National Congress of American Indians

National Indian Health Board

Submitted via e-mail

June 21, 2019

Dr. Nancy Potok, Chief Statistician
Office of Management and Budget
725 17th St NW
Washington, DC 20503

RE: Directive No. 14, "Consumer Inflation Measures Produced by Federal Statistical Agencies"

Dear Dr. Potok:

On behalf of the National Congress of American Indians (NCAI)[1] and the National Indian Health Board (NIHB),[2] we write regarding the Office of Management and Budget's (OMB) request for comments on using a different measure of inflation for calculating the poverty threshold each year. Specifically, OMB proposes to potentially revise the current method for adjusting the poverty threshold by using the Personal Consumption Expenditures Price Index (PCEPI), or the Chained Consumer Price Index for All Urban Consumers (C-CPI-U), among others, for the production of official statistics.

Based on our initial review, we are concerned that changing the method of calculating the poverty threshold could have a significant negative effect on American Indian and Alaska Native (AI/AN) Tribal citizens across Indian Country. The United States has recognized its treaty and trust obligations to protect and preserve Tribal nations and their resources, improve their housing conditions and socioeconomic status, and provide education and quality healthcare.[3] Many AI/AN people rely on national programs and services that use the poverty threshold to determine eligibility. Accordingly, NCAI and NIHB oppose any new method of calculation that would make it more difficult for AI/AN people to access these programs and services.

National programs of importance to Indian Country that use the federal poverty threshold to determine eligibility include but are not limited to:

- **Medicaid & Children's Health Insurance Program (CHIP):** Medicaid and CHIP benefit AI/AN individuals, their families, and their communities. Enrollment in Medicaid and CHIP helps reduce health disparities by providing AI/ANs with greater access to preventive and specialty care. Treatment of chronic care conditions on a continuous basis reduces the likelihood of AI/ANs facing unexpected or emergent care, and improves quality of life. In addition, increasing enrollment of AI/ANs into Medicaid and CHIP

improves the health status of Tribal citizens and strengthens Tribal nations. IHS, Tribal, and urban clinics (collectively referred to as I/T/U) that enroll their patients can use the saved funding and resources to provide health care access to additional patients. When Indian health care providers receive Medicaid and CHIP reimbursements for direct care services, more resources are brought into the Indian health care system to hire doctors and nurses, purchase equipment, renovate facilities, and meet accreditation and certification standards. Moreover, because of the trust responsibility to provide quality health care to AI/ANs, Congress provided AI/ANs with special protections in Medicaid to increase access; AI/ANs are exempt from copayments, premiums, and can receive services from an I/T/U facility even if the provider is not within a managed care network. In addition, Congress recognized that the provision of healthcare for AI/ANs is an entirely federal obligation so the federal government will reimburse states at 100 percent Federal Medical Assistance Percentage (FMAP) for Medicaid services provided to AI/ANs. These Medicaid revenues are critically important to the Indian health system and represent 13 percent of total IHS funding, and provide coverage for 34 percent of non-elderly AI/ANs and over half of AI/AN children. Any changes to the poverty threshold that would reduce Tribal access to Medicaid and CHIP would reduce the resources coming into an already overburdened health care system, resulting in poor health care delivery to AI/ANs, which runs directly contrary to the federal government's treaty and trust responsibilities.

- **Affordable Care Act (ACA) Marketplace Health Insurance for Individuals:** The ACA provides benefits to AI/AN individuals by providing special provisions in the Marketplace to promote AI/AN access to health insurance at little to no cost. This means that millions of AI/ANs now have access to previously unavailable health services. This increase in access to health insurance also means less dependence on Purchase/Referred Care (PRC), and subsequent greater access to health services. AI/ANs that purchase a Marketplace plan and have an income between 100 percent and 300 percent of the federal poverty threshold, can enroll in a "zero cost sharing" plan, meaning individuals do not have to pay any out-of-pocket costs like deductibles, copayments, and coinsurance. In addition, AI/ANs who fall between 100 percent and 300 percent of the federal poverty threshold may qualify for an advance premium tax credit through the Marketplace, which makes health insurance much more affordable. Enrolling in the Marketplace also allows AI/ANs to enroll in a private health insurance plan while continuing to receive services at the IHS, Tribal health programs, or urban Indian health programs. The essential health benefits provided by Marketplace insurance expand patients' access beyond what is typically available through PRC, meaning more health benefits and decreased financial burdens. Any changes to the federal poverty threshold that would reduce access to health insurance would diminish access to much-needed health services for all AI/ANs.

- **Head Start:** Head Start has played and continues to play an instrumental role in Native education. Head Start funds provide early education to over 24,000 AI/AN children. This vital program combines education, health, and family services to model traditional Native

education, which accounts for its success rate. Thousands of AI/AN families would lose their ability to send their children to Head Start if the inflation adjustment for the poverty measure is changed using any of the proposed methods.

- **Low Income Home Energy Assistance Program (LIHEAP):** LIHEAP is intended to assure that low-income families will not be forced to choose between food and heat. With high unemployment and long-standing barriers to economic development, much of Indian Country cannot afford the rising costs of heat and power. For example, Alaska Native villages are experiencing some of the highest costs for energy with fuel prices, recently reaching over $7 per gallon.

- **Supplemental Nutrition Assistance Program (SNAP):** SNAP provides food and nutrition assistance to families in need so they can purchase healthy food. Programs like SNAP have a significant impact on the overall health of AI/ANs. For instance, approximately 24 percent of AI/AN families across Indian Country received SNAP benefits in 2010, compared to 13 percent of U.S. households nationwide. This program is essential for addressing food insecurity and hunger in Tribal communities.

Given our concern that using the proposed methods of calculating the poverty threshold could reduce the number of AI/ANs that are eligible for vital health care, nutrition, and energy assistance programs, we urge OMB to engage in meaningful consultation with Tribal nations before taking any further action with respect to the proposal. Incorporating the perspectives and recommendations of Tribal nations will guarantee that the final policy is effective and consistent with the federal government's treaty and trust obligations to Tribal nations.

Conclusion

We appreciate the opportunity to provide comments and look forward to working with OMB to ensure that AI/AN people continue to have access to these and other vital programs and services. Should you have any questions regarding these comments, please contact NCAI Government Affairs Director Jacob Schellinger (jschellinger@ncai.org) or NIHB Policy Director Devin Delrow at (ddelrow@nihb.org).

Best regards,

Stacy A. Bohlen
Chief Executive Officer
National Indian Health Board

Ahniwake Rose
Interim Executive Director,
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[1] Founded in 1944, the National Congress of American Indians is the oldest, largest, and most representative American Indian and Alaska Native organization in the country. NCAI advocates on behalf of Tribal governments and communities, promoting strong Tribal-federal government-to-government policies, and promoting a better understanding among the general public regarding American Indian and Alaska Native governments, people and rights.

[2] Established in 1972, the National Indian Health Board (NIHB) is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care, the NIHB is their advocate.

3 *See, e.g.*, 20 U.S.C. § 7401 (Supp. IV 2016) ("It is the policy of the United States to fulfill the Federal Government's unique and continuing trust relationship with and responsibility to the Indian people for the education of Indian children."); 25 U.S.C. § 4101(2), (4) (Supp. IV 2016) "[T]here exists a unique relationship between the Government of the United States and the governments of Indian Tribes and a unique Federal responsibility to Indian people . . . the Congress, through treaties, statutes, and the general course of dealing with Indian Tribes, has assumed a trust responsibility for the protection and preservation of Indian Tribes and for working with Tribes and their members to improve their housing conditions and socioeconomic status so that they are able to take greater responsibility for their own economic condition . . . ."'); 25 U.S.C. § 1901(2)–(3) (Supp. IV 2016) ("Congress, through statutes, treaties, and the general course of dealing with Indian Tribes, has assumed the responsibility for the protection and preservation of Indian Tribes and their resources . . . there is no resource that is more vital to the continued existence and integrity of Indian Tribes than their children and that the United States has a direct interest, as trustee, in protecting Indian children who are members of or are eligible for membership in an Indian Tribe . . . ."); 25 U.S.C. § 3701(2) (Supp. IV 2016) ("[T]he United States has a trust responsibility to protect, conserve, utilize, and manage Indian agricultural lands consistent with its fiduciary obligation and its unique relationship with Indian Tribes . . . .").