

**Statement By**

**Darrell LaRoche, Deputy Director for Management Operations  
Indian Health Service  
U. S. Department of Health and Human Services**

**Before the  
Committee on Indian Affairs  
United States Senate**

**Legislative Hearing**

**S. 2098, Southcentral Foundation Land Transfer Act of 2025  
S. 1055, Indian Health Service Emergency Claims Parity Act  
S. 699, Purchased and Referred Care Improvement Act of 2025**

**February 4, 2026**

Good afternoon, Madam Chair, Vice Chairman Schatz, and Members of the Committee. I am Darrell LaRoche, Deputy Director for Management Operations at the Indian Health Service (IHS). Thank you for the opportunity to provide testimony on, S. 2098, the Southcentral Foundation Land Transfer Act of 2025, S. 1055, the Indian Health Service Emergency Claims Parity Act, and S. 699, the Purchased and Referred Care Improvement Act of 2025.

The Indian Health Service (IHS) is an agency within the Department of Health and Human Services (HHS), and our mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest level. This mission is carried out in partnership with AI/AN Tribal communities through a network of over 600 Federal and Tribal health facilities and 41 Urban Indian Organizations that are located across 37 states and provide health care services to approximately 2.8 million AI/AN people annually.

The IHS was established by statute and is the principal Federal health care provider and health advocate for AI/AN people. The IHS was established to carry out the responsibilities, authorities, and functions of the United States, as provided in Federal statutes and treaties to provide health care services to Indians and Indian tribes. IHS is the 18th largest health care system in the United States.

**S. 2098**

S. 2098, the Southcentral Foundation Land Transfer Act would direct the Secretary of the Health and Human Services to convey certain land in Anchorage, Alaska to the Southcentral Foundation by warranty deed.

Under S. 2098, the Southcentral Foundation (SCF) would not provide the Federal Government with any consideration for the property. In addition, the Federal Government would not retain any

reversionary interest in the property in the event SCF ceases to provide health care services. The bill would also require completing the conveyance as soon as practicable, but no later than two years from enactment. S. 2098 would free SCF of any liability that it otherwise would have assumed for any environmental contamination that may have occurred on or before the date of the transfer, except that the Secretary would not be liable for any contamination that occurred after the date that SCF controlled, occupied, and used the property.

We have seen similar bills of this sort move through Congress in previous years mandating transfer by warranty deed rather than by quitclaim deed. As with previous similar bills, HHS is concerned about the details of S. 2098.

In particular, the bill describes the use of the conveyance to be for health care purposes but does not specify the actual health programs in service to American Indians and Alaska Natives. Thus, conveyance of this property under S. 2098 does not guarantee health care services specifically for American Indians and Alaska Natives.

In addition, barring retention of a reversionary interest (as is statutorily required for transfers of property under the Indian Self-Determination and Education Assistance Act) deprives HHS of a means to ensure that the property will return to HHS ownership if, at any time, the property ceases to be used for the provision of health services in furtherance of the purposes of this bill. This means the Federal Government would not be able to impose any obligation, term, or condition on the Tribal Health Organization with regard to the property. It effectively deprives HHS of a means to ensure that the property will continue to be used for health care services.

HHS prefers to avoid Indian Self-Determination and Education Assistance Act (ISDEAA) transfers by warranty deed as such deeds create the potential for liability if a competing property interest is subsequently discovered. The requirements of this bill differ from the Secretary's existing statutory property disposal procedures including the ISDEAA and IHS regulations at 25 C.F.R. Part 900, Subpart I.

S. 2098 Section 4(a)(1) regarding "Conditions" mandates the conveyance by warranty deed. However, as stated above, the HHS practice under established procedures is to convey property by quitclaim deed. If the Secretary conveys the property by warranty deed, HHS would be responsible for clearing any liens or encumbrances, not just at the time of conveyance, but anytime thereafter. Therefore, HHS can be called upon at any time to defend the title and clear encumbrances, which is a potential liability of unknown cost.

Again, we welcome the opportunity to work with this Committee and the drafter of the bill on prospective amendments, including the reference to the environmental warranty required by the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9620(h)).

With these concerns in mind, HHS supports the purposes of the bill to convey the property to the Southcentral Foundation in order to facilitate providing improved health services to American Indians and Alaska Natives in Alaska.

S. 1055, the Indian Health Service Emergency Claims Parity Act, and S. 699, the Purchased and

Referred Care Improvement Act of 2025, both relate to the IHS Purchased/Referred Care Program (PRC). The Administration and the Department goals are to improve health outcomes for American families and protect patients from medical debt. Unfortunately, too many families across the country – including many families in Indian Country – are still saddled with crushing medical debt. This debt often forces families into making untenable decisions, between paying off the debt and purchasing lifesaving medications or putting food on the table. Medical debt is a barrier to economic mobility for working families across the country and exacerbates and contributes to existing disparities in health care by race, health, status, and income.

As this Committee may be aware, patients are not liable for PRC costs under section 222 of the Indian Health Care Improvement Act. Patients should not be forced into collections because of unpaid medical bills. American Indians and Alaska Natives – who already suffer disproportionately low life expectancies and disproportionate disease burden – should not be put at financial risk for seeking medical treatment.

### **Purchased/Referred Care Program**

In 1921, Congress enacted the Snyder Act, authorizing the Bureau of Indian Affairs (BIA) to provide health services to Indian tribes throughout the United States, and also contract out these health services to health care providers as needed. In 1955, the Transfer Act moved health care from BIA to the Department of Health, Education, and Welfare, the predecessor of HHS. Subsequently, those authorities have been carried out by IHS, which also operates under the authority of the Indian Health Care Improvement Act (IHCIA). The IHS receives annual lump-sum appropriations to carry out its authorities, including those under the Snyder Act and IHCIA. In January 2014, the Consolidated Appropriations Act, 2014, renamed the Contract Health Services program as the PRC program. IHS uses the PRC program to purchase health services that are not reasonably accessible or available through the IHS network.

PRC funds are used to supplement and complement other healthcare resources available to IHS-eligible American Indian/Alaska Natives — the IHS’ defined service population. Because IHS appropriations do not fully fund the healthcare needs of the AI/AN population, the PRC program must rely on specific regulations relating to eligibility, notification, residency, and a medical priority rating system. The 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. These mechanisms enhance the IHS’s ability to stretch the limited PRC dollars and are designed to extend services to more in the AI/AN community.

The Department and the IHS have worked hard to prioritize improvements to the PRC program and ensure that patients have access to accessible – and affordable – quality care. In fact, strengthening the Purchased/Referred Care Authorization and Payment Process and effectively managing PRC carryover balances was one of the top three goals of the IHS 2024 Work Plan. In June 2022, the HHS Office of Inspector General closed the seven open recommendations to improve the PRC program from the April 2020 Report<sup>1</sup> after the IHS implemented a multitude of corrective actions and staff trainings. Past implementation of PRC rates and Medicaid expansion

---

<sup>1</sup> A-03-16-03002

have increased the PRC Program's purchasing power to provide more care for our beneficiaries.

Just over two years ago, the IHS updated the medical priority levels and issued funding guidance to support a holistic, balanced, outcome-oriented, and consistent referral priority system. This change maximizes the efficiency of resource allocation and promotes evidence-based strategies that balance the preventive, mental health, chronic, and acute care needs in our service population with the goal of improved patient satisfaction and health outcomes. This balanced approach replaced a hierarchical concept that placed a higher emphasis on acute disease complications versus providing care for chronic and disease prevention strategies. As a result, the IHS has moved to re-assign and reclassify some preventative care services to a higher priority level within the IHS medical priority levels.

The IHS implemented routine monitoring to address some of the more common and difficult issues facing PRC programs from paying timely and appropriately for authorized care. This includes addressing provider billing issues, Fiscal Intermediary pending claims, and alternate resource issues. These efforts will go a long way to improve the PRC program and benefit to our PRC-eligible population.

The IHS acknowledges that there is still more to be done. As with other programs within the IHS, staff vacancies, space limitations, and proper training of staff at some sites have negatively impacted the ability to carry out PRC goals. The IHS continues to support new strategies to develop the workforce and leverage advanced practice providers and paraprofessionals to improve the access to quality care in AI/AN communities.

### **S. 699, Purchased and Referred Care Improvement Act of 2025**

The Purchased and Referred Care Improvement Act of 2025 would amend the Indian Health Care Improvement Act to address liability for payment of charges or costs associated with the provision of purchased/referred care services.

S. 699 would amend IHCIA by requiring the Secretary of HHS to notify a purchased/referred care provider and any patient who receives purchased/referred care by the Service that the patient is not liable to any provider, debt collector, or any other person for the payment of any charges or costs associated with the provision of the purchased/referred care not later than 5 business days after receipt of a notification of a claim by a provider of the purchased/referred care.

S. 699 would further require the Secretary, through the Service, and in consultation with Indian Tribes, and within 120 days, establish and implement procedures to allow a patient that paid out-of-pocket for purchased/referred care authorized by the Service under the IHCIA to be reimbursed by the Service for that payment not later than 30 days after the date on which the patient submits documentation to the Service under Section 2(d)(1)(B), Submitting Documentation, which includes submission electronically or in-person at a Service facility. Further, S. 699 would not apply to a PRC program operated by an Indian Tribe under the Indian Self Determination and Education Assistance Act unless expressly agreed to by the Indian Tribe.

S. 699 would also require the Secretary, within 180 days after enactment of S. 699, in consultation with Indian Tribes, to update applicable provision of the relevant provisions and sections of the

## Indian Health Manual.

This bill also proposes adding a new subsection (d) to section 222 of the Indian Health Care Improvement Act, and the Department's edits here account for other applicable authorities, such as the payer of last resort statute. Simply put, a patient should not be expected to pay out-of-pocket for PRC-authorized services, due to the existing patient protections in section 222, but if patients choose to do so in anticipation of reimbursement under this new subsection (d), they will need to be careful not to pay before alternate resources or in excess of PRC rates. Thus, as drafted, the bill may cause additional uncertainty for patients seeking care. Additionally, the Department has suggested a change to the timeline specified in subsection (d). While the IHS believes a 30-day timeline may be challenging to implement and impractical on an administrative level, PRC program should be able to accomplish this within 45 days.

In the overwhelming majority of cases, the PRC payment should occur between the PRC program and the PRC provider. As noted, the Department is concerned that there may be unintended effects of this statutory change on patients – that the bill may make the reimbursement process more confusing and difficult. Specifically, we are concerned that patients might make payments to a provider when it is not necessary, or in amounts greater than would be required. This could quickly undermine the purpose of the statute and expose these patients to financial harm, rather than protecting them from liability. The IHS would seek to educate patients on this issue but suggests that the drafters consider potential adverse consequences in this regard.

For the Committee's situational awareness, the Department also notes while the statute presently prohibits a provider from seeking payment from a patient, the IHS consistently witnesses that this is not being followed by bad actors. IHS notes that there are no consequences included in the proposed bill for a provider, debt collector, or any other person who violates this provision. Additionally, when a violation occurs, there can be impacts to the patient's credit that are not easy for the patient or the IHS to resolve.

### **S. 1055, Indian Health Service Emergency Claims Parity Act**

The Indian Health Service Emergency Claims Parity Act would amend the Indian Health Care Improvement Act to modify the notification requirement for emergency PRC. The current timeframe for non-elderly or disabled individual notification must be made within 72 hours, per current PRC regulation. If the individual is elderly (age 65 and older) or disabled, under existing law, section 406 of the Indian Health Care Improvement Act (25 U.S.C. 1646), the notification timeframe for such individual is within 30 days. The IHS in recent updates to the Indian Health Manual, we lowered the age for elderly to age 55, in order for more individuals to have 30 days to make notification.

The only concern with S. 1055 concerns flexibility. There may be a future need to amend such timeframe for notification of treatment or admission to more than 15 days for individuals not elderly or disabled. Such change would need an amendment to this statutory limitation if S.1055 were passed by Congress and signed into law. This codification, would limit the Service's current regulatory authority to no more than 15 days timeframe for such notifications.

All things considered, the Department shares the same goal as the drafters – to improve the PRC

program, protect patients from medical debt, and ensure that American Indians and Alaska Natives throughout Indian Country have access to high quality and affordable care. We look forward to continuing our work with Congress on these bills, and as always, welcome the opportunity to provide technical assistance as requested by the Committee or its members.

Thank you again for the opportunity to testify today. HHS is committed to working closely with tribal communities and other external partners and understands the importance of working together to address the needs of American Indians and Alaska Natives.