residing in Curry County, Oregon)

Funding Request: \$3.5 million

Nashville Area

- Tonawanda Nation (New Federally Recognized Tribe)
- Shinnecock Indian Nation (New Federally Recognized Tribe)

Funding Request: \$10.395 million

New Tribes Funding Total: \$13.895 million

❖ 4th Recommendation Permanent Exemption from Sequestration

In FY 2013, Indian Health programs were subject to a 5.1 percent automatic, across the board cut. This means \$220 million left the IHS. Several Members of Congress publicly stated that this was clearly an oversight, and that IHS should not have been held to the full sequester. Nevertheless, Tribes and federally run IHS programs were left with an impossible choice – either deny services or subsidize the federal trust responsibility. Many did, in fact, close their doors for several days per month and others were forced to only deliver PRC for Priority I.

For FYs 2014 and 2015, Congress has found a way out of sequestration for discretionary programs. However, the Budget Control Act (BCA) (P.L. 112-25), has mandated sequestration each year through FY 2021. Indian health simply cannot take any more sequestration cuts. Section 256 of the BCA explicitly holds IHS to 2 percent for any year other than FY 2013. However, with an already underfunded rate of 59 percent for the IHS, even a 2 percent cut is too much. Tribes should not be held responsible for the inability of the federal government to balance its books.

“Our country’s financial troubles are not really stemming from our obligations to Indian Country, and frankly, we’re not doing a good job in fulfilling those obligations.”

*Senator Maria Cantwell (D-WA)
November 14, 2013*

Should sequestration occur in FY 2016, the Workgroup encourages the Administration to work with Congress to ensure that Tribes do not find themselves in this situation again, and the FY 2016 budget should reflect that commitment by permanently exempting the IHS from sequestration.

❖ 5th Recommendation: Fund Indian Health Care Improvement Act New Authorities at \$300 Million

The Implementation of the Indian Health Care Improvement Act (IHCIA) remains a top priority for Indian Country. IHCIA provides new authorities for Indian health care, however additional funding is needed to fully implement the Act. Tribes recommend that IHS reprogram existing resources for Direct Service Tribes to take advantage of these new authorities that would be more beneficial for their communities, when requested and consulted. The battle for IHCIA renewal was over ten years in the making. When this historic law was signed, Indian Country was elated by the promise of a new and more efficient health care delivery system for AI/AN people. However, four years later many of the provisions of the Act remain unfunded, and in many ways, represents yet another broken promise for Indian people.

The American health care delivery system has been revolutionized while the Indian health care system waited for the reauthorization of the IHCIA. For example, mainstream American health care increased focus on prevention as a priority and a treatment, and coordinated mental health, substance abuse, domestic violence, and child abuse services into comprehensive behavioral health programs is now standard practice. Reflecting these improvements in the IHCIA was a critical aspect of the reauthorization effort. The time and resources paid off with the permanent reauthorization of IHCIA. Highlights of what is contained in the IHCIA Reauthorization include:

- Updates and modernizes health delivery services, such as cancer screenings, home and community based services and long-term care for the elderly and disabled.
- Establishes a continuum of care through integrated behavioral health programs (both prevention and treatment) to address alcohol/substance abuse problems and the social service and mental health needs of Indian people.

All provisions of the IHCIA are critical to advancing the health care of American Indian and Alaska Native people and should be implemented immediately. Adequate funding for the implementation of these long awaited provisions is needed now.

❖ Other Policy Recommendations

Advance Appropriations for the Indian Health Service

Tribes across Indian Country support the effort to obtain Advance Appropriations for the Indian Health Service. An advance appropriation is funding that becomes available one year or more after the year of the appropriations act in which it is contained. For example, if the FY 2015 advance appropriations for the IHS were included in the FY 2015 appropriations bills, those advance appropriations would not be counted against the FY 2015 funding allocation but rather, against the FY 2016 allocation.

Advance appropriations would allow Indian health programs to effectively and efficiently manage budgets, coordinate care, and improve health quality outcomes for AI/ANs. This change in the appropriations schedule will help the federal government meet its trust obligation to Tribal governments and bring parity to federal health care system. Adopting advance appropriations for IHS would result in the ability for health administrators to continue treating patients without wondering if –or when– they would have the necessary funding. Additionally, IHS administrators would not waste valuable resources, time and energy re-allocating their budget each time Congress passed a continuing resolution. Indian health providers would know in advance how many physicians and nurses they could hire without wondering if funding would be available when Congressional decisions funnel down to the local level. Health care services in particular require consistent funding to be effective.

The Veterans Administration (VA) achieved advance appropriations for its health programs in 2009. IHS, like the VA, also provides direct health care to individuals. We encourage the Administration support parity between VA and IHS and to request advance appropriations for IHS in its FY 2016 Budget.

Medicare Like Rates for non-hospital providers

In 2003, Congress amended the Medicare law to authorize the Secretary of Health and Human Services to establish a rate cap on the amount hospitals may charge IHS and tribal health programs for care purchased from hospitals under the PRC program, formerly known as the Contract Health Services (CHS) program.

Hospital services represent only a fraction of the services provided through the PRC system. PRC programs continue to routinely pay full billed charges for non-hospital services, including physician services. The IHS PRC program may be the federal government entity that does so; neither the VA nor the DOD pay full billed charges for health care from outside providers. Nor do insurance companies, including those with whom the federal government has negotiated favorable rates through the Federal Employee Health Benefits program.

On April 11, 2013, the Government Accountability Office (GAO) issued a report that concluded “Congress should consider imposing a cap on payments for physician and other nonhospital services made through IHS’s CHS program that is consistent with the rate paid by other federal agencies.” The GAO found that PRC program alone would have saved an estimated \$31.7 million annually if Medicare-Like Rates applied to non-hospital services. These savings would result in IHS being able to provide approximately 253,000 additional physician services annually. This number will even be greater when you consider Tribally run programs, which means that total savings are more likely to be around \$100 million.

The Workgroup requests that the Administration support legislative changes to enact Medicare-like rates for all IHS PRC programs. It would mean that these scarce dollars will be used more efficiently with no additional cost to the government.

CONCLUSION

LEGACY – CHAMPION FOR INDIAN HEALTH

President Obama has built his legacy on reforming America’s healthcare system, but the President should not only be known as a champion of health, but a champion of Indian health.

Above all else, securing this legacy requires fully funding the IHS. During the President’s time in office, significant advances have been achieved across Indian Country because of his Administration’s priority for increased IHS funding. Yet even with these steps forward, we remain significantly short of the funding level needed to eliminate the gap between Indian health and other federal health programs. Beyond this parity, the potential of the Indian Health Care Improvement Act and the critical services it authorizes, such as behavioral health and long-term care, remain a dream as current appropriation levels barely pay for current services.

This year’s request is the President’s last opportunity to put our people on a sustainable path toward a healthier future for generations to come; an investment in our children and our communities across the United States. We ask that the President stand with us and make FY2016 the year in which this future is made real and the federal government’s promise made true.

“We haven’t solved all our problems. We’ve got a long road ahead. But I believe that one day, we’re going to be able to look back on these years and say that this was a turning point.”

President Barack Obama
White House Tribal Nations
Conference
December 2, 2011

About the Workgroup: The National Tribal Budget Formulation Workgroup Members include Tribal representatives from each of the 12 IHS Areas who are tasked with consolidating budget recommendations developed by Tribal leadership and program staff of the 12 IHS Areas (regions) into a national set of budget and health priorities for a given fiscal year. The Workgroup provides input and guidance to the IHS Headquarters budget formulation team throughout the remainder of the budget formulation cycle for that fiscal year.

About the Indian Health Care Delivery System: The Indian health care delivery system consists of services and programs provided directly by the Indian Health Service; Indian Tribes and Tribal organizations who are exercising their rights of self-determination and self-governance; and services provided through urban organizations that receive IHS grants and contracts (collectively, the “Indian Health Care System”). This system is community-based and reflects a culturally appropriate approach to delivering health care to a population suffering severe health disparities and massive rates of poverty within the most remote and rural areas of America. The Indian Health Care System has a user population

of 2.7 million individuals. Currently, the IHS FY 2014 budget is \$4.5 billion, but remains at 59% of the level of needed funding system wide.

ⁱ Bureau of Labor Statistics, Chained CPI, CUSR0000SS5702, Extracted: February 27, 2014.

ⁱⁱ Bureau of Labor Statistics, Chained CPI, CUSR0000SS5703, Extracted: February 27, 2014.