National Indian Health Board

TESTIMONY OF WILLIAM SMITH
CHAIRMAN OF THE NATIONAL INDIAN HEALTH BOARD
FOR AMERICAN INDIAN AND ALASKA NATIVE PUBLIC WITNESS DAY
HOUSE APPROPRIATIONS SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES
May 8, 2024

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] In the enactment of the *Indian Health Care Improvement Act* (25 U.S.C. § 1602), Congress imposed upon itself the duty to provide the highest possible health status of Indians and provide the IHS with all resources necessary to effect that policy. Each year, the IHS National Tribal Budget Formulation Workgroup (NTBFWG), through Tribal input from the twelve IHS Areas, creates a budget recommendation to meet Indian Country's health needs. Unfortunately, Tribal communities continue to be underfunded and remain in a health crisis despite these efforts.

The Indian Health Service

For FY 2025, the NIHB supports the request of the NTBFWG for IHS in the amount of $53.8 billion for IHS, as a mandatory funded program. This includes full amount estimates for all services, facilities and improvements needed to bring the Indian health system up to the same standards as the U.S. population. Top ranked priorities of the workgroup are hospitals and health clinics, purchased/referred care, alcohol and substance use and mental health, and the Indian Health Care Improvement Fund (IHCIF). In facilities the workgroup recommends maintenance and improvement, healthcare facilities construction, and sanitation facilities construction.[3]

For the first time in FY 2024, the Appropriations Committees needed to cut IHS accounts to make room for growing Contract Support Costs and Section 105(*l*) Lease Payments. Without a mandatory IHS budget as the NTBFWG has proposed, the costs for these accounts must come from within the discretionary caps placed on the budget. With an already dramatically underfunded health system and the rising costs of providing health care nationwide, there is little room for crimping to accommodate these increasing costs. The accounts which bore the brunt were facilities and the electronic health record line-item. This of course is also compounded on top of years of sub-inflationary increase the Agency's budget has weathered, diminishing Services purchasing power for years. These types of cuts impact the health status of American Indians and Alaska Natives.

[1] *Worcester v. Georgia*, 31 U.S. 515 (1832).
[2] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).
[3] The NTBFWG's detailed request can be found here: https://www.nihb.org/government-relations/budget_formulation.php

According to the Indian Health Service and Tribal Health Care Facilities' Needs Assessment Report to Congress, the need for facilities funding remains enormous. In 1992, the IHS established its current new construction priority list. Of the original 27 facilities on the list, over 30 years later, seven remain to be fully funded. The IHS hospitals now average 39 years of age, over three times older than the average age of U.S. not-for-profit hospitals (which is 11.5 years). Aging facilities risk code non-compliance, lower productivity, and compromises for health care services. Put another way, at the existing replacement rate, a new 2021 facility would not be replaced ***for 290 years.***

Last year, the Centers for Disease Control and Prevention reported 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.[4] The cuts also impact the roll out of significant enterprise-level operation and systems changes, such as the new electronic health record system IHS is adopting. Without consistent funding for such important high-level programs, systems transitions can become marred by stalls, leadership changes, and implementation delays. The IHS budget is already dramatically underfunded as evidenced by the NTBFWG's fully funding estimates, but when additional cuts to critical accounts and line items occur, it only sets the Indian health system back further.

Reclassify Contract Support Costs (CSC) and Section 105(*l*) as Mandatory

The Indian Self-Determination and Education Assistance Act (ISDEAA) requires IHS to compensate Tribes for CSC and Section 105(*l*) leases thus making these payments legally mandatory. Congress provides "such sums as may be necessary" to meet these obligations but does not account for them as mandatory spending in the budget. Since the payments are provided through discretionary spending it means that annual increases mostly go to these two accounts, leaving all other programs in IHS, Bureau of Indian Affairs (BIA), and Bureau of Indian Education (BIE) budget flat-funded.

Congress intended for these payments to be mandatory when ISDEAA was first enacted. The Supreme Court upheld these payments as mandatory obligations. Appropriations Committees have cited this issue for nearly a decade and call on a solution, including reclassification of these accounts as mandatory. IHS has also consistently included this solution in their budget and this approach has been endorsed in the Committee report language throughout the years.

Congress can reclassify these accounts by simply coming to an agreement on how to score them with the Budget Committees, Congressional Budget Office, and OMB, as official scorekeepers. We believe that no changes in law are necessary – there merely must be an agreement on record stating whether the payment is a mandatory or discretionary obligation of the United States.

Now more than ever, this transition is critical. In FY 2024, 105(*l*) leases increased by 34.2 percent and CSC increased by 8.4 percent, whereas the total increased funding for IHS was only 0.05 percent. In fact, it was the first year where we saw actual IHS budget cuts – cuts from essential services and facilities – to fund these mandatory obligations. IHS funding last year did not even keep up with inflation, which is estimated to be 3.1 percent according to the Consumer Price Index. The U.S. Supreme Court is currently considering a case that could have major implications on the

[4] Arias E, Tejada-Vera B, Kochanek KD, Ahmad FB. *Provisional life expectancy estimates for 2021*. Vital Statistics Rapid Release; no 23. Hyattsville, MD: National Center for Health Statistics. August 2022. DOI: https://dx.doi.org/10.15620/cdc:118999.

funding obligations from CSC. The court is expected to soon rule on *Becerra v. San Carlos Apache Tribe and Northern Arapaho Tribe* which could significantly increase the obligations for CSC in coming years. In today's funding model, it is unclear where this funding would come from.

We are also cognizant that in FY 2025 the Appropriations Committee will have to work under the discretionary budget limits set forth by the Fiscal Responsibility Act (FRA) (P.L. 118-5) which will provide a maximum of $710.688 billion for nondefense programs; this is only ***1 percent*** over FY 2024. All other programs being equal, this would not leave room for IHS to fully fund CSC and 105(*l*) leases (if the increases next year are similar to what they were in FY 2024) without cuts to other areas of the IHS budget. Furthermore, it would impede the ability of the Appropriations Committee to fund staffing, inflation and population growth, let alone much needed program expansion. With these growing costs, the Interior Subcommittee would need a dramatic increase in its 302(b) allocation to avoid cuts to other critical programs funded by the subcommittee. The time to move these costs to mandatory is now.

Towards Full and Mandatory Funding for IHS

In addition to the transition of CSC and Section 105(*l*) Lease Payments to mandatory, the NTBFWG has recommended all IHS funding transition to mandatory appropriations. The recommendation includes the full funding estimate developed by the NTBFWG, $53.8 billion for FY 2025. IHS funding should be provided for through direct appropriations with adjustments for inflation and population growth in an allocation mutually agreed to by Indian tribes. These steps will secure the future of the Indian health system and meet the treaty and trust obligations of the federal government to provide for the health of AI/ANs. Until then, the provision, preservation, and enhancement of IHS advance appropriations is necessary.

For the first time, IHS was provided advance appropriations in the FY 2023 Consolidated Appropriations Act (P.L. 117-328). Proving the life-saving and cost-saving value of this authority in its first budget cycle, IHS and the Tribes were able to receive full-year appropriation starting on October 1, 2023 for FY 2024 for the first time in almost a decade. Advance appropriations is allowing IHS and Tribes to focus on implementation and execution of the core mission, instead of partial year budgets and reconciliations. Continuation of advance appropriations for IHS is imperative, however, not all IHS accounts and line items are included. All IHS accounts must be included in the advance appropriations as well as increases year-to-year that adjust for inflation, population growth, the IHCIF, and other necessary programs. Until IHS spending is mandatory, securing advance appropriations for every account in the IHS budget is critical to the health of every Tribal community in Indian Country.

Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination

On December 6, 2023, President Biden signed into law Executive Order (E.O.) 14112 marking the continuation and further advancement of the administration's historic commitment to uphold the nation's treaty and trust obligations to Tribal Nations and their citizens. Further, the Executive Order reiterates the United States' commitment to protect and support Tribal sovereignty and self-determination.

The Executive Order also directs the head of each agency to design, revise, provide waivers for, and otherwise administer Federal funding and support programs for Tribal Nations to achieve

objectives such as, compacting and contracting, funding for programs to allow Tribal set-asides, designing application and reporting criteria that reduces administrative burdens, and increasing the flexibility of federal funding Tribes receive.

At its core, E.O. 14112 recognizes three things: Tribal Nations have long-standing legal rights recognizing their inherent sovereignty; the United States owes a duty to Tribes that has not been met; and federal agencies have authority to make meaningful change and progress toward meeting those obligations, doing so in collaboration with the sovereign nations they seek to serve. We hope that Congress will also recognize the principles outlined in E.O. 14112 as it makes FY 2025 funding decisions.

HHS Program Funding and Report Language Requests

Due to the restrictions in the Interior Appropriations subcommittee's 302(b) allocation, and increasing CSC and 105(*l*) leases, the most likely and needed funding is from other operating divisions at the Department of Health and Human Services (HHS). As current law states and reiterated in E.O. 14112, all federal agencies have a federal trust responsibility to provide for Tribal nations. However, most agencies, including HHS, do not provide any significant, broad-based, dedicated funding to Tribal nations despite significant support to states, localities, and territories.

HHS consistently provides funding in the form of competitive grants, block grants to states only, and complicated overburdensome administrative procedures and reporting requirements that only serve to exclude the vast majority of Tribal nations. Those that get funding have a higher administrative capacity, the workforce to handle the significant reporting requirements, and likely receive more funding than Tribes who don't have this type of infrastructure. This increases a vicious cycle where those without resources continue to remain so.

CDC has engaged with states and localities for decades on this work, with nominal support to Tribal nations. Through COVID-19 supplemental funding IHS received limited funds to assist with public health capacity building. However, Congress took almost $800 million of that funding away through the Consolidated Appropriations Act, 2024 (P.L. 118-42) and the Fiscal Responsibility Act (P.L. 118-5). We call on the Appropriations Committee to end this epidemic of invisibility in the public health system by supporting Tribal nations beyond the IHS.

In recognition of new Executive Order and the constraints on Congress in the FY 2025 budget, particularly on the Interior, Environment, and Related Agencies budget, we are recommending further report language and increases for Tribal set-asides within the Labor, Health and Human Services, Education, and Related Agencies budget. We urge this Subcommittee to communicate the constraints on Tribal programs and the shared responsibility of the federal trust responsibility.

Conclusion

The IHS budget faces many pressures to meet the federal treaty and trust obligations to Tribes in such a constrained fiscal environment. This Subcommittee can make critical changes to the IHS budget, which are budget neutral and take pressure off the Interior budget and the IHS. Moving CSC and Section 105(*l*) Lease Payments, providing for full advance appropriations, and supporting expansion of Self-Governance and Tribal Support beyond the IHS can dramatically improve the outlook for Tribes without breaking a budget cap. This Subcommittee can break the cycle of inequity. We thank you for the opportunity to provide testimony and look forward to working with you for the betterment of Tribal nations.