



**TESTIMONY OF NATIONAL INDIAN HEALTH BOARD
HOUSE COMMITTEE ON VETERANS' AFFAIRS LEGISLATIVE HEARING
TESTIMONY ON H.R. 4908 AND H.R. 2791
THURSDAY JULY 23, 2020**

Chairman Takano, Ranking Member Roe, and Members of the Committee, 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, thank you for the opportunity to submit testimony for this important legislative hearing on critical bills addressing the needs of our Veterans. NIHB submits this testimony for the record on the bipartisan H.R. 2791 - *Department of Veterans Affairs Tribal Advisory Committee Act of 2019*; and H.R. 4908 – *Native American PACT Act*.

Specifically, NIHB urges the Committee to:

1. Pass the bipartisan H.R. 4908 – Native American PACT Act

- The federal government's Treaty obligations for healthcare for all AI/ANs encompasses every federal agency, including the Veterans Health Administration (VHA). In fact, the United States has a dual obligation to AI/AN Veterans – one obligation inherent to their political status and the treaty obligations of the federal government; and the other obligation due to their service in our nation's defense.
- While AI/ANs are not charged for healthcare services received from IHS or through the Medicaid program, AI/AN Veterans are charged copays by the VHA - a practice that shouldn't exist and that runs contrary to federal treaty obligations for healthcare for all AI/AN people. As such, it is imperative that Congress enact this legislation that would require the VHA to exempt AI/AN Veterans from copays and deductibles in the VA system in recognition of federal obligations for healthcare that exist in perpetuity.
 - Importantly, these copay costs must not be shifted to IHS or Tribes. The VHA must absorb these costs on behalf of AI/AN Veterans in recognition of their Trust and Treaty obligations to AI/AN Peoples.

2. Pass the bipartisan H.R. 2791 – Department of Veterans Affairs Tribal Advisory Committee Act of 2019

- Tribal Nations and NIHB have also strongly advocated for the seating of a Tribal Advisory Committee (TAC) within the Office of the Secretary at the VA.
- Establishing a Veteran TAC is essential for strengthening the government-to-government relationship between Tribes and the VA, and towards improving VA accountability to AI/AN Veteran health needs.
- Through the seating of a TAC, top VA officials would have the ability to hear directly from Tribal leaders about the unique health priorities and challenges that impact Native Veterans, including around telehealth. In addition, the TAC would create the opportunity to co-develop policy with the VA and that would help prevent the development of new rules or policies that would adversely affect the care for Native Veterans
 - NIHB also supports a proposed amendment to its Senate companion, S. 524, which would ensure at least one seat is reserved for urban Indian organizations (UIOs) and one seat is reserved for Native Hawaiian organizations, in addition to the twelve seats reserved for Tribal Nations and Tribal organizations.

Background: Federal Obligations to AI/AN Veterans

The United States federal government has a dual obligation to AI/AN Veterans – one obligation specific to their political status as citizens of sovereign Tribal Nations, and one obligation specific to their courageous service in our Armed Forces. By current estimates, there are over 140,000 Native Veterans, with AI/ANs enlisting to serve at nearly five times the national average, and at higher rates per capita than any other ethnicity.¹ Yet despite the bravery, sacrifice, and steadfast commitment to protecting the sovereignty of Tribal Nations and the entire United States, Native Veterans continue to experience among the worst health outcomes, and among the greatest challenges in receiving quality health services, among all Americans. These enduring challenges have left Native Veterans at significantly higher risk of COVID-19 due to disparities.

In 1955, Congress established the Indian Health Service (IHS) in partial fulfillment of its constitutional obligations for health services to all AI/ANs. The IHS is charged with a similar mission as the VHA as it relates to administering quality health services, with the exception of the following differences: (1) the federal government has Treaty and Trust obligations to provide health care for all American Indians and Alaska Natives; (2) IHS is severely and chronically underfunded in comparison to the VHA, with per capita medical expenditures within IHS at \$3,779 in Fiscal Year (FY) 2018 compared to \$9,574 in VHA per capita medical spending that same year²; and (3) unlike IHS, the VHA has been protected from government shutdowns and continuing resolutions (CRs) because Congress enacted advance appropriations for the VHA a decade ago.³ Moreover, **while the VHA service population is only three times the size of the Indian health system, its discretionary appropriations are *approximately thirteen times higher* than for IHS.**

Similarly, Congress has not provided comparable emergency funding to IHS compared to VHA in response to the COVID-19 pandemic. For instance, the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act invested \$15.85 billion into medical care at the VHA, including \$3.1 billion specifically for health information technology (HIT) and telemedicine; but only \$1.032 billion for IHS, of which only \$65 million was allocated for HIT support.

Health Outcomes for AI/AN Veterans

Destructive federal Indian policies and unresponsive human service systems have left Native Veterans and their communities with unresolved historical and intergenerational trauma. From 2001 to 2015, suicide rates among Native Veterans increased by 62% (50 in 2001 to 128 in 2015).⁴ In FY 2014, the Office of Health Equity within VHA reported significantly higher rates of mental health disorders among Native Veterans compared to non-Hispanic White Veterans, including in rates of PTSD (20.5% vs. 11.6%), depression symptoms (18.7% vs. 15.2%), and major depressive disorder (7.9% vs. 5.8%).⁵ Native Veterans are 1.9 times more likely to be uninsured than non-Hispanic White Veterans, and are significantly more likely to delay accessing care due to lack of

¹ Veterans Administration. 2017. American Indian and Alaska Native Veterans.

<https://www.va.gov/vetdata/docs/SpecialReports/AIAN.pdf>

² The full FY 2022 IHS Tribal Budget Formulation Workgroup Recommendations are available at

https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf

³ See 38 U.S.C. 117; P.L. 111-81

⁴ VA, Veteran Suicide by Race/Ethnicity: Assessments Among All Veterans and Veterans Receiving VHA Health Services, 2001-2014 (Aug. 2017) (citing CDC statistics).

⁵ Lauren Korshak, MS, RCEP, Office of Health Equity and Donna L. Washington, MD, MPH, Health Equity-QUERI National Partnered Evaluation Center, and Stephanie Birdwell, M.S.W., Office of Tribal Government Relations

timely appointments and transportation issues.⁶ Among all Veterans, Native Veterans are more likely to have a disability, service-connected or otherwise.⁷ Native Veterans are exponentially more likely to be homeless, with some studies showing that 26% of low-income Native Veterans experienced homelessness at some point compared to 13% of all low-income Veterans.⁸ There exists a paucity of Native Veteran specific health, housing, and economic resources and programs that are accessible and culturally appropriate. It is essential that the VHA work with IHS and Tribes to create more resources specifically for Native Veterans.

According to IHS, AI/ANs born today have a life expectancy that is on average 5.5 years less than the national average.⁹ In states like South Dakota, however, life expectancy for AI/ANs is as much as two decades lower than for Whites. Health outcomes among AI/ANs have either remained stagnant or become as AI/AN communities continue to encounter higher rates of poverty, lower rates of healthcare coverage, and less socioeconomic mobility than the general population. According to the Centers for Disease Control and Prevention, in 2016, AI/ANs had the second highest age-adjusted mortality rate of any demographic nationwide at 800.3 deaths per 100,000 people.

In addition, AI/ANs have the highest uninsured rates (25.4%); higher rates of infant mortality (1.6 times the rate for Whites); higher rates of diabetes (7.3 times the rate for Whites); and significantly higher rates of suicide deaths (50% higher). AI/ANs also have the highest Hepatitis C mortality rates nationwide (10.8 per 100,000); and higher rates of chronic liver disease and cirrhosis deaths (2.3 times that of Whites). Further, while overall cancer rates for Whites declined from 1990 to 2009, they rose significantly for AI/ANs. For instance, from 1999 to 2015 AI/ANs encountered a 519 percent increase in drug overdose deaths – the highest rate increase of any demographic nationwide.¹⁰ All of these health determinants of health and poor health status could be dramatically improved with adequate investment into the health, public health and health delivery systems operating in Indian Country.

The VA’s Veteran Outreach Toolkit lists AI/ANs as an “at-risk” population, citing this troubling suicide rate. Additionally, AI/ANs grapple with complex behavioral health issues at higher rates than any other population—for children of AI/AN veterans, this is compounded by the return of a parent who may suffer from post-traumatic stress disorder (PTSD). Outreach events for AI/AN communities should be a VA priority to increase wellness, decrease stigma, and prevent suicide. It is essential that the VHA continue to engage with Tribal leaders, through consultation, to assist in carrying out these activities.

⁶ Johnson, P. J., Carlson, K. F., & Hearst, M. O. (2010). Healthcare disparities for American Indian veterans in the United States: a population-based study. *Medical care*, 48(6), 563–569. doi:10.1097/MLR.0b013e3181d5f9e1

⁷ U.S. Department of Veterans Affairs. (2015a). American Indian and Alaska Native Veterans: 2013

American Community Survey. Retrieved from <https://www.va.gov/vetdata/docs/SpecialReports/AIANReport2015.pdf>

⁸ US Department of Housing and Urban Development, US Department of Veterans Affairs, National Center on Homelessness Among Veterans. *Veteran Homelessness: A Supplemental Report to the 2010 Annual Homeless Assessment Report to Congress*. Washington, D.C.2011:56

⁹ Indian Health Service. 2018. Indian Health Disparities. Retrieved from https://www.ihs.gov/newsroom/includes/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf

¹⁰ Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. *MMWR Surveill Summ* 2017;66(No. SS-19):1–12. DOI: <http://dx.doi.org/10.15585/mmwr.ss6619a1>

Lack of VA Data on COVID-19 Cases among AI/AN Veterans

As of July 21, 2020, the VA has confirmed 6,040 active COVID-19 cases and 1,927 known deaths. An interactive map on the VA website illustrates COVID-19 clusters across 140 VA facilities nationwide, with the largest cluster of cases concentrated in the Northeast stretching from Washington D.C. to Boston. Nevertheless, there are multiple positive case reports from many VA facilities in close proximity to Tribal lands and reservations, including in Arizona, Montana, Utah, eastern Washington State, South Dakota, Wyoming, and Oklahoma. **To date, however, the VA has yet to release breakdowns of COVID-19 case rates by race or ethnicity, yielding zero insight into population-specific disparities in COVID-19 health outcomes.** Like most healthcare systems, the VHA has transitioned to virtual care delivery via telehealth, reporting a 1,140% increase in telehealth visits since March 1, 2020 with an average of 138,766 weekly telehealth visits.¹¹ Yet **VHA also has yet to release any demographic-based breakdowns of use of telehealth-based care delivery, thereby yielding zero insight into any population-specific disparities in access to virtual health services.** However, COVID-19 data reporting from IHS and state health departments demonstrates that AI/ANs are, yet again, being disproportionately impacted by this public health crisis.

COVID-19 Impact on AI/AN Population

As of July 19 2020, the Indian Health Service (IHS) has reported 27,233 positive cases of COVID-19, with the overwhelming majority of positive cases reported out of the Phoenix and Navajo IHS Areas. However, IHS numbers are highly likely to be underrepresented because case reporting by Tribal health programs, which constitute roughly two-thirds of the Indian health system, is voluntary. According to data analysis by APM Research Lab, **AI/ANs are experiencing the second highest aggregated COVID-19 death rate at 36 deaths per 100,000.**¹² The Centers for Disease Control and Prevention (CDC) reported on July 11, 2020 that **age-adjusted COVID-19 hospitalization rates among AI/ANs are higher than any other ethnicity, at 273 per 100,000.**¹³ Reporting by state health departments has further highlighted disparities among AI/ANs.

- In New Mexico, AI/ANs represent roughly 8% of the population, yet account for over 44% percent of all COVID-19 cases.¹⁴
- As of this writing, the Oyate Health Center in South Dakota has conducted 839 COVID-19 tests, with 114 confirmed positive case results (13.5%). In Pennington County, the second-largest county in South Dakota, AI/AN People account for 53% of all COVID-19 cases despite representing less than a fifth of the county population. Statewide, AI/ANs account for nearly 17% of all cases despite representing only 10% of the population
- In Wyoming, AI/ANs account for over 22% of all COVID-19 cases statewide despite representing only 2.9% of the state population.¹⁵

¹¹ U.S. Department of Veterans Affairs. COVID-19 Pandemic Response Weekly Report.

https://www.va.gov/health/docs/VA_COVID_Response.pdf

¹² 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>

¹³ Centers for Disease Control and Prevention. COVID-19 Data Visualization. <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/data-visualization.htm>

¹⁴ New Mexico Department of Health. COVID-19 in New Mexico. <https://cvprovider.nmhealth.org/public-dashboard.html>

¹⁵ Wyoming Department of Health. COVID-19 Map and Statistics. <https://health.wyo.gov/publichealth/infectious-disease-epidemiology-unit/disease/novel-coronavirus/covid-19-map-and-statistics/>

- Similarly in Montana, where AI/ANs constitute about 6.6% of the state population, over 13% of confirmed COVID-19 cases are among AI/ANs.¹⁶

Most poignantly, in a data visualization of COVID-19 case rates per 100,000 by Tribal Nation created by the American Indian Studies Center at the University of California Los Angeles, **it was found that if Tribes were states, the top five infection rates nationwide would all be Tribal Nations.**¹⁷

The COVID-19 pandemic has further exposed the vast deficiencies in health care access, quality, and availability that exists across the Indian health system. Prior to COVID-19, the Indian health system was beset by an average 25% clinician vacancy rate¹⁸, and a hospital system that remains over four times older than the national hospital system.¹⁹ Limited intensive care unit (ICU) capacity to address a surge of COVID cases across many IHS and Tribal facilities has strained limited Purchased/Referred Care (PRC) dollars, creating further challenges that are contributing to rationing of critical health care services. Overall, per capita spending within IHS (\$3,779) is at only 40% of national health spending (\$9,409), making IHS the most chronically underfunded federal health care entity nationwide and thus severely ill-equipped to respond to COVID-19.

For example, while CDC has noted that hand-washing is the number one way of protecting against a COVID-19 infection, water and sanitation infrastructure in Indian Country is significantly underdeveloped. Approximately 6% of AI/AN households lack access to running water, compared to less than half of one percent of White households nationwide.²⁰ In Alaska, the Department of Environmental Conservation reports that over 3,300 rural Alaskan homes across 30 predominately Alaskan Native Villages lack running water, forcing use of “honey buckets” that are disposed in environmentally hazardous sewage lagoons.

Because of the sordid history of mineral mining on Navajo lands, groundwater on or near the Navajo reservation has been shown to have dangerously high levels of arsenic and uranium. As a result, roughly 30% of Navajo homes lack access to a municipal water supply, making the cost of water for Navajo households *roughly 71 times higher* than the cost of water in urban areas with municipal water access.²¹ In fact, in a new peer-reviewed study of 287 Tribal reservations and

¹⁶ Montana Department of Public Health and Human Services.

<https://dphhs.mt.gov/publichealth/cdepi/diseases/coronavirusmt/demographics>

¹⁷ University of California Los Angeles. American Indian Studies Center. Coronavirus in Indian Country: Latest Case Counts. Retrieved from https://www.aisc.ucla.edu/progression_charts.aspx

¹⁸ Government Accountability Office (GAO-18-580). <https://www.gao.gov/products/GAO-18-580>

¹⁹ Indian Health Service. 2016. IHS and Tribal Health Care Facilities’ Needs Assessment Report to Congress.

https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/RepCong_2016/IHSRTC_on_Facilities_NeedsAssessmentReport.pdf

²⁰ US Water Alliance. 2019. Closing the Water Access Gap in the United States. Retrieved from

http://uswateralliance.org/sites/uswateralliance.org/files/Closing%20the%20Water%20Access%20Gap%20in%20the%20United%20States_DIGITAL.pdf

²¹ Ingram, J. C., Jones, L., Credo, J., & Rock, T. (2020). Uranium and arsenic unregulated water issues on Navajo lands. *Journal of vacuum science & technology. A, Vacuum, surfaces, and films : an official journal of the American Vacuum Society*, 38(3), 031003. <https://doi.org/10.1116/1.5142283>

homelands, COVID-19 cases were found to be 10.83 times more likely in homes without indoor plumbing.²²

Substandard Care for AI/AN Veterans Before and During COVID-19 Pandemic

There are many reasons why the seating of a national Tribal advisory committee to the Secretary of the VA, as H.R. 2791 would accomplish, is critical towards improving care for Native Veterans. Through this seating, Tribal leaders, Native Veterans, and their advocates can engage in open and frequent dialogue directly with the Secretary to address longstanding patterns of substandard care experienced by Native Veterans at VA facilities

In a 2018 VHA Survey of Veteran Enrollees' Health and Use of Health Care, the VHA reported having 217,580 patients who self-identified as AI/AN – representing 2.5% of the agency's enrolled patient population.²³ Yet across the board, AI/AN Veterans report higher rates of issues around quality of care and accessibility that have undermined trust in the VHA system and left AI/AN Veterans significantly more vulnerable to adverse health outcomes, including for COVID-19. For instance, the 2018 survey found that only 66.9% of AI/AN Veterans reported that it was easy to schedule medical appointments in a reasonable time, compared to 78.7% of White Veterans. The same report found that only 67.2% of AI/AN Veterans reported easy access to the local VA or VA-approved facility (compared to 82.7% of White Veterans); and only 65.7% of AI/AN Veterans reported short wait times after arriving for an appointment (compared to 80.6% of White Veterans). Even more alarmingly, **only 79% of AI/AN Veterans reported receiving respect from VHA employees, and only 78.2% reported that VHA employees accepted them for who they are – percentages lower than any other ethnicity.**

AI/AN Veterans also reported the least satisfaction with three out of four indicators related to their healthcare decision-making process – reporting the least satisfaction with how healthcare problems were explained to them (72.4% compared to 84% among White Veterans); their personal level of participation in decisions about their healthcare (65.7% compared to 81.8% among White Veterans); and with explanations of their options for care (65.2 percent compared to 80.5% among White Veterans). **A whopping 45.2% of AI/AN Veterans reported prior dissatisfaction with the level of VA care received – nearly double the rate for White Veterans.**

These experiences of substandard care at VHA facilities have not miraculously disappear under the current COVID-19 crisis. In fact, it is much more likely that the negative experiences reported by AI/AN Veterans are contributing to even greater challenges in receiving sufficient, patient-centered care from VHA facilities during the COVID-19 pandemic. Moreover, while race-specific data on Veteran use of telehealth services during COVID-19 is unavailable, it is, unfortunately, safe to assume that the same experiences of inferior and inadequate care persist. These issues are likely exacerbated by pervasive gaps in broadband access in Indian Country. In a 2019 Federal Communications Commission (FCC) report, **only 46.6% of housing units on Tribal lands were reported to have a fixed terrestrial provider of 25/3 Mbps broadband service – a roughly 27**

²² Rodriguez-Lonebear, Desi PhD; Barceló, Nicolás E. MD; Akee, Randall PhD; Carroll, Stephanie Russo DrPH, MPH American Indian Reservations and COVID-19, Journal of Public Health Management and Practice: July/August 2020 - Volume 26 - Issue 4 - p 371-377 doi: 10.1097/PHH.0000000000001206

²³ Veterans Health Administration. 2018 Survey of Veteran Enrollees' Health and Use of Health Care.

https://www.va.gov/HEALTHPOLICYPLANNING/SOE2018/2018EnrolleeDataFindingsReport_9January2019Final508Compliance.pdf

point gap compared to homes on non-Tribal lands.²⁴ In addition, roughly 3% of people living on Tribal lands lack mobile LTE coverage, compared to only 0.2% of the total U.S. population.²⁵ These sobering statistics indicate that AI/AN Veterans are, once again, experiencing higher healthcare accessibility challenges than the general Veteran population as the COVID-19 pandemic continues.

COVID-19: Lack of Adequate VA and IHS Care Coordination

AI/AN Veterans are entitled to healthcare services from both the Veterans Health Administration (VHA) and the IHS. In Fiscal Year (FY) 2017, IHS reported that 48,169 active IHS users self-identified as Veterans.²⁶ According to the VA, more than 2,800 AI/AN Veterans are served at IHS facilities.²⁷ In instances where an AI/AN Veteran is eligible for a particular health care service from both the VA and IHS, the VA is the primary payer. Under section 2901(b) of the Patient Protection and Affordable Care Act (ACA), health programs operated by the IHS, Tribes and Tribal organizations, and urban Indian organizations (collectively referred to as the “I/T/U” system) are payers of last resort regardless of whether or not a specific agreement for reimbursement is in place. However, Congress has yet to exempt Native Veterans from copays for the care they receive at VHA facilities, creating further complications for care coordination and running afoul of treaty obligations to fully fund healthcare for all AI/AN People, including AI/AN Veterans. Congress must pass the bipartisan H.R. 4908.

Section 407(a)(2) of the Indian Health Care Improvement Act (IHCIA) reaffirms the goals of the 2003 Memorandum of Understanding (MOU) between the VHA and IHS established to improve care coordination for Native Veterans. In 2010, the VHA and IHS modernized their 2003 MOU to further improve care coordination for Native Veterans by bolstering health facility and provider resource sharing; strengthening interoperability of electronic health records (EHRs); engaging in joint credentialing and staff training to help Native Veterans better navigate IHS and VHA eligibility requirements; simplifying referral processes; and increasing coordination of specialty services such as for mental and behavioral health.

Of the twelve strategic goals of the 2010 MOU, four are directly or exclusively related to health information technology (HIT). Goal 2 is centered on improving care coordination, including through the establishment of standardized EHR mechanisms; Goal 3 is focused on improving care through the development and sharing of HIT to improve interoperability and joint development of applications and technologies; Goal 4 is specific to the development of implementation of new care technologies including and especially telehealth, tele-psychiatry, and tele-pharmacy; and Goal 6 revolves around improving availability of services through development of payment and reimbursement mechanisms, including as they relate to sharing and development of HIT. Yet in a 2019 Government Accountability Office (GAO) report on the VA-IHS MOU, 66% of VA, IHS and Tribal facilities surveyed in the report indicated significant challenges in accessing each

²⁴ Federal Communications Commission. 2019. Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018. <https://docs.fcc.gov/public/attachments/DOC-357269A1.pdf>

²⁵ U.S. Department of the Interior. 2020. Expanding Broadband in Indian Country.

<https://www.indianaffairs.gov/sites/bia.gov/files/assets/as-ia/ieed/pdf/Expanding%20Broadband%20in%20Indian%20Country%20Primer%20Final%203.17.20.pdf>

²⁶ Government Accountability Office. GAO-19-291. Retrieved from <https://www.gao.gov/assets/700/697736.pdf>

²⁷ VA/IHS listening session held on May 15, 2019

other's HIT systems, citing lack of EHR interoperability. In fact, the same report found that none of the fifteen performance measures created under the VA-IHS MOU have established targets to measure progress.

Since implementation of the 2010 MOU, the VHA has reported entering into 114 signed agreements with Tribal Health Programs (THPs), along with 77 implementation agreements to strengthen care coordination. While a single national reimbursement agreement exists between federally-operated IHS facilities and the VHA, THPs continue to exercise their sovereignty by entering into individual agreements with the VHA. From 2014 to 2018, those reimbursement agreements with THPs alone increased by 113%. Unfortunately, the VHA has largely failed during the COVID-19 pandemic to act on these existing partnerships and MOUs with IHS and Tribal programs to deliver resources, improve care coordination, and increase access to telehealth based delivery systems. According to the VHA COVID website, Navajo Nation is the only recipient of technical and personnel assistance, receiving a handful of respiratory therapists and nurses. The VHA also reported delivering 100 masks to AI/AN Veterans on the Cheyenne and Standing Rock lands. That is it. There is no further information on VHA efforts to act on its MOUs with IHS and Tribal Nations.

Conclusion

The federal government has a dual responsibility to AI/AN Veterans that must not be ignored. As the only national Tribal organization dedicated exclusively to advocating for the fulfillment of the federal trust responsibility for health, NIHB is committed to ensuring the highest health status and outcomes for Native Veterans. We applaud the House Committee on Veterans' Affairs for holding this important legislative hearing, **and urge swift passage of H.R. 2791 and H.R. 4908**. As always, we stand ready to work with Congress in a bipartisan manner to enact legislation that strengthens the government-government relationship, improves access to care for AI/AN Veterans, and raises health outcomes.