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SUBCOMMITTEE ON INDIAN AND INSULAR AFFAIRS
LEGISLATIVE HEARING ON H.R. 8658
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Chairman Hurd, Ranking Member Leger Fernandez, and the distinguished members of this Subcommittee, thank you for the opportunity to provide testimony on H.R. 8658, *the Indian Health Service Emergency Claims Parity Act*. On behalf of the National Indian Health Board (NIHB) and the 575+ federally recognized American Indian and Alaska Native (AI/AN) Tribal Nations we serve, we appreciate the Subcommittee's longstanding commitment to improving health outcomes for AI/AN communities. We believe that H.R. 8658 represents a common-sense solution that will help ensure emergency medical care is provided to all AI/AN patients, as intended, and restrictive administrative rules do not burden patients during medical crises. We thank the Subcommittee for your leadership on this issue and urge the swift advancement of this legislation.

The federal government maintains a unique legal obligation to provide health care for all AI/ANs, grounded in treaties, statutes, U.S. Supreme Court decisions, and the federal trust responsibility. Congress reaffirmed this duty through the Indian Health Care Improvement Act (IHCIA), declaring it the policy of the United States "to ensure the highest possible health status for Indians and to provide all resources necessary to effect that policy." [1] The federal government fulfills this obligation primarily through the Indian health system, also called the "I/T/U System," through which the Indian Health Service (IHS) provides services directly, through Tribal health programs, Urban Indian Organizations, and through services contracted from outside providers through the Purchased/ Referred Care (PRC) program. Together, these components form a comprehensive system intended to fulfill the obligation of providing high-quality health care for all AI/AN people.

IHS-funded hospitals and health clinics serve approximately 3.2 million people, many in rural and remote areas, however there are limitations to the care the Indian health system provides. The PRC program allows the IHS to purchase health services from non-IHS providers when care is not reasonably accessible or available within the IHS or Tribal health system. Specialty services, advanced diagnostics, and emergency care are often provided outside the IHS system through PRC. This is never more important than when patients find themselves in an emergency situation. For many Tribal communities, particularly those located in rural and remote areas, this program is the only way patients can obtain life-saving services. PRC is therefore not supplemental or optional. It is a fundamental mechanism through which the federal government fulfills its health care obligations.

[1] 25 U.S.C. § 1602

H.R. 8658 - The Indian Health Service Emergency Claims Parity Act

The Indian Health Service Emergency Claims Parity Act would provide a critical and long-overdue fix to the PRC program and help ensure patients are not penalized for seeking lifesaving emergency care. Currently, most IHS beneficiaries must notify the PRC program within seventy-two hours after receiving emergency services at a non-IHS facility for the care to be eligible for coverage by IHS. H.R. 8658 would extend this window to fifteen days,[2] ensuring patients can focus on their care and are not further burdened amid life-threatening or emergent health situations. This change would align PRC requirements with the realities of emergency medical care, reduce preventable claim denials, and help protect Tribal citizens from avoidable medical debt. By modernizing an outdated requirement, the legislation would strengthen the Indian health system and better ensure that the federal trust responsibility is fulfilled when patients need care most.

Emergency medical events are often chaotic, traumatic, and overwhelming. Patients may be hospitalized for days or weeks, transferred between facilities, or recovering from surgery, sedation, or intensive treatment. Families should be focused on the recovery of their loved ones, not on paperwork or claim filing. The expectation that patients or their families should have to simultaneously focus on care and on the PRC requirements or face massive medical debt is massively overburdensome and unrealistic.

Emergency medical situations represent the moment when the PRC program is most critical. In fact, all emergency medical situations are considered Priority Level 1 of IHS PRC Medical Priorities. However, the 72-hour notification window means they are all too frequently not covered. In a medical emergency, patients must seek care at the nearest facility capable of providing appropriate treatment, which often is a non-IHS hospital.

When the current seventy-two-hour notification requirement is not met, PRC claims may be denied, even when the services were medically necessary or even lifesaving. The consequences of these denials are severe and far-reaching. Tribal members frequently receive bills from hospitals, providers, and debt collection agencies for services they believed would be covered. These bills often include intimidating language and threats of legal action. Families may experience long-term financial hardship, damage to credit scores, and ongoing stress as they attempt to resolve debts that arose from emergency medical care. When emergency PRC claims are denied, Tribal members can experience repeated credit damage through no fault of their own. Lower credit scores can prevent access to lines of credit and loans that are essential to building financial stability and improving quality of life. As a result, the cost of financing vehicles, homes, or even basic credit can become inaccessible, compounding the long-term impact of a medical emergency far beyond the initial health crisis.

These harmful claim denials often occur not because patients acted irresponsibly, but because the system is difficult to navigate. Patients and families may not know about the seventy-two-hour rule, and hospitals may be unfamiliar with PRC requirements, and communication delays between providers and IHS can make the window difficult to meet.

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[2] The bill does not change the existing 30-day notification window for patients who are elderly or disabled under section 406 of IHCIA.

While PRC provides for essential services, it is not an entitlement program and does not receive indefinite appropriations, meaning IHS has limited resources to provide. IHS is designated as the payor of last resort, meaning that all other available alternate resources, including Medicare, Medicaid, private insurance, state or other health programs, etc., must be billed first before the IHS will pay for healthcare services, and that ensures dollars stretch as far as possible. However, resolving this issue should not depend on patients during medical emergencies complying with unrealistic deadlines. There are numerous other challenges facing the PRC program including chronic underfunding, and NIHB has testified about them in the past. This solution, however, is straightforward and no-cost.

Extending the notification window would significantly reduce claim denials and avoidable medical debt. It would allow patients time to stabilize, both medically and practically, after emergencies before navigating administrative requirements. It would improve communication between providers and the IHS and help ensure that emergency care is reimbursed as intended. Most importantly, it would help ensure that technicalities do not undermine access to care or the federal government's ability to meet its trust obligations.

The legislation also represents an important step toward reducing administrative burden on patients. In most health care systems, emergency billing and care coordination occur between providers and payors, such as insurance companies. Under the current PRC framework, however, patients bear more of this responsibility than they would in other health systems. This expectation is inconsistent with the realities of emergency medical care and places an unfair burden on individuals in crisis. By extending the notification period, Congress can help ensure that patients are not expected to act as billing professionals during medical emergencies and are not left with unnecessary and burdensome medical debt.

Ultimately, the IHS Emergency Claims Parity Act would align federal policy more closely with the federal obligation to provide high-quality medical care to AI/AN patients across the Nation. This legislation represents a meaningful improvement to an essential piece of the system that will strengthen health outcomes while better protecting Tribal communities.

The National Indian Health Board strongly supports H.R. 8658 and respectfully urges Congress to advance and enact this legislation. Extending the emergency notification window will reduce medical debt, improve program administration, strengthen trust in the Indian health system, and better uphold the federal government's commitment to Tribal Nations. Thank you for the opportunity to provide testimony. NIHB looks forward to continuing our work with the Subcommittee to strengthen the Indian health system and ensuring the highest-possible health status for all American Indians and Alaska Natives.