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SUMMARY

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Indian Health Service (IHS) FY2021 Budget Request and Funding History: In Brief

The Indian Health Service (IHS) within the Department of Health and Human Services (HHS) is the lead federal agency charged with improving the health of American Indians and Alaska Natives. IHS provides health care for approximately 2.6 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas. IHS provides services to members of 574 federally recognized tribes. It provides services either directly or through facilities and programs operated by Indian tribes or tribal organizations through self-determination contracts and self-governance compacts authorized in the Indian Self-Determination and Education Assistance Act (ISDEAA).

The IHS has three major sources of funding: (1) discretionary appropriations, (2) collections, and (3) mandatory appropriations. In FY2020, IHS also received emergency-designated discretionary appropriations to respond to the Coronavirus Disease 2019 (COVID-19) pandemic.

Unlike most agencies within HHS, which receive their appropriations through the Labor, Health and Human Services, and Education Appropriations Act, IHS receives its discretionary appropriations through the Interior/Environment Appropriations Act. IHS's discretionary appropriations are currently divided into three accounts: (1) Indian Health Services, (2) Contract Support Costs, and (3) Indian Health Facilities.

IHS collects payments for the health services it provides. Unlike other federal agencies, IHS has the authority to receive payments from other federal programs, such as Medicaid, Medicare, and the Department of Veterans Affairs, for the health services it provides to IHS beneficiaries who are enrolled in those programs. IHS also receives payments from state programs (such as workers' compensation) and from private insurance. In addition to these payments, IHS collects rent from the facilities it owns.

Since FY1998, IHS has received a mandatory appropriation each fiscal year to support the Special Diabetes Program for Indians. This funding source was most recently extended in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136), which provided funding for the remainder of FY2020 and for the first two months of FY2021.

This report focuses on (1) the funding that IHS received between FY2015 and FY2019, (2) the funding it has received in FY2020 as of the date of this report, and (3) the funding that has been proposed for FY2021.

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IHS Overview

The Indian Health Service (IHS) within the Department of Health and Human Services (HHS) is the lead federal agency charged with improving the health of American Indians and Alaska Natives.[1] IHS provides health care for approximately 2.6 million eligible American Indians/Alaska Natives through a system of programs and facilities located on or near Indian reservations, and through contractors in certain urban areas.[2] IHS provides services to members of 574 federally recognized tribes.[3] It provides services either directly or through facilities and programs operated by Indian tribes or tribal organizations through self-determination contracts and self-governance compacts authorized in the Indian Self-Determination and Education Assistance Act (ISDEAA).[4] IHS also awards grants to Urban Indian Organizations (UIOs) to operate programs in urban areas; there are 41 UIOs.[5]

The Snyder Act of 1921[6] provides general statutory authority for IHS.[7] In addition, specific IHS programs are authorized by two acts: the Indian Sanitation Facilities Act of 1959[8] and the Indian Health Care Improvement Act (IHCIA).[9] The Indian Sanitation Facilities Act authorizes the IHS to construct sanitation facilities for Indian communities and homes (e.g., providing water to American Indian/Alaska Native Homes). IHCIA authorizes programs such as urban health, health professions recruitment, and substance abuse and mental health treatment, and permits IHS to receive reimbursements from Medicare, Medicaid, the State Children's Health Insurance Program (CHIP), the Department of Veterans Affairs (VA), and third-party insurers. Also, the Public Health Service Act provides funds for the Special Diabetes Program for Indians grants administered by IHS.

Funding Sources

In general, IHS has three major sources of funding, described here in order of magnitude: (1) discretionary appropriations,[10] (2) collections, and (3) mandatory appropriations. In FY2020, IHS

[1] The Indian Health Service (IHS) does not provide care to Native Hawaiians, they instead may receive services through the Native Hawaiian Health Care Program administered by the Health Resources and Services Administration (HRSA) at the Department of Health and Human Services (HHS). See HHS, HRS, "Justification of Estimates for Appropriations Committees, FY2020," https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2021.pdf, p. 66.

[2] For more information about IHS, see CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

[3] HHS, IHS, "Justification of Estimates for Appropriations Committees, FY2021" https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY_2021_Final_CJ-IHS.pdf (hereinafter, FY2021 CJ).

[4] P.L. 93-638; 25 U.S.C. §§450 et seq.

[5] IHS, "IHS Profile," https://www.ihs.gov/newsroom/factsheets/ihsprofile/.

[6] P.L. 67-85, as amended; 25 U.S.C. §13.

[7] The Snyder Act established this authority as part of the Bureau of Indian Affairs within the Department of the Interior. The Transfer Act of 1954 (P.L. 83-568) transferred this authority to the U.S. Surgeon General within the Department of Health, Education, and Welfare (now the Department of Health and Human Services).

[8] P.L. 86-121; 42 U.S.C. §2004a.

[9] P.L. 94-437, as amended; 25 U.S.C. §§1601 et seq.; and 42 U.S.C. §§1395qq and 1396j (and amending other sections). This act was permanently reauthorized as part of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148). See CRS Report R41630, *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline*.

[10] Because IHS's main funding source is annual discretionary appropriations, the agency is affected by lapses in appropriations, which some have raised as an issue. For further discussion, see CRS Report R46265, *Advance*

also received emergency-designated discretionary appropriations in laws enacted in response to the COVID-19 pandemic. In some cases, Indian tribes, tribal organization, and UIOs were eligible for response funding directly. These funds were not appropriated or transferred to IHS; as such, they are not discussed in this report.[11]

Unlike most agencies within HHS, which receive their appropriations through the Labor, Health and Human Services, and Education Appropriations Act, the IHS receives its discretionary appropriations through the Interior/Environment Appropriations Act.[12] IHS's discretionary appropriations are divided into three accounts: (1) Indian Health Services, (2) Contract Support Costs, and (3) Indian Health Facilities.

In addition to funds appropriated to the agency, IHS collects and expends funds received as payment for health services provided. IHS has the authority to receive payments from other federal programs such as Medicaid, Medicare, CHIP, and the VA. IHS also receives payments from state programs (such as workers compensation) and from private insurance. Under its IHCIA collection authority, IHS is able to retain these payments to increase services available to its beneficiaries. In addition to these collections, IHS collects rent from the facilities it owns.

In most years, the smallest source of IHS funding is a mandatory annual appropriation of $150 million to support the Special Diabetes Program for Indians.[13] This funding was extended through November of 2020 in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136). Congress is considering proposals to further extend program funding.[14] For FY2020, emergency discretionary appropriations provided in response to COVID-19 were $1.85 billion, making these funds a significant source of agency funding in FY2020.

FY2021 Budget Request and Funding History

Table 1 presents IHS's funding from FY2015 through the President's proposed FY2021 budget submission. The table shows increases during that interval in both discretionary appropriated funds and funds collected by IHS, whereas the mandatory appropriations generally stayed at the same level. The table presents IHS's three budget accounts—Indian Health Services, Contract Support Costs, and Indian Health Facilities—and the funds collected and allocated to programs under these accounts. To show regular discretionary budget authority only, collections and proposed and actual mandatory funding are subtracted from program-level funding. The FY2020 emergency supplemental appropriations for COVID-19 response are also subtracted.

Although regular discretionary appropriations for IHS have increased over time, the largest funding increase relative to the prior year was in FY2018. In particular, FY2018 funding included increases for a number of programs funded under the Indian Health Facilities account, which includes maintenance and improvement and construction of new facilities. In addition, the FY2018 appropriation increased funding for mental health and alcohol and substance abuse

Appropriations for the Indian Health Service: Issues and Options for Congress.

[11] For information about funding made available to the Indian Health Service, Indian tribes, tribal organizations, and UIOs in response to COVID-19, see CRS Insight IN11333, *COVID-19 and the Indian Health Service*.

[12] For more information, see CRS Report R44934, *Interior, Environment, and Related Agencies: Overview of FY2019 Appropriations*, and CRS Report R45083, *Labor, Health and Human Services, and Education: FY2018 Appropriations*.

[13] U.S. Department of Health and Human Services, Indian Health Service, "Special Diabetes Program for Indians," October 2016, http://www.ihs.gov/newsroom/factsheets/diabetes/.

[14] Such proposals include, for example, in the 116th Congress, S. 3937, and H.R. 2680. See also CRS Insight IN11063, *Special Diabetes Programs Expire in FY2020: Policy Considerations and Extension Proposals*, and CRS Report R46331, *Health Care-Related Expiring Provisions of the 116th Congress, Second Session*.

services, and provided new funding for the Indian Health Care Improvement Fund, which distributes funds to facilities that have low funding levels relative to the populations they serve.[15] These increases generally were sustained in FY2019 and FY2020. Although the FY2021 request represents a total increase in IHS appropriations, this is not due to increases in all accounts. Rather the increases in the Indian Health Services account and in expected collections exceed the requested decreases in the Indian Health Facilities account.

The President's FY2021 request includes funding for two new line items. First, it proposes funding for electronic health records, which IHS is in a multi-year process of updating.[16] The President's budget would provide $125 million for this activity, an increase from the $8 million provided in FY2020. The second budget item is a legislative proposal for a new indefinite appropriation that would be similar to the structure of the Contract Support Costs account; however, in this instance, the appropriation would be for tribal leases. As it does with the Contract Support Costs account, IHS has a legal obligation to pay for these lease costs pursuant to a 2016 court decision, *Maniilaq Association v. Burwell*,[17] which requires IHS to reimburse "the Tribe or Tribal Organization for its reasonable facility expenses" when IHS enters into a "lease," upon request, with any tribe or tribal organization that is furnishing a facility that supports ISDEAA programs.[18] In other words, since FY2018 IHS has been paying lease costs in instances when an Indian tribe or tribal organization provides the facility for an ISDEAA program. Since that time, lease costs have increased from $18 million in FY2018 to $125 million in FY2020. In the table below, lease costs amounts for FY2018-FY2020 are not delineated separately; they are instead included within the Indian Health Services account.[19] The President's budget would provide $101 million for these leases as a separate discretionary account.[20]

Table 1. Indian Health Service (IHS)

(Millions of Dollars, by Fiscal Year)

Program or Activity	2015	2016	2017	2018	FY2019	FY2020	FY2021 Request
Indian Health Services Account	**4,820**[a]	**4,909**	**5,035**	**5,296**	**5,447**	**7,507**	**5,925**

[15] HHS, IHS, "Indian Health Care Improvement Fund," https://www.ihs.gov/ihcif/.

[16] FY2021 CJ, pp. 101-103.

[17] 170 F. Supp. 3d 243 (D.D.C. 2016). To carry out ISDEAA programs to deliver services on behalf of IHS, Indian tribes or tribal organizations may "lease" their facilities to IHS. These leases are entered into under the authority of Section 105(l) of ISDEAA (and are also referred to as Section 105(l) leases). A 2016 court decision, *Maniilaq Association v. Burwell*, required that IHS enter into a "lease," upon request, with any tribe or tribal organization furnishing a facility that supports ISDEAA programs, and that under any such lease, IHS reimburse "the Tribe or Tribal Organization for its reasonable facility expenses." This holding could extend to other instances when an Indian tribe or tribal organization furnishes a tribally leased or owned facility in support of the programs, services, functions, and activities carried out under its ISDEAA contract or compact. In other words, if an Indian tribe or tribal organization provides the facility for an ISDEAA program, IHS may have the responsibility to pay reasonable facility costs under these leases. IHS has interpreted the decision as it having this responsibility and has been paying these costs since FY2018. Both the Senate and the House Appropriations Committees raised the issue of these funds during hearings for FY2020 appropriations, and the House directed the agency in report language to consider whether these costs should be a separate line item (H.Rept. 116-100, p. 115). See discussion in FY2021 CJ, pp. 269 and 274.

[18] Language drawn from Letter from Michael D. Weahkee, Assistant Surgeon General, United States Public Health Service, and Acting Director, Indian Health Service to Tribal Leaders and Urban Organization Leader, July 18, 2018, https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/2018_Letters/DTLL_DUIOLL_07102018.pdf.

[19] Ibid. In FY2018, IHS provided $18 million for these leases. For FY2020 amounts, see FY2021 CJ, pp. 229-230.

[20] See https://www.whitehouse.gov/wp-content/uploads/2020/02/hhs_fy21.pdf, pp. 443-443.

Program or Activity	2015	2016	2017	2018	FY2019	FY2020	FY2021 Request
Coronavirus Testing, Treatment and Related Services	—	—	—	—	—	1,846[b]	—
Clinical and Preventive Services	**4,652**	**4,737**	**4,860**	**5,117**	**5,259**	**5,458**	**5,737**
Clinical Services	4,348	4,431	4,553	4,800	5,259	5,130	5,445
Hospitals and Health Clinics	1,837	1,857	1,935	2,055	2,147	2,325	2,432
Electronic Health Records	—	—	—	—	—	8	125
Purchased/ Referred Care[c]	914	914	929	963	965	965	965
Collections[d]	1,151	1,194	1,194	1,194	1,194	1,194	1,269
Mental Health/Alcohol and Substance Abuse	272	287	312	323	351	355	363
Indian Health Care Improvement Fund	—	—	—	72	72	72	72
Dental Services	*174*	*178*	*183*	*193*	*205*	*211*	*219*
Preventive Health	154	156	160	179	175	178	142
Special Diabetes Program for Indians	150	150	147[e]	150	150	150	150[f]
Other Health Services	168	172	175	179	188	203	188
Urban Health Projects	44	44	48	49	51	58	50
Indian Health Professions	48	48	49	49	57	65	52
Tribal Management/Self-Governance	*8*	*8*	*8*	*8*	*8*	*8*	*5*
Direct Operations	68	72	70	72	72	72	81
Contract Support Costs Account[a]	**663**	**718**	**718**	**763**	**822**	**820**	**855**
Payment for Tribal Leases	—	—	—	—	—	—	101
Indian Health Facilities Account	**469**	**532**	**554**	**876**	**887**	**920**	**780**
Maintenance and Improvement	62	82	84	176	176	177	178
Rental of Staff Quarters[d]	*8*	*9*	*9*	*9*	*9*	*9*	*10*
Sanitation Facilities Construction	79	99	102	192	192	194	193
Health Care Facilities Construction	85	105	118	243	243	259	125
Facilities/Environmental Health Support	220	223	227	241	252	262	260
Medical Equipment	23	23	23	24	24	28	24
Total, Program Level	**5,951**	**6,160**	**6,307**	**6,935**	**7,156**	**9,247**	**7,661**
Less Funds from Other Sources							
Collections	1,151	1,194	1,194	1,194	1,194	1,194	1,269

Program or Activity	2015	2016	2017	2018	FY2019	FY2020	FY2021 Request
Rental of Staff Quarters	8	9	9	9	9	9	10
Special Diabetes Program for Indians	150	150	147	150	150	97	150[f]
Coronavirus Testing, Treatment and Related Services	—	—	—	—	—	1,846	—
Total, Regular Discretionary Budget Authority	**4,642**	**4,808**	**4,957**	**5,582**	**5,953**	**6,048**	**6,232**

Sources: Funding amounts are from HHS budget documents available at https://www.ihs.gov/budgetformulation/congressionaljustifications/. Amounts for FY2015, FY2017, FY2018, FY2019, FY2020, and the FY2021 request are from IHS's congressional justifications. (The FY2020 amount for Coronavirus Testing, Treatment and Related Services is from CRS analysis of FY2020 supplemental appropriations acts enacted as of the date of this report.) FY2016 amounts are from IHS's operating plan for FY2017, available at https://www.ihs.gov/budgetformulation/includes/themes/newihstheme/display_objects/documents/FY2017-IHS-Operating-Plan.pdf.

a. In FY2015, Contract Support Costs were included in the Indian Health Services account. Beginning in FY2016, Contract Support Costs were funded as an indefinite discretionary appropriation. Amounts for FY2020 and FY2021 are estimated and may later be adjusted to reflect the amount provided.

b. This amount is the total funds appropriated to IHS in three COVID-19 response laws. IHS did not receive funding in the first response law (P.L. 116-123). The second law enacted in response to COVID-19, the Families First Coronavirus Response Act, provided $64 million to IHS for COVID-19 testing, administration of the test, and related items and services. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136) provided an additional $1.032 billion to prepare for, prevent, and treat coronavirus, and the Paycheck Protection Program and Health Care Enhancement Act (P.L. 116-139) transferred $750 million to IHS from Public Health and Social Services Emergency Fund for COVID-19 testing and related purposes. Additional funding was also made available directly to Indian tribes, Tribal organizations, and Urban Indian Organizations through transfers from other HHS agencies. For more information, see CRS Insight IN11333, *COVID-19 and the Indian Health Service*. See also CRS Report R46316, *Health Care Provisions in the Families First Coronavirus Response Act, P.L. 116-127*, and CRS Report R46325, *Fourth COVID-19 Relief Package (P.L. 116-139): In Brief*.

c. This was previously referred to as "Contract Health Services."

d. For information on IHS collections, see IHS budget requests, available at https://www.ihs.gov/budgetformulation/congressionaljustifications.

e. PHSA Section 330C provides an annual appropriation of $150 million for this program; this amount was reduced in FY2017 by 2% because of budget sequestration. See Office of Management and Budget, "OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2017," February 9, 2016, p. 19, https://obamawhitehouse.archives.gov/sites/default/files/omb/assets/legislative_reports/sequestration/jc_sequestration_report_2017_house.pdf. See also CRS Report R42050, *Budget "Sequestration" and Selected Program Exemptions and Special Rules*.

f. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act; P.L. 116-136) provides $25.07 million for October and November of 2020 (i.e., the first two months of FY2021).

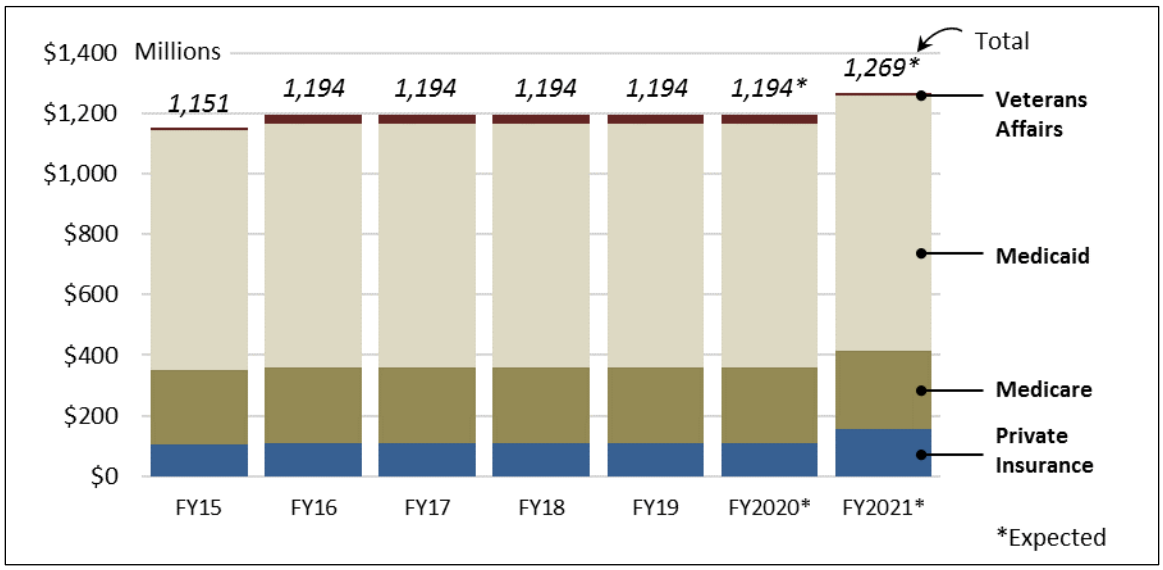
IHS Third-Party Collections

IHS facilities collect payments from third-party payors for services provided to IHS beneficiaries who are also enrolled in other programs. These collections—which represent the amounts collected by IHS-operated facilities—are a significant source of IHS's clinical services (see **Table 1**), adding more than $1 billion to IHS's clinical services budget. Collection data, however, are incomplete because facilities operated by Indian tribes, tribal organizations, and UIOs are not required to report these data. Although it is not possible for the Congressional Research Service to determine the degree to which the data provided by IHS-operated facilities may underestimate

true collections, it is possible that this underestimate may be significant, given that some facilities report that such collections account for more than 60% of their budget, according to IHS.[21]

With regard to the sources of the collections, Medicaid is the largest source of IHS's collections—accounting for approximately 68% of all third-party collections in FY2019, the most recent year of final data available—followed by Medicare (21% in FY2019) and private insurance (9% in FY2019). Beginning in FY2014, IHS began receiving payments from the VA for services provided to IHS beneficiaries who were enrolled in the VA (these payments were 2% of all of IHS's third-party collections in FY2019). For FY2021, VA estimates were based on a shorter collection period; as such, unlike other revenue types, IHS predicts that these payments from VA will decline from $28 million to $9 million in FY2021.[22]

Figure 1. IHS Reimbursements, by Source: FY2015-FY2019 (Actual) and FY2020-FY2021 (Expected)



Source: Figure created by CRS. Funding amounts are from FY2015-FY2021. HHS Budget documents are available at https://www.ihs.gov/budgetformulation/congressionaljustifications/.

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[21] FY2021 CJ. p. 188.

[22] FY2021 CJ. pp. 188-193.

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