

**TESTIMONY OF THE NATIONAL INDIAN HEALTH BOARD
HOUSE APPROPRIATIONS SUBCOMMITTEE FOR INTERIOR, ENVIRONMENT, AND RELATED AGENCIES
INDIAN COUNTRY COVID-19 RESPONSE AND UPDATE
SEPTEMBER 30, 2020**

Chair McCollum, Ranking Member Joyce, and members of the Subcommittee, thank you for the opportunity to provide testimony for this important hearing on Indian Country's response efforts to COVID-19. On behalf of the National Indian Health Board (NIHB) and the 574 sovereign Tribal Nations we serve, I submit this testimony for the record.

American Indian and Alaska Native (AI/AN) Tribal communities have been disproportionately impacted by the COVID-19 pandemic. No sector of Tribal economies or health systems have been spared from the devastation this crisis has unleashed. We are now, as of this writing, seven months in the throes of an unparalleled pandemic. While we may not have been able to prevent the outbreak of COVID-19, we absolutely could have mitigated the worst of its impacts – especially in Indian Country. But unfortunately, our Tribes are, once again, battling a catastrophic, unprecedented, once-in-a-lifetime disease without the necessary federal relief funds and resources to protect and preserve life.

Since June of this year alone, NIHB has submitted seventeen letters to Congress urging immediate action and passage of emergency stimulus funds for the Indian health system to better respond to COVID-19. We solemnly await congressional action. We have consistently urged long-term reauthorization of the Special Diabetes Program for Indians (SDPI), vital to Tribal efforts to mitigate the spread of COVID-19 by preventing, treating, and managing one of the strongest risk factors for a more serious COVID-19 illness: type II diabetes. We solemnly await congressional action. We have demanded that Congress work to fulfill Treaty obligations to Tribal Nations and Native people by ensuring congressional COVID-19 relief funds are on par with the recommendations outlined by Tribal leaders and health experts. We solemnly await congressional action. We have urged that burdensome administrative requirements for accessing federal grants and programs be eliminated to ensure expeditious delivery of relief resources. We solemnly await congressional action. We have urged that Congress not subject the Indian health system to a destabilizing continuing resolution (CR) as it continues to combat against an unparalleled pandemic; or to, *at the least*, attach emergency COVID-19 appropriations for IHS to the CR to mitigate the pain and disruption. Again, we solemnly await congressional action.

To be clear, we continue to appreciate the commitment and leadership of this Subcommittee in working to advance Tribal health priorities in response to COVID-19. But the Tribes require action from Congress on those commitments. On September 10, NIHB was joined by the National Congress of American Indians and the National Council of Urban Indian Health in a letter to congressional leadership urging immediate action on the priorities listed below. These priorities have remained intact since early summer, as Indian Country continues to bear the brunt of this extraordinary crisis. In short, these priorities have not changed because the situation in Indian Country remains just as dire. Once again, we solemnly await congressional action.

Tribal COVID-19 Priorities

- **Minimum \$2 billion in emergency funds to IHS for immediate distribution to I/T/U system**
- **\$1.7 billion to replenish lost 3rd party reimbursements across the I/T/U system**
- **Prioritize equitable distribution of a safe and effective COVID-19 vaccine across Indian Country, including a minimum 5% set-aside in vaccine funds for the I/T/U system**
- **Minimum \$1 billion for water and sanitation systems across IHS and Tribal communities**
- **Long-term reauthorization (5 years), higher funding, and expansion of self-determination and self-governance for the Special Diabetes Program for Indians**

COVID-19 Updates

The last time NIHB appeared before this Subcommittee was June 10, 2020. Since that time, the number of AI/AN COVID-19 case infections reported by IHS have nearly quadrupled¹. Similarly, the Centers for Disease Control and Prevention (CDC) reported a roughly 22% increase in COVID-19 hospitalization rates among AI/ANs – increasing from a rate of 272 per 100,000 in mid-July to 347.7 per 100,000 as of September 12, 2020.² Rates of death from COVID-19 among AI/ANs have more than doubled since the last time NIHB testified before the Subcommittee – from a rate of 36 per 100,000 on June 9 to 81.9 per 100,000 as of September 15.³

In August, the Centers for Disease Control and Prevention (CDC) reported that across 23 states, cumulative incidence rates of lab-confirmed COVID-19 cases among AI/ANs are 3.5 times higher than for non-Hispanic Whites.⁴ Also, according to CDC, age-adjusted rates of COVID-19 hospitalization among AI/ANs from March 1, 2020, through August 22, 2020, were 4.7 times higher than for non-Hispanic Whites.⁵ Without sufficient additional congressional relief sent directly to I/T/U systems, these shocking upward trends will more than likely continue as COVID-19 restrictions are eased, schools and businesses reopen, and the potential threat of a more severe flu season coincides with this pandemic. State-specific data further demonstrate the vast inequities in COVID-19 deaths between AI/ANs and the general population. Below are a few examples of these state-specific disparities based on NIHB's analysis of state-specific data.⁶

- In **Arizona**, AI/ANs account for **5.5% of the population**, but **13.4% of COVID-19 deaths**
- In **New Mexico**, AI/ANs account for **10.7% of the population**, but **nearly 57% of COVID-19 deaths**
- In **Montana**, AI/ANs account for **8.2% of the population**, but **27% of COVID-19 deaths**
- In **South Dakota**, AI/ANs account for **10.4% of the population**, but **nearly 23% of COVID-19 deaths**
- In **North Dakota**, AI/ANs account for **6.5% of the population**, but **13.3% of COVID-19 deaths**
- In **Mississippi**, AI/ANs account for **less than 1% of the population**, but **3% of COVID-19 deaths**

Even more alarming is the lack of complete data on COVID-19 outcomes among AI/ANs. Available COVID-19 data already highlight significant disparities between AI/ANs and the general population; shockingly, true estimates of disease burden and death resulting from COVID-19 in Indian Country are likely much higher. In CDC's own August 2020 report on COVID-19 in Indian Country, the authors noted the following:

This analysis represents an underestimate of the actual COVID-19 incidence among AI/AN persons for several reasons. Reporting of detailed case data to CDC by states is known to be incomplete; therefore, this analysis was restricted to 23 states with more complete reporting of race and ethnicity. As a result, the analysis included only one half of reported laboratory-confirmed COVID-19 cases among AI/AN persons nationwide, and the examined states represent approximately one third of the national AI/AN population. In addition, AI/AN persons are commonly misclassified as non-AI/AN races and ethnicities in epidemiologic and administrative data sets, leading to an underestimation of AI/AN morbidity and mortality

Indeed, there are multiple states that still have a significant percentage of COVID-19 cases missing critical

¹ Number of positive COVID-19 cases reported by IHS increased from 12,930 as of June 6, 2020 to 49,300 as of September 26, 2020.

² Centers for Disease Control and Prevention. COVIDView Weekly Summary. [https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html#:~:text=Severe%20Disease-,Hospitalizations,years%20\(255.1%20per%20100%2C000\).](https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html#:~:text=Severe%20Disease-,Hospitalizations,years%20(255.1%20per%20100%2C000).)

³ APM Research Lab. The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S. <https://www.apmresearchlab.org/covid/deaths-by-race>

⁴ Hatcher SM, Agnew-Brune C, Anderson M, et al. COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1166–1169. DOI: <http://dx.doi.org/10.15585/mmwr.mm6934e1>

⁵ Centers for Disease Control and Prevention. COVIDView Weekly Summary. Accessed 9/1/2020. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html>

⁶ National Indian Health Board. Comparing AI/AN COVID-19 Deaths to Total Population. https://public.tableau.com/profile/edward.fox#!/vizhome/September23CDCreportedAIANDeathsNon-HispanicAmericanIndianorAlaskaNative_/ComparingAmericanIndianandAlaskaNativesDeathsCDC9-23-2020toTotalPopulation_LabelhasofDeathsthatareAIANofPophatisAIANandtheTotalnumberofDeathsAIAN?publish=yes

demographic data. In California for instance, a whopping 31% of cases are still missing race and ethnicity. The State of New York has failed to report AI/AN data altogether – listing only Hispanic, Black, White, Asian, or Other on their COVID-19 data dashboards.

Meanwhile, the Special Diabetes Program for Indians (SDPI) – instrumental for COVID-19 response efforts in Indian Country because it is focused on prevention, treatment, and management of diabetes, one of the most significant risk factors for a more serious COVID-19 illness⁷ – has endured four short-term extensions since last September, placing immense and undue strain on program operations. Under the House-passed CR for FY 2021, H.R. 8337, ***SDPI is extended for a mere eleven days – its shortest reauthorization on record***. A national survey of SDPI grantees conducted by NIHB found that nearly 1 in 5 Tribal SDPI grantees reported employee furloughs, including for healthcare providers, with 81% of SDPI furloughs directly linked to the economic impacts of COVID-19 in Tribal communities. Roughly 1 in 4 programs have reported delaying essential purchases of medical equipment to treat and monitor diabetes due to funding uncertainty, and nearly half of all programs are experiencing or anticipating cutbacks in the availability of diabetes program services – all under the backdrop of a pandemic that continues to overwhelm the Indian health system.

Now, with the inevitability of a continuing resolution (CR) through at least December 11, 2020 – and the possibility of another CR thereafter – it is even more imperative that Congress provide emergency appropriations to better stabilize the Indian health system. This Subcommittee knows full well that IHS is the only federal healthcare system that is subject to government shutdowns and CRs. This Subcommittee is also acutely aware of the devastating impacts that endless CRs have had, and will continue to have, on the Indian health system. We commend Chair McCollum’s leadership in introducing H.R. 1128 and Ranking Member Joyce’s strong support for H.R. 1135 – both of which would authorize advance appropriations for IHS and permanently insulate it from the volatility of the annual appropriations process. But in the interim, Congress must ensure a funding fix that protects and preserves life in Indian Country and delivers critical pandemic relief in recognition of federal Treaty obligations. If Congress fails to provide sufficient emergency appropriations for the Indian health system, a stopgap measure will force a healthcare system serving roughly 2.6 million AI/ANs to operate during a pandemic without an enacted budget or even adjustments for rising medical and non-medical inflation. In short, that is a recipe for even more disaster, death, and despair.

We patiently remind you that federal Treaty obligations for healthcare to Tribal Nations and AI/AN Peoples exist in perpetuity and must be fully honored, especially in light of the current pandemic and its unparalleled toll in Indian Country. While we appreciate the roughly \$1 billion to IHS under the CARES Act and the \$750 million testing set-aside under the Paycheck Protection Program and Health Care Enhancement Act; these investments have been necessary but woefully insufficient to stem the tide of the pandemic in Tribal communities.

We thank you for your continued commitment to Indian Country, and as always, stand ready to work with you in a bipartisan fashion to advance the health of all AI/AN people.

Sincerely,

National Indian Health Board

⁷ The Centers for Disease Control & Prevention includes diabetes in a list of medical conditions that increase the chance of severe illness from COVID-19. Centers for Disease Prevention & Control, *People with Certain Medical Conditions* (Aug. 14, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>.