

**Testimony of the National Indian Health Board**  
**“Road to Recovery: Ramping Up COVID-19 Vaccines, Testing, and Medical Supply Chain”**  
**United States House of Representatives**  
**Energy and Commerce Committee**  
**Subcommittee on Health**  
**February 3, 2021**

Chairman Pallone, Ranking Member McMorris Rodgers, Chairwoman Eshoo, Ranking Member Guthrie, and Members of the subcommittee, thank you for holding this critical hearing *Road to Recovery: Ramping Up COVID-19 Vaccines, Testing, and Medical Supply Chain*. On behalf of the National Indian Health Board (NIHB) and the 574 federally-recognized sovereign American Indian and Alaska Native (AI/AN) Tribal Nations we serve, NIHB submits this testimony for the record.

**Recommendations**

**We strongly urge you to ensure that the next COVID-19 pandemic relief package includes direct set-aside funding to Indian Health Service (IHS), Tribal Nations, and urban Indian organizations (collectively “I/T/U”) for COVID-19 vaccine distribution, administration, monitoring, and tracking.**

Under both the 1918 Spanish Flu pandemic, and the 2009 H1N1 pandemic, AI/AN people had death rates four times higher than the nation. Unfortunately, under each of those public health crises - and despite their profound impact on Tribal communities and AI/AN People – access to and/or a distribution plan for vaccines were afforded last, if at all, to AI/AN communities. This is because under both of those previous pandemics, Congress failed to enact direct set-asides for the I/T/U system for vaccine access and distribution and the Administration failed to create specific plans to safeguard Tribes or their citizens. Neither Congress nor the Administration did any planning around vaccination, health promotion, disease prevention or other impacts in Indian Country during the H1N1 pandemic and other previous pandemics. **Congress has the opportunity to ensure this sordid history does not repeat itself with the COVID-19 pandemic.** Congress can achieve that by including a **minimum 5% direct, statutory set-aside in funds for the entire I/T/U system for COVID-19 vaccine distribution.** A 5% set-aside is reflective of the size of the national AI/AN population, and of numerous statutory funding set-asides Congress has previously enacted for issues like the opioid crisis, suicide, chronic disease, and many others.

Indian Country has been disproportionately impacted by this pandemic. This is a systemic reality rooted in large part in the chronic underfunding of IHS, including a long-term lack of investment in public health infrastructure. Per capita spending for those utilizing the I/T/U system reached only 40% of national health spending in 2018 (\$3,779 vs \$9,409), and, unsurprisingly, AI/AN people experience among the starkest disparities in the underlying conditions that increase the risk for a more serious COVID-19 illness. These include Type 2 diabetes, liver disease, heart disease, cancer, obesity and asthma.

The first year of the COVID-19 Pandemic has exposed the vulnerability of American Indian and Alaska Natives (AI/AN) to poor health outcomes due to social and economic factors. In addition to poverty, many AI/ANs live in rural areas, and geographic isolation limits access to quality health care. AI/ANs are more likely to live in multi-generational households, which, along with

overcrowded housing, enable COVID-19 to spread among family members. Several early reports published in the Morbidity and Mortality Weekly Report provided the evidence of the disproportionate impact on AI/ANs.<sup>1</sup> In response many states have adopted vaccination plans that prioritize the distribution and administration of vaccines for their AI/AN population.

### **COVID-19 Updates**

The last time NIHB appeared before this Subcommittee was June 25, 2020.<sup>2</sup> Since that time, the number of AI/AN COVID-19 case infections reported by IHS have nearly quadrupled.<sup>3</sup> Similarly, the Centers for Disease Control and Prevention (CDC) reported a roughly 40% increase in COVID-19 hospitalization rates among AI/ANs – increasing from a rate of 347.7 per 100,000 in mid-September to 866.9 per 100,000 as of January 23, 2021.<sup>4</sup>

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.<sup>5</sup> Also, according to CDC, age-adjusted rates of COVID-19 hospitalization among AI/ANs from March 1, 2020, through January 23, 2021, were 3.6 times higher than for non-Hispanic Whites.<sup>6</sup> 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.<sup>7</sup>

- In Arizona, AI/ANs account for 5.5% of the population, but 9.2% of COVID-19 deaths
- In New Mexico, AI/ANs account for 10.7% of the population, but nearly 28.8% of COVID-19 deaths
- In Montana, AI/ANs account for 8.2% of the population, but 19.8% of COVID-19 deaths
- In South Dakota, AI/ANs account for 10.4% of the population, but nearly 11.7% of COVID-19 deaths

---

<sup>1</sup> Morbidity and Mortality Weekly Report, CDC, December 11, 2020.

<sup>2</sup> National Indian Health Board. June 25, 2020 [https://www.nihb.org/covid-19/wp-content/uploads/2020/06/FINAL\\_-\\_EnergyCommerce\\_6.10.20-Hearing\\_Health-Care-Inequity-hearing.pdf](https://www.nihb.org/covid-19/wp-content/uploads/2020/06/FINAL_-_EnergyCommerce_6.10.20-Hearing_Health-Care-Inequity-hearing.pdf)

<sup>3</sup> 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.

<sup>4</sup> Centers for Disease Control and Prevention. COVIDView Weekly Summary. [https://www.cdc.gov/coronavirus/2019-ncov/coviddata/covidview/index.html#:~:text=Severe%20Disease-Hospitalizations,years%20\(255.1%20per%20100%2C000\).](https://www.cdc.gov/coronavirus/2019-ncov/coviddata/covidview/index.html#:~:text=Severe%20Disease-Hospitalizations,years%20(255.1%20per%20100%2C000).)

<sup>5</sup> 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>

<sup>6</sup> 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>

<sup>7</sup> National Indian Health Board. Comparing AI/AN COVID-19 Deaths to Total Population. [https://public.tableau.com/profile/edward.fox#!/vizhome/September23CDCreportedAIANDeathsNonHispanicAmericanIndianorAlaskaNative\\_/ComparingAmericanIndianandAlaskaNativesDeathsCDC9-23-2020toTotalPopulation\\_LabelhasofDeathsthatareAIANofPopthatisAIANandtheTotalnumberofDeathsAIAN?publish=yes/](https://public.tableau.com/profile/edward.fox#!/vizhome/September23CDCreportedAIANDeathsNonHispanicAmericanIndianorAlaskaNative_/ComparingAmericanIndianandAlaskaNativesDeathsCDC9-23-2020toTotalPopulation_LabelhasofDeathsthatareAIANofPopthatisAIANandtheTotalnumberofDeathsAIAN?publish=yes/)

- In North Dakota, AI/ANs account for 6.5% of the population, but 9.3% of COVID-19 deaths
- In Oklahoma, AI/ANs account for less than 13.3% of the population, but 14.9% 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 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.

#### *Vaccine Distribution: IHS Patients*

The Indian Health Service (IHS) asked Tribes and Urban Indian Health Programs whether they wanted to receive their vaccines from IHS or from their respective states. The Indian Health Service (IHS) reports that as of January 29, 2021 they had distributed 493,000 vaccines.<sup>8</sup> IHS’s COVID-19 Vaccine Distribution List includes the 340 IHS, Tribal health programs, and Urban Indian Organizations that choose to receive COVID-19 vaccine from IHS; the balance get their vaccines from their respective states. Tribes in the Alaska Area chose to have the State serve as the distribution point for vaccines.

#### *Vaccine Administration: IHS Patients*

CDC reports that just over 50 percent of doses (CDC lists 493,000 distributed) have been administered.<sup>9</sup> This may not include state-distributed vaccines. There are now multiple reports directly from Tribes that the administration of vaccines is proceeding apace with the delivery of vaccines— “Shots in Arms” soon after receipt of the vaccines is the standard operating procedure, so that none go to waste. In the Northwest, typical first rounds of 200 to 800 doses received are reported and second doses have also been received in the same amounts for the Tribes contacted by NIHB. The amounts received have been sufficient to allow Tribes to extend offerings beyond early priority groups (health workers, other frontline professionals, and nursing home residents) to elders (those over 55 in some Tribes, or over 65). The Navajo Nation reports 78,520 doses received

<sup>8</sup> [IHS COVID-19 Vaccine Distribution by IHS Area.](#)

<sup>9</sup> CDC COVID Data Tracker, February 8, 2021

and 55,671 administered as of February 4, 2021.<sup>10</sup> Alaska Native Health Programs are receiving and administering vaccines at very high rates and priority groups have expanded to include young adults in some areas of the state.<sup>11</sup> The Eastern Band of Cherokee Health Program also reports success in its vaccination effort, outperforming the state-wide average.

### **Treaty and Trust Obligations for Healthcare and Public Health**

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.”<sup>12</sup>

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 not sufficient to keep up with rising medical and non-medical inflation, population growth, facility maintenance costs, construction of new facilities, 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. 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*”

### **Conclusion**

The priority standing of Tribes and their citizens has resulted in early success in the distribution and administration of COVID-19 vaccines. Many Tribes have received their second doses to complete the two-dose regimen for the highest priority groups (including health workers) and are ready to expand the eligibility groups but are concerned about the continued flow of vaccines once more are eligible. Early evidence indicates that AI/ANs are receiving vaccines at a steady rate, as

---

<sup>10</sup> Navajo Nation COVID-19 Website, February 8, 2021. <https://www.ndoh.navajo-nsn.gov/COVID-19/COVID-19-Vaccine>

<sup>11</sup> Anchorage Daily News, Jan 15, 2021. Alaska has received the highest per capita allocation of vaccines in the nation due to high percentage of population (19.5%) that are AI/ANs.

<sup>12</sup> 25 U.S.C. § 1602

expected, although some concerns are like that reported for states nationwide. That concern is the uncertainty about future deliveries of vaccines.

We thank the Subcommittee for holding this important hearing. The treaty obligations of the entire federal government to Tribal Nations and AI/AN People exist in perpetuity. They represent a solemn promise to our nation's First People. Congress must act swiftly and comprehensively to create greater access to vaccines. As always, NIHB remains committed to working with Congress in a bipartisan fashion to advance Tribal health.