National Indian Health Board

STATEMENT OF THE NATIONAL INDIAN HEALTH BOARD
HOUSE COMMITTEE ON NATURAL RESOURCES
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
THE OPIOID CRISIS IN TRIBAL COMMUNITIES
APRIL 5, 2022

Good morning, Chairman Porter, Ranking Member Moore, and Members of the Subcommittee. On behalf of the 574 federally-recognized Tribal nations and the member organizations the National Indian Health Board serves, thank you for the opportunity to provide written testimony on "*The Opioid Crisis in Tribal Communities*".

Background

The U.S. Constitution recognized the political and government-to-government relationship between the U.S. and Tribal nations. As sovereign nations, the U.S. and Tribal governmentsentered treaties - which exist in perpetuity - in which the Tribes exchanged millions of acres of land for the federal obligations and responsibilities, including the obligation for the provision of comprehensive health care from the federal government.

The U.S. Supreme Court decisions acknowledged this relationship while also recognizing a trust relationship and obligation to Tribes existed to honor these agreements, among other duties. This trust and treaty obligation extends and applies throughout the federal government, including all agencies. These responsibilities are carried out, in part, by the primary agency, Indian Health Service, within the Department of Health and Human Services (HHS). This agency provides both direct care and resources for health care services to American Indian and Alaska Native (AI/AN) people. Among all federal health care-related agencies, the IHS and the Indian health care delivery system are unique in this regard.

The IHS provides health care services either directly to AI/AN people, or through contracts or compacts with Tribal nations which provide the services. The IHS may also enter contracts with urban Indian organizations to provide health care services to AI/AN people in certain urban locations. For specialty care and other services not available within the Indian health system, the IHS may – contingent upon available funding - purchase or provide funding to Tribes to purchase such care through the Purchased Referred Care program.

According to the IHS, "[t]he IHS provides comprehensive primary health care and disease prevention services to approximately 2.6 million American Indians and Alaska Natives through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in rural primary care settings and are managed by IHS, Tribal, and urban Indian health programs."[1]

[1] Justification of Estimates for the Appropriations Committees. Department of Health and Human Services. Fiscal Year 2022. Indian Health Service. At CJ-1.

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Tribal Communities in Crisis

In his December 2021 Advisory, the U.S. Surgeon General found that Native youth were at a higher risk for mental and behavioral health challenges during the pandemic. While the Advisory focused on youth, these findings could also apply to our adults and other health challenges.

Before the pandemic, Tribal communities were already in a behavioral health crisis. According to the National Center for Health Statistics, American Indian and Alaska Native women experienced the highest increase in suicide rates of 139% from 1999 to 2017. The men between the ages of 15 to 44 experience the highest rates of suicide of all race and ethnicity groups.

The overall death rate of adults from suicide is about 20 percent higher compared to the non-Hispanic white population.[2] Suicides have skyrocketed for Native veterans, from 19.1 to 47 in 100,000 persons. [3] But most shocking, for those aged 18 to 39, it was 66 in 100,000 persons.

These facts, combined with down-spiraling health disparities experienced by AI/ANs, demonstrate the human consequences of underfunding IHS. Deferral of care due to funding and workforce shortages has pushed more and more Tribal members into health conditions wherein prescription opioids are used to treat chronic pain that would otherwise successfully be treated earlier with non-opioid therapies, if they were available. Failure to address basic health needs through routine visits and preventative care also has led to preventable diseases becoming fatal when the diagnoses are too late to seek treatment.

Congress Must Invest in Tribal Communities for Prevention and Treatment

Congress must tackle these issues head-on with aggressive funding for prevention and treatment measures for Tribes. The Indian health system is underfunded by nearly 50% of the minimum levels necessary to begin addressing the existing health care disparities. In FY 2020, the national health expenditure was $12,530 per capita which also accounted for COVID-19 relief spending. In FY 2019, the national health expenditure was $11,582 per capita. In FY 2019, based on the latest information provided by the IHS, the IHS expenditure was only $4,078 per user population. As funding gaps grow and the IHS funding increases cannot close those gaps, the AI/AN people suffer.

The persistent chronic underfunding of the IHS, historical trauma, and other social and economic conditions contribute to the unacceptable health conditions. The AI/AN people often face the most significant health disparities among all populations in the United States - besides behavioral health challenges - including diabetes, suicides, and COVID-19 infections, hospitalizations, and deaths.

The pandemic devastated our communities. It highlighted the consequences of chronic underfunding. For example, according to the Substance Abuse and Mental Health Service Administration, 13% of the Native population needs substance abuse treatment, but only 3.5% receives any treatment.

[2] Office of Minority Health. Minority Population Profiles, American Indian and Alaska Natives. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39 . Accessed on March 21, 2018.
[3] High suicide rates in American Indian/Alaska Native veterans | Wolters Kluwer

Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, again, due to lack of funding availability and the challenges with the grant-funded model, several culturally responsive in-patient treatment centers have had to close their doors leaving major gaps in service availability and more specifically availability of detox beds with the rising number of opioid and/or other addictions. Opioid and heroin use is high in many IHS regions, with limited treatment facilities available.

In FY 2008, Congress appropriated $14 million to support a national methamphetamine and suicide prevention initiative to be allocated at the discretion of the IHS director. Today, those funds continue to be allocated through competitive grants, despite Tribal objections. For over a decade, Tribes have noted that IHS reliance on grant programs is counter to the federal trust responsibility and undermine self-determination tenets. Furthermore, because grant funding is never guaranteed, vulnerable communities, with the greatest needs but least capacity, often slip through the cracks. The needed increase must be applied to IHS funding base and away from the inefficient use of grants in order to stabilize programs and ensure the continuity of the program and care to our struggling Tribal members and their families.

Tribes have recommended full funding of the Indian health care system at $49.8 Billion beginning in FY 2023. The fundamental responsibilities of IHS to deliver excellent health care and reduce health care disparities – including opioid overdoses and use - cannot happen without the appropriate support and resources from Congress.

However, these services must be provided in appropriate settings and facilities. Specialty care and other health care facilities are also necessary to make an impact on these problems. In 2010, Congress authorized the construction of inpatient behavioral health and other specialty facilities, such as long-term care and dialysis. While suicides, other health problems, and costs escalate, construction of these specialty care facilities has yet to be funded. In fact, Congress has not funded the completion of several health care facilities still on a nearly 30-year-old, 1993 waiting list. The IHS has indicated that the health care and specialty care facilities construction cost alone is now up to $22 Billion – yet Congress funded the entire Indian health care ***system*** at only $6.6 Billion for FY 2023.

As a result, Tribal leaders and health policy experts determined that full funding of the IHS at $49.8 Billion is required to make a difference. This figure takes into account medical and non-medical inflation, compliance with costly federal mandates, and other emerging needs. It also uses a more accurate per user benchmark based on the national health expenditure.

Congress Can Swiftly Adopt Legislative Behavioral Health-Related Improvements

Native Behavioral Health Access Improvement Act. The bill, H.R.4251, the *Native Behavioral Health Access Improvement Act*, was introduced by Representatives Frank Pallone and Raul Ruiz on June 30, 2021. It was referred to the House Committee on Energy and Commerce, Subcommittee on Health and the Committee on Natural Resources.

There is a Senate companion bill as well, S.2226, introduced by Senators Smith and Cramer on June 24, 2021. The bill was referred to the Senate Committee on Indian Affairs, but no further action has been taken.

This bill would amend the *Indian Health Care Improvement Act* by establishing a special behavioral health program for Indians to treat and prevent mental health and substance use disorders. It would provide funding through grants to the IHS, Tribes and urban Indian health programs at $200 Million for each fiscal year from 2022 to 2026 according to a formula developed through consultation with Tribes and urban Indian organizations. The grantees would agree, as a condition of receiving funds, to submit data and reports consistent with the submission requirements established through consultation.

This base funding is important to Tribal communities and would complement the comprehensive behavioral health provisions of Title VIII of the *Indian Health Care Improvement Act*. Likewise, the interplay of the *Indian Self-Determination and Education Assistance Act* with the funding approaches, data collection, and reporting requirements is a necessary consideration to ensure this legislation is most effective for Tribal communities in reducing the opioid and other behavioral health crises. We urge Congress to move swiftly on finalizing this bill in close collaboration with NIHB and Tribal nations.

Comprehensive Addiction Resources Emergency Act of 2021. On December 16, 2021, Representative Maloney introduced the *Comprehensive Addiction Resources Emergency Act of 2021*. There are 105 co-sponsors. This Senate companion bill, S.3418, was introduced by Senator Warren and is currently pending before the Senate Health, Education, Labor, and Pensions Committee.

The bill requires the Secretary of the Department of Health and Human Services to provide grants to address substance abuse and increase access to preventive, medical, and recovery care. It includes direct funding to Tribal nations and includes Tribal representation on the planning council, among other things.

The bill has been referred to four Committees including the Natural Resources Committee. We urge this Committee to secure swift passage of this bill and NIHB and Tribal nations stand ready to join you in this effort.

Conclusion

Aggressive solutions are needed to make a difference. The President challenges Congress to move the bar through his FY 2023 Budget Request for the IHS and his mental health initiative introduced in his State of the Union address. Indian Country challenges Congress to also make a difference and move in the right direction. NIHB and Tribal nations stand ready to join in this fight for the lives, health, and future of American Indians and Alaska Native people.

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