TESTIMONY OF CONRAD JACKET, BOARD MEMBER, ALBUQUERQUE AREA INDIAN HEALTH BOARD, INC.

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON APPROPRIATIONS, SUBCOMMITTEE ON INTERIOR, ENVIRONMENT AND RELATED AGENCIES

FISCAL YEAR 2027 INDIAN HEALTH SERVICES BUDGET

March 17, 2026

Thank you, Chairman Simpson, Ranking Pingree, and respected members of the Committee for the opportunity to provide this written testimony on behalf of the member tribes of the Albuquerque Area Indian Health Board, Inc. (AAIHB). AAIHB acknowledges and appreciates that there has been broad bipartisan Congressional support for addressing health and wellness issues facing Indian country.

AAIHB was established in 1980 and is a consortium of several federally recognized tribes in New Mexico and Southern Colorado.[1] AAIHB provides direct health care services not only to citizens of member tribes, but to citizens of other tribes throughout New Mexico, Southern Colorado, and West Texas. AAIHB's purpose is to assess and advocate for the well-being of 27 tribal communities through the improved development of public health services and health education. AAIHB is almost entirely federally funded and approximately one-third of our federal funding is from the Indian Health Service (IHS).[2]

As Congress knows, Indian tribes have a unique political and legal status recognized by the U.S. Constitution. The elimination or disruption of federal funding for Indian country has a huge impact on the ability of tribes and tribal organizations to provide essential services to American Indians and Alaska Natives. Indeed, the problems that face communities nationwide are far more severe for Indian communities, with tribes having far fewer resources to address basic health care needs and larger problems like substance abuse, mental health, and other issues.

[1] Member tribes include the To'Hajiilee Band of Navajos, the Ramah Band of Navajos, the Jicarilla Apache Nation, the Mescalero Apache Tribe, the Ute Mountain Ute Tribe, and the Southern Ute Indian Tribe. For financial purposes the AAIHB is considered a government because the AAIHB board of directors is appointed by members of tribal governments.

[2] Approximately two-thirds of our funding is from non-IHS programs within HHS.

We appreciate Secretary Kennedy's strong support for IHS and although we have not yet seen the President's FY27 Budget, we believe that it is critically important for Congress to understand that without any increases in the budget, health care related programs that Indian country relies on will experience broad across-the-board cuts as a result of medical inflation and the increasing number of patients being served through IHS direct service clinics and by tribally contracted or compacted programs under the Indian Self-Determination Education and Assistance Act, P.L. 93-638. For example, AAIHB has contracted some services from the IHS on behalf of tribes in our area, such as audiology—which provides hearing health services in rural tribal communities for tribal members including elders, veterans, and children. Basic increases in the IHS budget are necessary to keep pace with medical inflation and meet the needs of additional patients as explained below.

The National Tribal Budget Formulation Workgroup estimated that, to meet the current and expanded clinical services needs across Indian country, the IHS would require $54.6 billion. We understand that this is not feasible, but Congress must at least keep pace with medical inflation. Thus, we ask the Subcommittee to provide a minimum 8% increase across the board for all IHS clinical services and preventative health services. This modest increase would allow tribes, tribal organizations, and IHS direct service clinics to at least be able to maintain the level of care that is being provided today. More specifically, we are asking the Subcommittee to provide a $420 million programmatic increase to be distributed equally across all programs within the IHS clinical services programs and the preventative health services programs.

Moreover, we urge Congress to continue to protect and preserve advance appropriations for IHS. Congress has taken the lead on securing advance appropriations with bipartisan support. AAIHB applauds Congress for that achievement and respectfully requests that Congress continue to support advance appropriations for IHS. Having advance appropriations in recent fiscal years has ensured stability within the Indian healthcare system provided by tribes, tribal organizations, and IHS directly. This has allowed continuity of care for our patients and stability among professional health care staff. We also urge the Subcommittee to make funding for Contract Support Costs (CSCs) mandatory costs. The U.S. Supreme Court has been clear on the legal obligation of IHS to provide CSCs and making these funds mandatory would eliminate the conflict within IHS to meet its legal obligations while balancing funding for other discretionary line items.

AAIHB continues to support increased sanitation funding. The COVID-19 pandemic highlighted that Indian country lacks the most basic infrastructure necessary to ensure healthy communities. Many of our member tribes lack access to good sanitations systems, which means people throughout Indian country do not have functioning septic or waste disposal systems. We urge Congress to increase funding in this area.

We also urge Congress to continue to support and fund Medicaid with expanded coverage, at a minimum for American Indians and Alaska Natives (AI/AN). This must include all IHS AI/AN beneficiaries because that group includes more than just enrolled tribal members. And tribally contracted and compacted programs, like ours, as well as IHS direct service clinics are required to serve all AI/AN beneficiaries living in our service areas. Medicaid reimbursements help offset—but do not eliminate—the lack of sufficient funding received through IHS.

Within AAIHB is the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC), which is a designated public health authority and 1 of only 12 tribal epidemiology centers nationwide. AASTEC is funded through the Clinical Services/Hospitals and Health Clinics line item in the Human Health and Services budget, as well as through some CDC grants. The work performed by AASTEC is critical to our overall ability to manage public health information systems, investigate diseases of concern, manage disease prevention and control programs, and respond to public health emergencies in collaboration with our member tribes. As such we also urge Congress to continue to support funding in these areas because AASTEC programs work in synergy with other AAIHB and tribally led health programs funded by IHS.

As the Administration carries out realignment efforts within the Indian Health Service, we strongly urge this subcommittee and Congress ensure funding for Indian Health Service programs remains a priority. In particular, we ask this Committee to ensure the following programs are fully funded: Division of Epidemiology and Disease Prevention, Tribal Epidemiology Centers (TEC), Special Diabetes Program for Indians (SDPI), Community Health Representatives (CHR), Division of Behavioral Health, Injury Prevention, and HIV/HCV/STI Program. These programs provide critical, life-saving services and deliver substantial value to Tribes and Tribal organizations nationwide. We also request that Congress provide flexibility in a budget to ensure that if realignment efforts result in changes to how these programs are structured or housed within the Indian Health Service, congressional funding will

remain available to Indian country for carrying out the same program purposes. Realignment should not result in less funding for Indian country.

Eliminating funding streams that tribes and tribal organizations, like AAIHB, rely on will only further exacerbate the health disparities that AI/ANs face. As Congress considers the FY 2027 Budget, we urge you to protect all IHS and non-IHS funding sources tribes and tribal organizations depend on. Thank you.