National Indian Health Board

TESTIMONY OF NATIONAL INDIAN HEALTH BOARD – STACY A. BOHLEN
HEARING ON REVIEWING THE BROKEN PROMISES REPORT: EXAMINING THE CHRONIC FEDERAL FUNDING SHORTFALLS IN INDIAN COUNTRY
HOUSE COMMITTEE ON NATURAL RESOURCES SUBCOMMITTEE FOR INDIGENOUS PEOPLES OF THE UNITED STATES
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Chairman Gallego, Ranking Member Cook, and Members of the Subcommittee, thank you for holding this important hearing on the findings of the U.S. Commission on Civil Rights report entitled *Broken Promises: Continuing Federal Funding Shortfalls for Native Americans*. On behalf of the National Indian Health Board (NIHB) and the 573 federally-recognized sovereign Tribal Nations we serve, I submit this testimony for the record. The findings of the *Broken Promises Report* reaffirm what American Indian and Alaska Native (AI/AN) Peoples have endured first-hand for centuries: one, that the United States federal government has never fully honored its Treaty and Trust obligations to Tribal Nations and AI/AN Peoples; and two, that the federal government's failure to honor its Treaty obligations continues to adversely impact the health, welfare, livelihood, and economic vitality of Indian Country.

Trust Responsibility for Health Care

In 2003 the US Commission on Civil Rights issued a report called *A Quiet Crisis Federal: Funding and Unmet Needs in Indian Country*. The report brought to light how the current dire needs found across Indian Country, whether in infrastructure, employment, economies or in our health and judicial systems, are a result of centuries of the federal government's underfunding Indian Country. The current unmet needs in Indian Country demonstrate that with the publishing of the Commission's 2018 follow up report, *Broken Promises*, only marginal progress has been made. As the Commission observes, despite some progress, the "crisis the Commission found in 2003 remains, and the federal government continues to fail to support adequately the social and economic wellbeing of Native Americans."[1] As valuable as both reports are, one truth can be clearly drawn from them: incremental change is not working. Incremental improvements are not effective. Rather, Congress must make a comprehensive, long term commitment to work with Indian Country to rebuild Tribal Nations and restore our People to health, safety, functionality and opportunity. Congress must found such plans in the form of a significant investment.

As valuable as both reports are, one truth can be clearly drawn from them: incremental change is not working.

We are pleased that the *Broken Promises Report* did an effective job of contextualizing these shortfalls within the political status of Native Nations and our relationship with the federal

[1] Broken Promises: Continuing Federal Funding Shortfalls for Native Americans, US Commission on Civil Rights Report, December 2018

government. Through its discussion of the treaties and the Trust responsibility that exists between the federal government and Indian Country, the Commission rightly discusses issues from this root. This is the solid ground on which to stand when examining Indian Country's alarming health disparities, funding shortfalls for health care and the whole host of issues that together create the crisis in American Indian and Alaska Native health.

As stated in the *Broken Promises Report* transmittal letter to President Trump, "The United States Expects All Nations to Live up to their treaty obligations; it should live up to its own." From this ground on which we stand it is worthy to further mention that over the course of a century, sovereign Tribal Nations and the United States signed 375 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The form of these agreements was nearly identical to the Treaty of Paris ending the Revolutionary War between the U.S. and Great Britain. The negotiations ended in a mutually signed pact which had to be approved by the U.S. Congress. Non-tribal citizens were required to have a passport to cross sovereign Indian lands.[2] The terms codified in those Treaties – including the provisions of quality and comprehensive health resources and services – have been reaffirmed by the United States Constitution, Supreme Court decisions, federal legislation and regulations, and even presidential executive orders. These federal promises have no expiration date, and collectively form the basis for what we now refer to as the federal Trust responsibility. In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations for health services to all AI/ANs. Yet at no time since the founding of IHS has Congress fully funded health care in Indian Country at the level of need.

> *"The United States Expects All Nations to Live up to their treaty obligations; it should live up to its own."*

As a direct result of the immense dearth of health care and public health resources and services afforded to Indian Country, the Tribes founded NIHB in 1972 to serve as the unified national voice on behalf of all Tribal Nations to advocate for the fulfillment of the federal government's Trust and Treaty obligations for our Peoples' health and public health needs. To that end and at the Commission's invitation, NIHB provided testimony, guidance and recommendations to the U.S. Commission on Civil Rights during the development of *the Broken Promises Report.* Our contributions were on topics such as the federal Trust responsibility for AI/AN health, the unique health disparities experienced throughout Indian Country, appropriations and budget realities in Indian health and how to best address those disparities as envisioned by sovereign Tribes.

While the final *Broken Promises* report covers a wide range of federal Indian policy in addition to health care, nowhere are the consequences of the federal government's abrogation of its Treaty

[2] https://www.archives.gov/research/native-americans/treaties

obligations more apparent than in the lower life expectancy and more dire health conditions faced by AI/AN Peoples in comparison to the general public. Below is a detailed summary of AI/AN health challenges, priorities, and outcomes, followed by specific policy recommendations to ensure the highest health status for all Tribal Nations and AI/AN Peoples.

Likewise, while the report examines the Indian Health Service, the federal government's responsibility for the health care of American Indian and Alaska Native Peoples extends far beyond the Indian, Tribal and Urban health systems (I/T/U). For example, when the United States was building and investing in its public health infrastructure, there was no concurrent investment into a public health system within Indian Country. When the United States was investing into the infrastructure, safety and accessibility of water, no such investment was made in Tribal communities. The same is true of the construct and investment in health professions, emergency preparedness, broadband, health IT and a host of other health related policies and opportunities that do not reside within the Indian Health Service. That lack of investment is reflected throughout Indian Country and investment into Indian health care means investments in Tribes in all of these areas. Bringing investment into American Indian and Alaska Native health will require cooperation and collaboration between the Administration and Congress to ensure that both budgets and appropriations reflect the Trust responsibility throughout all aspects of American Indian and Alaska Native health and well-being.

Perhaps the greatest contribution of this report is *who* made these observations and statements – because of who rang the alarm. Tribal Nations are very adept at speaking the truth about our health systems. Our history, the shamefully low funding levels of our systems and the poor health status of our people. Sometimes it feels like we are only listening to each other – as one Tribal leader described it – we are shouting in an echo chamber. However, when the US Commission on Civil Rights takes note of our plight, decision makers are taking note and paying attention and that's when change becomes possible. We are grateful that the voice of the US Commission on Civil Rights listened, learned, examine, verified and reported the truth – our truths – about the health and health systems conditions in Indian Country. And we are grateful that they accurately describe why these conditions exist.

We are grateful to this Committee and to Congress for listening and for holding this important hearing today. And change is in your hands.

Where Do We Start? Health Outcomes and Funding in Indian Country

The solemn legacy of colonization is epitomized by the severe health inequities facing Tribal Nations and AI/AN Peoples. When you compound the impact of destructive federal policies towards AI/ANs over time, including through acts of physical and cultural genocide; forced relocation from ancestral lands; involuntary assimilation into Western culture; and persecution and outlawing of traditional ways of life, religion and language, the inevitable result are the disproportionately higher rates of historical and intergenerational trauma, adverse childhood experiences, poverty, and lower health outcomes faced across Indian Country.

Despite major improvements in federal Indian policy and the government-to-government relationship made in recent decades, promised resources to address these issues and restore Native

nations remain in short supply. The repercussions of such historical federal policy towards the Tribes and the lack of meaningful support to address them sustains lingering chronic and pervasive health disparities. The only certain solution to these health challenges is for Congress to fully and sustainably meet its constitutional obligations to Tribal Nations for quality health infrastructure, resources and services.

When Congress permanently reauthorized the Indian Health Care Improvement Act (IHCIA) in 2010, it reaffirmed that it has a sacred duty to AI/ANs, 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 urban Indians and to provide all resources necessary to effect that policy*."[3] Yet, as the *Report* documents, the Indian health system continues to face chronic resource shortages that ensure our Peoples will continue to have a lower quality of health, worse health outcomes and significantly lower life expectancy compared to the general population.

The only certain solution to these health challenges is for Congress to fully and sustainably meet its constitutional obligations to Tribal Nations for quality health infrastructure, resources and services.

We need changes at the systems level that are structural, funded and sustained.

What Are We Talking About? Notable Health Disparities in Indian Country

As noted in the Report, health outcomes among AI/ANs have either remained stagnant or become worse in recent years as Tribal communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. On average, AI/ANs born today have a life expectancy that is 5.5 years less than the national average, with some Tribal communities experiencing even lower life expectancy. For example, in South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.[4]

In 2016, 26.2% of AI/ANs were estimated to be living in poverty, compared to the national average of 14.0%. Just under a fifth of AI/ANs lacked health coverage in the same year, while nationally only 8.6% of Americans were uninsured. While accurate data on rates of homelessness in Tribal communities is difficult to obtain due to undercounting of AI/ANs in the U.S. Census, rates of overcrowded housing clearly indicate a significant shortage of available housing in Indian Country. Specifically, 16% of AI/AN households were reported to be overcrowded compared to 2.2% nationally.[5]

[3] 25 U.S.C. § 1602.
[4] South Dakota Department of Health. Mortality Overview. Retrieved from https://doh.sd.gov/Statistics/2012Vital/Mortality.pdf
[5] U.S. Department of Housing and Urban Development. 2017. Housing Needs of American Indians and Alaska Natives in Tribal Areas: A Report From the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs. Retrieved from https://www.huduser.gov/portal/sites/default/files/pdf/HNAIHousingNeeds.pdf

AI/AN communities also face high rates of food insecurity, which can increase risk for future chronic diseases such as diabetes, obesity, and other ailments. While majority-AI/AN counties represent less than 1% of counties nationwide, as high as 60% of them are classified as food insecure.[6] In California, just under 40% of AI/AN families with incomes under 200% of the federal poverty line (FPL) were food insecure[7]; in Oklahoma, 1 in 4 AI/ANs were reported to be food insecure in 2015[8]; and in Montana, an analysis of 187 AI/AN households found 43% to be food insecure.[9]

According to the Centers for Disease Control and Prevention (CDC), in 2017, at 800.3 deaths per 100,000 people, AI/ANs had the second highest age-adjusted mortality rate of any population.[10] In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites)[11]; higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). American Indians and Alaska Natives also have the highest Hepatitis C mortality rates nationwide, as well as the highest rates of Type 2 Diabetes, chronic liver disease and cirrhosis deaths. Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for American Indians and Alaska Natives.

Behavioral health outcomes are similarly much lower in Indian Country compared to the general population. IHS annual spending increased by roughly 18% - roughly 12% per capita. In comparison, annual spending at the Veterans Health Administration (VHA), which has a similar charge to IHS, increased by 32% overall, with a 25% per capita increase during the same time period[12] Alarmingly, rates of prescription opioid deaths among AI/ANs increased 10.8% from 2016 to 2017 – the highest percentage increase of any demographic, and this happened despite national and IHS efforts to crack down on unnecessary opioid prescribing.[13] The opioid epidemic has also triggered significant increases in rates of infectious diseases such as Hepatitis C (HCV) among AI/ANs – raising from 1.8 to 3.1 acute cases per 100,000 from 2015 to 2016.[14] In 2014, 9% of AI/ANs over the age of 18 had a co-occurring mental health and substance use disorder – more than 3 times the rate of the general population.[15] Studies have also demonstrated that AI/ANs

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[6] Feeding America. 2017. Map the Meal Gap: Highlights for Overall and Child Food Insecurity. Retrieved from https://www.feedingamerica.org/sites/default/files/research/map-the-meal-gap/2015/2015-mapthemealgap-exec-summary.pdf

[7] lue Bird Jernigan V, Garroutte E, Krantz E, Buchwald D. Food insecurity and obesity among American Indians and Alaska Natives and whites in California. J Hunger Environ Nutr. 2013;8:458–471

[8] Blue Bird Jernigan V. Healthy makeovers in rural tribal convenience stores as part of the Tribal Health and Resilience in Vulnerable Environments (THRIVE) Study. Paper presented at: 143rd APHA Annual Meeting and Exposition; October 31–November 4; New Orleans, LA. Washington, DC: American Public Health Association; 2015.

[9] Brown B, Noonan C, Nord M. Prevalence of food insecurity and health-associated outcomes and food characteristics of Northern Plains Indian households. J Hunger Environ Nutr. 2007;1(4):37–53.

[10] Kochanek KD, Murphy SL, Xu JQ, Arias E. Deaths: Final data for 2017. National Vital Statistics Reports; vol 68 no 9. Hyattsville, MD: National Center for Health Statistics. 2019.

[11] Centers for Disease Control and Prevention. Infant, neonatal, post-neonatal, fetal, and perinatal mortality rates, by detailed race and Hispanic origin of mother: United States, selected years 1983–2014.

[12] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveill Summ 2017;66(No. SS-19):1–12. DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1

[13] Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;67:1419–1427. DOI: http://dx.doi.org/10.15585/mmwr.mm675152e1

[14] Centers for Disease Control and Prevention. Surveillance for Viral Hepatitis: United States, 2016. Retrieved from https://www.cdc.gov/hepatitis/statistics/2016surveillance/commentary.htm

[15] Whitesell NR, Beals J, Crow CB, Mitchell CM, Novins DK. Epidemiology and etiology of substance use among American Indians and Alaska Natives: risk, protection, and implications for prevention. Am J Drug Alcohol Abuse. 2012;38(5):376-82. doi:

have a younger age of initiation of drug and alcohol use than the general population.[16] Approximately 75 percent of AI/AN adults are classified as being overweight or obese[17], thus increasing their risk of heart disease, stroke, hypertension, and numerous other ailments.

Suicide is the #2 cause of death for our children and young people ages 10-34.[18] Nearly 36% of suicide deaths occurred among AI/ANs aged 10-24 year olds, compared to 11.1% among Whites in the same age group.[19] In 2015, suicide rates among AI/ANs in 18 states were more than 3.5 times higher than the lowest rates recorded.

All of these determinants of health and poor health status could be dramatically improved with adequate federal investment into the health systems, health care, public health systems and infrastructure in Indian Country. Even while Congress has provided IHS increases during the past 10 years, those increases barely keep pace with medical inflation and appropriations for health services in Indian Country continue to fall significantly below need. According to the IHS Tribal Budget Formulation Workgroup, IHS appropriations must reach $37.61 billion annually – phased in over twelve years – to fully meet current health needs.[20] This is "needs based" budgeting.

In contrast, Fiscal Year (FY) 2019 IHS appropriations were at only about $5.8 billion. Per capita medical expenditures within IHS were $4,078 in FY 2017, compared with $9,726 in national spending and $3,185 per capita spending for Medicare that same year. Although the IHS budget has nominally increased by 2-3% each year, these increases are barely sufficient to keep up with rising medical and non-medical inflation, population growth, facility maintenance costs, and other expenses. According to a 2018 report by the Government Accountability Office (GAO-19-74R), from 2013 to 2017, IHS annual spending increased by roughly 18% - roughly 12% per capita. In comparison, annual spending at the Veterans Health Administration (VHA), which has a similar charge as IHS, increased by 32% overall, with a 25%per capita increase during the same time period.[21] Similarly, spending under Medicare and Medicaid increased by 22% and 31% respectively during the same time period.

While it is true that the higher funding levels at VHA, Medicare, and Medicaid are explained in part by their larger service populations, this does not negate the fact that Congress has a unique legal responsibility to fully fund health care in Indian Country. Indeed, IHS is the only federal health entity created as the result of federal Treaty obligations. But because Congress continues to

10.3109/00952990.2012.694527. PubMed PMID: 22931069; PubMed Central PMCID: PMCPMC4436971.

[16] Heart MY, Chase J, Elkins J, Altschul DB. Historical trauma among Indigenous Peoples of the Americas: concepts, research, and clinical considerations. J Psychoactive Drugs. 2011;43(4):282-90. doi: 10.1080/02791072.2011.628913. PubMed PMID: 22400458.

[17] Centers for Disease Control and Prevention. 2017. Summary Health Statistics: National Health Interview Survey: 2015. Table A-15 http://www.cdc.gov/nchs/nhis/shs/tables.html

[18] Centers for Disease Control and Prevention

[19] Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242. DOI: http://dx.doi.org/10.15585/mmwr.mm6708a1

[20] The full IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF

[21] Government Accountability Office. 2018. Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. Retrieved from https://www.gao.gov/assets/700/695871.pdf

chronically underfund IHS, quality and comprehensive health services remain inaccessible across many Tribal communities.

Quality of Care and Health Infrastructure in Indian Country

Chronic and pervasive health staffing shortages – for everything from physicians to nurses to behavioral health practitioners – stubbornly persist across Indian Country, with 1,550 healthcare professional vacancies documented as of 2016. For example, a Government Accountability Office (GAO) report from August 2018 found an average 25% provider vacancy rates for physicians, nurse practitioners, dentists, and pharmacists across two-thirds of IHS Areas (GAO 18-580). In addition, many Tribes do not have housing for health care professionals. In these communities, even if the providers were hired they would not have a place to live. This is an outrageous idea in any community in the United States – except in our communities.

In addition, the Indian health system continues to face immense challenges in health IT modernization, without any dedicated funding within the IHS budget to meet this need. Congress must ensure that the Indian health system is fully integrated across the development and implementation of the VHA's transition to Cerner; however, this assurance requires significant investment and Congress has failed to make that investment. By the current estimates, the full transition to Cerner will take VHA up to 10 years, with a current price tag of roughly $16 billion. None of the existing estimates include calculations of how much it will cost to include IHS in this transition; however, through its Health IT Modernization Project, IHS is attempting to arrive at an estimated dollar figure for this cost. When that number is reached, Congress must act.

Tribes and NIHB were pleased to see that the FY 2020 President's Budget included a request for a new $20 million line item in the IHS budget to assist with health IT modernization, and that this request was included in the House-passed FY 2020 Interior Appropriations package. But in comparison, the FY 2020 House Military Construction Appropriations bill budgeted $1.6 billion to assist VHA in its transition. **NIHB strongly recommends that Congress ensure parity in appropriations and technical assistance resources for VHA and IHS health IT modernization** to ensure sufficient health system interoperability and improve quality of care in Indian Country.

Similarly, longstanding facility maintenance issues remain largely unchanged over time. While the average age of hospitals nationwide is roughly 10 years, it is 37 years for IHS hospitals – nearly four time older.[22] In 2013, funding shortfalls for facilities maintenance and upgrades created a $166 million backlog. Basic medical devices and equipment are routinely outdated, as hospital administrators express strong concerns that use of the equipment *may increase one's risk for hospital-acquired infections*. A 2016 Office of the Inspector General (OIG) report found trauma centers lacking necessary computerized tomography (CT) scans, or were missing essential medicines. Use of antiquated equipment also deters new medical graduates from working in the Indian health system, most of whom are trained on advanced technologies and thus unable or unwilling to use outdated equipment. **NIHB strongly recommends that Congress fully fund**

[22] Office of Inspector General. 2016. IHS Hospitals: Longstanding Challenges Warrant Focused Attention (OEI-06-14-00011)

modernization of all IHS, Tribal, and urban Indian (collectively I/T/U) health facilities at the funding level outlined by the IHS Tribal Budget Formulation Workgroup.

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. The OIG noted that more than two-thirds of IHS hospitals have insufficient space including for exam rooms, diagnostic services, and even pharmacies. Lack of sufficient services and workforce within the Indian health system forces a greater reliance on outside, contracted care through the Purchased/Referred Care (PRC) system. But because Congress has also failed to fully fund PRC needs, 146,928 PRC referral requests were denied in 2013 – totaling $760 million in unmet need.

These ongoing challenges further complicate opportunities to recruit and retain quality providers. Numerous federal watchdog accounts have documented how IHS and Tribal facilities struggle to keep providers when competing with healthcare entities that can easily offer higher wages and better working conditions. It should come as no surprise that the Indian health system has largely failed to make meaningful strides towards reducing provider vacancies. Again and again, the federal government fails to live up to its obligations to provide adequate health services to the nation's First Peoples. **NIHB recommends that Congress make the IHS Loan Repayment Program and provider scholarship programs tax exempt, so that every dollar can be maximized towards provider recruitment.**

Unfortunately, the challenges do not end with chronic underfunding. Of the four major federal healthcare entities, IHS is the only one subject to the devastating impacts of government shutdowns and continuing resolutions (CRs). This is because Medicare and Medicaid receive mandatory appropriations, and Congress authorized the VHA to receive advance appropriations nearly a decade ago. It is true that no section of our economy and government are spared from the negative consequences of government shutdowns and endless CRs – but the repercussions are neither equal nor generalizable across all entities.

For instance, during the 2013 federal budget sequester, the IHS budget was slashed by 5.1% - or $221 million. This was levied on top of the damage elicited by that year's government shutdown. In fact, IHS was the only federally funded healthcare entity that was subject to full sequestration, as Congress had already exempted entities such as the VHA when it authorized it to receive advance appropriations in 2009. While Tribes and NIHB were glad to hear that the Bipartisan Budget Act of 2019 finally put an end to sequestration, the protection only lasts through the expiration of the Budget Control Act of 2011, which currently sunsets at the end of FY 2021. Indeed, should Congress seek to enact a similar law that reestablishes budget sequesters in the future, it would be incumbent upon Congress to ensure that IHS is exempt.

Once again, during the most recent 35-day government shutdown – the nation's longest and most economically disastrous – IHS was the only federal healthcare entity to be shut down. While direct care services remained non-exempt, providers were not receiving pay. Administrative and technical support staff – responsible for scheduling patient visits, conducting referrals, and processing health records – were furloughed. Contracts with private entities for sanitation services

and facilities upgrades went weeks without payments, prompting many Tribes to exhaust alternative resources to stay current on bills. Several Tribes shared that they lost physicians to other hospitals and clinics not impacted by the shutdown. Some Tribal leaders even shared how administrative staff volunteered to go unpaid so that the Tribe had resources to keep physicians on the payroll. These are just a few examples of the everyday sacrifices and ongoing struggles that widen the chasm between the health services afforded to AI/ANs and to the nation at large.

With the Bureau of Indian Affairs (BIA) also shutdown, roads were not cleared after heavy snowfalls, leaving our Tribal citizens stranded for hours if not days. Public safety was heavily compromised, as BIA officers were furloughed and thus unauthorized to respond to emergency calls. Tragically, closure of vital services led to deaths in some of our Tribal communities. While it is impossible to measure the full scope of adversity brought on by the 35-day government shutdown, one reality remains clear – Indian Country was both unequivocally and disproportionately impacted.

In 2018, GAO released a seminal report examining the benefits of authorizing advance appropriations for the IHS and thus establishing parity between IHS and the VHA (GAO-18-652). The report outlined how Congress has been forced to use short-term or full-year CRs in all but four of the last 40 years. While use of a CR is always preferable to a government shutdown, they too create additional obstacles that directly impact patient care. Because of the budget authority constraints under a CR, agencies are prohibited from initiating any new activities or projects that were not expressly authorized or appropriated in the previous fiscal year. In addition, agencies are required to exercise significant precautions around expenditures, and are generally limited to simply maintaining operations as opposed to improving them.

When you compound the impact of chronic underfunding and endless use of CRs, the inevitable result are the chronic and pervasive health disparities across Indian Country. NIHB was pleased to participate in a legislative hearing before the Subcommittee for Indigenous Peoples on H.R. 1128 – *Indian Programs Advance Appropriations Act*; and H.R. 1135 – *Indian Health Service Advance Appropriations Act of 2019* in September, 2019. With growing bipartisan momentum to protect Indian programs from devastating government shutdowns and CRs, **NIHB implores Congress to quickly pass H.R. 1135 and H.R. 1128, thus authorizing advance appropriations for Indian programs.**

Indian Country has experienced first-hand the incredible health and cost returns of public health prevention programming. For example, the Special Diabetes Program for Indians (SDPI) was created over 20 years ago to target the high rates of Type 2 diabetes in AI/AN populations. SDPI is currently funded at $150 million per year in mandatory appropriations, and supports over 300 IHS, Tribal and urban Indian programs aimed at improving nutrition, increasing physical activity, and improving chronic disease-related health outcomes.

This innovative program uses a combination of public health, clinical and traditional healing methods to reduce the risk and complications of type 2 diabetes. It has worked.[23] A1C levels

[23] Indian Health Service. Special Diabetes Program for Indians: 2017 Fact Sheet. Retrieved from https://www.nihb.org/sdpi/docs/08032017/SDPI_FactSheet_July2017.pdf

among AI/ANs nationwide are down by an entire percentage point, rates of diabetic eye disease have decreased by 50%, and rates of End Stage Renal Disease (ESRD) – one of the biggest contributors to Medicare costs – has decreased by 54%.

In fact, rates of diabetes among AI/AN adults have not increased since 2011 while rates of diabetes and obesity among AI/AN youth have not increased in more than 10 years. In a 2019 report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), SDPI was estimated to result in roughly 2,200 to 2,600 fewer cases of ESRD from 2006 to 2015, thus reducing Medicare expenditures by up to $520 million over a ten-year period.[24]

The SDPI program has been so successful for a number of reasons. One, each Tribal grantee develops a community-driven program that is uniquely tailored to address the health needs of their specific population. Two, the programs address a wide variety of social factors such as limited access to healthy food and lack of safe spaces for physical activity and exercise, thus promoting a higher culture of health in the community. And three, many SDPI programs integrate traditional and culturally appropriate activities and strategies that promote community buy-in and support for the program.

Despite the demonstrated success of SDPI, the initiative has been flat funded at $150 million since 2004, and as a result, has lost roughly a third of its buying power to medical inflation. In fact, if SDPI funding were to be adjusted to account for medical inflation over the past fifteen years, appropriations would need to reach $234 million in order to retain the same buying power the program had in 2004. In addition, lack of new funding resources has restricted the ability of current grantees to expand services under the program and the ability for new Tribes to enter into SDPI.

NIHB is grateful that Congress extended SDPI through Thursday, November 21, 2019 as part of H.R. 4378 – *Continuing Appropriations Act, 2020, and Health Extenders Act of 2019*, and that SDPI is again included in the new draft CR, H.R. 3055, slated to fund the government through December 20, 2019. While a short-term extension is always preferable to program expiration, for far too long SDPI has been subject to volatile incremental reauthorizations stretching from only several weeks to one or two years. These short-term extensions impose significant challenges for long-term planning and program development, and create undue anxiety for grantees who lack assurances of continued funding availability. **NIHB strongly urges Congress to permanently reauthorize and fully fund SDPI at the level of need.**

Ongoing Threats to the Trust Responsibility for Health

NIHB, along with Tribal Nations and other national Tribal organizations are highly concerned about the potential impact that the outcome of *Texas v. United States* may have on the Indian health system. A full repeal of the ACA could include the Indian Health Care Improvement Act (IHCIA) and other significant Indian-specific provisions in the ACA, such as the requirement that the I/T/U system be the payer of last resort, Medicare Part B Reimbursement, and health benefits provided

[24] Office of the Assistant Secretary for Planning and Evaluation. 2019. The Special Diabetes Program for Indians: Estimates of Medicare Savings. Retrieved from https://aspe.hhs.gov/pdf-report/special-diabetes-program-indians-estimates-medicare-savings

to Tribal members are not included as taxable income. As a result, NIHB, along with 483 Tribes and Tribal organizations, filed an amicus brief before the Fifth Circuit.

The purpose of the amicus brief was to convey to all involved parties that IHCIA and the Indian-specific provisions of the ACA serve an entirely separate and distinct purpose from the rest of the legislation, and exist to partially fulfill the federal government's constitutional obligations to provide health services to Tribal Nations and AI/AN peoples. Moreover, the brief highlights how IHCIA and the Indian-specific provisions of the ACA are completely independent from, and not reliant on, the individual mandate, and should thus not be struck down. As such, the amicus brief focuses exclusively on how IHCIA and the Indian-specific provisions should be preserved regardless of the ultimate decision of the Fifth Circuit in regards to the broader ACA bill itself.

Repeal of IHCIA would have disastrous consequences for the Indian health system. This would include loss of third party revenue – in which Medicaid revenue alone constituted 13% of total IHS program funding in FY2017 – loss of grant-making authorities to Tribes, Tribal organizations, and urban Indian organizations, and loss of life-saving programs to address critical health concerns ranging from diabetes to substance abuse. Preservation of the Indian health system has long been a bipartisan, bicameral objective that is integral to upholding the federal government's constitutional obligations to Tribal Nations and AI/AN peoples. **NIHB strongly urges Congress to acknowledge the inherent separateness of IHCIA and certain Indian specific provisions within the ACA, and to ensure all of those provisions are maintained and protected as it considers any long-term changes to the national health system.**

In addition to what we articulated within this testimony, NIHB identified a few key policy changes that would result in vastly improved health care for American Indians and Alaska Natives. They are offered in no particular order, as all are priority recommendations:

- Honor the Treaties, the Trust responsibility and honor the government to government relationship with the Tribes.
- Respect inherent Tribal sovereignty.
- Listen to the Tribes, respect cultural knowledge and traditions, and heal the past through current infrastructure investment to rebuild Native communities.
- The Federal Trust Responsibility for American Indian and Alaska Native Health extends to the entire federal government. Appropriations should reflect this reality.
- Protect the Indian Health Care Improvement Act and Tribally-specific gains in the Affordable Care Act.
- Fully fund the Indian Health Service at "Level of Need" funding as identified by the IHS National Tribal Budget Formulation Work Group.
- Make a long term commitment and investment in Tribal health and public health infrastructure, capacity and services, such as, through making the Indian Health Service an entitlement program or through a trust fund.
- We urge immediate enactment of legislation to achieve advance appropriations for Indian Programs. Acting upon lessons learned through the 2018-2019 partial government

shutdown, when appropriations for the I/T/U system fail, the I/T/U system cannot function. Enacting advance appropriations for the Indian Programs would mitigate this problem.

- Tribal Self Determination Works: Expand Indian self-determination and self-governance throughout IHS and the federal government.
- Block Grants to the States don't work for Tribes, we urge Congress to establish separate, distinct, direct and recurring funding for Tribes and Tribal organizations.
- Fund Tribes Directly, not through competitive grant making.
- NIHB strongly recommends that Congress ensure parity in appropriations and technical assistance resources for VHA and IHS health IT modernization to ensure sufficient health system interoperability and improve quality of care in Indian Country.

Alleviate American Indian and Alaska Native Veterans of all copays and cost sharing – both in the Indian Health system and in the VA system. Further, we urge Congress to clarify policy requiring the VA to reimburse the I/T/U system for services rendered under the purchase and referred care program.

Conclusion

The federal government has constitutional obligations to provide quality and comprehensive health services for all AI/AN Peoples that it has continuously failed to achieve. The *Broken Promi*ses report summarized and brought national attention to the gravity of those failures, and provided recommendations for how to address those failures. WE embrace most of the recommendations for Native health contained in the US Civil Rights Commission Report; however, we believe they are too incremental and represent stop-gap measures in what is a crisis. NIHB recommends several systemic, long term policy changes and investments into Indian health care and public health infrastructures and systems. NIHB thanks the Subcommittee for holding this significant hearing on the *Broken Promises* report, and stands ready to work with Congress in a bipartisan fashion to achieve the fulfillment of the federal trust responsibility for health.