National Indian Health Board

TESTIMONY OF CHAIRMAN WILLIAM SMITH OF THE NATIONAL INDIAN HEALTH BOARD FOR AMERICAN INDIAN AND ALASKA NATIVE PUBLIC WITNESS DAYS HOUSE APPROPRIATIONS SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES

March 3, 2023

Chairman Simpson, Ranking Member Pingree, and the distinguished members of this Subcommittee, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally recognized American Indian and Alaska Native (AI/AN) Tribal nations we serve, thank you for the opportunity to provide testimony on the Indian Health Service (IHS).

Tribal nations have a unique legal and political relationship with the United States. Through its acquisition of land and resources, the United States formed a fiduciary relationship with Tribal nations whereby it has recognized a trust relationship to safeguard Tribal rights, lands, and resources.[1] In fulfillment of this tribal trust relationship, the United States "charged itself with moral obligations of the highest responsibility and trust" toward Tribal nations.[2] Congress reaffirmed its duty to provide for Indian health care when it enacted the *Indian Health Care Improvement Act* (25 U.S.C. § 1602), declaring that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—to ensure the highest possible health status for Indians and to provide all resources necessary to effect that policy. Unfortunately, those responsibilities and legal obligations remain unfulfilled and Indian Country remains in a health crisis.

The Health Status of Indian Country

The Centers for Disease Control and Prevention (CDC) now reports that life expectancy for AI/ANs has declined by nearly 7 years, and that our average life expectancy is now only 65 years—equivalent to the nationwide average in 1944.[3] With a life expectancy 10.9 years less than the national average,[4] Native Americans die at higher rates that those of other Americans from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory disease.[5] Native American women are 4.5 times more likely than non-Hispanic white women to die during pregnancy.[6] The CDC also found that, between 2005 and 2014, every racial group experienced a decline in infant mortality except for Native Americans[7] who had infant mortality rates 1.6 times higher than non-Hispanic whites and 1.3 times the national average.[8] Native Americans are also more likely than people in other U.S. demographics to

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[1] *Worcester v. Georgia*, 31 U.S. 515 (1832).
[2] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).
[3] U.S. Department of Health and Human Services, *Centers for Disease Prevention and Control, Provisional Life Expectancy Estimates for 2021* (hereinafter, "*Provisional Life Expectancy Estimates")*, Report No. 23, August 2022, available at: https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf, accessed on: October 13, 2022 (*total for All races and origins minus non-Hispanic American Indian or Alaska Native*).
[4] *Id*.
[5] *See*, U.S. Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* (hereinafter "*Broken Promises*"), 65, available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf, accessed on: November 20, 2022.
[6] *Broken Promises* at 65.
[7] *Broken Promises* at 65.
[8] *Broken Promises* at 65.

experience trauma, physical abuse, neglect, and post-traumatic stress disorder.[9] Additionally, Native Americans experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups[10] which have been attributed, in part, to the ongoing impacts of historical trauma.[11] The chronic underfunding of the HIS is one significant contributing factor to this disparities.

The Resources Provided to the Indian Health Service

Although annual appropriations for IHS have increased significantly since 2009, after adjusting for inflation and population growth, the IHS budget has remained static in recent decades.[12] In December 2018, the U.S. Commission on Civil Rights' *Broken Promises* report found that Tribal nations face an ongoing funding crisis that is a direct result of the United States' chronic underfunding of Indian health care for decades, which contributes to vast health disparities between Native Americans and other U.S. population groups.[13] We saw this crisis manifest in the worst way possible during the COVID-19 pandemic, and now we see it in the data.

Supplemental appropriations enacted during the pandemic were historic investments for Indian Country. It cannot be lost to history that Congress' swift action saved lives, democracy saved lives, but it must also be clear that the IHS is so disproportionately underfunded by Congress that a historic investment in response to a global virus still provided less resources than the estimate of annual obligations for IHS services – an amount collaboratively developed each year by the IHS National Tribal Budget Formulation Workgroup.

According to IHS data from April 2022, actual IHS spending per user remains less than half of Medicaid spending per enrollee, less than half of Veterans medical spending per patient, and less than one-third of Medicare spending per beneficiary – even after including 3rd party revenue received by IHS.[14] The Federal Disparity Index Benchmark, which assumes IHS users are provided services similar to those available to the U.S. population, recommends more than twice the investment per user than IHS receives[15] – an estimate that excludes approximately two-thirds of the population that could be served by an appropriately funded IHS.[16]

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[9] *Broken Promises* at 79-84.

[10] Walls, et al., *Mental Health and Substance Abuse Services Preferences among American Indian People of the Northern Midwest*, COMMUNITY MENTAL HEALTH J., Vol. 42, No. 6 (2006) at 522, https://link.springer.com/content/pdf/10.1007%2Fs10597-006-9054-7.pdf, accessed on: November 20, 2022.

[11] Kathleen Brown-Rice, *Examining the Theory of Historical Trauma Among Native Americans*, PROF'L COUNS, available at: http://tpcjournal.nbcc.org/examining-the-theory-of-historical-trauma-among-native-americans/, accessed on: November 22, 2022.

[12] *Broken Promises* at 67.

[13] *Broken Promises* at 65.

[14] Indian Health Service, *email correspondence to the National Tribal Budget Formulation Workgroup*, attachment "*2021 IHS Expenditures Per Capital and other Federal Care Expenditures Per Capita – 4-27-2022*," dated February 14, 2023.

[15] *Id*.

[16] The Indian Health Service estimates the population served as of January 2020 at 2.56 million; The U.S. Census Bureau estimates the AI/AN population as of July 2021 at 7.2 million.

Congress provides more than $1 trillion in resources for federal health care each year, it just disproportionately under funds IHS. When comparing FY 2023 omnibus spending for IHS to other Department of Health and Human Services (HHS) spending, only 0.66 percent of the total funding is provided to IHS. While this analysis of HHS spending includes spending from other Appropriations Subcommittee jurisdictions, it underscores the purposeful inequity that continues to result in AI/ANs with some of the worst health statistics. Surely, this cannot be the highest possible health status promised by the United States in the *Indian Health Care Improvement Act*.

Just Like our Life Expectancy – U.S. Spending Policy is Stuck in the Termination Era

Regardless of the Fund source or authorizing provision, Congress is making an annual budget policy decision much like the dark Termination Era policy that we pretend is behind us. Tribes and their citizens originally had a system of health care delivery imposed on them. Meanwhile, States and local governments violated Tribes' tax jurisdiction, effectively rendering Tribal nations without a way to fund basic infrastructure and governance in often isolated and drastically reduced or wholly taken lands. As part of this imposed system, the resources provided to the IHS have been chronically underfunded and measurably unequal compared to investments in other U.S. populations. We see this systematic isolation, sovereign infringement, forced dependence, assimilation, and termination in the annual appropriations process each year. We feel it in our communities, and the outcomes and data have been placed before us. We cannot expect Tribal communities' health to improve when they are consistently starved for resources. Too often, Tribal nations are trapped in a federal funding structure operating on the assumption that only state governments are worthy of base funding, essentially, assuming that we do not exist as jurisdictional sovereigns.

Full Funding for the Indian Health Service

Since 2003, Tribal leaders, technical advisors, and other policy advisors have met during the annual national Tribal Budget Formulation work session to collaboratively develop an estimate for full IHS funding. The IHS need-based funding aggregate cost estimate for Fiscal Year (FY) 2024 is approximately $51.4 billion, and the cost estimate for FY 2025 is $53.8 billion.[17] For FY 2024 and 2025, the Workgroup continues to request the Hospitals & Health Clinics ($13.6 billion for FY 2025) and Purchased/Referred Care ($9.1 billion for FY 2025) IHS line items receive the largest increase. The Workgroup also continues to request the Alcohol and Substance Abuse ($4.8 billion for FY 2025), Mental Health ($4.5 billion for FY 2025), Indian Health Care Improvement Fund ($3.7 billion for FY 2025), and Healthcare Facilities Construction ($2.5 billion for FY 2025) line items receive the next largest increases for IHS. The annual Workgroup request includes a detailed justification for spending by IHS account or budget policy issue and NIHB supports the Tribally-driven, data-based cost estimates and justifications of the National Tribal Budget Formulation Workgroup for the IHS.[18]

[17] Workgroup publications available at: https://www.nihb.org/legislative/budget_formulation.php, accessed on: February 26, 2023.
[18] *Id*.

Mandatory Funding for the Indian Health Service

IHS spending should be provided through mandatory direct appropriations with adjustments for inflation and population growth in an allocation mutually agreed to by Tribal governments. NIHB supports Tribes in their call for a direct appropriation codified in statute. Additionally, and as this Subcommittee has reported for years, certain IHS account payments, such as Contract Support Costs and Payments for Tribal Leases, fulfill obligations that are typically addressed through mandatory spending. Inclusion of accounts that are mandatory in nature under discretionary spending caps has resulted in a net reduction on the amount of funding provided for Tribal programs and, by extension, the ability of the federal government to fulfill its promises to Tribal nations.

Expand and Sustain IHS Advance Appropriations

Until such time that IHS is provided mandatory direct appropriations, advance appropriations for the IHS are consistent with the trust and treaty obligations reaffirmed by the United States in the *Indian Health Care Improvement Act*. The advance appropriation enacted in the FY 2023 omnibus excluded certain accounts in the IHS budget and flat-funded the IHS accounts that it did include. While historic in its inclusion, a flat-funded IHS needs FY 2024 adjustments, at a minimum, for fixed costs and staffing for newly completed facilities and should also include the amounts requested by the IHS National Tribal Budget Formulation Workgroup. As the process begins to normalize, both IHS and Tribes have the collaborative tools to produce reliable advance appropriation requests. For this appropriations cycle, Tribes have already provided official input on the FY 2025 budget to IHS with representatives of the Office of Management and Budget in attendance.

Hold the Indian Health Service Harmless in any Spending Cuts or Control Measures

The IHS budget remains so small in comparison to the national budget that spending cuts or budget control measures would not result in any meaningful savings in the national debt, but it would devastate Tribal nations and their citizens. As Congress considers funding reductions in FY 2024, IHS must be held harmless. As we saw in FY 2013 poor legislative drafting subjected our tiny, life-sustaining, IHS budget to a significant loss of base resources. Congress must ensure that any budget cuts – whether automatic or explicit – hold IHS and our people harmless. We cannot balance the budget on the backs of the First Americans.

Conclusion

This Subcommittee can break the cycle of inequity. You can each stop terminating our people. Tribal nations seek no more than the duty affirmed and reaffirmed by the U.S. Constitution, treaties, statutes, court decisions, and federal administrative law. The Budget Committee and Appropriations Committee must put the spending caps in place to achieve Tribal health spending equity, and this Subcommittee must prioritize IHS funding within its jurisdiction. We thank you, again, for the opportunity to provide testimony and look forward to working with you for the betterment of the American people. Again, we encourage you to review in detail the Tribal Budget Formulation Workgroup's request for IHS, which is available on NIHB's website.