National Indian Health Board

TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD – VICTORIA KITCHEYAN, CHAIR
ADVANCE APPROPRIATIONS: PROTECTING TRIBAL COMMUNITIES FROM THE EFFECTS OF GOVERNMENT SHUTDOWNS HEARING
HOUSE COMMITTEE ON NATURAL RESOURCES SUBCOMMITTEE FOR INDIGENOUS PEOPLES OF THE UNITED STATES
SEPTEMBER 25, 2019, 2:00PM

Chairman Gallego, Ranking Member Cook, and Members of the Subcommittee, thank you for holding this important legislative hearing. On behalf of the National Indian Health Board (NIHB) and the 573 federally-recognized Tribes we serve, I submit this testimony for the record on H.R. 1128: *Indian Program Advance Appropriations Act* and H.R. 1135: *Indian Health Service Advance Appropriations Act of 2019*. Authorizing advance appropriations for Indian programs has been a longstanding priority of Tribal Nations and NIHB towards guaranteeing the fulfillment of the federal government's Treaty and Trust obligations to Tribes and American Indian and Alaska Native (AI/AN) Peoples. But before discussing how the aforementioned legislation achieves these priorities, it is critical to demonstrate first how we got here, and why authorizing advance appropriations would provide a critical lifeline for Indian Country.

Over the course of a century, sovereign Tribal Nations and the United States signed over 300 Treaties requiring the federal government to assume specific, enduring, and legally enforceable fiduciary obligations to the Tribes. The terms codified in those Treaties – including for 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 – which have no expiration date - collectively form the basis for what we now refer to as the federal trust responsibility. During permanent reauthorization of the Indian Health Care Improvement Act, Congress declared 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*."[1]

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations. But at no point since the founding of IHS has Congress fully funded the agency at the level of need. 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. The effective result is, year after year, the Indian health system is unable to make meaningful improvements towards reducing the significant health disparities experienced by AI/AN Peoples.

According to the IHS Tribal Budget Formulation Workgroup, IHS appropriations must reach $37.61 billion – phased in over twelve years – to fully meet current health needs.[2] 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 that same year. As a direct result of the continued underfunding of IHS, quality and comprehensive

[1] 25 U.S.C. § 1602
[2] The full IHS Tribal Budget Formulation Workgroup Recommendations are available at https://www.nihb.org/docs/04242019/307871_NIHB%20IHS%20Budget%20Book_WEB.PDF

health services remain inaccessible across many Tribal communities. 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. The Tribal Budget Formulation Workgroup is also establishing a new budget subcommittee to reexamine true budget shortfalls in preparation for the FY 2022 budget.

For example, a Government Accountability Office (GAO) report from August, 2018 found an average 25% provider vacancy rate for physicians, nurse practitioners, dentists, and pharmacists across two-thirds of IHS Areas (GAO 18-580). Meanwhile, growing expenses associated with Section 105(l) lease obligations, emergent health threats, health information technology modernization, and other outstanding priorities go largely unmet, or require the agency to redirect funds from other essential services. It triggers national outrage whenever the government reallocates funds from one critical priority to pay for another – yet these are daily occurrences in the Indian health system that are felt across Indian Country and go largely unnoticed in the public eye.

Similarly, longstanding 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 higher.[3] 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.

In fact, an IHS facility built today could not be replaced for nearly 400 years under current funding constraints. 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.

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

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 the Veterans Health Administration (VHA) was authorized by Congress 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 – 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.

Indeed, AI/ANs suffer some of the worst health disparities of all Americans. Overall life expectancy for AI/ANs is 5.5 years less than the national average. In states like South Dakota, however, life expectancy for AI/ANs is as much as two decades lower than for Whites. According to the Centers for Disease Control and Prevention, in 2016, AI/ANs had the second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people. In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide (10.8 per 100,000); and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites). Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for AI/ANs. All of these health determinants of health and poor health status could be dramatically improved with adequate investment into the health, public health and health delivery systems operating in Indian Country.

The only surefire solution to ongoing health resource shortages and challenges in Indian Country is for Congress to fully fund IHS and transition the agency to mandatory appropriations. While mandatory funding for IHS remains the long-term goal, there are preliminary steps that can lead to greater stability for the Indian health system, and reduce the threat of funding lapses due to government shutdowns. Namely, authorizing advance appropriations for IHS and other Indian programs would significantly move the needle forward towards improving the dependability of funding and the continuity of health services. In addition, it would protect Indian programs from any future threats related to budget sequestration.

Advance appropriations would help honor the federal trust responsibility and help ensure that the federal government meets its obligations to the Tribes in the event that Congress cannot enact a new budget by the start of each fiscal year. Furthermore, as noted in the 2018 GAO report (GAO-18-652), "*…uncertainty resulting from recurring CRs and from government shutdowns has led to adverse financial effects on tribes and their health care programs*." Clearly, the current funding schedule is hampering the already strained IHS budget. Advance appropriations would help provide much better continuity and stability of care, resulting in better health outcomes for AI/ANs. Moreover, it would allow for more efficient use of appropriated dollars by removing budgetary restrictions that force IHS to neglect long-term planning and focus limited resources on the most imminent health needs. In addition, it would ensure parity between IHS and the VHA – both of which have the federal charge to provide direct care services.

Tribes and NIHB are encouraged by the growing momentum in recent years to authorize advance appropriations for Indian programs. In March 2019, NIHB led advocacy efforts that secured the signatures of 60 bipartisan members of the House of Representatives in a letter to the House Budget Committee in support of advance appropriations. Today, we are discussing two such pieces of legislation that continue to garner bipartisan support. The first is H.R. 1128 – *Indian Programs*

Advance Appropriations Act; the second is H.R. 1135 – *Indian Health Service Advance Appropriations Act of 2019.*

NIHB appreciates the bipartisan support that both bills have garnered; however, there are notable differences between the bills that, if enacted, will lead to different outcomes. For instance, H.R. 1128 authorizes advance appropriations for both the IHS and BIA, while H.R. 1135 authorizes it for IHS only. There are also differences between the IHS accounts that either bill would authorize to receive advance appropriations. H.R. 1135 would authorize it for IHS Services and IHS Facilities; on the other hand, H.R. 1128 authorizes it for IHS Services and Contract Support Costs. NIHB supports both bills; however, NIHB fundamentally believes that every IHS account should be subject to advance appropriations, as each IHS account directly impacts patient care.

As the only national Tribal organization dedicated exclusively on advocating for the fulfillment of the federal trust responsibility for health, NIHB strongly believes that authorizing advance appropriations for Indian programs would bolster continuity of care, enable greater long-term planning, improve the stability of the Indian health system, and reduce health disparities. NIHB would like to thank the Subcommittee for holding this important hearing and looks forward to working with Congress in a bipartisan fashion to secure advance appropriations for Indian programs.