TESTIMONY ON THE
FY 2015 BUDGET FOR PROGRAMS WITHIN
THE JURISDICTION OF THE
SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND
RELATED AGENCIES,
HOUSE COMMITTEE ON APPROPRIATIONS,

Submitted by
The SEATTLE INDIAN HEALTH BOARD
Ralph Forquera, Executive Director

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Mr. Chairman and members of the House Interior, Environment, and Related Agencies Appropriation Subcommittee, my name is Ralph Forquera. I am the Executive Director for the Seattle Indian Health Board in Seattle, Washington. I also direct our Urban Indian Health Institute. I am an enrolled member of the Juaneño Band of California Mission Indians, a state-recognized Indian tribe. My tribe was one of 43 tribes and bands of California Indians terminated in 1958 through the California Rancheria Termination Act (P.L. 85-671). Thank you for inviting me to testify.

The Indian Health Service has requested an inflationary increase for urban Indian health of $646,000. This is only a 1.58% increase over the FY14 enacted, far below medical inflation in the nation. I ask the Subcommittee to consider an increase of at least $5 million to address the growing urban Indian population needs.

Urban American Indians now represent more than 7 out of 10 Americans self-identifying as having heritage in an American Indian or Alaska Native tribe, according to the 2010 United States Census. The permanent reauthorization of the 1976 Indian Health Care Improvement Act in the Affordable Care Act, claims, in its declaration of policy, an obligation to aid urban Indians. Title V of the Act spells out a discrete authority to assist local, non-profit, Indian-governed organizations in enhancing access and assuring health improvements to meet the national goal of health parity for Indian people.

The movement of Indian people to American cities has been steady since first documented with the 1970 census. Analysis using the American Community Survey for the period 2006 - 2009 finds that more than 1 in 4 urban Indians have incomes at or below 200% of the federal poverty level. This description likely undercounts the number of urban Indians in poverty, since the collection method for this national survey does not reach a sizeable portion of the urban Indian population, particularly those living in unstable households that are a common problem among poorer urban Indians. There is currently no specific assessment of urban American Indians and Alaska Natives. Our understanding is derived from federal and state regularly scheduled data collection strategies and agency reporting standards that often do not specify Indian identity in their collection processes to document conditions and outcomes among for the general population.

The Indian Health Service itself has not focused attention on a reporting mechanism explicit for addressing urban specific health concerns. Instead, the IHS has

tried to include our work in their tribally-based reporting standards that, in my view, misrepresent the health disparities among urban Indians. This lack of information that could paint a more accurate portrayal of the health and social conditions that influence the health status of urban Indians leads to inappropriate and misguided policies that disrupt our ability to effectively serve our communities.

But regardless of the limitations of the data sources, evidence grows that health disparities are extensive for urban Indians and that factors that contribute to poor health generally affect urban Indians across the nation. For example, evidence of low academic achievement, high unemployment, high rates of mobility among the population, and a general over-representation in social metrics known to contribute to poor health are consistently found upon analysis. The fact that this evidence can be identified in work not explicit to urban Indians reinforces the fact that these social factors are crucial in perpetuating health disparities among urban Indians.

In the past several years, a growing awareness of how social factors influence health has drawn attention from policy makers, elected officials, and the general public. Key factors like low educational attainment and substandard or inadequate housing, particularly in cities indicate that urban Indians are often listed as living with conditions that adversely influence health. This reality places urban Indians at greater risk for health problems and early and unnecessary death and disability.

The Affordable Care Act calls for data to identify and track changes in the health status of groups like urban Indians. But to collect and analyze this information, funding is needed to build the infrastructure and support the personnel needed to gather data and perform the necessary analysis. Our Institute has discussed building this capacity with CMS and other Federal agencies but funding has not been forthcoming. Therefore, as noted, we do our best to find ways to use national and state data collection strategies and apply scientifically-sound methodologies to understand health conditions for urban Indians. While these methods are limiting, the preponderance of findings reinforce the disparities we see daily at my organization.

Members of this Subcommittee have noted the grave inequity in the funding appropriated to assist Indians between those on Indian reservations and those living in cities. The question is frequently asked whether Indians living in cities retain eligibility for Indian health benefits. Legal analysis shows that Indians leaving reservations do not lose the right to the benefits and protections granted Indians by the Congress, but that the extent of these Indian-specific programs and services is subject to the level of funding devoted to them by the Congress. Over the decades, in spite of the dramatic shift in the Indian and Native population's living arrangements, resources to help urban Indians have fallen farther and farther behind.

There are some who have argued that only enrolled members of federally-recognized Indian tribes and those living on Indian reservations are eligible for federal assistance. Currently, this policy is being applied to the Affordable Care Act as it affects the Marketplace aspect of reform. This claim misinterprets the nature of the Indian trust relationship.

Back in 2005, I prepared a paper I would be happy to share with the Subcommittee illustrating the historical and legislative history of aid for urban Indians in response to a question from the Senate Committee on Indian Affairs. This response became the foundation for this Subcommittee increasing urban Indian health funding by

$7 million in 2008. However, other problems have since disrupted this appreciation for the need for financial aid for urban Indians and the current funding allocated for urban Indian health now represents only 0.92% of the overall Indian Health Service budget.

When the line item for urban Indian health was first established in 1979, about 1.48% of that year's IHS appropriation was directed for urban Indians. Over the decades, the percentage devoted for urban Indians has fluctuated around the 1% threshold until 2009, when the allocation dropped below 1%. The most recent allocation for FY2014 places the investment at only 0.92%.

A further review of the IHS budget process finds that the agency has seldom requested additional funds for urban Indians. At best, the agency has sought inflationary increases that are generally far less than health care inflation has run over the decades including for FY-15. As each year passes, the inability to meet just the inflationary challenges has forced reductions in services. Since the agency responsible for advocating for the health of Indian people fails to request funding to aid urban Indians, it should not be a surprise that the agency is not actively seeking solutions and support for our work.

As an example, the recent reauthorization of the Indian Health Care Improvement Act requires that the IHS create a conferring policy similar to the tribal consultation policy to assure that the guidance of the urban contractors is given when considering policy or programmatic change. It is now more than four years after the law was enacted and a conferring policy has not been approved, leaving those of us who operate Urban Indian Health Organizations without a formal means of communicating our ideas or sharing our concerns with the Indian Health Service. In larger tribal consultation sessions, we are mostly overshadowed by the tribal leadership present. Essentially, the voices of the majority of Indian people are not reflected in Indian policy today.

It should also be noted that the urban Indian health program defined as Title V of the Indian Health Care Improvement Act is a discrete authority intended to improve access to health care for Indians living in cities. This role was expanded in 1987 as increased evidence arose that the *acceptability* of health care service was critically important to many urban Indians that carry the ill effects of past failed federal actions toward Indians as a core belief. Given the continuing lack of attention toward urban Indians, this reality is still an important characteristic of the work we do on their behalf.

Few today remember the forced sterilization of Indian women during the 1970s or the sense of abandonment that accompanied the termination of tribes in the 1950s. Many today experience denial of help from IHS and tribal facilities that only treat members of federally recognized tribes. Others feel thwarted by the Bureau of Indian Affairs that does not recognize displaced Indians. My tribe, for example, has had its petition for re-acknowledgment rejected on several occasions by the Bureau of Indian Affairs, leaving members without benefits and protections granted those that have been restored to federal recognition in the past several decades. These continuing actions reflect the reality that urban Indians are not seen as equals to those who were fortunate not to experience termination or who continue to reside on reservation lands. This treatment helps to foster the sense of second-class citizenry for urban Indians within Indian Country. Some tribes under self-governance compacts have recognized the discriminatory nature of these actions and, when financially feasible, offer some help.

It should also be noted that the lack of attention to the health and welfare of urban Indians is best illustrated by both the lack of funding, but also a lack of recognition and

understanding of this portion of Indian Country. Little effort has been made by the Indian Health Service or others to describe the health status of urban Indians or to find ways to aid those urban communities with sizable Indian populations but lacking an urban Indian health organization. In fact, there are fewer urban Indian health organizations today than there were in the mid-1980s.

When the Indian Health Care Improvement Act was passed in 1976, the House Report accompanying the passage of the bill made the bold claim that *"The most basic human right must be the right to enjoy decent health. Certainly, any effort to fulfill Federal responsibilities to the Indian people must begin with the provision of health services. In fact, health services must be the cornerstone upon which rest all other Federal programs for the benefit of Indians. Without a proper health status, the Indian people will be unable to fully avail themselves of the many economic, educational, and social programs already directed to them or which this Congress and future Congresses will provide them."* H.R. Report No. 94-1026, pt. I at 13 (1976) *as reprinted in* 1976 U.S.C.C.A.N. 2652, 2653. It is clear that this proclamation has not been fulfilled for urban Indians.

The inequity in funding for urban Indian health is an artifact of history. The reality of funding inadequacy reinforces the administrative policy of limiting both the work and the scarce resources to the more limited aspect of Indian Country – members of federally recognized tribes and those living on or near Indian reservations. However, Congress has the authority to allocate additional funds to assist urban Indians if they so choose.

As mentioned earlier, another hat I wear is as the Director for the Urban Indian Health Institute. I founded the Institute in July of 2000 to find ways to document and study health disparities among urban Indians to help build a case for needed resources. In 2004, the Institute published the first large scale national report, illustrating the severity of health problems faced by urban Indians. These findings were reinforced when an independent Urban Indian Health Commission funded by the Robert Wood Johnson Foundation, made similar claims in its 2007 report. (find reports at www.uihi.org). Additional reports and studies including several published in peer-reviewed professional journals verify the disparity in health experienced by urban Indians, but these findings have not successfully translated to the provision of the essential resources needed.

We recognize and respect the fact that Indians living on reservations who are enrolled in a federally-recognized Indian tribe have needs deserving of Congressional support. But just caring for reservation Indians is insufficient in addressing the broad trust obligation that the nation bears towards its indigenous citizens, especially since more than 7 out of 10 Indian and Native people now live in cities.

After spending more than three decades working to improve the health of urban Indians, I recognize that we face daunting challenges. Expectations that the Affordable Care Act will improve conditions for urban Indians fail to take into account the historic maltreatment and broken promises experienced by Indian people that large scale programs like the ACA will not correct. In this regard, it is my hope that this Subcommittee will recognize and renew its commitment to assure that all Indian people, regardless of their place of residence or their standing as being federally-recognized, achieve the House's proclamation of the importance of health in Indian affairs.

Thank you.