The Confederated Tribes of the Colville Reservation

Prepared Statement of the Honorable Dayna Seymour
Chair, Health and Human Services Committee
Colville Business Council
Confederated Tribes of the Colville Reservation

Senate Committee on Indian Affairs

Legislative Hearing on S. 699, the "Purchased and Referred Care Improvement Act of 2025"

February 4, 2026

The Confederated Tribes of the Colville Reservation ("Colville Tribes" or the "CCT") appreciates the Committee holding today's hearing on S. 699, the "Purchased and Referred Care Improvement Act of 2025." The CCT developed the bill in response to a litany of issues it has endured with the Indian Health Service's ("IHS's") mismanagement of the Purchased-Referred Care ("PRC") program on the Colville Reservation. The CCT appreciates the leadership of Senators Rounds and Cantwell in introducing this important legislation.

On October 1, 2025, the CCT assumed all IHS functions under title I of the Indian Self-Determination and Education Assistance Act. Prior to that, the CCT was a direct service tribe, which meant that health care and associated billing and administrative support was provided by IHS employees. The primary reason the CCT contracted IHS functions was to enable the CCT to have direct control over the PRC program and not have to rely on IHS to administer it. Since the CCT assumed IHS functions, PRC has improved, but we are still dealing with a backlog of issues caused by IHS's prior administration of the program.

The PRC Improvement Act would clarify IHS's duties to inform providers that tribal members are not liable for PRC bills. The bill would also require IHS to reimburse tribal members who have paid medical bills out-of-pocket for PRC services when IHS failed to pay the PRC provider for those services.

Although now considered a single Indian tribe, the Confederated Tribes of the Colville Reservation is a confederation of twelve aboriginal tribes and bands from across eastern Washington state, northeastern Oregon, Idaho, and British Columbia. The present-day Colville Reservation is in north-central Washington state and was established by Executive Order in 1872. The Colville Reservation covers more than 1.4 million acres, and its boundaries include portions of both Okanogan and Ferry counties, two of the lowest median income counties in the state. Geographically, the Colville Reservation is larger than the state of Delaware and is the largest Indian reservation in the pacific Northwest.

A. **Mismanagement of the PRC Program on the Colville Reservation**

IHS has a trust responsibility to provide health care to Indian beneficiaries through direct care at IHS or tribally operated health facilities and through the PRC program. The PRC program provides IHS beneficiaries with specialty or other care from private, non-IHS health providers when such care is unavailable at IHS facilities. The Colville Tribes, like other Indian tribes in the Portland IHS Area, is particularly reliant on the PRC program because of the lack of inpatient IHS hospital facilities in the Portland Area. Without full-service hospital facilities, many health care services must be referred to private providers through the PRC program because those services are not available in outpatient clinics.

Private health providers voluntarily participate in the PRC program by executing an agreement with IHS. For tribal members to receive health care services through the PRC program, IHS must approve a purchase order for the services, which is essentially a voucher that the PRC provider relies on to get paid by IHS for providing the services. Even with a duly authorized purchase order, private providers will, as a matter of course, require tribal members who seek PRC services to sign boilerplate forms that provide that the patient will be financially responsible for any medical bills that private insurance or IHS does not pay.

When Congress reauthorized the Indian Health Care Improvement Act in 2010, it amended section 222[1] of that Act, which relates to liability for payment. Section 222 states that for PRC care authorized by IHS, the patient is not liable for payment associated with the care. It also requires IHS to communicate this to both the PRC provider and the patient within five business days after receiving notice of a claim by the PRC provider.

IHS has never uniformly or effectively implemented section 222 at federally managed service units, including on the Colville Reservation. Beginning in 2017, IHS moved the PRC program from the local Colville Service Unit to the Portland Area Office for reasons that were never fully explained to the Colville Tribes. This change, which continued until October 2022, meant that federal employees 350 miles away from the Colville Reservation were responsible for approving and processing purchase orders, communicating with local PRC providers, ensuring that providers were paid in a timely manner, and otherwise administering the PRC program.

During the time the Portland Area administered the PRC program for the Colville Service Unit, IHS personnel did not provide the notice to providers and patients required by section 222 on a timely or consistent basis, if at all. Payment for purchase orders to our local PRC providers consistently went unpaid, which prompted the providers to pursue tribal members for payment of the bills when the providers did not receive payment from IHS. Our local IHS personnel, most of whom are Colville tribal members, went to great efforts to try to get PRC services for our tribal members and otherwise make the PRC program workable. The IHS Portland Area Office, however, would impose new obstacles at every turn. Again, this was the CCT's primary motivation to contract IHS functions last fall.

For every year since 2018, IHS accumulated a backlog of between 1500 to 2000 purchase orders that were either unpaid or not fully closed out. Prior to commencing negotiations with IHS to assume

[1] Section 222 is codified at 25 U.S.C. § 1621u.

IHS functions, the Colville Tribes believed that of the approximately $30 million in PRC carryover funds in the IHS Portland Area, as much as $24 million of that amount was attributable to open purchase orders IHS authorized for tribal members that utilized the Colville Service Unit. Near the end of our negotiations, however, we were shocked to learn that the carryover amount of PRC at the Colville Service Unit *was an astonishing $42 million*. This carryover amount is money that should have been spent on health care for our tribal members had IHS administered the PRC program properly.

B. IHS Mismanagement has Inflicted Hardships on Tribal Members and Eroded Health Care Delivery on the Colville Reservation

IHS's mismanagement of the PRC program—specifically its failure to pay PRC providers—created a domino effect of negative outcomes. Since most tribal members cannot afford to pay medical bills, when IHS does not pay PRC providers and the providers do not receive payment from tribal members, the providers will usually assign the debt to third party debt collectors. Even though section 222 generally states that individuals are not liable for bills associated with authorized PRC services, the PRC providers rely on the consent form that they require all patients to sign as an independent basis to pursue the debt.

Being referred to collection agencies negatively impacts tribal members' credit scores, which results in higher interest rates for mortgages and consumer loans and, in some cases, the inability to obtain credit or financing altogether. Because of IHS's mismanagement of the PRC program, many tribal members on the Colville Reservation, including elected tribal officials, have had their credit negatively impacted through no fault of their own. For those tribal members who are able and choose to pay medical bills from PRC services out of fear of having their credit impacted by collections activity, IHS does not have a readily accessible process to reimburse those payments.

IHS's mismanagement of the PRC program has resulted in many Colville tribal members avoiding IHS altogether out of fear of being saddled with medical bills and having their credit negatively affected. When tribal members shun IHS facilities, the user population for a given IHS service unit will decrease, which ultimately will reduce the service unit's allocation of PRC funds under the PRC distribution formula. This has been happening at the Colville Service Unit for years and our allocation of PRC has decreased because of it.

Yet another consequence of IHS's mismanagement is a dwindling number of local health providers that are willing to participate in the PRC program. Like most rural communities, north central and northeastern Washington has a limited number of private health providers. When these providers cannot predict if or when IHS will pay them for PRC services, they have little reason to continue participating in the PRC program.

We are aware of PRC providers that have refused to schedule appointments with tribal members with unpaid balances from previous PRC purchase orders. We are also aware of providers that have dropped out of the PRC program because of IHS's prior administration of the program. The limited and shrinking number of PRC providers is aggravated by the high vacancy rate of IHS employed health providers. There has been a 60 percent vacancy rate at the Colville IHS Service Unit and many of these

vacancies have been unfilled for months, or even years. Now that the CCT has assumed IHS functions, we are working hard to fill these vacancies, but it will not happen overnight.

C. The PRC Improvement Act would Provide Overdue Clarity to the PRC Program

S.699 would amend section 222 of the IHCIA to clarify that individuals that receive PRC care that is authorized by IHS shall not be liable to any "provider, debt collector, or other any other person." The current section 222 does not mention debt collectors.

The inclusion of "[n]otwithstanding any other provision of law" at the beginning of section 222(a) is intended to preempt the boilerplate consent forms that providers customarily require patients to sign before receiving care from being used by PRC providers to assign medical bills generated by the visit (that IHS does not pay) to collection agencies. Preempting the use of these forms would keep the focus and responsibility for paying the medical bills with IHS, where it should be.

There is nothing in current law or regulations that prohibits IHS from reimbursing beneficiaries when beneficiaries pay medical bills arising from PRC services out-of-pocket to avoid damage to their credit. IHS, however, has informally indicated that it is unable to reimburse for reasons that it has never explained to the Colville Tribes.

The PRC Improvement Act would add a new subsection to section 222 that requires IHS to reimburse individuals who paid medical bills out-of-pocket from IHS authorized PRC services. The new subsection requires IHS to implement reimbursement procedures by allowing individuals to submit evidence of payment electronically or in-person at IHS facilities. On the Colville Reservation, many elders who have been sent to collections for unpaid IHS PRC bills require the option to provide documents in-person instead of online. This provision is intended to accommodate those circumstances.

The CCT has discussed this reimbursement provision in detail with IHS officials and makes two observations. First, based on informal estimates we obtained communicating with IHS, the number of PRC beneficiaries that are currently in collections and have the financial means to pay a medical bill out-of-pocket is extremely low. And for those individuals who did pay a medical bill out-of-pocket to avoid damage to their credit, the money that IHS would reimburse would be in the PRC carryover funds for that Service Unit. In other words, *the reimbursement requirement in the bill would not cost IHS or taxpayers anything because the money is sitting in the IHS system as unreconciled PRC funds*.

While there are many issues with IHS's management of the PRC program, the PRC Improvement Act would address the critical issue of tribal members being sent to collections agencies. The Colville Tribes urges the Committee to take whatever steps necessary to secure enactment of S.699 into law.

Finally, the Colville Tribes also fully supports S.1055, "Indian Health Service Emergency Claims Parity Act." Extending the timeframe from 72 hours to 15 days for reporting PRC emergency care services to IHS will minimize instances of PRC care being denied for emergency care.

***