# TOWARD TRIBAL HEALTH SOVEREIGNTY

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## INTRODUCTION

The COVID-19 pandemic has highlighted existing gaps in public health systems across the country,[1] including federal Indian health systems.[2] Despite treaty and trust obligations to provide health care to American Indians and Alaska Natives, the federal government has consistently underfunded Indian health facilities.[3] Federal Indian health programming remains piecemeal, often falling victim to congressional

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1. *See generally* David Blumenthal, Elizabeth J. Fowler, Melinda Abrams & Sara R. Collins, *Covid-19—Implications for the Health Care System*, 383 NEW ENG. J. MED. 1483 (2020).

2. Aila Hoss, *COVID-19 and Tribes: The Structural Violence of Federal Indian Law*, 2 ARIZ. ST. L.J. ONLINE 162, 167–69 (2020).

3. U.S. COMM'N ON C.R., BROKEN PROMISES: CONTINUING FEDERAL FUNDING SHORTFALL FOR NATIVE AMERICANS 6 (2018), https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf [https://perma.cc/7VJW-JLW8].

politics for continued funding,[4] requiring inter-Tribal competition for grant and cooperative agreement funding[5] or Tribal cost sharing.[6]

Tragically, yet unsurprisingly, due to failures in federal Indian health policy,[7] many American Indian and Alaska Native communities have experienced health inequities throughout the pandemic.[8] In several states, American Indians experienced higher rates of COVID-19 infections, as well as worse health outcomes—including higher mortality—than their non-Indian counterparts.[9]

By exercising their inherent sovereignty as Tribal nations, many Tribes have mitigated some of the failings in federal Indian health policy in their COVID-19 responses.[10] Unfortunately, lack of engagement with

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4. *See Latest Legislative Updates*, NAT'L INDIAN HEALTH BD., https://www.nihb.org/sdpi/legislative_updates.php [https://perma.cc/9JRT-BBUY] (last visited Mar. 6, 2022).

5. *See, e.g.*, CTR. FOR STATE, TRIBAL, LOC., & TERRITORIAL SUPPORT, CTRS. FOR DISEASE CONTROL & PREVENTION, CDC COVID-19 FUNDING FOR TRIBES (2020), https://www.cdc.gov/tribal/documents/cooperative-agreements/CDC-COVID-19-Funding-for-Tribes-August-2020-508.pdf [https://perma.cc/KQW6-L2ET]; *Budget, Grants, and Funding*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 5, 2021), https://www.cdc.gov/tribal/consultation-support/funding/index.html [https://perma.cc/B3DZ-RYF8].

6. *See* 42 U.S.C. §§ 5170(c), 5191(c); 44 C.F.R. § 206.47 (2021).

7. *See* Hoss, *supra* note 2, at 167–69.

8. *See Hospitalization and Death by Race/Ethnicity*, CTRS. FOR DISEASE CONTROL & PREVENTION (Feb. 1, 2022), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html [https://perma.cc/4SFE-J8TK]; *COVID-19 Cases by Race/Ethnicity*, KAISER FAM. FOUND. (Jan. 24, 2022), https://www.kff.org/other/state-indicator/covid-19-cases-by-race-ethnicity/ [https://perma.cc/RJ4A-XC2X].

9. *See* Sarah M. Hatcher et al., *COVID-19 Among American Indian and Alaska Native Persons—23 States*, *January 31–July 3, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1166 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6934e1-H.pdf [https://perma.cc/C78H-9M4A]; Emma Gibson, *Analysis: Native Americans Infected with COVID-19 at Higher Rates in Arizona*, ARIZ. PUB. MEDIA (July 10, 2020), https://news.azpm.org/p/coronavirus/2020/7/10/176298-analysis-native-americans-infectedwith-covid-19-at-higher-rates-in-arizona/ [https://perma.cc/YQ5K-7C2H]; Elise Kaplan & Theresa Davis, *'Huge Disparity' in COVID-19 Death Rates for Native Americans in NM*, ALBUQUERQUE J. (May 31, 2020, 12:05 AM), https://www.abqjournal.com/1461218/huge-disparity-in-covid19-death-rates-for-nativeamericans-in-nm.html [https://perma.cc/TY8Z-B97J]; Danielle Kaeding, *Health Disparities Leave Native Americans More Vulnerable to COVID-19*, WIS. PUB. RADIO (July 13, 2020, 6:30 AM), https://www.wpr.org/health-disparities-leave-native-americans-more-vulnerable-covid-19 [https://perma.cc/F55P-7DXC].

10. *See, e.g.*, The Associated Press, *South Dakota Tribe Sues Feds to Keep COVID-19 Checkpoints*, ABC NEWS (June 24, 2020, 4:31 PM), https://abcnews.go.com/Health/wireStory/south-dakota-tribe-suesfeds-covid-19-checkpoints-71437306 [https://perma.cc/F6TN-92S7]; Lynda V. Mapes, *Washington State Tribes, Allies Mobilize to Gather Medical Protection Needed in Coronavirus Fight*, SEATTLE TIMES (May 20, 2021, 3:36 PM), https://www.seattletimes.com/seattle-news/washington-state-tribes-allies-mobilize-to-gather-medical-protection-needed-in-

Tribes remains the norm for many government agencies.[11] This infringes on Tribal sovereignty and undermines the efficacy of Tribal public health programming.[12]

Although federal law defines Tribal sovereignty as the "right . . . [of Tribes] to make their own laws and be ruled by them,"[13] Tribes have been exercising their sovereign powers since long before the establishment of the United States. For the purposes of this Essay, I discuss Tribal health sovereignty in the context of a Tribe's ability to make, implement, and enforce its own health programs and policies based on its culture and values. Tribal health sovereignty must also include adequate oversight and accountability over federal Indian health obligations. This, of course, is just a snapshot of the ways in which a Tribe may exercise its health sovereignty. I argue that reforms in federal Indian health policy are essential to securing Tribal health sovereignty.

This Essay begins by briefly describing Tribal governments and their relationships with the federal government under federal law. It then describes the inherent authority of Tribes to engage in public health activities. Next, this Essay describes Indian health systems under existing law, arguing for more Tribal-driven health programming and highlighting the legal barriers to achieving this. This Essay concludes by making specific, concrete recommendations for reforms under federal law and describes how these reforms can promote Tribal health sovereignty. Tribal

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coronavirus-fight/ [https://perma.cc/ZSN3-8U2E]; Patty Talahongva, *Dean Seneca: 'Optimistic' Tribes Are Stepping Up to the Plate During Pandemic*, INDIAN COUNTRY TODAY (Aug. 12, 2020), https://indiancountrytoday.com/newscasts/dean-seneca-optimistic-tribes-are-stepping-up [https://perma.cc/H5QV-25P4]; Aila Hoss & Heather Tanana, *Upholding Tribal Sovereignty and Promoting Tribal Public Health Capacity During the COVID-19 Pandemic*, *in* ASSESSING LEGAL RESPONSES TO COVID-19, at 77, 77–79 (Scott Burris, Sarah de Guia, Lance Gable, Donna E. Levin, Wendy E. Parmet & Nicolas P. Terry eds., 2020), https://static1.squarespace.com/static/5956e16e6b8f5b8c45f1c216/t/5f4d6578225705285562d0f0/1598908033901/COVID19PolicyPlaybook_Aug2020+Full.pdf [https://perma.cc/DS9X-XYLR]. For examples of tribal efforts to respond to the COVID-19 pandemic, see Kewa Pueblo (N.M.), INDIANZ.COM (Aug. 11, 2020), https://www.indianz.com/covid19/?p=7781 [https://perma.cc/MC98-7DKT]; Nina Lakhani, *Native American Tribe Takes Trailblazing Steps to Fight Covid-19 Outbreak*, GUARDIAN (Mar. 18, 2020, 1:25 PM), https://www.theguardian.com/us-news/2020/mar/18/covidcoronavirusnative-american-lummi-nation-trailblazing-steps [https://perma.cc/2Q9G-2U3S]; *How the Cherokee Nation Is Beating Back COVID*, SLATE (Dec. 8, 2020, 5:00 AM), https://slate.com/podcasts/what-next/2020/12/the-cherokee-nation-is-showing-real-leadership-in-the-face-of-the-coronavirus [https://perma.cc/RDW2-36ND].

11. Sahir Doshi, Allison Jordan, Kate Kelly & Danyelle Solomon, *The COVID-19 Response in Indian Country: A Federal Failure*, CTR. FOR AM. PROGRESS (June 18, 2020), https://www.americanprogress.org/article/covid-19-response-indian-country/ [https://perma.cc/EB79-E4PE].

12. *Id.*

13. *Williams v. Lee*, 358 U.S. 217, 220 (1959).

health sovereignty must center on Tribal law[14] and also will require reforms in state law.[15] These two important issues are outside the scope of this Essay.

When referring to the Indigenous people of what is commonly referred to as the United States, this Essay uses various terms, including American Indian and Alaska Native, Native, Indian, and Indigenous. Depending on the context, each of these can be appropriate and is used in practice.[16] This Essay capitalizes these terms, as well as "Tribe" and "Tribal."

## I. TRIBAL SOVEREIGNTY AND FEDERAL INDIAN LAW

Since time immemorial, Tribes have existed as distinct sovereign nations, governing their people and protecting their lands.[17] Colonization and genocide diminished Indigenous populations and undermined Tribal governments.[18] Yet Tribes have persisted. The United States recognizes the sovereignty of 574 Tribes.[19] Tribal sovereignty is a Tribe's "right . . . to make their own laws and be ruled by them."[20] It is a "plenary and

14. *See, e.g.*, Danielle Hiraldo, Kyra James & Stephanie Russo Carroll, *Case Report: Indigenous Sovereignty in a Pandemic: Tribal Codes in the United States as Preparedness*, FRONTIERS SOCIO., Mar. 2021, at 2; AILA HOSS, TRIBES ARE PUBLIC HEALTH AUTHORITIES: PROTECTING TRIBAL SOVEREIGNTY IN TIMES OF PUBLIC HEALTH CRISIS 5 (2021), https://static1.squarespace.com/static/5930883f17bffcfab9debf8d/t/5ff396bd9d513670e3c76471/1609799358131/Tribes+are+Public+Health+Authorities+FINAL.pdf [https://perma.cc/FG8G-JNHF].

15. *See, e.g.*, Gabriel S. Galanda, *Advancing the State-Tribal Consultation Mandate*, INDIAN COUNTRY TODAY (Sept. 12, 2018), https://indiancountrytoday.com/archive/advancing-the-state-tribal-consultation-mandate [https://perma.cc/W6YJ-AN9R]; Diana Cournoyer, *In Support of Tribal-State Data Sharing Partnerships and Cooperative Agreements*, NAT'L CONG. OF AM. INDIANS (Oct. 2019), https://www.ncai.org/resources/resolutions/in-support-of-tribal-state-data-sharing-partnerships-and-cooperative-agreements [https://perma.cc/KQP3-E8YS].

16. *See* ICT Staff, *Native American vs. Indian*, INDIAN COUNTRY TODAY (Sept. 13, 2018), https://indiancountrytoday.com/archive/native-american-vs-indian [https://perma.cc/5KLK-E9VT]; NAT'L CONG. OF AM. INDIANS, TRIBAL NATIONS AND THE UNITED STATES: AN INTRODUCTION 11, 24 (2020), https://www.ncai.org/tribalnations/introduction/Indian_Country_101_Updated_February_2019.pdf [https://perma.cc/2GNZ-CDU2].

17. STEPHEN L. PEVAR, THE RIGHTS OF INDIANS AND TRIBES 3 (4th ed. 2012).

18. *See* ROXANNE DUNBAR-ORTIZ, AN INDIGENOUS PEOPLES' HISTORY OF THE UNITED STATES 39–42, 46 (2014).

19. Indian Entities Recognized by and Eligible to Receive Services from the United States Bureau of Indian Affairs, 85 Fed. Reg. 5,462 (Jan. 30, 2020); PEVAR, *supra* note 17, at 81. Other Tribal governments are recognized by states or do not have governmental recognition. *See Federal and State Recognized Tribes*, NAT'L CONF. OF STATE LEGISLATURES (Mar. 2020), http://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx [https://perma.cc/UB8S-WUHN].

20. *Williams v. Lee*, 358 U.S. 217, 220 (1959).

exclusive power over their members and their territory" and includes governmental power to tax and regulate, among other powers.[21] Each Tribe has its unique history, laws, governments, and cultures[22] and chooses to exercise its sovereignty in different ways. Importantly, political sovereignty is "inextricably linked" to a Tribe's culture "because the ultimate goal of political sovereignty is protecting a way of life."[23] Wallace Coffey and Rebecca Tsosie define cultural sovereignty as "encompass[ing] the spiritual, emotional, mental, and physical aspects of [Native peoples'] lives."[24]

Federal Indian law governs the relationships between Tribes, states, and the federal government.[25] One of its tenets is the plenary power doctrine. According to the Supreme Court, Congress has plenary power to legislate on all issues regarding Tribes or American Indians and Alaska Natives.[26] Plenary power allows Congress to preempt Tribal jurisdiction and even abrogate Tribal treaty rights; the use of this power to erode Tribal sovereignty is disfavored, however. Unfortunately, the federal government has used the plenary power doctrine to reduce Tribal jurisdiction,[27] remove Indian children from their communities,[28] and limit cultural and religious practices.[29] Although the general rule is that state jurisdiction does not extend to Tribal lands,[30] the federal government has utilized its plenary power to authorize state jurisdiction in certain circumstances.[31]

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21. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW § 4.01(1)(b), (2) (Nell Jessup Newton ed., 2012).

22. *See id.* § 4.01, 4.07; Wallace Coffey & Rebecca Tsosie, *Rethinking the Tribal Sovereignty Doctrine: Cultural Sovereignty and the Collective Future of Indian Nations*, 12 STAN. L. & POL'Y REV. 191, 197 (2001).

23. Coffey & Tsosie, *supra* note 22, at 202, 210 (quoting Michelle Hibbert, Comment, *Galileos or Grave Robbers? Science, the Native American Graves Protection and Repatriation Act, and the First Amendment*, 23 AM. INDIAN L. REV. 425, 435 (1999)).

24. *Id.* at 210.

25. MATTHEW L.M. FLETCHER, FEDERAL INDIAN LAW § 1.2 (2016).

26. *Ex parte Crow Dog*, 109 U.S. 556, 561–62 (1883); *United States v. Kagama*, 118 U.S. 375, 383–85 (1886).

27. *See, e.g.*, Curtis Act, ch. 517, 30 Stat. 495 (1898); *Oliphant v. Suquamish Indian Tribe*, 435 U.S. 191, 212 (1978); *Montana v. United States*, 450 U.S. 544, 557 (1981).

28. *See* Civilization Fund Act, ch. 85, 3 Stat. 516 (1819); DUNBAR-ORTIZ, *supra* note 18, at 151, 153.

29. *See, e.g.*, *Code of Indian Offenses*, OFF. OF ROBERT N. CLINTON, http://robert-clinton.com/?page_id=289 [https://perma.cc/9B8L-GLVW] (last visited Mar. 6, 2022); *Lyng v. Nw. Indian Cemetery Protective Ass'n*, 485 U.S. 439, 441–42 (1988).

30. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW, *supra* note 21, § 6.01(1).

31. *Id.* Federal courts have also authorized state jurisdiction without congressional allocation at the expense of Tribal authority. *Id.* § 6.01(4).

The federal government also maintains a trust responsibility, a moral and fiduciary duty, to Tribes.[32] This trust responsibility requires the federal government to protect Tribal treaties, lands, resources, and rights as established under federal law.[33] As the D.C. District Court stated in 2020, "[T]he United States has mismanaged Indian trusts for nearly as long as it has been trustee."[34]

## II. TRIBAL INHERENT PUBLIC HEALTH AUTHORITY

Nearly ten million people identify as American Indian and Alaska Native nationwide.[35] American Indians and Alaska Natives experience a variety of health inequities at higher rates than other racial/ethnic groups.[36] According to 2019 data, the leading causes of death for American Indians and Alaska Natives are heart disease, cancer, and unintentional injuries.[37] Early in the pandemic, across states like Arizona,[38] New Mexico,[39] and Wisconsin,[40] American Indians and Alaska Natives experienced higher rates of COVID-19 infections. In exercising their public health authority, Tribes have mitigated these health inequities; these measures are discussed

32. *See United States v. Mitchell*, 463 U.S. 206, 224, 228 (1983); *Menominee Tribe of Indians v. United States*, 391 U.S. 404, 406 (1968); *Joint Tribal Council of the Passamaquoddy Tribe v. Morton*, 528 F.2d 370, 379 (1st Cir. 1975); *Seminole Nation v. United States*, 316 U.S. 286, 296–97 (1942).

33. *What Is the Federal Indian Trust Responsibility?*, U.S. DEP'T OF THE INTERIOR: INDAN AFFS., https://www.bia.gov/frequently-asked-questions [https://perma.cc/4P2J-846E] (last visited Mar. 6, 2022); *Seminole Nation*, 316 U.S. at 296–97 ("In carrying out its treaty obligations with the Indian tribes, the Government is something more than a mere contracting party. Under a humane and self imposed policy which has found expression in many acts of Congress and numerous decisions of this Court, it has charged itself with moral obligations of the highest responsibility and trust.") (footnote omitted).

34. *Cherokee Nation v. Dep't of the Interior*, No. 1:19-c-02154, 2020 WL 22486, at *1 (D.D.C. Jan. 15, 2020) (citing *Cobell v. Norton* ("*Cobell VT*"), 240 F.3d 1081, 1086 (D.C. Cir. 2001)).

35. Nicholas Jones, Rachel Marks, Roberto Ramirez & Merarys Ríos-Vargas, *2020 Census Illuminates Racial and Ethnic Composition of the Country*, U.S. CENSUS BUREAU (Aug. 12, 2021), https://www.census.gov/library/stories/2021/08/improved-race-ethnicity-measures-reveal-united-states-population-much-more-multiracial.html [https://perma.cc/7B7H-M5C3].

36. *Disparities*, INDIAN HEALTH SERV. (Oct. 2019), https://www.ihs.gov/newsroom/factsheets/disparities/ [https://perma.cc/J7TX-SMK8].

37. Elizabeth Arias, Jiaquan Xu, Sally Curtin, Brigham Bastian & Betzaida Tejada-Vera, *Mortality Profile of the Non-Hispanic American Indian or Alaska Native Population, 2019*, NAT'L VITAL STAT. REP., Nov. 9, 2021, at 1, 3.

38. Gibson, *supra* note 9.

39. Kaplan & Davis, *supra* note 9.

40. Kaeding, *supra* note 9.

in more detail in subsequent Sections.[41] Here, this Essay discusses the legal foundations of Tribal public health jurisdiction.

Public health authority refers to the authority of a government to engage in public health activities as part of its official duties. Although the federal government defines this term as part of statutory and regulatory schemes,[42] being recognized as a public health authority under a federal law is distinct from being the official public health authority for a sovereign government.[43]

No law, federal or Tribal, is needed to grant Tribes the authority to engage in public health activities. Protecting the public's health, safety, and welfare is among the core powers and duties of sovereign governments.[44] Engaging in isolation, quarantine, case investigations, contact tracing, and disease surveillance are essential public health services.[45] These powers are inherent to all sovereign nations, including Tribes.[46] Some Tribal constitutions explicitly refer to the authority to protect and promote health and welfare as a power of the government.[47]

Federal Indian law holds that Tribal sovereignty is not a grant of authority by the United States.[48] Instead, federal law recognizes this sovereignty, which Tribes have exercised since time immemorial.[49] Under federal law, congressional plenary power can be used to divest Tribes of their jurisdiction, including their ability to exercise sovereignty in certain matters; divestment of Tribal government power requires a clear statement

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41. *See* discussions *infra* Sections IV.A, D.

42. *See infra* Part II.

43. For example, the Health Insurance Portability and Accountability Act (HIPAA) recognizes Tribal Epidemiology Centers (TECs) as public health authorities for the purposes of access to protected health information. 25 U.S.C. § 1621m(e)(1)–(2). This does not mean, however, that TECs are the governmental public health authority of each Tribal sovereign nation it serves.

44. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 8–9 (2d ed. 2008).

45. *See 10 Essential Public Health Services*, CTRS. FOR DISEASE CONTROL & PREVENTION (Mar. 18, 2021), https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html [https://perma.cc/C6E7-ESMA].

46. AILA HOSS, MONTRECE RANSOM & MATTHEW PENN, CTRS. FOR DISEASE CONTROL & PREVENTION, MENU OF SELECTED TRIBAL LAWS RELATED TO INFECTIOUS DISEASE CONTROL 1–3, 5 (2014), https://www.cdc.gov/phlp/docs/tribalidlaws-brief.pdf [https://perma.cc/6WTZ-ES9E].

47. Aila Hoss, *A Framework for Tribal Public Health Law*, 20 NEV. L.J. 113, 126 (2019).

48. *See Talton v. Mayes*, 163 U.S. 376, 384–85 (1896); *United States v. Wheeler*, 435 U.S. 313, 323–24, 332 (1978); FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 122 (1942) ("[T]hose powers which are lawfully vested in an Indian tribe are not, in general, delegated powers granted by express acts of Congress, but rather inherent powers of a limited sovereignty which has never been extinguished.").

49. *See* PEVAR, *supra* note 17, at 3.

by Congress, however.[50] No federal law that clearly divests Tribes of their authority to engage in public health activities exists. And while the federal government has concurrent authority "to intervene in infectious disease threats in Indian country, through isolation and quarantine as an example, the day-to-day management of public health rests with the Tribes."[51]

No federal law is needed to grant Tribes the authority to engage in public health activities. As discussed above, this authority is inherent to Tribal sovereignty. Federal law, however, does recognize Tribal public health authority as it relates to federal law and programming. For example, the Health Insurance Portability and Accountability Act (HIPAA) authorizes "public health authorities" to access identifiable health information otherwise protected under federal law in order to prevent or control disease or injury.[52] For the purposes of HIPAA, "public health authorities" are defined to include state, local, and Tribal agencies.[53] Federal law also refers to state and Tribal "public health authorities" in the context of grants for tuberculosis programs in correctional facilities[54] and consultation with the National Biodefense Science Board.[55]

Federal programming also provides examples of federal recognition of Tribal public health authority. The Centers for Disease Control and Prevention's (CDC) Center for State, Tribal, Local, and Territorial Support provides support through programming and technical assistance to health agencies across state, Tribal, local, and territorial governments.[56] It recognizes each of the 574 federally recognized Tribes as the agencies it serves.[57] Federal funding, such as the Preventative Health and Health Services Block Grant and the Stafford Act, includes distribution mechanisms to states and Tribes.[58]

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50. *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 72 (1978).

51. Hoss, *supra* note 47, at 125 & n.102 (citing 25 U.S.C. § 198).

52. 45 C.F.R. § 164.512(b) (2021); *see also id.* § 164.501 ("*Public health authority* means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.").

53. *Id.* § 164.501 (2013).

54. 34 U.S.C. § 12271(c)(1) (2012 & Supp. V. 2017).

55. 42 U.S.C. § 247d-4(c)(7)(A).

56. Ctr. for State, Tribal, Loc., & Territorial Support, *Improving Community Health Outcomes by Strengthening State, Tribal, Local, and Territorial Public Health Agencies*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/publichealthgateway/docs/cstlts-factsheet.pdf [https://perma.cc/L3ZX-DA2C] (last visited Mar. 7, 2022).

57. *About CSTLTS*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jan. 7, 2022), https://www.cdc.gov/publichealthgateway/about-cstlts/index.html [https://perma.cc/HS4U-3EHV].

58. 42 U.S.C. §§ 300w-1(a)(1), 300w-1(d)(1)(A)–(B), 5170(a)–(b)(1), 5191(a)–(c)(1).

## III. INDIAN HEALTH SYSTEMS

Indian health systems are a complex system of providers and organizations across Tribal, state, and federal governments and private and nonprofit organizations.[59] The laws governing these entities and the health care they provide vary. This Part describes these systems—federal, Tribal, and others—and the laws that govern them.

In exchange for ceded territories, the federal government agreed to provide health services to Tribes under numerous treaties.[60] The texts of these treaty commitments varied but often included requirements to provide physicians[61] and certain health services like vaccinations[62] to Tribes and their members. Many of these treaty obligations to provide health care discontinued after a term of years.[63] Despite the sunset of these obligations for some Tribes, the continued federal obligation to provide health services extended from other law and doctrine.

The trust doctrine, for example, reinforces treaty obligations in the federal provisions of health care.[64] The trust doctrine, also described as the trust responsibility or trust relationship, originates from common law[65] and holds that the federal government owes a variety of duties to Tribes.[66] These duties include protecting Tribal assets, property, and legal rights.[67] The Supreme Court has described this as "a humane and self imposed policy [in] which . . . [the United States] has charged itself with moral obligations of the highest responsibility and trust."[68] "[T]he historical

59. REDSTAR INNOVATIONS, TRIBAL PUBLIC HEALTH INSTITUTE FEASIBILITY PROJECT: PROJECT FINDINGS REPORT 5 (2013), https://redstarintl.org/wp-content/uploads/2018/12/tphi_findings_report.pdf [https://perma.cc/FVP4-Z42C].

60. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW, *supra* note 21, § 22.04(1).

61. *See, e.g.*, Treaty with the Kiowa and Comanche, arts. II, IV, XI, Oct. 21, 1867, 15 Stat. 581; Treaty with the Klamanth and Moadoc Tribes and Yahooskin Band of Snake Indians, arts. I, V, Oct. 14, 1864, 16 Stat. 707.

62. *See, e.g.*, Treaty with the Makah, arts. I, XI, Makah Tribe-U.S., Jan. 31, 1855, 12 Stat. 939; Treaty with the Ottawas, etc., art. IV, Mar. 28,1836, 7 Stat. 491.

63. *See, e.g.*, Treaty with the Klamanth and Moadoc Tribes and Yahooskin Band of Snake Indians, *supra* note 61, at art. V (obligating the federal government to pay for the services of a physician for twenty years); Treaty with the Cherokee, art. VIII, Cherokee Nation-U.S., Dec. 29, 1835, 7 Stat. 478.

64. *Rosebud Sioux Tribe v. United States*, 9 F.4th 1018, 1025–26 (8th Cir. 2021); *see also Basis for Health Services*, INDIAN HEALTH SERV. (Jan. 2015), https://www.ihs.gov/newsroom/factsheets/basisforhealthservices/ [https://perma.cc/5NDZ-F65V] (stating that "[t]he trust relationship establishes a responsibility for a variety of services and benefits to Indian people based on their status as Indians, including health care").

65. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW, *supra* note 21, § 5.04(3)(a).

66. *What Is the Federal Indian Trust Responsibility?*, *supra* note 33.

67. *Id.*

68. *Seminole Nation v. United States*, 316 U.S. 286, 296–97 (1942).

record reflects decades of the Government providing healthcare after the Treaty, in exchange for the Tribe's continued trust in the Government."[69]

Federal legislation has codified treaty and trust obligations to provide health care[70]—first in the Snyder Act of 1921, Congress's earliest legislative authorization of federal funds to support Indian health,[71] then via the Indian Health Care Improvement Act (IHCIA)[72] and the Indian Self-Determination and Education Assistance Act (ISDEAA).[73] Today, federal Indian health care delivery is based on a three-tier system, referred to as "I/T/U."[74] "I" refers to direct health care provided by the Indian Health Service (IHS);[75] "T" refers to Tribally provided health care through 638 programs;[76] and "U" refers to health care provided by urban Indian health programs.[77] IHS is divided into 12 service regions (Figure 1)[78] and operates 26 hospitals, 59 health centers, and 32 health stations.[79] The Tribally operated 545 facilities include 19 hospitals, 284 health centers, 79 health stations, and 163 clinics.[80] Finally, there are over 40 urban Indian health programs.[81] Tribal and urban health systems are discussed in more detail below.

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69. *Rosebud Sioux Tribe*, 9 F.4th at 1024.

70. *See, e.g.*, 25 U.S.C. § 13; Indian Self-Determination and Education Assistance Act, Pub. L. No. 93-638, § 104(b)(1)–(2), 88 Stat. 2203, 2208 (1975); Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (1976).

71. 25 U.S.C. § 13.

72. Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (1976).

73. Indian Self-Determination and Education Assistance Act, Pub. L. No. 93-638, § 104(b)(1)–(2), 88 Stat. 2203, 2208 (1975).

74. Aila Hoss & Michelle Castagne, *Public Health Law and American Indians and Alaska Natives*, *in* PUBLIC HEALTH LAW: CONCEPTS AND CASE STUDIES 209, 216–17 (Montrece McNeill Ransom & Laura Magaña Valladares eds., 2022).

75. *Id.*

76. *Id.*

77. *Id.*

78. *Locations*, INDIAN HEALTH SERV., https://www.ihs.gov/physicians/locations/ [https://perma.cc/2C3B-MN5L] (last visited Feb. 17, 2022).

79. *Quick Look*, INDIAN HEALTH SERV., https://www.ihs.gov/newsroom/factsheets/quicklook/ [https://perma.cc/G3LG-KZEK] (last visited Feb. 17, 2022).

80. *Id.*

81. *Office of Urban Indian Health Programs*, INDIAN HEALTH SERV., https://www.ihs.gov/urban/ [https://perma.cc/3ZRM-C2GF] (last visited Feb. 17, 2022).


*Figure 1. Indian Health Service Regions*[82]

The federal government consistently has underfunded federal Indian health services.[83] In a scathing 1928 report commissioned by the Institute of Government Research and presented to the secretary of the interior, the Meriam Report documented the atrocious standards on reservations—and the federal role in perpetuating them—across education, health, housing, and other areas.[84] Some of the numerous documented cases related to health included malnutrition, lack of treatment, and high infant mortality.[85] Ninety years later, per a 2018 U.S. Commission on Civil Rights report, conditions remain substandard.[86] In *Broken Promises: Continuing Federal Funding Shortfall for Native Americans*, the Commission documented that "[t]he efforts of the federal government have been insufficient to meet the promises of providing for the health and wellbeing of [T]ribal citizens, as a vast health disparity exists today between Native Americans and other population groups."[87] While this report focuses on funding numbers and

82. David R. Wilson, *Community Based Research with AI/AN Tribes and Villages*, NAT'L INSTS. OF HEALTH, https://bioethics.nih.gov/sites/nihbioethics/files/bioethics-files/courses/pdf/2018/session4_wilson.pdf [https://perma.cc/E55Q-6NT8] (last visited Feb. 17, 2022).

83. U.S. COMM'N ON C.R., *supra* note 3, at 65–66, 209 ("Funding for the Indian Health Service (IHS) and Native American health care is inequitable and unequal.").

84. INST. FOR GOV'T RSCH., THE PROBLEM OF INDIAN ADMINISTRATION 3–9 (1928).

85. *Id.* at 192, 194, 206.

86. U.S. COMM'N ON C.R., *supra* note 3, at 65.

87. *Id.* at 65.

overall disparities, specific areas of inadequate health care are well-documented.

The litigation in *Rosebud Sioux Tribe v. United States*[88] chronicles the inadequate emergency care provided by the IHS-operated Rosebud Hospital.[89] The "simply horrifying"[90] conditions at the hospital included a physician vacancy rate of forty-five percent;[91] failure to adequately treat a pediatric head injury;[92] and the unattended delivery of a premature baby on the hospital floor.[93]

A 2019 *Wall Street Journal* report documented the consistent hiring of unqualified physicians at IHS facilities.[94] The report found that, since 2006, the U.S. had "paid out about $55 million in settlements in 163 malpractice cases" at IHS facilities.[95] Tragically, "[a]t least 66 patients in those cases died in IHS's care."[96] Prior to seeking employment with IHS, several of these providers had past criminal convictions, sanctioned and revoked medical licenses, and multiple medical malpractice claims.[97] They were hired anyway.[98] Numerous cases have come to light regarding sexual abuse of patients while in IHS care.[99] An IHS report found that the agency had received complaints regarding one of the physicians over the course of several years but failed to take any action.[100]

Tribal governments are the foundation of Tribal health systems.[101] Promoting public health, safety, and general welfare is an essential

88. 9 F.4th 1018 (8th Cir. 2021).

89. *Id.* at 1021.

90. Brief of Appellant Rosebud Sioux Tribe at 5, *Rosebud Sioux Tribe*, 9 F.4th 1018 (No. 20-2062).

91. Expert Report of Donald K. Warne, MD, MPH, *Rosebud Sioux Tribe v. United States*, No. 16CV03038, 2019 WL 3753563 (D.S.D. Mar. 22, 2019).

92. Brief of Appellant Rosebud Sioux Tribe, *supra* note 90, at 5.

93. *Id.*

94. Christopher Weaver, Dan Frosch & Lisa Schwartz, *The U.S. Gave Troubled Doctors a Second Chance. Patients Paid the Price.*, WALL ST. J. (Nov. 22, 2019, 12:05 PM), https://www.wsj.com/articles/the-u-s-gave-troubled-doctors-a-second-chance-patients-paid-the-price-11574439222 [https://perma.cc/2Y9M-85DD].

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.* The conduct of Weber is documented in *United States v. Weber*, 987 F.3d 789, 790–91, 793 (8th Cir. 2021); Order Denying Motion to Change Venue, *United States v. Weber*, No. CR-18-14-GF-BMM, 2018 U.S. Dist. LEXIS 122996, at *1 (D. Mont. July 23, 2018); *United States v. Weber*, 346 F. Supp. 3d 1335, 1337, 1339 (D.S.D. 2018); Order Granting Redaction Request, *United States v. Weber*, No. CR. 17-50033-JLV, 2020 U.S. Dist. LEXIS 168713, at *1 (D.S.D. Sept. 15, 2020); *United States v. Weber*, 793 F. App'x 586, 587 (9th Cir. 2020).

100. Weaver, Frosch & Schwartz, *supra* note 94.

101. *See* Hoss, *supra* note 47, at 119–20.

attribute of any sovereign, including Tribes.[102] How each Tribe exercises its own public health authority and the structure of its health institutions varies.[103] Some Tribes will centralize health activities in one or two departments, and others will decentralize health activities across multiple government entities.[104] Despite the variation of Tribal government structures,[105] many Tribes have designated specific health agencies responsible for providing health programming.[106]

As discussed, IHS has been unable to provide consistent, quality health care services. This failure is coupled with limitations in holding the federal government accountable, through litigation, for underfunding Indian health care programming.[107] In an effort to improve the quality of direct health care services to American Indians and Alaska Natives, Congress passed the Indian Self-Determination and Education Assistance Act in 1975.[108] ISDEAA authorizes Tribes to assume the management of IHS services via contracts and compacts at the request of any Tribe.[109] This funding would otherwise be delegated to IHS to provide health care services directly.[110] ISDEAA also authorizes contract support costs, which allow additional funding to cover administrative costs associated with the programs.[111] Today, approximately sixty percent of IHS's budget supports

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102. GOSTIN, *supra* note 44, at 8–9.

103. *See* Hoss, *supra* note 47, at 119–20.

104. M.T. Allison, P.A. Rivers & M.D. Fottler, *Future Public Health Delivery Models for Native American Tribes*, 121 PUB. HEALTH 296, 300–02, 305–06 (2007).

105. FLETCHER, *supra* note 25, at 235.

106. *See* ALANA KNUDSON, ALEENA HERNANDEZ, JESSICA KRONSTADT, PAUL ALLIS, MICHAEL MEIT, SHENA POPAT, MARILYN G. KLUG & CHRIS FRANCIS, NORC WALSH CTR. FOR RURAL HEALTH ANALYSIS, A PROFILE OF TRIBAL HEALTH DEPARTMENTS 1–3 (2012), http://www.norc.org/PDFs/Walsh%20Center/Research%20Briefs/Research%20Brief_W18_KnudsonA_Profile_2012.pdf [https://perma.cc/5BC3-TG2H].

107. *See, e.g.*, *Lincoln v. Vigil*, 508 U.S. 182, 193 (1993) ("'[T]o [that] extent,' the decision to allocate funds 'is committed to agency discretion by law.' The Service's decision to discontinue the Program is accordingly unreviewable . . . .") (alterations in original) (citation omitted) (quoting 5 U.S.C. § 701(a)(2)); *Rosebud Sioux Tribe v. United States*, 9 F.4th 1018, 1023 (8th Cir. 2021) ("Here, the Tribe seeks only declaratory and injunctive relief arising under the Treaty, the Snyder Act, the IHCIA, and federal common law. The Tribe makes no claim for money damages, which necessarily means that the Indian Tucker Act cannot provide jurisdiction.").

108. *See* 25 U.S.C. §§ 5301–5302.

109. *Tribal Self-Governance*, INDIAN HEALTH SERV., https://www.ihs.gov/newsroom/factsheets/tribalselfgovernance/ [https://perma.cc/6823-GZ74] (last visited Feb. 17, 2022); 25 U.S.C. §§ 5382–87.

110. 25 U.S.C. §§ 5382–5386.

111. *Contract Support Costs*, INDIAN HEALTH SERV., https://www.ihs.gov/odsct/contract-support-costs/ [https://perma.cc/F69M-4CH7] (last visited Feb. 17, 2022).

Tribal health facilities under ISDEAA.[112] The Tribal management of health care through ISDEAA has resulted in improved health service quality and outcomes.[113]

IHS also funds urban Indian organizations that provide health care to American Indians and Alaska Natives.[114] There are over forty urban Indian health programs operating across the United States to serve American Indians and Alaska Natives living and working in urban areas.[115] These programs operate as nonprofits and receive federal funding.[116]

Not all American Indians and Alaska Natives rely solely on the I/T/U system for health care. Many also have employer-sponsored insurance, qualify for federal coverage under Medicaid, or receive services elsewhere.[117]

## IV. FEDERAL INDIAN HEALTH REFORM

A variety of changes to the legal regime governing federal Indian health policy can advance Tribal health sovereignty and improve health outcomes for American Indian and Alaska Native communities. Some important recommendations have received detailed treatment elsewhere and thus are not included in this Essay. I recently argued the importance of improved Tribal consultation in advancing Tribal health.[118] Recent legislation proposes that the IHS director should be elevated to an assistant secretary position to ensure more attention is directed toward federal Indian health programs.[119] The National Indian Health Board (NIHB) has

112. *IHS Profile*, INDIAN HEALTH SERV., https://www.ihs.gov/newsroom/factsheets/ihsprofile/ [https://perma.cc/TY8Y-XYU2] (last visited Mar. 17, 2022).

113. *See, e.g.*, *The Success and Shortfall of Self-Governance Under the Indian Self-Determination and Education Assistance Act After Twenty Years: Hearing Before the S. Comm. on Indian Affs.*, 110th Cong. 2 (2008) (statement of Sen. Lisa Murkowski, Vice Chairman, S. Comm. on Indian Affs.); Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance Under the Indian Self-Determination and Education Assistance Act*, 39 AM. INDIAN L. REV. 1, 4–5 (2014); Hoss & Tanana, *supra* note 10, at 78–79.

114. *Office of Urban Indian Health Programs*, *supra* note 81.

115. *Id.*

116. *Id.*

117. *Health and Health Care for American Indians and Alaska Natives (AIANs) in the United States*, KAISER FAM. FOUND. (May 10, 2019), https://www.kff.org/infographic/health-and-health-care-for-american-indians-and-alaska-natives-aians/ [https://perma.cc/8AHL-9T3U].

118. Aila Hoss, *Securing Tribal Consultation to Support Indian Health*, 14 NE. U. L. REV. 155 (2022).

119. Stronger Engagement for Indian Health Needs Act of 2022, H.R. 6406, 117th Cong.; James Arkin, *Reps. Float Bipartisan Bill to Improve Native American Health*, LAW360 (Jan. 18, 2022, 6:37 PM), https://www.law360.com/nativeamerican/articles/1455682/reps-float-bipartisan-bill-to-

long argued for permanent reauthorization of the Special Diabetes Program for Indians.[120] Professor Matthew Lawrence and organizations such as NIHB have argued that federal Indian health care programming should not be dependent on annual appropriations—and thus vulnerable to shutdowns.[121] Loyola University Chicago School of Law JD Candidate Lauren E. Schneider brilliantly argues for an enforceable breach-of-trust obligation for federal Indian health programming failures.[122] The list goes on. The subsequent Sections of this Essay offer a brief discussion of health reform in the United States and a detailed discussion of how reforms in federal law can provide better support to federal and Tribal health systems.

### *A. Health Reform Generally*

Most recent health care reform efforts refer to health policies established and stewarded by the Affordable Care Act of 2010 (ACA).[123] The ACA reformed public and private health insurance to facilitate improved insurance coverage and reduce health care costs.[124] The ACA was marked by three goals: (1) improve health insurance coverage; (2) expand Medicaid to cover poor adults; and (3) reduce the cost of health care delivery.[125] The ACA requires certain employers to offer insurance coverage.[126] It also offered coverage through federal or state-operated exchanges.[127]

After the ACA's enactment, the number of uninsured Americans dropped to a historic low in 2016, as more than twenty million previously uninsured individuals secured health insurance.[128] Even with increases in

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improve-native-american-health?nl_pk=67ca70de-a1b8-43ea-a2a2-a44c6fc08389&utm_source=newsletter&utm_medium=email&utm_campaign=nativeamerican.

120. *See SDPI Overview*, NAT'L INDIAN HEALTH BD., https://www.nihb.org/sdpi/sdpi_overview.php [https://perma.cc/2F37-BXEK] (last visited Mar. 7, 2022).

121. Matthew B. Lawrence, *Subordination and Separation of Powers*, 131 YALE L.J. 78, 98–104 (2021); Nat'l Indian Health Bd. (@NIHB1), TWITTER (Oct. 5, 2021, 3:57 PM), https://twitter.com/nihb1/status/1445493484010434568?s=11.

122. Lauren E. Schneider, Comment, *Trust Betrayed: The Reluctance to Recognize Judicially Enforceable Trust Obligations Under the Indian Health Care Improvement Act (IHCIA)*, 52 LOY. U. CHI. L.J. 1099 (2021).

123. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

124. *Affordable Care Act (ACA)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/affordable-care-act/ [https://perma.cc/385J-4UPV] (last visited Mar. 7, 2022).

125. *Id.*

126. *See* Patient Protection and Affordable Care Act § 1511.

127. *Id.* §§ 1311, 1321(c)(1).

128. Jennifer Tolbert, Kendal Orgera & Anthony Damico, *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. (Nov. 6, 2020),

the number of uninsured Americans in subsequent years, the number remains significantly lower than it was prior to the passage and implementation of the ACA.[129] Medicaid has been expanded in thirty-eight states and the District of Columbia,[130] leading to improved access to care for low-income individuals.[131] Some studies have found an increased use of preventative and primary care in states that have expanded Medicaid.[132] One study has attributed to the ACA a reduction in socioeconomic disparities in health care access,[133] while other studies have attributed a reduction of evictions,[134] improved financial wellbeing,[135] and improved employment status[136] to the ACA.

Despite these improvements, many commentators continue to advocate for "reforming reform." In states that have not expanded Medicaid, over two million people remain without health care coverage.[137] Additionally, access to insurance does not necessarily equate to access to quality, cost-effective, equitable care.[138] As Professor Nicole Huberfeld has highlighted, the ACA did not address the high cost of health care in

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https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/ [https://perma.cc/P8HK-DZ7H].

129. *Id.*

130. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Feb. 24, 2022), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/8AQX-HPLB].

131. Gerald F. Kominski, Narissa J. Nonzee & Andrea Sorensen, *The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations*, 38 ANN. REV. PUB. HEALTH 489, 498–99 (2017).

132. *See, e.g.*, Sri Lekha Tummalapalli & Salomeh Keyhani, *Changes in Preventative Health Care After Medicaid Expansion*, 58 MED. CARE 549, 554–55 (2020); Laura R. Wherry & Sarah Miller, *Early Coverage, Access, Utilization, and Health Effects Associated with the Affordable Care Act Medicaid Expansions: A Quasi-Experimental Study*, 164 ANNALS INTERNAL MED. 795, 800 (2016); Sarah Miller & Laura R. Wherry, *Health and Access to Care During the First 2 Years of the ACA Medicaid Expansions*, 376 NEW ENG. J. MED. 947, 951 (2017).

133. Kevin Griffith, Leigh Evans & Jacob Bor, *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, 36 HEALTH AFFS. 1503, 1508 (2017).

134. Heidi L. Allen, Erica Eliason, Naomi Zewde & Tal Gross, *Can Medicaid Expansion Prevent Housing Evictions?*, 38 HEALTH AFFS. 1451, 1454–55 (2019).

135. Naomi Zewde & Christopher Wimer, *Antipoverty Impact of Medicaid Growing with State Expansions over Time*, 38 HEALTH AFFS. 132, 135 (2019); Luojia Hu, Robert Kaestner, Bhaskar Mazumder, Sarah Miller & Ashley Wong, *The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing*, 163 J. PUB. ECON. 99, 100 (2018).

136. Renuka Tipirneni et al., *Association of Medicaid Expansion with Enrollee Employment and Student Status in Michigan*, JAMA NETWORK OPEN, Jan. 2020, at 1, 7.

137. Rachel Garfield, Kendal Orgera & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ [https://perma.cc/DVR8-EMN8].

138. John Z. Ayanian, *Looking Back to Improve Access to Health Care Moving Forward*, 180 JAMA INTERNAL MED. 448 (2020).

the United States, which continues to limit access regardless of insurance coverage.[139] The efficacy of the exchanges also remains in question given the varied implementation across states.[140]

Larry Levitt, Executive Vice President for Health Policy with the Kaiser Family Foundation, recently commented on "reforming reform" and both incremental and major changes to federal health policy.[141] Major changes include Medicare for All or other forms of universal coverage.[142] Incremental reform would include, for example, (1) expanding outreach funding limited under the Trump administration or (2) limiting the use of waivers under the Trump administration.[143] Professor Aaron McKethan has cautioned against framing future health care reform so narrowly as to exclude public health, primary care, and behavioral health.[144] McKethan also argues that social and wraparound services, such as education and transportation, can be effective in tackling the social determinants of poor health outcomes.[145]

In what they dubbed "health reform reconstruction," Professor Lindsay Wiley and her colleagues argue that the COVID-19 pandemic has highlighted structural reforms needed to eliminate health inequities.[146] They argue that fiscal fragmentation, privatization, and incrementalism have perpetuated these inequities and suggest that a single-payer system could eliminate them.[147]

Missing from much of the discourse on health care reform are its impacts on American Indians and Alaska Natives. Thanks to the advocacy of Tribes and various Tribal-serving organizations like the NIHB, Tribes have not been completely erased from this discussion. The ACA itself included numerous provisions regarding Indian health programming.[148] It permanently reauthorized the Indian Health Care Improvement Act,[149] ensuring the authorization of appropriations for Indian health

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139. Nicole Huberfeld, *Is Medicare for All the Answer? Assessing the Health Reform Gestalt as the ACA Turns 10*, 20 HOUS. J. HEALTH L. & POL'Y 69, 125–26 (2020).

140. David K. Jones, Sarah H. Gordon & Nicole Huberfeld, *Have the ACA's Exchanges Succeeded? It's Complicated*, 45 J. HEALTH POL. POL'Y & L. 661, 672–73 (2020).

141. Larry Levitt, *The Language of Health Care Reform*, 325 JAMA 215 (2021).

142. *Id.*

143. *Id.* at 216.

144. Aaron McKethan, *Reforming Health Care Reform*, JAMA HEALTH F., Aug. 2020, at 1.

145. *Id.* at 2.

146. Lindsay F. Wiley, Elizabeth Y. McCuskey, Matthew B. Lawrence & Erin C. Fuse Brown, *Health Reform Reconstruction*, 55 U.C. DAVIS L. REV. 657 (2022).

147. *Id.* at 662, 729–31, 733.

148. *See Affordable Care Act*, INDIAN HEALTH SERV., https://www.ihs.gov/aca/ [https://perma.cc/XV6F-XH52] (last visited Mar. 7, 2022).

149. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935–36 (2010).

programming under the law. It also ensured that I/T/U facilities would be the payer of last resort for health services,[150] established improved data collection efforts,[151] and increased funding to support Indian health programs,[152] among other provisions.[153] Increased health care access across the population generally also resulted in increased coverage among American Indians and Alaska Natives.[154] But these provisions, while important, did not offer the comprehensive reforms needed to adequately support Indian health programming. The U.S. Commission on Civil Rights[155] and NIHB[156] continue to highlight areas for reform.

India-based writer Arundhati Roy wrote that the tragedy of the pandemic response is not a new phenomenon in health care but "wreckage of a train that has been careening down the track for years."[157] She writes,

> Historically, pandemics have forced humans to break with the past and imagine their world anew. This one is no different. It is a portal, a gateway between one world and the next.
>
> We can choose to walk through it, dragging the carcasses of our prejudice and hatred, our avarice, our data banks and dead ideas, our dead rivers and smoky skies behind us. Or we can walk through lightly, with little luggage, ready to imagine another world. And ready to fight for it.[158]

Roy's pandemic-as-portal metaphor resonates with so many who look to the lessons of the pandemic as opportunities to leverage the tragedy for effective policy reform. It resonates with me, too. Thus, this Essay

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150. *Id.* § 2901(b).

151. *Id.* § 3015.

152. *Id.* §§ 4201, 4304, 5507.

153. NAT'L INDIAN HEALTH BD., PATIENT PROTECTION AND AFFORDABLE CARE ACT (AFFORDABLE CARE ACT) SUMMARY OF INDIAN HEALTH PROVISIONS (2010), https://www.nihb.org/docs/05142010/Affordable_Care_Act_Provisions_Summary.pdf [https://perma.cc/JD4C-WT6R].

154. Molly Frean, Shelbie Shelder, Meredith B. Rosenthal, Thomas D. Sequist & Benjamin D. Sommers, *Health Reform and Coverage Changes Among Native Americans*, 176 JAMA INTERNAL MED. 858, 859 (2016); Mark Walker, *For Tribal Members in Oklahoma, Medicaid Expansion Improves Access to Specialty Care*, N.Y. TIMES (Sept. 4, 2021), https://www.nytimes.com/2021/09/04/us/politics/oklahoma-medicaid-indian-health-service.html [https://perma.cc/A328-FH34].

155. U.S. COMM'N ON C.R., *supra* note 3, at 89–93.

156. NAT'L INDIAN HEALTH BD., 2021 LEGISLATIVE AND POLICY AGENDA FOR INDIAN HEALTH (2021), https://www.nihb.org/covid-19/wp-content/uploads/2021/03/NIHB-2021-Legislative-and-Policy-Agenda.pdf [https://perma.cc/3E7Y-VTYT].

157. Arundhati Roy, *'The Pandemic Is a Portal,'* FIN. TIMES (Apr. 3, 2020), https://www.ft.com/content/10d8f5e8-74eb-11ea-95fe-fcd274e920ca [https://perma.cc/WPG2-R798].

158. *Id.*

offers a handful of concrete recommendations for federal reforms to support Indian health programs in the hope that policymakers will acquire an increased appetite for them in the wake of the pandemic.

### *B. Amend 25 U.S.C. § 231*

In 1929, Congress passed a law authorizing the secretary of the interior to establish regulations that would permit state health officials to inspect health conditions and enforce health laws.[159] The law also authorized the enforcement of state compulsory education laws.[160] No regulations were established at the time. This law was amended in 1946.[161] According to House and Senate reports, the bill was rephrased to address ongoing concerns for lack of school attendance.[162] The updated language also required Tribal consent for the enforcement of any state compulsory attendance laws.[163] The current statute reads,

> The Secretary of the Interior, under such rules and regulations as he may prescribe, shall permit the agents and employees of any State to enter upon Indian tribal lands, reservations, or allotments therein (1) for the purpose of making inspection of health and educational conditions and enforcing sanitation and quarantine regulations or (2) to enforce the penalties of State compulsory school attendance laws against Indian children, and parents, or other persons in loco parentis except that this subparagraph (2) shall not apply to Indians of any tribe in which a duly constituted governing body exists until

159. Act of Feb. 15, 1929, ch. 216, 45 Stat. 1185 ("[T]he Secretary of the Interior shall permit the agents and employees of any State to enter upon Indian tribal lands, reservations, or allotments therein for the purpose of making inspection of health and educational conditions and enforcing sanitation and quarantine regulations or to enforce compulsory school attendance of Indian pupils, as provided by the law of the State, under such rules, regulations, and conditions as the Secretary of the Interior may prescribe.").

160. *Id.*

161. Act of Aug. 9, 1946, ch. 930, 60 Stat. 962 ("The Secretary of the Interior, under such rules and regulations as he may prescribe, shall permit the agents and employees of any State to enter upon Indian tribal lands, reservations, or allotments therein (1) for the purpose of making inspection of health and educational conditions and enforcing sanitation and quarantine regulations or (2) to enforce the penalties of State compulsory school attendance laws against Indian children, and parents, or other persons in loco parentis except that this subparagraph (2) shall not apply to Indians of any tribe in which a duly constituted governing body exists until such body has adopted a resolution consenting to such application.").

162. S. REP. NO. 79-1923 (1946); H.R. REP. NO. 79-2494 (1946).

163. 25 U.S.C. § 231(2).

> such body has adopted a resolution consenting to such application.[164]

Under this statutory authority, the Bureau of Indian Affairs promulgated a regulation in 1957 that mandated "school attendance of Indian children."[165] While the Department of Interior (DoI) has never issued health-related regulations on this topic,[166] the law remains on the books today. In the context of health authority, this is not harmless.

As discussed above, the Supreme Court has held that Congress maintains plenary power to legislate on all matters concerning Tribes and Indians.[167] The Court has further held that plenary power can be used to divest Tribes of their jurisdiction or treaty rights; such divestment of Tribal government power, however, requires a clear statement by Congress.[168] One could argue that 25 U.S.C. § 231 divests Tribal authority to engage in public health activities. Over twenty-five judicial opinions have cited the

164. *Id.* § 231.

165. 25 C.F.R. § 31.4 (2021); 22 Fed. Reg. 10,533 (Dec. 24, 1957).

166. Justin B. Barnard, *Responding to Public Health Emergencies on Tribal Lands: Jurisdictional Challenges and Practical Solutions*, 15 YALE J. HEALTH POL'Y L. & ETHICS 251, 268–69 (2015).

167. *United States v. Kagama*, 118 U.S. 375, 384–85 (1886); *Ex parte Crow Dog*, 109 U.S. 556, 572 (1883); *Lone Wolf v. Hitchcock*, 187 U.S. 553, 565–67 (1903).

168. *Santa Clara Pueblo v. Martinez*, 436 U.S. 49, 60 (1978).

provision,[169] and several courts have considered its impact on jurisdiction.[170]

In considering the state's jurisdiction over Tribal citizens on reservation, the Supreme Court of Minnesota in *County of Beltrami v. County of Hennepin*[171] held that states cannot assert jurisdiction over Tribal citizens on Tribal lands.[172] The court further noted an exception regarding "enforce[ment of] state sanitation and quarantine laws, to make inspection of health and educational conditions, and to enforce our compulsory school attendance laws" under 25 U.S.C. § 231.[173] The case dealt with neither school attendance nor public health, so the outcome did not hinge on 25 U.S.C. § 231. But the court's interpretation of the statute would grant state jurisdiction even though the condition precedent outlined in the provision has not been met—the same interpretation of section 231 adopted by the New Mexico Supreme Court in cases unrelated to school attendance or public health.[174] The New Mexico court stated that "[e]xamples of express grants of the exercise of jurisdiction by states . . . are the Acts of Congress making various state laws, such as laws respecting health and education, applicable on Indian reservations."[175]

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169. *Meyers v. Bd. of Educ.*, 905 F. Supp. 1544, 1558 (D. Utah 1995); *State v. Bear*, 452 N.W.2d 430, 433–34 (Iowa 1990); *People v. Snyder*, 532 N.Y.S.2d 827, 829 (Erie Cnty. Ct. 1988); *State ex rel. May v. Seneca-Cayuga Tribe of Okla.*, 711 P.2d 77, 85 n.41 (Okla. 1985); *Thomsen v. King County.*, 694 P.2d 40, 44–45 (Wash. Ct. App. 1985); *Confederated Bands & Tribes of the Yakima Indian Nation v. Washington*, 550 F.2d 443, 446 n.8 (9th Cir. 1977); *Prince v. Bd. of Educ.*, 543 P.2d 1176, 1183 (N.M. 1975); *Geraud v. Schrader*, 531 P.2d 872, 882 (Wyo. 1975); *Norvell v. Sangre de Cristo Dev. Co.*, 372 F. Supp. 348, 357 n.33 (D.N.M. 1974); *McClanahan v. Ariz. State Tax Comm'n*, 411 U.S. 164, 177 n.16 (1973); *State Sec., Inc. v. Anderson*, 506 P.2d 786, 789 (N.M. 1973); *Rincon Band of Mission Indians v. County of San Diego*, 324 F. Supp. 371, 374 n.1 (S.D. Cal. 1971); *Snohomish County. v. Seattle Disposal Co.*, 389 U.S. 1016, 1018–20 (1967) (Douglas, J., dissenting); *Snohomish County. v. Seattle Disposal Co.*, 425 P.2d 22, 27 (Wash. 1967); *Warren Trading Post Co. v. Ariz. Tax Comm'n*, 380 U.S. 685, 687 n.3 (1965); *State v. McCoy*, 387 P.2d 942, 957 (Wash. 1963) (Donworth, J., dissenting); *County of Beltrami v. County of Hennepin*, 119 N.W.2d 25, 30 n.24 (Minn. 1963); *Montoya v. Bolack*, 372 P.2d 387, 393 (N.M. 1962); *Organized Village of Kake v. Egan*, 369 U.S. 60, 73 (1962); *Your Food Stores, Inc. v. Village of Espanola*, 361 P.2d 950, 954 (N.M. 1961); *State ex rel. Adams v. Superior Ct.*, 356 P.2d 985, 990 (Wash. 1960); *In re Colwash*, 356 P.2d 994, 995 (Wash. 1960); *Anderson v. Gladden*, 188 F. Supp. 666, 677 (D. Or. 1960); *Williams v. Lee*, 319 P.2d 998, 1000 (Ariz. 1958); *Acosta v. San Diego County*, 272 P.2d 92, 97 (Cal. Dist. Ct. App. 1954); *United States v. Nez Perce County*, 16 F. Supp. 267, 268 (D. Idaho 1936).

170. *See, e.g.*, *Thomsen*, 694 P.2d at 44; *State ex rel. Adams*, 356 P.2d at 990; *McClanahan*, 441 U.S. at 177 n.16; *Geraud*, 531 P.2d at 882; *Confederated Bands & Tribes of the Yakima Indian Nation*, 550 F.2d at 446 n.8; *Snyder*, 532 N.Y.S.2d at 829.

171. 119 N.W.2d 25.

172. *Id.* at 32.

173. *Id.* at 30.

174. *Montoya*, 372 P.2d at 394; *Your Food Stores, Inc.*, 361 P.2d at 954; *State Sec., Inc.*, 506 P.2d at 788–89.

175. *Your Food Stores, Inc.*, 361 P.2d at 954.

Are agency regulations a condition precedent for states to assert public health jurisdiction on Tribal lands? The Indian canons of statutory construction prove useful in conducting such an analysis. Since the nineteenth century, federal courts have employed these canons to resolve ambiguities in statutory language regarding Tribes and Indians.[176] The canons should be used in lieu of standard canons of statutory interpretation.[177] The canons include the following:

1. Liberally construe statutes in favor of the Tribes.
2. Resolve ambiguities in favor of the Tribes.
3. Presume that the United States intends its enactments to benefit Tribal interests.
4. Presume that Indian rights and sovereignty are retained unless congressional intent to diminish is clear.[178]

Each of these canons may prove relevant to interpreting whether section 231 alone authorizes state public health jurisdiction without corresponding DoI regulations. Perhaps most importantly, canon four requires a clear statement from Congress when diminishing Tribal sovereignty. Federal courts have applied this canon so consistently that it can be safely applied as a binding precedent, one often referred to as the clear statement rule.[179] Is the language that the DoI "under such rules and regulations as [the secretary] may prescribe, shall permit the agents and employees of any State to enter upon Indian tribal lands" a clear statement divesting Tribes of their public health jurisdiction and authorizing state jurisdiction? Is it a clear statement authorizing concurrent state jurisdiction? I would argue that it is not. If the statute is ambiguous and subject to multiple interpretations, canons one through three can help resolve this ambiguity.

Canons one and two above dictate that statutes should be interpreted in favor of Tribes. While both subjective and paternalistic to presume what is the best interpretation for any one Tribe or Tribes generally, I believe that an interpretation that limits the authority of states by requiring DoI regulations would favor Tribes. Similarly, canon three presumes that Congress intended to benefit Tribal interests and is also subjective and paternalistic. And, considering many of the harmful enactments Congress

176. *See* COHEN'S HANDBOOK OF FEDERAL INDIAN LAW, *supra* note 21, § 2.02(1).

177. *See id.* ("[T]he standard principles of statutory interpretation do not have their usual force in cases involving Indian law.") (alteration in original) (quoting *Montana v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985)).

178. *See* COHEN'S HANDBOOK OF FEDERAL INDIAN LAW, *supra* note 21, § 2.02.

179. FLETCHER, *supra* note 25, at 226–27.

has passed, such as the Termination Act, Allotment Act, and others, that presumption hardly holds true to the realities of policymaking.[180]

With the support of the canons, I would argue that DoI regulations are a condition precedent to asserting state public health jurisdiction on Tribal lands. Interestingly, none of the cases referenced above offered any statutory analysis or application of the Indian canons to discern the meaning of section 231 before citing it as authority for state jurisdiction.

Regardless, given that courts have cited to the statute, it remains a threat to Tribal public health authority at a time when such authority is more important than ever. Accordingly, the statute needs to be repealed or amended. Given that my analysis focuses exclusively on the public health jurisdiction component of the provision, I cannot speak to the need, impact, or threat of the school attendance component. Thus, if repeal would be inappropriate, an amendment removing the language would be appropriate.

### *C. Ensure Tribal Public Health Data Access and Governance*

Tribal health practitioners have documented the various challenges to collecting and accessing quality public health data to support American Indians and Alaska Natives.[181] These challenges include racial misclassification, small population sizes, and inappropriate data collection methods.[182] For the purposes of this Section, I will discuss issues relating to accessing data from partners and the federal government.

The Health Insurance Portability and Accountability Act (HIPAA) establishes requirements for the security and transfer of protected health information by covered entities.[183] HIPAA's corresponding regulations authorize exceptions for "public health authorities" to access identifiable health information otherwise protected for public health purposes.[184] By definition, public health authorities include state, local, and Tribal governments.[185] IHCIA's 2010 reauthorization extended the definition of

180. *See generally* Joseph D. Matal, *A Revisionist History of Indian Country*, 14 ALASKA L. REV. 283 (1997).

181. *See, e.g.*, TRIBAL EPIDEMIOLOGY CTRS., BEST PRACTICES IN AMERICAN INDIAN & ALASKA NATIVE PUBLIC HEALTH 118–22 (2013), http://itcaonline.com/wp-content/uploads/2014/03/TEC_Best_Practices_Book_2013.pdf [https://perma.cc/LBZ7-B3FD] (listing the parent organizations of the TECs).

182. *Id.* at 124–37.

183. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

184. 45 C.F.R. § 164.512(b) (2021).

185. *Id.* § 164.501 ("*Public health authority* means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors

public health authorities to include Tribal Epidemiology Centers (TECs) for the purposes of HIPAA.[186] Importantly, although HIPAA permits the sharing of data to public health authorities, it does not compel it.[187] Tribes and TECs are regularly denied access to important public health data.[188]

IHCIA expressly requires that HHS provide TECs access to data the agency possesses: "The Secretary shall grant to each epidemiology center . . . access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary."[189] Despite this clear language, agencies sometimes are reluctant to provide TECs with such data access. For example, throughout the COVID-19 pandemic, the CDC refused or delayed providing TECs data.[190]

Unfortunately, there is no corresponding language that clearly directs HHS to provide Tribes with data as IHCIA does for TECs. Here, too, HHS and its agencies regularly deny Tribes access to data. The trust relationship may obligate the federal government to provide access to such data. Even so, the trust responsibility alone has proven insufficient in compelling government action in many instances. Federal courts have created a complex set of rules governing the enforceability for breach of trust.[191] A more direct method of ensuring Tribal data access is for Congress to enact legislation requiring the federal government to do so. Bills such as the

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or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.").

186. 25 U.S.C. § 1621m(e)(1).

187. Stephen B. Thacker, *HIPAA Privacy Rule and Public Health Guidance from CDC and the U.S. Department of Health and Human Services*, 52 MORBIDITY & MORTALITY WKLY. REP. 1 (2003), https://www.cdc.gov/mmwr/preview/mmwrhtml/m2e411a1.htm [https://perma.cc/5QQP-VMCG].

188. *See* NAT'L CONG. OF AM. INDIANS, TRIBAL LEADER BRIEFING BOOK 35, 36 (2014), https://www.ncai.org/conferences-events/ncai-events/WHTNC_-_Final_briefing_book_2014-11-21.pdf [https://perma.cc/T7RG-93RX]; *cf.* OFF. FOR C.R., U.S. DEP'T OF HEALTH & HUM. SERVS., HIPAA, HEALTH INFORMATION EXCHANGES, AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR PUBLIC HEALTH PURPOSES (2020), https://www.hhs.gov/sites/default/files/hie-faqs.pdf [https://perma.cc/XA7V-K6FM].

189. 25 U.S.C. § 1621m(e)(2).

190. Letter from Martin Henrich, Sen. for New Mexico, U.S. Senate, to Robert R. Redfield, Dir., Ctrs. for Disease Control & Prevention (June 18, 2020) https://www.heinrich.senate.gov/download/?id=04654AA9-B1DF-41F7-ADE8-04722C2B89CE&download=1 [https://perma.cc/6WGS-QEPF]; *Oversight of the Trump Administration's Response to the COVID-19 Pandemic: Hearing Before the H. Comm. on Energy & Com.*, 116th Cong. 148–50 (2020); *see also* Darius Tahir & Adam Cancryn, *American Indian Tribes Thwarted in Efforts to Get Coronavirus Data*, POLITICO (June 11, 2020, 11:45 PM), https://www.politico.com/news/2020/06/11/native-american-coronavirus-data-314527 [https://perma.cc/WEU4-FM85].

191. *United States v. Mitchell* (*Mitchell I*), 445 U.S. 535 (1980); *United States v. Mitchell* (*Mitchell II*), 463 U.S. 206 (1983); *United States v. Navajo Nation* (*Navajo I*), 537 U.S. 488 (2003); *United States v. Navajo Nation* (*Navajo II*), 556 U.S. 287 (2009).

Tribal Health Data Improvement Act of 2020 have proposed such language but have not made it through the legislative process.[192]

There is a long history of government and researcher misuse of Indigenous health data. "Inaccurate or misleading data presentations can negatively impact policy and funding decisions, and perpetuate stigma and stereotypes that compromise effective public health programming."[193] To prevent such practice, many Tribes have developed robust policies governing research and data ownership with the goal of ensuring that the collection, distribution, and presentation of Tribal-related data is done in accordance with Tribal goals.[194] A recent report offered the following compelling recommendation to ensure this happens: "Consult with [T]ribal nations on the best ways to collect and report state-level tribal data for American Indians and Alaska Natives; some [T]ribal nations may not want tribal level data reported publicly but will want it used in local policy decisions."[195] Agreements between Tribes and state and local governments can be memorialized in data-sharing agreements that govern data use.

### *D. Reform Tribal Medicaid Policies*

Medicaid, a public insurance program for low-income individuals, is funded by the federal government and the states.[196] Although state Medicaid programs are required to follow federal law and policy, states administer their own programs and have substantial flexibility in program structure and participant eligibility.[197] American Indians and Alaska Natives have access to health care through the I/T/U system,[198] but access to Medicaid offers several benefits, including increased access to providers outside the I/T/U system.[199] Additionally, because IHS is a payer

192. Tribal Health Data Improvement Act of 2020, H.R. 7948, 116th Cong.

193. Hoss & Tanana, *supra* note 10, at 80.

194. Stephanie Russo Carroll, Desi Rodriguez-Lonebear & Andrew Martinez, *Indigenous Data Governance: Strategies from United States Native Nations*, 18 DATA SCI. J., art. no. 31, 2019, at 7–8.

195. ASIAN & PAC. ISLANDER AM. HEALTH F., POLICY RECOMMENDATIONS: HEALTH EQUITY CANNOT BE ACHIEVED WITHOUT COMPLETE AND TRANSPARENT DATA COLLECTION AND THE DISAGGREGATION OF DATA 10 (2021), https://www.apiahf.org/wp-content/uploads/2021/02/APIAHF-Policy-Recommendationas-Health-Equity.pdf [https://perma.cc/D6YN-XN8Q].

196. *Program History*, MEDICAID.GOV, https://www.medicaid.gov/about-us/program-history/index.html [https://perma.cc/V5U5-6LQ8] (last visited Mar. 7, 2022).

197. *See id.*; CTR. ON BUDGET & POL'Y PRIORITIES, POLICY BASICS: INTRODUCTION TO MEDICAID 1 (2020), https://www.cbpp.org/sites/default/files/atoms/files/policybasics-medicaid_0.pdf [https://perma.cc/T6FN-JNUK].

198. 42 C.F.R. § 136.30(b) (2021).

199. *E.g.*, TARA JENSEN, MONT. BUDGET & POL'Y CTR., MEDICAID EXPANSION IN INDIAN COUNTRY: IMPROVING THE HEALTH OF INDIVIDUALS AND COMMUNITIES 2, 4 (2018),

of last resort vis-à-vis other federal health programs, Medicaid enrollment provides income to I/T/U facilities when serving a participant who can be billed to Centers for Medicare and Medicaid Services.[200]

State Medicaid policies do not always align with best practices proffered by health policy experts. For example, work requirements, which set employment as a condition for Medicaid eligibility,[201] reduce health coverage without increasing employment.[202] An early Arizona plan for establishing work requirements was developed without Tribal consultation and exempted American Indians and Alaska Natives.[203] This was problematic because if fewer patients were eligible for Medicaid[204] in a state with a substantial Native population, the income stream to I/T/U facilities would be reduced.

Work requirements have also been found to increase the administrative burdens for maintaining enrollment. Research on work requirements for securing benefits through the Temporary Assistance for Needy Families program found that these requirements created extra reporting and tracking responsibilities.[205] Arkansas, the first state to implement Medicaid work requirements in June 2018, saw eligible enrollees losing coverage due to difficulties in reporting work activities.[206]

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https://mbadmin.jaunt.cloud/wp-content/uploads/2018/11/Med-Ex-in-Indian-Country-2018-FINAL.pdf [https://perma.cc/TW2E-CWK4].

200. *See* JENSEN, *supra* note 199, at 1, 4–5; NAT'L INDIAN HEALTH BD., MEDICAID WORK REQUIREMENTS WILL NOT WORK IN INDIAN COUNTRY (2017), https://www.nihb.org/docs/09182017/Medicaid%20Work%20Requirements%20One%20pager.pdf [https://perma.cc/7L32-8DHM].

201. *See Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAM. FOUND. (Feb. 1, 2022), https://www.kff.org/report-section/section-1115-waiver-tracker-work-requirements/ [https://perma.cc/NHU2-B6NS].

202. *See, e.g.*, Leighton Ku & Erin Brantley, *Medicaid Work Requirements: Who's at Risk?*, HEALTH AFFS. (Apr. 12, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170412.059575/full/ [https://perma.cc/DCP6-3Q6E]; MaryBeth Musumeci & Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience*, KAISER FAM. FOUND. (Aug. 18, 2017), https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/ [https://perma.cc/4VCH-AA8J].

203. Felicia Fonseca, *Arizona Is Only State Where Tribes Avoid Medicaid Work Rules*, AP NEWS (Jan. 18, 2019), https://apnews.com/article/north-america-ut-state-wire-ar-state-wire-az-state-wire-native-americans-fc5cfaea775542a7ad761b1b98183ec2.

204. *See* sources cited *supra* note 200; Jessica Bylander, *Propping Up Indian Health Care Through Medicaid*, 36 HEALTH AFFS. 1360, 1360–62 (2017).

205. Musumeci & Zur, *supra* note 202, at 3 & n.12 (citing U.S. GOV'T ACCOUNTABILITY OFF., GAO-13-431, TEMPORARY ASSISTANCE FOR NEEDY FAMILIES: POTENTIAL OPTIONS TO IMPROVE PERFORMANCE AND OVERSIGHT (2013)); *see also* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, WORK AS A CONDITION OF MEDICAID ELIGIBILITY: KEY TAKE-AWAYS FROM THE TANF (2017), https://www.macpac.gov/wp-content/uploads/2017/10/Work-as-a-Condition-of-Medicaid-Eligibility-Key-Take-Aways-from-TANF.pdf [https://perma.cc/NY7A-A96L].

206. *The Implementation of Work Requirements in Arkansas Has Been Complex and Many Enrollees Are Not Aware of New Rules or Face Obstacles in Complying*, KAISER

Enrollee administrative burdens may be felt more keenly amongst patients who primarily secure care at I/T/U facilities; if they are already eligible to receive care at no cost at these facilities, why spend time tackling cumbersome enrollment requirements if there is no immediate, direct benefit to their own health care access? Rather, this benefit is experienced by the I/T/U facility in the form of extra income and felt by the patients collectively.[207] Thus, enrollment burdens may deter I/T/U patients from enrolling in Medicaid at higher rates than others.

Recent conversations regarding Medicaid policy and Tribes focus almost exclusively on the role of Tribal facilities as Medicaid managed care providers.[208] Medicaid managed care organizations (MCOs) are health care delivery systems that provide care to Medicaid patients through contracts with state Medicaid agencies.[209] MCOs provide comprehensive plan benefits with a set per-patient cost.[210] As most states have expanded Medicaid since the passage of the ACA,[211] the use of MCOs has also increased.[212] Managed care is the primary mechanism by which states provide health care access to beneficiaries.[213]

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FAM. FOUND. (Oct. 9, 2018), https://www.kff.org/medicaid/press-release/the-implementation-of-work-requirements-in-arkansas-has-been-complex-and-many-medicaid-enrollees-are-not-aware-of-new-rules-or-face-obstacles-in-complying/ [https://perma.cc/X37D-3XX8].

207. *Tribes Watch as Oklahoma Moves Toward Managed Care for Medicaid*, CITIZEN POTAWATOMI NATION (Sept. 4, 2020), https://www.potawatomi.org/blog/2020/09/04/tribes-watch-as-oklahoma-moves-toward-managed-care-for-medicaid/ [https://perma.cc/4EVJ-DWDW].

208. *But see* Robert Onders, Comment, *Medicaid: Can Federal Responsibilities, State Authorities, and Tribal Sovereignty Be Reconciled?*, 15 WYO. L. REV. 165, 183–84 (2015) (briefly discussing the exploration of Tribal Medicaid Agencies).

209. *Managed Care*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/managed-care/index.html [https://perma.cc/5LWR-QMAD] (last visited Mar. 7, 2022).

210. 42 C.F.R. § 438.2 (2021) ("Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract," which is a "contract between the State and an MCO that covers comprehensive services."); *Managed Care Entities*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/managed-care/managed-care-entities/index.html [https://perma.cc/J58S-A5PG] (last visited Mar. 7, 2022).

211. *Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 130.

212. Elizabeth Hinton & Lina Stolyar, *10 Things to Know About Medicaid Managed Care*, KAISER FAM. FOUND. (Feb. 23, 2022), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/ [https://perma.cc/8Y4K-QK7H].

213. KATHLEEN GIFFORD, EILEEN ELLIS, AIMEE LASHBROOK, MIKE NARDONE, ELIZABETH HINTON, ROBIN RUDOWITZ, MARIA DIAZ & MARINA TIAN, A VIEW FROM THE STATES: KEY MEDICAID POLICY CHANGES 19 (2019), https://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes [https://perma.cc/6VQF-SY4W].

Tribal health facilities can opt into being a provider in MCOs.[214] As NIHB has documented, however, MCO provider agreements require state oversight of these health facilities in a way that compromises Tribal jurisdiction in areas like liability, licensing, and sovereign immunity.[215] Several Tribes have worked toward the development of Indian managed care entities in Oregon.[216] These MCOs are Tribally governed.[217] In 2019, one of the Navajo Nation's business entities, The Naat'áani Development Corporation, announced that it would be establishing an Indian managed care entity.[218] The proposal has not yet secured support from Tribal leadership, however.[219]

Tribal representation as MCO providers and Indian managed care entities is an important development in Indian Medicaid policy. The advocacy work of Tribes and organizations like NIHB is essential to ensuring that the policies governing these developments do not undermine Tribal sovereignty. Nevertheless, reforming the Medicaid landscape to better serve Indian country does not adequately address the underlying issues crippling federal Indian health policy, namely, the chronic underfunding of the I/T/U system and centralizing policymaking across federal and state governments instead of Tribes.

Given the resounding success of Tribal 638 programming,[220] perhaps Indian Medicaid policy also would benefit from a Tribally governed policy

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214. Social Security Act § 1932(h), 42 U.S.C. § 1396u-2(h); The American Recovery and Reinvestment Act (ARRA) of 2009, Pub. L. No. 111-5, § 5006(d), 123 Stat. 115, 505–11; 42 C.F.R. § 438.14 (2021).

215. NAT'L INDIAN HEALTH BD., MEDICAID MANAGED CARE LISTENING SESSION (2021), https://www.nihb.org/tribalhealthreform/wp-content/uploads/2021/03/Medicaid-Managed-Care-Listening-Session_March-4.pdf [https://perma.cc/YLQ8-F8QH].

216. OR. HEALTH AUTH., CMS-PM-10120, STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT (2021), https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/21-0008.pdf [https://perma.cc/KG78-J6GJ]; *The Oregon Experiment: The Tribes and Care Coordination Organizations*, *in* NAT'L INDIAN HEALTH BD., *supra* note 215.

217. *The Oregon Experiment: The Tribes and Care Coordination Organizations*, *supra* note 216.

218. *Navajo Nation to Create 'One-of-a-Kind Medicaid Program*,*'* AP NEWS (Dec. 18, 2019), https://apnews.com/article/21cca3fc520d6cb8f0c0e2fbd28e3408.

219. *Compare* Press Release, The Navajo Nation Off. of the President & Vice President, Nez-Lizer Express Concerns with Naat'áani Development Corporation's Actions to Gain Approval to Oversee Medicaid Funds (Jan. 17, 2021), https://www.navajo-nsn.gov/News%20Releases/OPVP/2021/Jan/Nez-Lizer%20express%20concerns%20with%20Naat%20aani%20Development%20Corporations%20actions%20to%20gain%20approval%20to%20oversee%20Medicaid%20funds.pdf [https://perma.cc/FV73-V8PZ], *with* Seth Damon, *Navajo Nation's Revolutionary Biz Approach Awaits Governor's OK*, ALBUQUERQUE J. (Jan. 24, 2021, 12:02 AM), https://www.abqjournal.com/2083432/navajo-nations-revolutionary-bi-zapproach-awaits-governors-ok.html [https://perma.cc/J893-T5NK].

220. *The Success and Shortfall of Self-Governance Under the Indian Self-Determination and Education Assistance Act After Twenty Years*, *supra* note 113.

instead of accommodating the state decisions regarding important decisions like expansion and MCOs. Is there any reason why Tribes should not have the opportunity to administer their own Medicaid programs that are structured to support Tribal community needs? Although some differences exist in its administration, federal law authorizes territories to operate their own Medicaid programs.[221] The five territories that operate these programs (American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands) have the flexibility to determine beneficiary eligibility and services provided.[222]

Known as "Treatment as a State" (TAS) provisions, federal law already authorizes Tribes to assume authority over areas previously earmarked for states.[223] The Clean Air Act,[224] for example, establishes standards to limit the emission of air pollutants.[225] The law requires that states ensure compliance with these standards.[226] The 1990 Clean Air Act Amendments authorized Tribes to be treated as states to develop their own implementation and enforcement plans.[227] TAS provisions are also found in other federal laws, including the Clean Water Act, the Safe Drinking Water Act, and the Toxic Substance Control Act.[228] Perhaps these environmental TAS provisions could be applied in the Medicaid context to allow Tribes to have the option to develop their own policies. As it stands, reforms are needed to ensure that Tribes are in the position to craft policies based on their community's needs rather than being forced to defer and accommodate state decisions.

## CONCLUSION

In their writing on cultural sovereignty, Tsosie and Coffey stated that "only Native people can decide what the ultimate contours of Native

221. Social Security Act § 1101(a)(1), 42 U.S.C. § 1301(a)(1).

222. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MEDICAID AND CHIP IN THE TERRITORIES (2021), https://www.macpac.gov/wp-content/uploads/2019/07/Medicaid-and-CHIP-in-the-Territories.pdf [https://perma.cc/LVE6-PQ3P].

223. *See Tribal Assumption of Federal Laws – Treatment as a State (TAS)*, U.S. ENV'T PROT. AGENCY, https://www.epa.gov/tribal/tribal-assumption-federal-laws-treatment-state-tas [https://perma.cc/Z3HC-P8SY] (last visited Mar. 7, 2022).

224. 42 U.S.C. ch. 85.

225. *Id.* § 7409; *Clean Air Act Requirements and History*, U.S. ENV'T PROT. AGENCY, https://www.epa.gov/clean-air-act-overview/clean-air-act-requirements-and-history [https://perma.cc/XK28-W8K5] (last visited Mar. 7, 2022).

226. § 7410.

227. Clean Air Act Amendments of 1990, Pub. L. No. 101-549, § 107(d), 104 Stat. 2399, 2464–65.

228. *Tribal Assumption of Federal Laws – Treatment as a State (TAS)*, *supra* note 223.

sovereignty will be."[229] While I cannot speak to the full contours of Tribal health sovereignty, federal Indian health reform is essential to ensuring health sovereignty for all Tribes. The chronic, persistent, and egregious failures of federal Indian health policy cannot be overstated. Tangible reforms can be made to federal law to facilitate Tribally led health programming. This Essay proposes some of these reforms in the hope that the pandemic will highlight the urgency of addressing persistent health inequities in Indian country.

229. Coffey & Tsosie, *supra* note 22, at 196.