National Indian Health Board

WRITTEN TESTIMONY OF JANET ALKIRE, GREAT PLAINS AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

BEFORE THE
HOUSE NATURAL RESOURCES COMMITTEE
SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS
"CHALLENGES AND OPPORTUNITIES FOR IMPROVING HEALTHCARE DELIVERY IN TRIBAL COMMUNITIES"

March 29, 2023

Chairwoman Hageman, Ranking Member Leger Fernández, and distinguished members of the Subcommittee, on behalf of the National Indian Health Board and the 574 sovereign federally recognized American Indian and Alaska Native Tribal nations we serve, thank you for this opportunity to provide testimony on challenges and opportunities for improving healthcare delivery in Tribal communities. My name is Janet Alkire. I serve as Tribal Council Chairwoman for the Standing Rock Sioux Tribe and Great Plains Area Representative for the National Indian Health Board (NIHB).

The Indian Health Service (IHS) is the principal federal health care provider and health advocate for Indian people.[1] Its success is essential to our success as an organization, and to meeting this Nation's stated policy goal of ensuring the highest possible health status for Indians.[2] The NIHB therefore appreciates this Subcommittee's focus on Indian healthcare and stands ready to work with the Subcommittee towards achieving this national goal. We have a long way to go.

The NIHB Board of Directors sets forth an annual Legislative and Policy Agenda to advance the organization's mission and vision. Our objectives are to educate policymakers about Tribal priorities, advocate for and secure resources, build Tribal health and public health capacity, and support Tribally led efforts to strengthen Tribal health and public health systems. Today's testimony includes a subset of recommendations from this Agenda.

Summary Recommendations

1. **Reauthorize the Special Diabetes Program for Indians (SDPI) before September 30, 2023.**
2. **Authorize full mandatory funding for all IHS programs. Until then:**
   a. **Authorize mandatory funds for Contract Support Costs and 105(l) Lease Payments.**

[1] https://www.ihs.gov/aboutihs/
[2] 25 U.S.C. 1602(1)

   b. **Authorize discretionary advance appropriations.**
   c. **Protect the IHS budget from "sequestration" cuts**
   d. **Authorize Medicaid reimbursements for Qualified Indian Provider Services**
   e. **Authorize federally-operated health facilities and IHS headquarters offices to reprogram funds at the local level in consultation with Tribes**
3. **Oversee federal agency data sharing policies to ensure compliance with existing law**
4. **Improve Health Professional Staffing in the Indian Health System**
5. **Support Tribal self-governance expansion at the Dept. of Health and Human Services**

The Trust Obligation

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.[3] In fulfillment of this tribal trust relationship, the Supreme Court declared in 1832 that the United States "charged itself with moral obligations of the highest responsibility and trust" toward Tribal nations.[4] In 1976, Congress reaffirmed its duty to provide for Indian health care when it enacted the *Indian Health Care Improvement Act* (IHCIA) (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.

Current Health Status

Today, 47 years after the enactment of IHCIA, American Indians and Alaska Natives (AI/ANs) collectively still face the lowest health status of any group of Americans. The Centers for Disease Control and Prevention (CDC) reported last year that life expectancy for AI/ANs has declined by nearly 7 years, and that our average life expectancy has *declined* to 65 years—10.9 years less than the national average and equivalent to the nationwide average in 1944.[5,6] Native Americans die at higher rates than those of other Americans from chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide,

[3] *Worcester v. Georgia*, 31 U.S. 515 (1832).
[4] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942).
[5] 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: March 20, 2023 (total for All races and origins minus non-Hispanic American Indian or Alaska Native).
[6] *Id.*

intentional self-harm/suicide, and chronic lower respiratory disease.[7] Native American women are 4.5 times more likely than non-Hispanic white women to die during pregnancy.[8] The CDC also found that, between 2005 and 2014, every racial group experienced a decline in infant mortality except for Native Americans who had infant mortality rates 1.6 times higher than non-Hispanic whites and 1.3 times the national average.[9] Native Americans are also more likely than people in other U.S. demographics to experience trauma, physical abuse, neglect, and post-traumatic stress disorder.[10] According to a 2020 study by the Substance Abuse and Mental Health Services Administration, AI/ANs experience the highest rates of suicide,[11] with a recent, February 2023 CDC report finding that teen girls are experiencing record high levels of violence, sadness, and suicide risk.[12]

Historical—and Ongoing—Trauma

Native Americans experience some of the highest rates of psychological and behavioral health issues as compared to other racial and ethnic groups which have been attributed, in part, to the ongoing impacts of historical trauma.[13,14] AI/ANs have suffered physical, mental, emotional and spiritual harms resulting from historical and intergenerational trauma that began with colonization and the Doctrine of Discovery, whereby Tribal lands were seized and claimed by governments under the auspices that Tribal lands were "undiscovered" prior to colonization. Colonization further includes a history of genocide against AI/AN people, which spread with westward expansion and forced removal and relocation of numerous Tribes in the 1830s.

Cultural genocide followed. In 1869, the United States government, as a part of efforts to assimilate AI/ANs into non-Native culture, adopted the Indian Boarding School Policy to eradicate AI/AN language, culture, and identity through forced separation and removal of

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[7] *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: March 20, 2023.
[8] *Broken Promises* at 65.
[9] *Broken Promises* at 65.
[10] *Broken Promises* at 79-84.
[11] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States, Results from the 2020 National Survey on Drug Use and Health*, available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt35325/NSDUHFFRPDFWHTMLFiles2020/2020NSDUHFFR1PDFW102121.pdf, accessed on: March 22, 2023.
[12] Centers for Disease Control and Prevention, *PRESS RELEASE: U.S. Teen Girls Experiencing Increased Sadness and Violence*, available at: https://www.cdc.gov/media/releases/2023/p0213-yrbs.html, accessed on: March 22, 2023.
[13] 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: March 20, 2023.
[14] 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: March 20, 2023.

AI/AN children from their families and Tribal communities. Between 1869 and the 1960s, more than 100,000 AI/AN children were removed from their family homes and placed in over 350 schools operated by the Federal Government and churches. Children were punished for speaking their Native languages, banned from expressing traditional or cultural practices, stripped of traditional clothing and hair, and experienced physical, mental, emotional, and spiritual abuse, including malnourishment, sexual assault, and medical experimentation. Many AI/AN children died at boarding schools while separated from their families and Tribal communities, the true number of which is currently unknown due in part to suppression and inaccessibility of both government and church records.

Over 100 years of cultural genocide at Indian Boarding Schools is not relegated to distant memory but exists in the living memory of many Tribal members today, and the legacy of unresolved historical and intergenerational trauma caused by the schools has created health inequities and disparities, detrimental physical and behavioral health outcomes, and lack of meaningful connection to Native identity for many Tribal members. Research links AI/AN historical and intergenerational trauma to increased rates of depression, suicidal ideation, substance use disorders, domestic violence and sexual assault, and a lower life expectancy than any other group in the United States. That is why addressing the harm of historical and intergenerational trauma and the efficacy of Tribally led and culturally appropriate healing is an essential component of improving holistic health outcomes for AI/AN people.

Chronic Underfunding

In December 2018, the U.S. Commission on Civil Rights' Broken Promises report found that Tribal nations face an ongoing health 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.[15]

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.[16] 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[17] – an estimate that excludes

[15] *Broken Promises* at 65.
[16] 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.
[17] *Id.*

approximately two-thirds of the population that could be served by an appropriately funded IHS.[18]

Chronic and pervasive health staffing shortages—from physicians to nurses to behavioral health practitioners—stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies documented as of 2016. Further, a 2018 GAO report found an average 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two thirds of IHS Areas (GAO 18-580). Lack of providers also forces IHS and Tribal facilities to rely on contracted providers, which can be more costly, less effective and culturally indifferent, at best – inept at worst. Relying on contracted care reduces continuity of care because many contracted providers have limited tenure, are not invested in community and are unlikely to be available for subsequent patient visits. Along with lack of competitive salary options, many IHS facilities are in serious states of disrepair, which can be a major disincentive to potential new hires. While the average age of hospital facilities nationwide is about 10 years, the average age of IHS hospitals is nearly four times that – at 37 years. In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding practices. As the IHS eligible user population grows, it imposes an even greater strain on availability of direct care.

Tribal nations are also severely underfunded for public health and were largely left behind during the nation's development of its public health infrastructure. As a result, large swaths of Tribal lands lack basic emergency preparedness and response protocols, limited availability of preventive public health services, and underdeveloped capacity to engage in disease surveillance, tracking, and response.

<u>Recommendations</u>

1. **Reauthorize the Special Diabetes Program for Indians (SDPI) before September 20, 2023.**

   Congress established the Special Diabetes Program for Indians (SDPI) in 1997 to address the disproportionate impact of type 2 diabetes in AI/AN communities. This program has grown and become our nation's most strategic and effective federal initiative to combat diabetes in Indian Country. SDPI has effectively reduced incidence and prevalence of diabetes among AI/ANs and is responsible for a 54% reduction in rates of End Stage Renal Disease and a 50% reduction in diabetic eye disease among AI/AN adults.[19] A 2019

[18] 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.
[19] Indian Health Service, *Special Diabetes Program for Indians 2020 Report to Congress*, available at https://www.ihs.gov/sdpi/reports-to-congress/, accessed on: March 20, 2023.

federal report found SDPI to be largely responsible for $52 million in savings in Medicare expenditures per year.[20]

Still, diabetes and its complications remain major contributors to death and disability in nearly every Tribal community. AI/AN adults have the highest age-adjusted rate of diagnosed diabetes (14.5 percent) among all racial and ethnic groups in the United States, more than twice the rate of the non-Hispanic white population (7.4 percent).[21] In some AI/AN communities, more than half of adults 45 to 74 years of age have diagnosed diabetes, with prevalence rates reaching as high as 60 percent.[22]

The NIHB strongly supports the permanent reauthorization of the SDPI at a minimum of $250 million annually, with automatic annual funding increases matched to the rate of medical inflation. SDPI has been flat funded since FY 2004. It is also important to note that last year, the Department of Health and Human Services (HHS) expanded the pool of potential grantees beyond current grantees to all eligible grantees. Practically, in 2022, this meant that there were additional, new grantees in the SDPI program, with the same level of funding. Additionally, the NIHB supports amending the SDPI's authorizing statute, the Public Health Service Act, to permit Tribes and Tribal organizations to receive SDPI funds through self-determination and self-governance contracts and compacts. This change will establish SDPI as an essential health service and remove the barriers of competitive grants – which do not honor the Trust and treaty obligation to tribal nations. Self-governance also removes unnecessary administrative burdens which leaves more funding available for services. Self-governance Supports Tribal sovereignty by transferring control of the program directly to Tribal governments.

2. Authorize full mandatory funding for all IHS programs.

Through its coerced acquisition of land and resources and genocide destruction of cultures and peoples the United States formed a fiduciary relationship with Tribal nations whereby it has created a trust relationship to safeguard Tribal rights, lands, and resources. As part of this coerced exchange, Congress has continuously reaffirmed its duty to provide for Indian health care. Unfortunately, Tribal nations face an ongoing health crisis directly resulting from the United States' chronic underfunding of Indian health care for decades. This contributes to ongoing health and persistent inequities and

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[20] Department of Health and Human Service, *The Special Diabetes Program for Indians: Estimates of Medicare Savings*, ASPE Issue Brief, May 10, 2019, available at https://aspe.hhs.gov/sites/default/files/private/pdf/261741/SDPI_Paper_Final.pdf, accessed on: March 20, 2023.
[21] Centers for Disease Control and Prevention. National Diabetes Statistics Report website. https://www.cdc.gov/diabetes/data/statistics-report/index.html. Accessed March 20, 2023.
[22] Lee ET, Howard BV, Savage PJ, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45-74 years: the Strong Heart Study. Diabetes Care. 1995;18:599-610.

disparities. Mandatory appropriations for the IHS are consistent with the trust responsibility and treaty obligations reaffirmed by the United States in IHCIA. Even today, 13 years after IHCIA was permanently enacted, many provisions of IHCIA remain unfunded and without implementation. Full and mandatory funding must include the full implementation of all authorized IHCIA provisions.

Until Congress passes full mandatory funding for all IHS programs, the NIHB urges Congress to pass the following incremental funding measures:

a. Authorize mandatory funds for Contract Support Costs and 105(l) Lease Payments.

As the Appropriations Committee 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.

b. Authorize discretionary advance appropriations.

Advance appropriations for the IHS marks a historic paradigm shift in the nation-to-nation relationship between Tribal nations and the United States. With advance appropriations, AI/ANs will no longer be uniquely at risk of death or serious harm caused by delays in the annual appropriations process. However, the inclusion of advance appropriations each year is not guaranteed, and the solution in the FY 2023 Omnibus is far from perfect. NIHB urges Congress to pass a bill authorizing annual advance appropriations for all areas of the IHS budget and providing for increases from year to year that adjust for inflation, population growth, and necessary program increases. NIHB supports advance appropriations until full, mandatory appropriations are enacted.

c. Protect the IHS budget from "sequestration" cuts.

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—automatic or explicit—hold IHS and our people harmless.

d. Authorize federally-operated health facilities and IHS headquarters offices to reprogram funds at the local level in consultation with Tribes

The Indian Self-Determination and Education Assistance Act (ISDEAA) authorized Tribal nations to take greater control over their own affairs and resources by contracting or compacting with the federal government to administer programs that were previously managed by federal agencies. This includes the ability to develop and implement their own policies, procedures, and regulations for the delivery of these services. Tribal nations may also receive direct services from the IHS. Unfortunately, some of the flexibility that makes ISDEAA so cost effective at delivering services is not available at the local level when direct services are provided by the IHS. Fundamentally, the ability to direct resources is one of Tribal sovereignty and self-determination. Just because a Tribe chooses to receive direct services from IHS does not mean it forfeits these rights. IHS must have greater budget flexibility, especially at the local service unit level to reprogram funds to meet health service delivery priorities, as directed by the Tribes who receive services from that share of the IHS funding.

e. Authorize Medicaid reimbursements for Qualified Indian Provider Services

In 1976, Congress gave the Indian health system access to the Medicaid program in order to help address dramatic health and resources inequities and to implement its trust and treaty responsibilities to provide health care to AI/ANs and today, Medicaid remains one of the most critical funding sources for the Indian health system. In order to ensure that States not bear the increased costs associated with allowing Indian health care providers access to Medicaid resources, Congress provided that the United States would pay 100 percent of the costs for services received through Indian health care providers (100 percent FMAP). While Congress provided equal access to the Medicaid program to all Indian health care providers, in practice access has not been equal. Because States have the option of selecting some or none of the optional Medicaid services, the amount and type of services that can be billed to Medicaid varies greatly state by state. So, while the United States's trust and treaty obligations apply equally to all tribes, it is not fulfilling those obligations equally through the Medicaid program. To further the federal government's trust responsibility, and as a step toward achieving greater health equity and improved health status for AI/AN people, we request that Congress authorize Indian health care providers across all states to receive Medicaid reimbursement for a new set of Qualified Indian Provider Services. These would include all mandatory and optional services described as "medical assistance" under Medicaid and specified services

authorized under the IHCIA when delivered to Medicaid-eligible AI/ANs. This would allow all Indian health care providers to bill Medicaid for the same set of services regardless of the state they are located in. States could continue to claim 100 percent FMAP for those services so there would be no increased costs for the states for services received through IHS and tribal providers.

3. Oversee federal agency data sharing policies to ensure compliance with existing law.

As sovereign nations, AI/AN Tribes maintain inherent public health authority to promote and protect the health and welfare of their citizens, using the methods most relevant to their communities. Respecting and upholding Tribal sovereignty is core to any Tribal data policy. Tribal governments must always control how their data is accessed, used, and released.

Section 214 of the IHCIA designated Tribal Epidemiology Centers (TECs) as public health authorities. The designation of TECs as public health authorities is derived from the inherent position of Tribal nations as public health authorities. As sovereign nations, Tribes have the right of self-determination. They can carry out their public health functions or delegate that authority to another entity, such as their area TEC.

We support the ability of TECs to access data in the same way state, and local health departments do, but none of these entities should have access to Tribal data without the informed consent of Tribes. HHS is responsible for developing a data policy that both ensures Tribal sovereignty is respected and ensures Tribes and TECs have unfettered access to data to be able to carry out their duties as public health authorities.

The NIHB urges this Subcommittee to conduct oversight on this issue to ensure that federal agencies follow the letter and spirit of the law upholding our right to access public health data.

4. Improve Health Professional Staffing in the Indian Health System

The IHS and Tribal health care providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. To strengthen the health care workforce, IHS and Tribal programs need investment from the federal government to educate, recruit, and expand the pool of qualified medical professionals. IHS currently provides scholarship opportunities to AI/AN students to enter the health professions. IHS also provides loan repayment opportunities for those who work in the Indian health system. However, both of these programs are severely underfunded. Congress should increase appropriations for both IHS scholarship and loan repayment programs. NIHB

also supports legislation to move IHS loan repayment program to a tax-exempt status to increase the dollars available for the program, which is similar treatment to the National Health Service Corps loan repayment program. IHS should also provide loan repayment opportunities to those in health support positions such as Administrators, coders, and billers. Like other health professionals, these staff are desperately needed to keep Tribal health systems operating efficiently.

NIHB also encourages Congress to enact legislation that would make it easier for IHS to recruit and retain medical staff. For example, Congress should provide the Indian Health Service Discretionary Use of all Title 38 Personnel Authorities, similar to authorities enjoyed by the Veterans' Health Administration (VHA). This would make IHS a more attractive employer for paid time off and scheduling options.

a. Reimburse for traditional healing services.

Integrating traditional health services with medical, dental, and behavioral health services allows for holistic care to tend to the mind, body, and spirit of AI/AN individuals. Tribal Nations know that health care programs are more effective at improving health for AI/AN people when they incorporate traditional medicine. Tribal nations, Tribal organizations, and UIOs have developed processes and policies for credentialing traditional practitioners in parity with western clinical privileges. They have also developed several traditional health models that the Centers for Medicare and Medicaid Services (CMS) can reimburse. Medicare and Medicaid reimbursement for traditional health services would support access to culturally appropriate services, which will improve health outcomes for AI/ANs and advance health equity. Designing the paths to credentialing and billing for traditional healing services must be Tribally led and approached with sensitivity and cultural humility, since traditional healing often includes protected, sacred practices.

b. Support and Expand the Community Health Aide Program (CHAP) and the Dental Health Aide (DHAT) Program

Since the 1960s, the Community Health Aide Program (CHAP) has empowered frontline medical, behavioral, and dental providers to serve Alaska Native communities, successfully expanding access in these communities to urgently needed health and dental services. CHAP is now a crucial pathway for AI/AN peoples to become health care providers. The IHCIA authorized the IHS to expand the CHAP to Tribes outside Alaska. Based on the IHCIA and the CHAP's success in Alaska, IHS developed CHAP expansion policies from 2016 to 2020. However, IHS' implementation of the nationalization of CHAP has been slow, and years after it was

initiated, Tribes outside of Alaska are still waiting for IHS' to implement this highly successful program. IHS must work to swiftly operationalize the use of Dental Health Aides, Dental Health Aide Therapists, and Behavioral Health Aides. As Tribes confront health care provider shortages and chronically poor health outcomes, they urgently need the pathways and resources CHAP provides. IHS must finish the expansion work expeditiously so Tribes outside Alaska can benefit from the program.

5. Support Tribal self-governance expansion at the Dept. of Health and Human Services.

Tribal self-determination and self-governance honor and affirm inherent Tribal sovereignty. A self-governance program model promotes efficiency, accountability, and best practices in managing Tribal programs and administering federal funds at the Tribal level. Because Tribes can tailor programs according to the communities' needs, self-governance results in more responsive and effective programs. The Indian Self-Determination and Education Assistance Act (ISDEAA) provides the mechanisms to achieve this. However, ISDEAA is not applied to all IHS programs or applicable throughout the HHS. Legislation and administrative action are needed to expand and strengthen Tribal self-determination and self-governance in healthcare-related programs throughout HHS. NIHB supports the introduction of legislation establishing a demonstration project to implement Title VI of the Indian Self-Determination and Education Assistance Act across HHS.

Conclusion

For the last 47 years, the United States has had a policy of ensuring 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. Clearly, the status quo isn't working.

Time will tell if today's hearing on the challenges and opportunities for improving healthcare delivery in Tribal communities marked the beginning of significant change, or the continuation of the status quo. The challenges are many, but most are equally matched by the opportunities and solutions already identified by Tribal leaders, Congresses, and Administrations past and present.

There is a way forward if Congress can overcome perhaps the greatest remaining challenge: political will. The NIHB recognizes that the recommendations offered in this testimony will require coordination with other committees of jurisdiction, and we stand ready to help with that effort. But the heavy lifting must be borne by this Subcommittee. No other subcommittee

in the House is as focused on Indian affairs as this one. For the sake of our People, we hope this Subcommittee in the 118th Congress is up to the challenge.