



September 4, 2020

National Academies Sciences, Engineering, and Medicine

**Subject: National Indian Health Board Public Comment on a Discussion Draft of the Preliminary Framework for Equitable Allocation COVID-19 Vaccine**

On behalf of the National Indian Health Board (NIHB) please accept these comments in response to the National Academies of Sciences discussion draft of the Preliminary Framework for Equitable Allocation of the COVID-19 Vaccine. Founded by the Tribes in 1972, our organization serves all 574 federally recognized Tribes, both American Indian and Alaska Native (AI/AN). NIHB works to strengthen Tribal sovereignty and ensure the federal government upholds its Trust and Treaty obligations to the Tribes for the improvement of health care, health outcomes and systems and public health infrastructure, capacity and systems in Indian Country.

NIHB applauds the Academies' recognition that the disproportionately negative impact of COVID-19 on Tribal Communities, health, businesses and socioeconomic well-being is a direct result of systemic racism. When you compound the impact of broken treaty promises, chronic underfunding of the American Indian and Alaska Native health system, the inevitable result is the chronic and pervasive health disparities that exist across Indian Country. **These inequities created a vacuum for COVID-19 to spread like wildfire throughout Indian Country, as it continues to do.** Indeed, AI/AN health outcomes 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.

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 marred by 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. 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. In California, for example, just under 40% of AI/AN families with incomes under 200% of the federal poverty line were food insecure; in Oklahoma, 1 in 4 AI/ANs were reported to be food insecure in 2015 ; and in Montana, an analysis of 187 AI/AN households found 43% to be food insecure.

These are among the reasons NIHB also applauds and supports the Academies' draft recommendation that Tribal communities, American Indian and Alaska Native, are prioritized in receiving the vaccine. As reflected in the draft report, applying the Centers for Disease Control and Prevention's Social Vulnerability Index clearly elevates the stark equity issues that exist among American Indians and Alaska Natives compared to Non-Hispanic Whites. This consideration furthers the case that vaccine distribution will reflect an equity model when AI/ANs are prioritized to receive it.

NIHB disagrees with the assertion that vaccines for Tribal citizens should be distributed through the states. This did not work during H1N1, when Tribes were almost summarily left out of access, and it will not work now. Specific to tribal nations, it is important to acknowledge that the federal government would allocate vaccine to tribal, urban Indian, and Indian Health Service (IHS) facilities directly through the existing IHS system. Federal trust responsibility for health care to Native people mandates that. To do so successfully, IHS allocation will require additional funding and external oversight. Consistent with recommendations in the draft, NIHB agrees that while the AI/AN Tribal supply must be separate from state allocation, it may also be in states' best interest to supplement IHS allocation with a portion of their own supply in order to protect the public's health. Even in this scenario, states would not oversee how tribal governments allocate vaccine in order to ensure tribal sovereignty.

Equitable distribution of a COVID-19 vaccine to Indian Country through a minimum 5% statutory set-aside in funding for IHS, Tribal, and urban Indian (collectively I/T/U) systems. Further, in keeping with Treaty obligations, the federal government must cover the cost of the distribution of the vaccine to patients, holding the Indian health system harmless. **Tribes must be specifically and included in distribution plans.**

### **Background: Health and Economic Toll of COVID-19 in Indian Country**

The health and economic toll of COVID-19 in Indian Country has been both severe and disproportionate, further increasing the urgency of passing the Tribal health policy provisions outlined above. First let's examine the health data. As of August 1, 2020, IHS has reported 32,525 positive case infections. 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. Aggregated data from States and other sources demonstrate that AI/ANs have the highest COVID-19 hospitalization rate at 281 per 100,000. National data on death rates also show that AI/AN People are experiencing the second highest COVID-19 death rate, at 60.5 deaths per 100,000. Further, a data visualization comparing State and Tribal COVID-19 case rates found that if Tribal Nations were States, the top seven case infection rates nationwide would all be Tribal Nations.

Economic losses have significantly worsened the health impacts of the pandemic on Tribal communities. Unlike state and local governments, Tribes do not have a tax base to supplement business revenue losses. Thus, the financial toll of COVID-19 has translated into even fewer available dollars for healthcare and public health services for AI/AN people. In May 2020, a national survey of Tribal governments and business enterprises conducted by the Federal Reserve Bank of Minneapolis' found that over 50% of Tribes responding to the survey had laid off or furloughed employees at the time the survey was conducted. Because of cancellations of non-emergent care procedures in response to COVID-19, many Tribes have

experienced shortfalls in reimbursement from private insurance, Medicare, and other sources ranging from \$800,000 to \$5 million per Tribe, per month. Because of the gross and chronic underfunding of the Indian health system, Tribes rely on these reimbursements as a necessary supplement. In two separate appearances before Congress since the COVID pandemic arose IHS Director Rear Admiral (RADM) Weahkee stated that third party collections have plummeted 30-80% below last year's collections levels, and that it would likely take years to recoup these losses. These funding shortfalls have forced Tribes across the lower 48 and Alaska to furlough hundreds of workers, curtail available healthcare services, or close down clinics entirely. For example, Tribes in the Bemidji Area reported that nearly 20% of their healthcare system and 35% of their government services staff were forced to be furloughed due to revenue shortfalls. Meanwhile, over 193,000 AI/ANs have become uninsured as a result of COVID-19 job losses.

Tribal business closures have compounded the devastation of the COVID pandemic in Indian Country. According to the Harvard Project on American Indian Economic Development (HPAIED), before COVID-19 hit, Tribal governments and businesses employed 1.1 million people and supported over \$49.5 billion in wages, with Tribal gaming enterprises alone responsible for injecting \$12.5 billion annually into Tribal programs. During the six week period (through May 4, 2020) whereby all 500 Tribal casinos were closed in response to COVID-19 guidelines, Tribal communities lost \$4.4 billion in economic activity, with 296,000 individuals out of work and nearly \$1 billion in lost wages. Extrapolated across the entire U.S. economy, collectively \$13.1 billion in economic activity was lost during the same time period, in addition to \$1.9 billion in lost tax revenue across federal, state and local governments.

Finally, NIHB found within the Academies' discussion draft that references to State and Local governments were saturated throughout the draft – alarmingly absent was the inclusion Tribal Governments within these discussions. *NIHB recommends that wherever the report references State and Local Government, it adds Tribal Government.* Finally, it is worthy of note that when filling out the frame provided to submit comments, we were asked to check a box best describing our organizational affiliation. State and Local government were provided a box to check – Tribal Government were not provided as an option.

Thank you for your attention to this information and we look forward to assisting you as we can. Please do not hesitate to call on the National Indian Health Board should you find that we can be of service.