WRITTEN TESTIMONY OF MR. ANTHONY C. LOCKLEAR II

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BEFORE THE HOUSE NATURAL RESOURCES COMMITTEE

SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS

“LEGISLATIVE HEARING ON H.R. 741”

February 5, 2025

Chairman Hurd, Ranking Member Leger Fernández, and distinguished members of the Subcommittee, on behalf of the National Indian Health Board (NIHB) and the 574+ sovereign federally recognized American Indian and Alaska Native Tribal nations we serve, thank you for this opportunity to provide testimony on H.R. 741, the Stronger Engagement for Indian Health Needs Act of 2025. My name is A.C. Locklear. I am a member of the Lumbee Tribe of North Carolina and serve as the Interim Chief Executive Officer for the National Indian Health Board (NIHB).

The Indian Health Service (IHS), an operating division of the U.S. Department of Health and Human Services (HHS),[1] delivers culturally competent health services for American Indians and Alaska Natives (AI/ANs). IHS is one of four core federal health delivery systems.[2] Elevating the Director of the IHS to an Assistant Secretary of the HHS is a long-time request among Tribal Leaders, Tribal members, and American Indian and Alaska Native Health Advocates. The IHS is the principal federal entity charged with fulfilling the federal trust responsibility for Indian health care. Elevating the IHS Director to an Assistant Secretary for Indian Health would raise the priority and presence of Indian health matters within HHS and within the federal government. H.R. 741, the Stronger Engagement for Indian Health Needs Act of 2025, seeks to meet the Trust and Treaty obligations of the federal government by elevating this critical role to an assistant secretary, which would require this individual to be nominated by the President and confirmed in the Senate.

During Robert F. Kennedy’s, nominee for Secretary of the Department of Health and Human Services, confirmation hearing in front of the Senate Health, Education, Labor, and Pensions (HELP) Committee, the nominee stated, “I’m going to bring in a native at the assistant secretary level.” He later committed that all of the agency’s decisions will be conscious of their impacts on the first nations. This is the first time that a Secretary nominee for the HHS has committed to making these changes within the agency. It is time for Congress to take the necessary step of

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[1] Congressional appropriations for IHS flow through the Interior, Environment and Related Agencies Appropriations bill.

[2] Other federal health systems include: Veterans Health Administration; Defense Health Agency; and Bureau of Prisons Health Services Division.

passing legislation, such as H.R. 741, that meets the same level of commitment to the health of Tribal people.

Unique Government-to-Government Relationship

The U.S. Constitution recognizes three sovereigns: the Federal government, States, and Indian Tribes. As sovereigns, Tribes predate the United States, and retain rights of self-government.[3] When the United States was established, the Constitution's Indian Commerce Clause granted Congress the authority to pass legislation specific to Indian Affairs.[4] The Supreme Court has upheld Indian-specific legislation, determining that it is political in nature, rather than based on an unconstitutional racial classification.[5] Health care reform legislation that reflects the unique federal responsibility to provide health care for American Indians and Alaska Natives is subject to rational basis review and does not violate the equal protection clause so long as it is "tied rationally to the fulfillment of Congress' unique obligation toward the Indians."[6]

Congress has the constitutional authority and responsibility to provide for Indian health care. Tribes signed treaties and negotiated other agreements with the United States in which they ceded vast amounts of territory in exchange for certain solemn promises. These promises include protecting Tribal self-government and providing for the health and well-being of Indian peoples.[7] Indian treaties are the supreme law of the land, and the United States has "moral obligations of the highest responsibility and trust" in carrying out these treaty obligations.[8]

Congress has passed numerous Indian-specific laws to provide for Indian health care, including establishing the Indian health care system and passing the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 *et seq.* In the IHCIA, for instance, Congress found that "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." *Id.* § 1601(1). In the Indian Self-determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 *et seq.*, Congress enabled Tribes to contract to run their own health care programs while also preserving Tribes' right to choose that services continue to be provided directly by the Indian Health Service. Congress has also legislated to provide Indians with access to general health programs, such as Medicaid, while creating Indian-specific protections within those programs that reflect this unique political relationship.

Congress has full constitutional authority to legislate with regard to Indian health care, and should continue to promote Tribal sovereignty and uphold the government-to-government relationship

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[3] *Worcester v. State of Ga.*, 31 U.S. 515, 559 (1832).
[4] U.S. CONST., art. I, § 8, cl. 3; *see also Morton v. Mancari*, 417 U.S. 535, 552–55 (1974).
[5] *Morton*, 417 U.S. at 555; *see also Moe v. Confederated Salish & Kootenai Tribes of Flathead Reservation*, 425 U.S. 463, 479–80 (1976); *Washington v. Washington State Commercial Passenger Fishing Vessel Ass'n*, 443 U.S. 658, 673 n.20 (1979); *United States v. Antelope*, 430 U.S. 641, 645–47 (1977); *Am. Fed'n of Gov't Employees, AFL-CIO v. United States*, 330 F.3d 513, 520-21 (D.C. Cir. 2003).
[6] *Morton*, 417 U.S. at 555.
[7] *See United States v. Winans*, 198 U.S. 371, 380–81 (1905).
[8] *Seminole Nation v. United States*, 316 U.S. 286, 296-97 (1942); *see also* U.S. CONST., art. VI, cl. 2; *Worcester*, 31 U.S. at 539.

between the United States and Tribes in fulfillment of its trust and legal responsibilities. Elevating the IHS Director to Assistant Secretary for Indian Health, is not just within Congressional purview, it supports increased awareness and elevated status of Indian health within the Department.

The Health Status of AI/ANs and Underfunding of IHS

AI/ANs experience worse health outcomes compared with the rest of the U.S. population. AI/ANs continue to experience historical trauma from damaging federal policies, including those of forced removal, boarding schools, and taking of Tribal lands, and continuing threats to culture, language, and access to traditional foods. These compounding events have resulted in AI/AN populations experiencing high rates of poverty, high unemployment rates, barriers to accessing higher education, poor housing, lack of transportation, geographic isolation, and lack of economic mobility which all contribute to poor health outcomes. Historic and persistent under-funding of the Indian healthcare system has resulted in problems with access to care and has limited the ability of the Indian healthcare system to provide the full range of medications and services that could help prevent or reduce the complications of chronic diseases.

Year after year, the federal government has failed American Indians and Alaska Natives by drastically underfunding the Indian Health Service (IHS) far below the demonstrated need. For example, in 2023, IHS spending for medical care per user was only $4,078, while the national average spending per user was $13,493. This correlates directly with the unacceptable higher rates of premature deaths and chronic illnesses suffered throughout Tribal communities.

In 2018, the U.S. Commission on Civil Rights found that: "Federal funding for Native American programs across the government remains grossly inadequate to meet the most basic needs the federal government is obligated to provide. Native American program budgets generally remain a barely perceptible and decreasing percentage of agency budgets."[9]

Due to chronic underfunding, the Centers for Disease Control and Prevention (CDC) reported that life expectancy for AI/ANs has declined by nearly 7 years, such that the life expectancy for our People is only 65.2 years, which is the same life expectancy of the total U.S. population in 1944. This is 11.2 years less than the non-Hispanic White population's life expectancy of 76.4 years. It will take a more meaningful investment targeted toward primary and preventative health, including public health services, in order for Tribes to begin reversing the trend of rising premature death rates and early onset of chronic illnesses.

During the last four years, bipartisan collaboration between Congress and the Administration has resulted in just an 11.6% increase to the IHS budget. In reality, many of the increases in funding over the past several years have barely supported population growth, rising medical inflation, staffing funding for specific new/expanded facilities, and the rightful funding of legal obligations such as Contract Support Costs (CSC). For example, based on the House and Senate budgets drafted for consideration for FY 2025, CSC and section 105(*l*) leases made up 87-93% of the increase assessed. A more significant funding increase, including necessary investments in

[9] U.S. Commission on Civil Rights. "Broken Promises: Continuing Federal Funding Shortfall for Native Americans." December 2018. Available at: https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf

adequate facilities, modernized infrastructure, and a qualified workforce, is needed so that quality healthcare services can be delivered in a safe manner within all AI/AN communities. Only then will we expect to see a noticeable correlating improvement in health outcomes for our people.

This legislation would raise the profile of Indian health, which is important to bringing education and attention to the health disparities Tribal communities face. An Assistant Secretary for Indian Health can better support the U.S. government in meeting its trust and treaty responsibilities to Tribes for health care and it also brings Indian health in parity with other Indian programs in sister Departments which already enjoy the recognition of an Assistant Secretary. To appropriately implement this legislation's purpose, Congress should also fully fund the IHS to meet the healthcare needs of Tribal members adequately. This legislation can be successful, and I urge Congress to take the steps necessary to ensure that success.

Conclusion

The Stronger Engagement for Indian Health Needs Act of 2025 is one small step toward meeting the trust and treaty obligation between the federal government and Tribes. The federal government made promises in its Tribal treaties to provide for, among other things, the healthcare of Tribal members. This legislation will help repair this one portion of the broken promises of the federal government and will support a step towards healthier Tribal communities.