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Health Care Reform for Native Americans

The Long-Awaited Permanent Reauthorization of the Indian Health Care Improvement Act

By Sarah Somers

Sarah Somers
Senior Attorney

National Health Law Program
101 E. Weaver St. Suite G-7
Carrboro, NC 27510
919.968.6308
somers@healthlaw.org

This year's extensive health care reform featured a long-awaited permanent reauthorization of the Indian Health Care Improvement Act.[1] The Act states that

> a major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States.[2]

To this end, the Act authorizes ongoing appropriations for health service programs for Indians and Native Alaskans, primarily through the Indian Health Service. It bestows authority on tribes to conduct their own programs, provides for expansion of the health care workforce serving Native Americans, makes organizational improvements to the Indian Health Service, and contains other provisions designed to increase access to and quality of health services. And, consistent with goals of tribal self-determination, the Act is intended to ensure maximum participation by tribes themselves in directing and providing health care services in order to establish a system that is more responsive to the needs of Indian and Native Alaskan communities.[3]

Here, after some background on health care for Native Americans, I describe the major components of the Indian Health Care Improvement Act as permanently reauthorized in 2010.

Background on Health Care for Native Americans

Federal and tribal governments have long struggled to deliver adequate and effective health care services to Native Americans. Indians and Alaska Natives suffer disproportionately from chronic conditions and disabilities, injuries, and physical and mental health illnesses. They also die at higher rates than other Americans of many

[1]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010) (Indian Health Care Improvement Act codified at 25 U.S.C. §§ 1601–1680o). Immediately after President Obama signed the Patient Protection and Affordable Care Act on March 23, 2010, the Act was amended by the Health Care and Education Reconciliation Act (Pub. L. No. 111-152, 124 Stat. 1029 (2010)), which the president signed a week later; the resulting combined legislation is referred to as the Affordable Care Act. The changes under the Health Care and Education Reconciliation Act do not affect the Indian Health Care Improvement Act; thus I do not discuss or cite the Health Care and Education Reconciliation Act here. For a comprehensive discussion of the new health care law, see Sarah Somers & Jane Perkins, *The Affordable Care Act: A Giant Step Toward Insurance Coverage for All Americans*, in this issue.

[2]Indian Health Care Improvement Act, 25 U.S.C. § 1601(2).

[3]Detailed technical definitions of the terms "Indian," "Indian tribe," "Tribal organization," "Urban Indian," and "Urban Indian organization" are set forth in the Indian Health Care Improvement Act (*id.* § 1603(13), (14), (26), (28), (29)).

preventable causes, including tuberculosis (500 percent higher), alcoholism (519 percent higher), diabetes (195 percent higher), unintentional injuries (149 percent higher), suicide (72 percent higher), and homicide (92 percent higher).[4] That many Native Americans live in remote, rural areas exacerbates the problems with health service delivery.[5]

Three federal statutes provide the foundation for contemporary health services for Native Americans. In 1921 Congress passed the Snyder Act, which authorized the Bureau of Indian Affairs to conduct programs "for the relief of distress and conservation of health" for Native American people.[6] In 1975 Congress enacted the Indian Self-Determination and Education Assistance Act, authorizing tribes and Alaska Native villages to contract with federal agencies to provide Indians and Alaska Natives with federal services, including health care.[7] And in 1976 Congress enacted the Indian Health Care Improvement Act, consolidating existing Indian Health Service programs, authorizing additional funding to improve care provided by the Indian Health Service, and establishing programs to educate health professionals to work in Indian communities.[8] The last permanent reauthorization of the Act, in 1992, appropriated funds through 2000.[9] Since 2001, Congress has appropriated funds annually, pursuant to the authority of the Snyder Act.[10]

Primary responsibility for Indian health care lies with the Indian Health Service, which provides health care services for more than 1.8 million people.[11] This agency, currently within the U.S. Department of Health and Human Services (HHS), is intended to be a comprehensive service delivery system for Indians and Native Alaskans and to allow for tribal involvement in managing and overseeing health programs.[12] All people of Native American or Alaska Native descent, whether they are enrolled in a federally recognized tribe or not, are eligible for services from the Indian Health Service.[13] Through hospitals, clinics, school health centers, and other facilities, the Indian Health Service provides its services.[14] And, through self-governance compacts, American Indian Tribes and Alaska Native corporations administer hospitals, health centers, health stations, and Alaska Village clinics.[15]

The Indian Health Service is chronically underfunded.[16] Recruiting and retaining

[4]Indian Health Service, U.S. Department of Health and Human Services, IHS [Indian Health Service] Fact Sheets: Indian Health Disparities (Jan. 2010), http://bit.ly/c7uFk3. These figures are based on 2003–2005 data, which the Indian Health Service uses in its fact sheets describing the state of Native Americans' health.

[5]Byron L. Dorgan, Senator Dorgan Concept Paper: Reforming the Indian Health Care System 3 (July 6, 2009), http://bit.ly/bvEqvM.

[6]Snyder Act, 25 U.S.C. § 13; see also Indian Health Service, U.S. Department of Health and Human Services, The First 50 Years of the Indian Health Service: Caring and Curing 8 (n.d.), http://bit.ly/c3ieek (discussing Snyder Act and history of Native American health from 1921–1955). For an in-depth discussion of the laws establishing the right to health care for Indians, see Carole Goldberg et al., Cohen's Handbook of Federal Indian Law § 22.04 (2005).

[7]Indian Self-Determination and Education Assistance Act, 25 U.S.C. §§ 450–458bbb-2; see also Indian Health Service, *supra* note 6, at 10 (discussing Indian Self-Determination and Education Assistance Act).

[8]Indian Health Care Improvement Act, Pub. L. No. 94-437, 94 Stat. 437 (1976) (codified as amended at 25 U.S.C. §§ 1601–1683); see also Indian Health Service, *supra* note 6, at 10 (discussing Indian Health Care Improvement Act); Goldberg et al., *supra* note 6, § 22.04[1] (same).

[9]Indian Health Amendments of 1992, Pub. L. No. 102-573, 106 Stat. 4526 (codified as amended at 25 U.S.C. 1601–1680o).

[10]Dorgan, *supra* note 5, at 3; see Snyder Act, 25 U.S.C. § 13.

[11]Elayne J. Heisler & Roger Walke, Congressional Research Service, No. R41152, Indian Health Care Improvement Act Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148) 1 (March 30, 2010), http://bit.ly/ajfr28.

[12]Indian Health Service, IHS Fact Sheets: Tribal Self-Governance (Jan. 2010), http://bit.ly/bE64qP.

[13]42 C.F.R. § 136.12 (2010).

[14]Indian Health Service, IHS Fact Sheets: IHS Year 2010 Profile (Jan. 2010), http://bit.ly/a3Tf5i.

[15]Indian Health Service, *supra* note 12.

[16]See, e.g., Dorgan, *supra* note 5, at 2.

staff is a challenge for the agency. The agency reports that the current vacancy rate is 21 percent for physicians, 16 percent for nurses, 17 percent for dentists, and 11 percent for pharmacists.[17]

To help overcome some of the barriers to service delivery, federal law authorizes contract health services, from non–Indian Health Service and nontribal providers and either paid for by or based on a referral from the Indian Health Service.[18] Contract health services may be used only when "necessary health services … are not reasonably accessible or available" from an Indian Health Service or tribal source.[19]

Indian Health Care Improvement Act—2010

In this year's health care reform legislation, the Patient Protection and Affordable Care Act, Congress included a permanent reauthorization of the Indian Health Care Improvement Act, appropriating sums necessary for the 2010 fiscal year and each fiscal year thereafter.[20] The law contains provisions addressing

- recruitment, education, training, and retention of Indian health care providers to serve Indian communities;
- funding for Indian Health Service or tribally operated health facilities and for specific health services;
- delivery of services for dental health, behavioral health, and chronic disease;
- organizational improvements to the Indian Health Service;
- a comprehensive behavioral health prevention and treatment program;
- Indian youth suicide prevention programs;
- urban Indians;
- public health insurance coverage; and
- other miscellaneous health-related issues.[21]

The Indian Health Care Improvement Act declares a national Indian health policy to ensure

> the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy [and] to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives.[22]

The intent of Congress in establishing this policy is to ensure maximum direction of health care services by Indians themselves, and the policy requires that all actions mandated by the Act be carried out with "active and meaningful consultation" with tribes.[23]

The Indian Health Care Improvement Act includes numerous provisions intended to increase and improve the meager ranks of Indian health care workers.[24] The Act, among other measures, authorizes the HHS secretary to fund health professional chronic shortage demonstration programs to provide practical, clinical experience to health professional

[17]Indian Health Service, IHS Fact Sheets: Workforce (Jan. 2010), http://bit.ly/8YhU2W.

[18]25 U.S.C. § 1603(5); see also 42 C.F.R. § 136.23(a) (2010) (governing coverage of contract health services); Indian Health Service, IHS Fact Sheets: Contract Health Services (Jan. 2010), http://bit.ly/9KoObV.

[19]42 C.F.R. §§ 136.21(e), .23(a) (2010).

[20]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935–36 (2010) (Indian Health Care Improvement Act codified at 25 U.S.C. § 1680o).

[21]25 U.S.C. § 1680o.

[22]*Id.* § 1602. Healthy People 2010 is a set of health objectives to be achieved during the first decade of this century; it builds on previous objectives that developed from a report of the U.S. Surgeon General in 1979 (see What Is Healthy People? (n.d.), http://bit.ly/at9upF).

[23]25 U.S.C. § 1602.

[24]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221(a), 124 Stat. 119, 935–36 (2010) (enacting Subtitle A of Indian Health Care Improvement Act Reauthorization and Amendments) (codified in scattered sections of 25 U.S.C.).

students and residents and academic and scholarly opportunities for health professionals serving Indians.[25] The Act reauthorizes and amends provisions governing the use of community health aides. The community health aide program authorizes Native Alaskan aides and nonphysician and nondentist practitioners to provide health prevention and treatment services to Alaska Natives living in rural villages.[26]

The Act requires that an independent study be conducted to ensure that any dental health aide services through the community health aide program are of high quality.[27] Dental health aides are strictly prohibited from performing oral or jaw surgery.[28] Aides may perform simple extractions and pulpal therapy only if a licensed dentist certifies after consultation that the procedure is a medical emergency.[29] The law also allows the HHS secretary to authorize a national community health aide program that does not include dental health aide therapists.[30] Only if a tribe elects to do so, and state law authorizes their use, may dental health aide therapists be a part of a community health aide program in a state other than Alaska.[31]

The Indian Health Care Improvement Act authorizes an Indian Health Care Improvement Fund to eliminate deficiencies in health status and resources, backlogs in service provision, and inequities in funding and to help meet in an equitable manner Indians' health needs, such as the use of telehealth services when appropriate.[32] Funds may be used to help the Indian Health Service meet needs for clinical and preventive care, including dental care; mental health and substance abuse treatment; emergency services; injury prevention, including data collection and evaluation, demonstration projects, training, and capacity building; home health care; and other needs.[33] Funds are to be allocated to Indian Health Service units, tribes, or tribal organizations and may not be used to offset or limit other appropriations to the Indian Health Service.[34] Increased funding is provided to a Catastrophic Health Emergency Fund, to be used to meet extraordinary medical costs associated with treating victims of disaster or catastrophic illness for whom the Indian Health Service is responsible.[35]

Other provisions relate to specific conditions or types of services. For example, the HHS secretary, in concert with the Indian Health Service, tribes, and tribal organizations, is required to survey the prevalence and impact of diabetes among Indians and to determine measures to be taken to reduce, prevent,

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[25]Indian Health Care Improvement Act, 25 U.S.C. § 1616p.

[26]*Id.* § 1616l.

[27]*Id.* § 1616l(c).

[28]*Id.* § 1616l(b)(7).

[29]*Id.*

[30]*Id.* § 1616l(d).

[31]*Id.* The requirements related to dental health aides are rooted in conflict between dentists and Native Alaskan tribes. In 2002 a consortium of Alaska Native groups authorized the certification and use of dental health aide therapists to perform dental procedures, such as extraction of teeth, normally reserved to dentists. The Alaska and American Dental Associations, claiming that dental health aide therapists were engaging in the unauthorized practice of dentistry, sued to halt the use of dental health aide therapists. An Alaska state court, rejecting these claims, ruled that the state dental practice laws conflicted with the federal statute governing the community health aide program and that the state law thus was invalid and could not be used to prevent dental health aide therapists from providing services (Alaska *Dental Society v. Alaska,* No. 3AN-06-04797CI, at 11 (Alaska Sup. Ct. June 27, 2007) (order granting summary judgment)).

[32]25 U.S.C. § 1621(a). Telehealth is defined as "the use of electronic information and telecommunications technologies to support long distance clinical health care, patient and professional health-related education, public health, and health administration" (*id.* § 1603(23); 42 U.S.C. § 254c-16(a)(4)).

[33]25 U.S.C. § 1621(a)(5).

[34]*Id.* § 1621(b).

[35]*Id.* § 1621(a).

and treat the disease.[36] And, to the extent medically indicated, every Indian who receives services from the Indian Health Service must be screened for diabetes.[37] The Act also requires the establishment of a director of HIV/AIDS (human immunodeficiency virus/acquired immune deficiency syndrome) prevention and treatment.[38] The Act authorizes the HHS secretary to fund various long-term care services such as home- and community-based services, assisted living facility services, and hospice care.[39] The secretary may contract with tribes or tribal organizations to deliver facility-based long-term care and related health care services, for example, by constructing or expanding a long-term care or similar facility.[40] Such agreements must provide for sharing of staff among the Indian Health Service, tribal health programs, and any long-term care facilities or providers.[41] The Act specifies that any nursing facility services under this provision must comply with the Nursing Home Reform Act.[42]

The Indian Health Care Improvement Act requires the development of a comprehensive behavioral health and substance abuse treatment program.[43] It requires collaboration among alcohol and substance abuse services, social services, and mental health programs.[44] The program must give information, direction, and guidance to the various federal, state, tribal, and local agencies responsible for service programs in Indian communities.[45] The secretary must provide a comprehensive continuum of behavioral health care and programs consisting of (1) community-based prevention, intervention, outpatient care, and behavioral health aftercare; (2) detoxification; (3) acute hospitalization; (4) intensive outpatient and day treatment (5) residential treatment; (6) transition living; (7) emergency shelter; (8) intensive case management; (9) diagnostic services; and (10) promotion of injury prevention.[46]

The Indian Health Care Improvement Act authorizes specific behavioral health programs, one being a mental health technician program through which mental health paraprofessionals provide education, prevention, and treatment and use traditional health practices.[47] The Act also authorizes programs for treating Indian women and Indian youth; providing training and community education; dealing with fetal alcohol spectrum disorders, child sexual abuse, and domestic and sexual violence; and developing innovative behavioral health services.[48]

The HHS secretary is directed to carry out an Indian youth suicide prevention demonstration program to test the use of telemental health services in delivering suicide prevention services.[49] This demonstration program uses psychotherapy, psychiatric assessments, and diagnostic interviews as well as consultation, ad-

[36] *Id.* § 1621c(a).

[37] *Id.* § 1621c(b).

[38] *Id.* § 1680v.

[39] *Id.* § 1621d.

[40] *Id.* § 1680l(b)(3).

[41] *Id.* § 1680l(a).

[42] *Id.* § 1680l(c); see also Nursing Home Reform Act, 42 U.S.C. § 1396r.

[43] 25 U.S.C. § 1665a(1).

[44] *Id.*

[45] *Id.* § 1665a(a), (b).

[46] *Id.* § 1665a(c).

[47] *Id.* § 1665d.

[48] *Id.* §§ 1665f–1665l.

[49] *Id.* § 1667(b)(1).

vice, and training for providers working with youth.[50] The development and use of culturally appropriate practices and education materials are emphasized.[51]

The Indian Health Care Improvement Act expands authority for urban Indian organizations to operate health projects to serve urban Indians. Despite urban Indians having high levels of unmet health needs, only thirty-four urban Indian programs serve more than 150,000 individuals.[52] The Act authorizes such measures as behavioral health training, substance abuse and communicable disease prevention programs, and grants to implement health information technology.[53] The Act also authorizes the secretary to contract with urban Indian organizations to operate community health representative programs.[54] Indian health paraprofessionals who provide health care services as well as health, education, and health promotion programs are community health representatives.[55] Tribes have been able to operate community health representative programs for several decades.[56]

A number of the Act's provisions relate to public health insurance coverage. For example, a provision gives tribal health programs authority to bill the federal government directly for governmental services that are reimbursable by Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or any third-party payor.[57] The HHS secretary is authorized to make grants to or contract with Indian tribes and tribal organizations to establish outreach programs on or near reservations to help Indians enroll in Medicaid, Medicare, or CHIP and to help pay premiums or cost sharing for such benefits.[58] And the Act requires all federal health care programs to accept an Indian Health Service or tribally operated entity as an eligible provider to receive payment for health care services to an Indian on the same basis as any other provider if it meets generally applicable state and other requirements.[59]

The Indian Health Care Improvement Act also reauthorizes and extends the Native Hawaiian Health Care Act of 1988 until 2019.[60]

■ ■ ■

Native Americans and their allies finally achieved the goal of permanent reauthorization of the Indian Health Care Improvement Act. The breadth and scope of the Act inspire hope that the persistent problem of Indian health disparities will be alleviated. Yet advocates need to be mindful that much work remains. As Reno Keoni Franklin, chairman of the Indian Health Board, said, "[w]hile we celebrate this historic event in bringing hope to our communities, we look forward to working together to start a new legacy for the Indian health care system."[61] Improving the lives of Native Americans will be the work of many years to come.

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[50]*Id.* §§ 1667b(b).

[51]*Id.*, § 1667b(b)(1)(D).

[52]Dorgan, *supra* note 5, at 11.

[53]25 U.S.C. §§ 1651–1660h.

[54]*Id.* § 1616.

[55]*Id.* § 1660f.

[56]See Indian Health Service, Community Health Representative [CHR]: General CHR Information: Information and Background Development of the Program (n.d.), http://bit.ly/anzDs4.

[57]25 U.S.C. § 1641(d).

[58]*Id.* § 1644.

[59]*Id.* § 1647a.

[60]Native Hawaiian Health Care Act of 1988, 42 U.S.C. §§ 11705, 11706, 11709, 11711.

[61]Press Release, National Indian Health Board, America Reaffirms Health Care for Indian Country (March 21, 2010), http://bit.ly/dp0dJV.

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