National Indian Health Board

**TESTIMONY OF ANTHONY C. LOCKLEAR**
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**FOR AMERICAN INDIAN AND ALASKA NATIVE PUBLIC WITNESS DAY**
**HOUSE APPROPRIATIONS SUBCOMMITTEE ON INTERIOR, ENVIRONMENT, AND RELATED AGENCIES**

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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 (NTBFW), 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 system has also been caught up in recent Administrative actions which are creating uncertainty for Indian health programs, their employees, and Tribal citizens. This includes freezing and potentially reallocating vital federal funding, dismissing essential federal employees, and proposing changes to important Indian programs.

Indian programs within this budget are part of the United States' legal requirement to deliver on its trust and treaty obligations to Tribal Nations. Although the Administration has provided leeway for Departments to implement its guidance and orders in such a way as to honor statutory and legal requirements, Indian Country programs, which are legally required by trust and treaty obligations and associated implementing statutes, have not had clarity on their exemption under this guidance. The Departments of Health and Human Services and the Interior have worked to provide further guidance on the application of these new policies to Indian programs, but they have been limited and Tribes need broader exemptions. We urge Congress to share with the Administration the importance of engaging in government-to-government Tribal consultation with us prior to executing on its priorities, so that we could help the Administration clarify and avoid unintended harm to Indian Country programs. Further, we call upon Congress to do its part in upholding trust and treaty obligations, including by appropriating the funding that Indian Country has pre-paid through land and resources.

**The Indian Health Service Budget**

For FY 2026, the NIHB supports the request of the NTBFW for IHS in the amount of $63 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

[1] *Worcester v. Georgia*, 31 U.S. 515 (1832).
[2] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).

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, IHS accounts were cut to make room for growing Contract Support Costs (CSC) and Section 105(*l*) Lease Payments. Without a mandatory IHS budget as the NTBFW 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 increases the Agency's budget has weathered, diminishing Services purchasing power for years. Further, without a final FY 2025 appropriation to provide necessary increases and address these growing required costs, the Agency continues to struggle to meet service needs.

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 healthcare services. At the existing replacement rate, a new 2026 facility would not be replaced ***for 290 years.***

In 2023, 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. Such cuts to the IHS budget only sets the Indian health system back further.

Finally, Tribal Nations wish to express ongoing support for IHS advance appropriations. Advance appropriations has helped for continuity of services and program planning even during uncertain budget and funding environments, including recent funding pauses. Although some Tribal grants were impacted, advance appropriations helped to ensure availability of resources for Tribes. We urge Congress to provide IHS advance appropriations in FY 2026 and into the future, and to expand advance appropriations to all accounts within the IHS budget.

**Include Bill Language that Preserves Funding and FTEs that Serve Indian Country**

Recent Administrative actions have also dramatically impacted staffing at the Indian Health Service, even when staff have not been laid off. NIHB has been concerned about the short- and long-term impacts to the federal workforce at the IHS and other HHS Tribal programs. Even when limited exemptions have been provided, the actions continue to impact critical support staff necessary for billing, administration, scheduling, and oversight. The constant and continual

[3] The NTBFW's detailed request can be found here: legacy.nihb.org/resources/NIHB-FY26-Budget.pdf

[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.

messaging is also impacting staff moral more generally, which is creating anxiety and driving providers and other staff to look for employment outside the Indian health system. The IHS already has a 30 percent provider vacancy rate, and the Indian health system cannot sustain significant loss of staffing while maintaining current level of services and accreditation for facilities.

Our Direct Service Tribes are some of the most impacted by these staffing reduction activities. A Tribal government's decision to receive health care directly from the IHS is an action based on Tribal Sovereignty and Self-Determination. Direct Service Tribes have exercised their Self-Determination right for IHS to provide some or all health services to their Tribal citizens, covering activities and programs from delivery of care to billing. This is all done by federal IHS employees. The choice to retain Tribal shares with IHS and cover the costs of full-time employees (FTEs) is an act of Tribal Sovereignty made by the Direct Service Tribes. Any reductions in staff of the federal workforce on Indian programs, including the termination of certain probationary employees and deferred resignations, will reduce resources for Direct Service Tribes. This is grossly unfair and penalizes Direct Service Tribes for exercising their Tribal Sovereignty and Self-Determination rights.

If a Tribe elected to contract all IHS functions under the Indian Self-Determination and Education Assistance Act (ISDEAA), they would be entitled to those shares and FTEs which they chose to retain at IHS. Staffing and funding reductions limit the available resources which Tribes may be currently, or in the future, looking to self-govern through ISDEAA. We can already see that Tribes which have self-governed have been buffered from the worst of these hiring freezes and reduction in force (RIF) activities. The recent developments may inspire more Tribes to move towards self-governance. The resources associated with any FTEs will be lost and unavailable to an ISDEAA contract unless reinstated by a future administration or Congress. Tribes should not see programs that they may one day intend to contract gutted in the interim.

For all these reasons, NIHB requests that the Committee include bill language in its FY 2025 and FY 2026 bills that will preserve Tribes' ability to contract or compact BIA, IHS, and Bureau of Indian Education funding and functions at FTE staffing levels that existed at the beginning of FY 2024. This will ensure that intervening Executive Orders and memoranda do not have the effect of reducing staffing, funding, and functions which rightfully serve Tribes and would otherwise be eligible to contract under ISDEAA.

**Reclassify Contract Support Costs 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 over 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.

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, FY 2024 was the first year where we saw actual IHS budget cuts – cuts from essential services and facilities – to fund these mandatory obligations. The U.S. Supreme Court's ruling in *Becerra v. San Carlos Apache Tribe* and *Northern Arapaho Tribe* has resulted in significant increases to the obligations for CSC in particular. In FY 2025, the draft appropriations bills in the Senate and the House marked the CSC and Section 105(l) Lease cost increases as 87 percent and 93 percent of the total agency increases, respectively. In today's funding model, it is unclear where this funding would come from. We urge the Committee to make the commonsense reclassification for these required costs.

**HHS Program Funding, Report Language, Self-Governance Expansion**

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). 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 Tribes that get funding have a higher administrative capacity, the workforce to handle the significant reporting requirements, and likely receive more funding than Tribes who do not have this type of infrastructure. This increases a vicious cycle where those without resources continue to remain so.

Further, Tribal Nations wish to see flexibility in funding and programs beyond the IHS. For years, Tribal leaders have worked with HHS on expansion of ISDEAA under Title VI to support a demonstration project at HHS Agencies and Programs. The success of self-governance supports the efficiencies Congress and the New Administration see as priorities. The ISDEAA turns 50 this year, and it is time to support and celebrate the success of Tribal Sovereignty and Self-governance.

We call on the Appropriations Committee to end this epidemic of invisibility in the public health system by supporting Tribal Nations beyond the IHS. 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 Indian 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. Further, recent Administrative actions have impacted the Indian health system threatening funding and staffing critical to meeting those obligations. This Subcommittee can make critical changes to the IHS budget, which are budget neutral, take pressure off the Interior budget, and support IHS and Tribes. Preserving funding and staffing, moving CSC and Section 105(*l*) Lease Payments, providing for full advance appropriations, and supporting expansion of resources and Self-Governance beyond the IHS can dramatically improve the outlook for Tribes without breaking a budget cap. We thank you for the opportunity to provide testimony and look forward to working with you for the betterment of Tribal Nations.