Alaska Native
Tribal Health Consortium

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POSITION PAPER

SB 12/HB 50 – "An Act relating to limitations on mandatory overtime for registered nurses and licensed practical nurses in health care facilities; and providing for an effective date."

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POSITION: Oppose

The Alaska Native Tribal Health Consortium (ANTHC) is a tribally controlled, non-profit, statewide tribal health organization formed pursuant to federal law to provide a range of medical and community health services for more than 130,000 Alaska Natives. It is part of the Alaska Tribal Health System (ATHS), which is owned and managed by the 231 federally recognized tribes in Alaska and by their respective regional health organizations.

ANTHC and Southcentral Foundation jointly manage the Alaska Native Medical Center (ANMC), the tertiary hospital of the ATHS located in Anchorage. We employ 500 nurses. In January of this year ANMC was recognized for a second time as a Magnet Hospital, a highly prized award given by the American Nursing Association. Only five percent of all U.S. hospitals achieve Magnet Status, and even fewer are designated a second time. ANMC is the first and only Alaska hospital to receive Magnet Status. Magnet hospitals have demonstrated that they meet a set of criteria designed to measure the strength and quality of their nursing, including the ability of its nurses to contribute to patient outcomes, and where nurse job satisfaction, low turnover rates and appropriate grievance resolution are part of the standard.

We value our nurses, but we do not support SB 12 or HB 50, bills that seek to legislate work schedules and tie the hands of managers who are constantly juggling the demands of patient care against workforce availability and rising costs/chronic underfunding in the tribal health care system. We have three primary concerns about the bill as currently written:

1) *It would have a disproportionate and detrimental impact on patients in rural Alaska*
2) *It conflicts with Alaska's longstanding policy of supporting access to health care through allowing health care facilities an appropriate degree of flexibility in scheduling direct health care providers.*
3) *It creates the inaccurate impression that it applies to federal and tribal facilities and programs that comprise the Alaska Tribal Health System*

1) Disproportionate and Detrimental Impact on Patients in Rural Alaska

The bill provides no new resources and no new options. In rural Alaska recruiting and retaining qualified nurses is not merely a challenge, as it is for all of Alaska and much of the United States; it is a constant struggle. Vacancy rates, recruitment costs and staff turn-over continually plague these providers, especially tribal health providers.

This bill restricts the ability of hospital managers to work with their nursing staff to craft options in a health system that is already stretched to its limits in both staffing and financial resources. There is a real risk that the bill would lower nurse/patient ratios and decrease the quality of care patients receive by tying the hands of providers to balance patient needs with available workforce, including nurses. In rural Alaska, when nurses are not available, then patients must be diverted to another facility. Since there are no other options in rural Alaska, patients typically get diverted to the Alaska Native Medical Center. Because ANMC, as a statewide facility, serves all regions, then we experience a compounding effect at ANMC, a facility that is already too small to meet patient care needs. When ANMC is at capacity, we too are forced to divert patients to other facilities in Anchorage. This is an every day challenge, but is especially problematic during public health outbreaks. Diverting patients disrupts the continuity of care for our patients and imposes an additional financial burden on our already under-funded health system.

The bill also sets forth a reporting requirement to the State Department of Labor. Because tribal health facilities are not licensed by the state, as explained below, we believe we would not be subject to the reporting requirements. To the extent a tribal provider did comply, it would create a new, costly system of collecting data and preparing reports. ANMC employs nurses who are licensed by the state and nurses who are part of the Commissioned Corp under the federal Public Health Service, further complicating any perception of what would be required under a state law.

2) Conflict with Longstanding State Policy of Supporting Access to Health Care

The Alaska Legislature has recognized the necessity of promoting access to health care through appropriate limitations to wage and hour requirements since at least 1962 when it enacted the "hospital employee" exemption.[1] From 1962 to 1983, all employees of *non-profit hospitals* were exempt from that law. While the exemption was narrowed slightly in 1983 to cover only those employees who provide "medical services," the Legislature also expanded the exemption to the employees of *all hospitals*, not just those employed by non-profits.[2] This change addresses the "interest in keeping medical facilities open and providing more flexible schedules for employees whose extended hours of labor were needed to maintain the hospital in operation at all time" and more generally the need to "enhanc[e] access to health care" in Alaska.[3]

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[1] AS 12.10.060 (1962); *Hutka v. Sisters of Providence*, 102 P.3d 947, 952 (Alaska 2004).
[2] *Hutka*, 102 P.3d at 952-53.
[3] *Hutka*, 102 P.3d at 953.

3) Applicability to Federal and Tribal Health Providers

Providing health care services to Alaska Natives and American Indians is a federal function that contributes to the fulfillment of the federal government's trust responsibility to Alaska Natives and their Tribes.[4] A federal facility performing a federal function is not subject to state regulation, even if the function is carried out by another entity, unless Congress clearly authorizes such regulation.[5] Congress has not authorized state regulation of federal health facilities serving Indian tribes and their members or of tribal facilities that fulfill this federal function pursuant to the Indian Self-Determination and Education Assistance Act.

Rather, Congress has taken pains to promote self-determination and self-governance by ensuring that Tribes and tribal organizations have sufficient flexibility to address the unique needs of Native Americans and the extraordinary challenges of providing quality, culturally appropriate health care with very limited resources, often in extremely remote locations. This is because one of the purposes of the ISDEAA is to provide

> a meaningful Indian self-determination policy which will permit the orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services.[6]

For similar reasons, Congress has provided an explicit exemption for Tribes and tribal organizations from the operation of most federal employment law, including Title VII of the Civil Rights Act of 1964, the American with Disabilities Act, and the Davis-Bacon prevailing wage rate requirements.[7] Courts have also recognized tribal exemptions with respect to other federal laws, like the Age Discrimination in Employment Act (ADEA), that do not specifically address their applicability to Tribes and tribal organizations.[8] One federal appellate court ruled that other federal laws and interests must give way to ISDEAA's overriding objectives when it

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[4] *See, e.g.*, 25 USC § 1616*l*; S. Rep. No. 102-392 at 2 (1992), *as reprinted in* 1992 USCCAN 3943, 3944. *See, also,* note 2, *supra.*

[5] *Goodyear Atomic Corporation v. Miller*, 486 U.S. 174, 181 (1988).

[6] 25 USC § 450a(b).

[7] 42 USC § 2000e(b)(1); 42 USC § 12111(5)(B)(i); 25 USC § 450e(a). *See also, Pink v. Modoc Indian Health Project*, 157 F.3d 1185, 1188-89 (9th Cir. 1998) (non-profit corporation created by two tribes qualified as an "Indian tribe" under Title VII where corporation was formed to deliver health care services under an ISDEAA agreement, even though services were provided outside the boundaries of a reservation), *Setchell v. Little Six, Inc.*, No. C4-95-2208, 1996 WL 162560, at *2 (Minn.App. April 9, 1996), *cert. den.* 521 U.S. 1124 (1997).

[8] 29 USC§ 626(d). *E.g.*, *EEOC v. Karuk Tribe Housing Authority*, 260 F.3d 1071, 1081 (9th Cir. 2001) (ADEA inapplicable to tribal housing authority that "occupies a role quintessentially related to self-governance"); *Taylor v. Alabama Intertribal Council*, 261 F.3d 1032 (11th Cir. 2001) (employee's race discrimination claim concerned tribal self-governance and intramural Indian matters). *See also Penobscot Nation v. Fellencer*, 164 F.3d 706 (1st Cir. 1999) (employment of a non-Native in federally funded public health nurse position is an "internal tribal matter" and not subject to state regulation).

addressed the potential applicability of the National Labor Relations Act to the Yukon-Kuskokwim Health Corporation.[9]

Congress and the federal courts have thus essentially deemed the Fair Labor Standards Act (FLSA) to be sufficient protection for tribal employees.[10] Because of the unique nature of nursing care, however, some nurses are exempt from FLSA's wage and hour requirements while others are protected through special provisions that specifically accommodate the need for scheduling flexibility. The Act's implementing regulations were recently revised with the benefit of comprehensive comments from nursing associations, patient advocacy groups, and health care facilities and they continue to recognize the need and appropriateness of allowing for this degree of flexibility. Alaska's own wage and hour laws and regulations are quite similar to the federal scheme in this respect.

At the same time, the Indian Health Care Improvement Act (IHCIA) and the Indian Self-Determination and Education Assistance Act (ISDEAA) provide a comprehensive framework for regulating tribal health care. Their broad language, together with the exemption from most federal employment law, provide a clear indication that Congress did not intend to allow federal agencies to impose their own rules on Tribes and tribal organizations, much less subject them to potentially overlapping and less flexible requirements enacted by individual states. Otherwise state law would "obstruct[] the execution of the purpose of the federal [law]."[11] The Supremacy Clause and the federal preemption doctrine prohibit this, especially in areas like Indian health care that has been a federal responsibility for centuries.[12]

"The Alaska courts have noted that the provision of Indian health care services is an area that is "comprehensively and pervasively regulated by the federal government which is manifested in both the ISDEAA and the IHCIA."[13] Once the federal government has thus occupied the field, there is no allowance for state regulations, even if it is consistent with statutory purposes.[14]

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[9] *YKHC v. NLRB*, 234 F.3d 714, 718 (D.C. Cir. 2000) ("NLRA must make in order to accommodate federal Indian law, as reflected in [ISDEAA]").. The Board concluded that it was inappropriate to exercise jurisdiction over YKHC in light of its role in fulfilling federal government's trust responsibility to provide free health care to Alaska Natives. *See also* 29 USC § 151, *et seq.; YKHC and International Brotherhood of Teamsters, Local 959, AFL-CIO, CLC*, 341 NLRB No. 139, May 28, 2004 (declining to exert jurisdiction over off-reservation tribal health organization fulfilling federal trust responsibility to provide free health care to Alaska Natives, even though organization employs many non-Natives and provides health care services to a small number of non-Natives).

[10] 29 USC § 201, *et seq.*

[11] *The Alaska Dental Society, et. al. v. State of Alaska, et. al*, 3AN-0604797 CI, 12 (June 27, 2006), *quoting Catalina Yachts v. Pierce*, 105 P.3d 125, 128 (Alaska 2005).

[12] *Alaska Dental Society* at 15, *citing Wachovia Bank, N.A. v. Burke,* 414 F.3d 305, 313 (2d Cir. 2005) (no presumption against federal preemption in fields substantially occupied by federal authority for extended time); *United States v. Locke*, 529 US 89, 108 (2000) (no presumption against preemption is triggered when significant history of a federal presence,).

[13] *Alaska Dental Society* at 15, *citing Ketchikan Gateway Borough v. Ketchikan Indian Corporation*, 75 P.3d 1043, 1049 (Alaska 2003). *See also, id.* at 1048 (majority setting aside issues of whether tribal health clinic is "subject to comprehensive and pervasive federal oversight.")

[14] *E.g., National Audubon Society v. Davis*, 307 F.2d 835, 851 (9th Cir. 2002).

In addition to this existing federal law, CMS quality standards and Joint Commission standards impose high quality standards on federal and tribal facilities that participate in the Medicare and Medicaid programs. In Alaska, this includes all of the major IHS and tribal health facilities.

Together, these federal laws address the same concerns intended to be addressed by SB12/HB50. However, they do so in a way that allows facilities more flexibility. While they impose certain performance and quality standards, they do not dictate the means for accomplishing them by imposing rigid requirements that may or may not lead to the same level of performance or quality (or, in the case of rural Alaska, undermine the very goals that the bill sponsor is trying to promote).

Conclusion

We understand that the bill sponsors and supporters are trying to protect nurses from being overworked and patients from accidental errors that may occur as a result. However, we don't believe legislating hours is the right solution. ANTHC and our partner tribal health facilities work very hard to recruit and retain quality nurses. We place high value on the nurses who work for us, and are actively involved in programs like the University of Alaska's Rural Nursing Program. We have been innovative in crafting solutions where physician and nursing services have been non-existent—principal among them, the Community Health Aide Program.

We also value the partnerships we have with many of our non-tribal hospitals/health system partners. We understand the value of flexibility in workforce negotiations. Legislation, of course, takes discussion regarding choices off the table. We in the tribal health system have our own history of suffering unintended consequences from legislation that started with the best of intentions. Today, through our compact with the Indian Health Service, we engage each year in a very formal negotiation, where challenges for everyone involved are brought to the table and worked through to the point of consensus. We support the request of our partners that this legislation be held and to let the process of labor negotiations to proceed.

Thank you for your careful consideration of these issues. We would be happy to provide any further information upon request.