

# American Indian Health Policy: Historical Trends and Contemporary Issues

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The United States has a trust responsibility to provide services to American Indians and Alaska Native (AI/AN) persons. However, a long-standing history of underfunding of the Indian Health Service (IHS) has led to significant challenges in providing services.

Twentieth century laws, including the Snyder Act, Transfer Act, Indian Self-Determination and Education Assistance Act, and Indian Health Care Improvement Act (IHCIA) have had an effect on the way health services are provided. IHCIA was reauthorized as part of the Patient Protection and Affordable Care Act (ACA). Several provisions in ACA allow for potential improvements in access to services for AI/AN populations and are described herein.

Although policy developments have been promising, IHS underfunding must be resolved to ensure improved AI/AN health. (*Am J Public Health*. 2014;104:S263–S267. doi:10.2105/AJPH.2013.301682)

## AMERICAN INDIAN AND

Alaska Native (AI/AN) tribes have had a unique history with the United States that is mixed with conflict, warfare, cooperation, and partnership. This history has resulted in a complex web of federal Indian policy, treaties, and inter-governmental relationships. Services provided to AI/AN persons (e.g., housing, education, health care) have been guaranteed through treaties, executive orders, and other legal bases. For example, between 1778 and 1868, at least 367 treaties were ratified by the federal government.<sup>1</sup> The Supremacy Clause of the US Constitution establishes the Constitution, federal statutes, and treaties as “the supreme law of the land.” Typical language in many of the treaties signed between the United States and tribal nations included phrases like “promise of all proper care and protection” in exchange for tribal land and natural resources. The result is that there is a trust responsibility on behalf of the federal government to provide services to AI/AN persons. The federal Indian trust responsibility is a legal obligation under which the government “has charged itself with moral obligations of the highest responsibility and trust” toward Indian tribes.<sup>2</sup> This obligation was initially described by Chief Justice John Marshall in 1831 in reference to the Supreme Court case *Cherokee Nation v Georgia*.<sup>3</sup> Trust responsibility is also a legally administrated financial obligation on the part of the US government to defend tribal treaty rights, lands, assets,

and resources, as well as a duty to provide health services. However, a long-standing history of underfunding of the Indian Health Service (IHS) and its predecessor agencies has led to significant challenges in providing proper care and protection. This article provides a brief overview, history, and evolution of AI/AN health policy as well as recent trends and contemporary issues.

## POLICY HISTORY

A deficiency of resources has plagued the provision of health services to AI/AN persons since the last treaties were signed in 1871. For example, according to the 1890 Annual Report of the Commissioner of Indian Affairs, physicians working with Indian populations were paid an average annual salary of \$1028 compared with \$2823 and \$2622 for Army and Navy physicians, respectively.<sup>4</sup> In 1914, Warren K. Moorehead, a commissioner for the Bureau of Indian Affairs, stated that “It is incomprehensible to me that appropriations for combating disease are so meager.”<sup>5</sup> Unfortunately, underfunding of the IHS continues to this day (Figure 1). However, numerous laws passed in the 20th century have had a significant impact on the way health services are provided to AI/AN persons. Several of them, including the Snyder Act, Transfer Act, Indian Self-Determination and Education Assistance Act, and the Indian Health Care Improvement Act, are described here. These 4 laws

encompass only a small portion of the exhaustive list of laws and policies affecting how AI/AN individuals receive health services.

### Snyder Act

Before 1955, the Indian health program was operated by the Bureau of Indian Affairs (BIA)—an agency within the Department of the Interior. The Snyder Act of 1921 states that

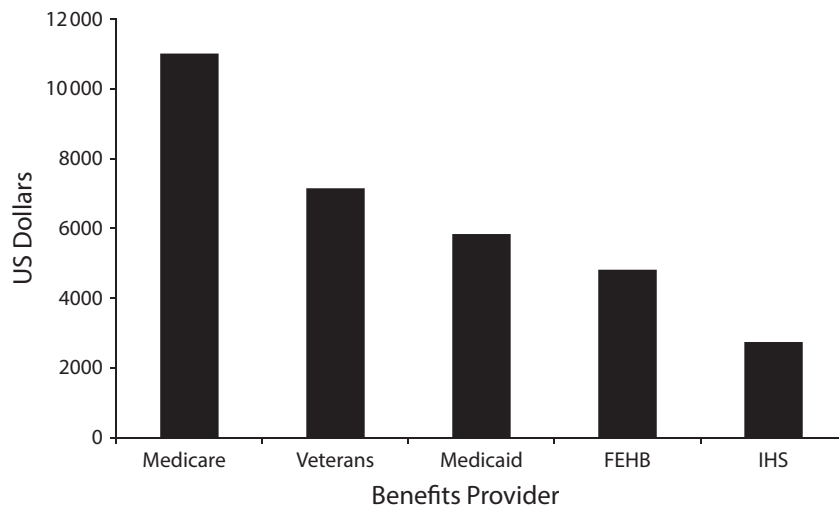
The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States.

This was the first law that allowed Congress to appropriate funds to address AI/AN health on a recurring basis. Included in the list of acceptable uses of Congressional appropriations was “for relief of distress and conservation of health,” and “for the employment of . . . physicians.”<sup>7</sup> The funding authority for many of the current activities of the IHS is rooted in the Snyder Act.

### Transfer Act

The Indian health program became a responsibility of the Public Health Service under the Transfer Act of 1954. The act states

that all functions, responsibilities, authorities, and duties. . . relating to the maintenance and operation of hospital and health facilities for Indians, and the conservation of Indian health . . . shall be administered by the Surgeon General of the United States Public Health Service.



Note. FEHB = Federal Employee Health Benefits; IHS = Indian Health Service.  
Source. National Tribal Budget Formulation Workgroup.<sup>6</sup>

**FIGURE 1—2009–2010 Indian health expenditures per capita compared with other federal health care expenditures per capita.**

The act also states that

whenever the health needs of the Indians can be better met thereby, the Secretary . . . is authorized in his discretion to enter into contracts with any . . . institution providing for the transfer of Indian hospitals or health facilities

with the condition that such a transfer cannot be made “unless such action has been approved by the governing body of the tribe.”<sup>8</sup> This language recognized tribal sovereignty and afforded a degree of tribal self-determination in health policy decision-making. The authorities contained in the Snyder Act were also transferred to the Secretary of Health, Education, and Welfare (now Health and Human Services).

### Indian Self-Determination and Education Assistance Act

The Indian Self-Determination and Education Assistance Act (ISDEAA) was enacted in 1975, and it is perhaps the most significant law affecting how health services are provided to AI/AN tribes.<sup>9</sup>

This act is the basis for authorizing tribes to assume the management of BIA and IHS programs, and it directs the Secretaries of Interior and Health and Human Services to enter into self-determination contracts at the request of any tribe.<sup>10</sup> In terms of health services, any program, function, service, or activity of the IHS can be assumed by the tribe under a “638 contract.” Under Title I of the ISDEAA, a tribe may become a federal contractor to provide services as outlined in the IHS line item budget for a given service unit (clinic or hospital). Under Title V of ISDEAA, the funding agreement is a “638 compact” and is essentially a block grant for a total budget amount, and the tribes have greater flexibility in reprogramming resources to meet local health needs. Several financial and administrative advantages are available to the tribes via ISDEAA:

- *Carry-Over Funding.* Unlike many federally funded programs that require complete budget

expenditures within a given fiscal year, under the ISDEAA, “any funds for any fiscal year which are not obligated or expended shall remain available for obligation or expenditure during such succeeding fiscal year for which they were originally appropriated, contract, or granted. No additional justification need be provided by the tribal organization.”<sup>11</sup>

- *Third-Party Revenue.* Revenue collected from private or public insurance is treated as supplemental revenue and does not affect the negotiated dollar amounts in 638 funding agreements.
- *Eligibility for Grants.* Tribal 638 programs are eligible for numerous federal grants for which the IHS, as a federal agency, is not eligible. For example, a tribe is eligible for Community Health Center grants from the Health Resources and Services Administration under Section 330 of the Public Health Service Act. These grants support health centers in health professions shortage areas, which include

many Indian reservations. A tribe can combine contracted or compacted funds from ISDEAA with Section 330 grants in addition to collecting third-party revenue, resulting in significantly greater resources to address community health.

- *Contract Support Costs.* Contract Support Costs (CSCs) are administrative funds used to manage a contract and are based on the tribes’ indirect cost rates. For example, if a tribe has a 30% indirect cost rate, the ISDEAA contract would include all direct costs of contracted services plus 30% for CSCs. The IHS does not have similar line items for administrative costs. However, federal budgets in recent years have not supported 100% of CSCs owed to the tribes, thus creating significant controversy.<sup>12</sup>

More than half of the IHS budget is now managed by the tribes under ISDEAA.<sup>13</sup> Although there are numerous examples of successfully implemented tribal health programs, some tribal leaders have expressed concerns over contracting or compacting for services that are chronically and significantly underfunded.<sup>14</sup>

### Indian Health Care Improvement Act

The Indian Health Care Improvement Act (IHICIA) was enacted in 1976 and was instrumental in setting national policy to improve the health of Indian people. The language regarding the responsibility of the United States to maintain and improve the health of AI/AN persons was needed to enhance the intent of previous laws by expanding and describing modern health services.<sup>15</sup> Title V of IHICIA established the Urban Indian Health Programs, of which there are 34 nationally.<sup>16</sup> The act

also included the initial authorization that allowed IHS and tribal 638 health programs to bill Medicare and Medicaid. Since 1976, reimbursements from Medicare, Medicaid, and Children's Health Insurance Program (CHIP) have aided Indian health programs to expand access to services.

### I/T/U Health Care Delivery and Funding Authorities

With the legislative initiatives of the 20th century, the provision of services for AI/AN persons has evolved significantly. The health care delivery system is now described as the "I/T/U" system, in which "I" represents IHS, "T" represents tribal 638 programs, and "U" represents the urban health centers. The funding authority for IHS is rooted in both the Snyder Act and the Transfer Act. ISDEAA allows tribes to take over the management of health programs from the IHS via contracts or compacts, and Title V of the IHICIA established the Urban Indian Health Centers.

### Level of Need Funded

A long-standing issue in the provision of health services to AI/AN persons is underfunding of the IHS.<sup>17</sup> For example, between 1993 and 1998, IHS appropriations increased by 8%, while medical inflation increased by 20.6%. As a result, when both the rate of medical inflation and increases in the AI/AN population were considered, there was, in reality, a decrease of 18% in the per capita appropriation for IHS during this period.<sup>18</sup> In 1998, Congress requested that the IHS develop a report on health status and resource shortages. A Level of Need Funded (LNF) Workgroup was established to develop a methodology for determining appropriate funding levels for Indian health.<sup>19</sup> Because both

federal employees and AI/AN persons have a legal right to health services, the LNF Workgroup compared IHS per capita expenditures with the Federal Employee Health Benefits (FEHB) plan. The LNF study in 1998 showed a 46% shortfall in funding for AI/AN persons receiving care through the IHS compared with FEHB.<sup>20</sup>

### RECENT TRENDS AND FUTURE DIRECTIONS

Since the passage of the IHICIA in 1976, the role of the Centers for Medicare and Medicaid Services (CMS) in Indian health has expanded. In our experience, some tribes and AI/AN persons have been reluctant to enroll in CMS programs for various reasons, including trust issues related to sharing personal information with a non-Indian government agency and the fact that many tribes have treaties that ensure access to health care. However, these treaties are with the federal government, not the IHS, and CMS is a component of the federal government. CMS has a much larger budget than IHS, and its programs should be considered an important component of the federal trust responsibility to provide health services. For many IHS and tribal service units, the funds generated from third-party revenue exceeds the funding from direct Congressional appropriations, and in most cases, Medicaid is the primary payer because of high rates of poverty. The percentage of AI/AN adults living at or below the federal poverty level in 2009 (20.4%) was about 2.5 times greater than the percentage of Whites living in poverty (8.4%).<sup>21</sup> Medicaid expansion under the Patient Protection and Affordable Care Act (ACA) should increase the number of AI/AN individuals eligible for and enrolled in

Medicaid. This should result in increased access to health services; however, some states have elected not to expand Medicaid. It is unclear what the impact will be on AI/AN persons in states that choose not to expand Medicaid.

A separate and parallel Medicaid system exists for the IHS and tribal 638 programs. States are reimbursed with 100% Federal Medical Assistance Percentage for payments made to these programs, and therefore, state funds are not used to pay for Medicaid-covered services in IHS or 638 facilities. However, the urban Indian health centers are not eligible for 100% Federal Medical Assistance Percentage, and the states must pay their percentage of Medicaid costs to these facilities.

### Potential Impact of the ACA

Although the ACA is often referred to as "health care reform," in truth, it is health insurance reform. In addition to Medicaid expansion, another key provision includes the requirement of health insurance companies to pay for preventive services and cancer screening. For AI/AN persons, when specialty and other services are not directly available at an IHS or tribal facility, services are purchased in the public and private sectors through the Contract Health Services (CHS) program of the IHS. With high rates of diseases like colorectal cancer among AI/AN populations in certain regions of the United States, access to screening or diagnostic colonoscopy could result in earlier detection and potentially life-saving interventions. However, the IHS is not health insurance, and the guidelines for referrals under the CHS are not affected by the ACA. Therefore, a procedure like colonoscopy, which is not considered to be a high priority referral by a CHS program,

could be denied. As a result, disparities in colorectal cancer mortality could worsen unless AI/AN persons have access to health insurance—Medicaid or otherwise.

Another provision in the ACA that could affect AI/AN health is expansion of Federally Qualified Health Centers (FQHCs). FQHCs are funded by grants from the Health Resources and Services Administration that are authorized by Section 330 of the Public Health Service Act.<sup>22</sup> Although the ACA authorizes FQHC expansion, it will be up to Congress to appropriate the funds needed to implement this expansion. Tribal 638 programs and urban Indian health centers are eligible for these grants; however, as a federal agency, IHS is not eligible. Nationally, several tribal 638 programs and urban Indian health facilities receive "330 grants" and are within the network of community health centers funded by the Health Resources and Services Administration.

### Permanent Reauthorization of the IHICIA

Although it was due for reauthorization in 2000, the IHICIA was permanently reauthorized as part of the ACA in March 2010.<sup>23</sup> The Declaration of National Indian Health Policy in the IHICIA states that

Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.

This version of the IHICIA differs in multiple ways from the original IHICIA. It includes several modifications designed to improve the provision of health services to AI/ANs, such as:

- Augmented authorities of the IHS director;

- Authorization for hospice, assisted living, long-term care;
- Modernization of current law concerning collecting reimbursements from Medicare, Medicaid, and CHIP;
- Permission for tribes and tribal organizations to purchase health benefits for their community members;
- Allowing IHS to enter into agreements with the Departments of Veterans Affairs and Defense to share health facilities and services;
- Allowing a tribe or tribal organization that operates programs under ISDEAA and an urban Indian organization to purchase health insurance coverage for its employees from FEHB;
- Authorization for the establishment of a Community Health Representative (commonly called community health workers in other sectors) program for urban Indian organizations; and
- Directing the IHS to establish comprehensive behavioral health, prevention, and treatment programs.<sup>24</sup>

Although the provisions in the new version of the IHCIA are promising, this act authorizes Congress to appropriate resources to meet these goals. However, there is no guarantee that Congress will appropriate adequate resources.

### Policy Innovations

Although significant numbers of AI/AN persons are impoverished,<sup>25</sup> many tribal communities are successful financially. With economic development comes the opportunity to expand health programs. In our experience, many tribes are successfully implementing health policy innovations, including tribal self-insurance programs. The process of combining tribal 638 programs with self-insurance substantially increases access to services by coordinating

multiple funding streams and by overcoming the limitations of CHS. In addition, some tribal communities are entering into private sector partnerships with hospital systems, insurance companies, the pharmaceutical industry, academic institutions, and other sectors to develop novel solutions to health services needs. Also, integration of Traditional Indian Medicine is occurring at many I/T/U programs. Creative policies that allow for coordination of care across medical disciplines and Traditional Indian Medicine allow for improved cultural competence and patient satisfaction.

### CONCLUSIONS

AI/AN health policy has a complex history, and it is a collection of sometimes conflicting federal Indian law, health policy, and inter-governmental relationships. US history has borne out a unique relationship between AI/AN tribes and the federal government, including forced acculturation, warfare, and severely underfunded health services, leading to severe AI/AN health disparities. The Indian health system is diverse and vulnerable, and the need exists to closely monitor laws and regulations that challenge the ability of tribes to receive and to provide health services. Policy and program development needs to avoid unnecessary barriers and to improve tribal relationships with all levels of government.

Key elements of federal Indian health law and policy include treaties, federal trust responsibility, tribal sovereignty, and the government-to-government relationship. Citizens who are eligible for I/T/U services generally consider access to health services as “pre-paid” by the vast amounts of AI/AN land and natural resources that were taken by the US government.

Congress appropriates funds annually for the IHS. However, unlike Medicaid and Medicare, the IHS is not an entitlement program in the federal budget. Rather, it is a discretionary program, its means of support is susceptible to unrelated political agendas, and it is dependent on the will of Congress. The IHS budget has not kept pace with medical inflation and the increases in AI/AN population. Long-term underfunding of the IHS is a contributing factor to AI/AN health disparities, and Congress needs to abide by its trust responsibilities and its treaty obligations to provide proper care to AI/AN persons.

Finally, in our experiences in providing health services and in administering health programs in AI/AN communities, the amount of needless suffering and loss of life related to preventable and treatable illness make IHS funding a matter of social justice and civil rights, and this issue needs to be a national priority for all public health advocates, not just for the AI/AN population. Resources and services available to AI/AN persons from across the Department of Health and Human Services and other agencies need to be expanded to meet the public health, clinical, research, and workforce needs of this population. To bring the IHS budget to an equitable level similar to the FEHB benchmark would require approximately an additional \$3 billion per year. With a Department of Health and Human Services budget of more than \$800 billion per year, this increase represents only a few tenths of 1%, and this increase would have a significant return on investment in terms of saving lives and reducing human suffering. Perhaps with strong partnerships in advocacy, in the 21st century, we can overcome the scourge of

Indian health underfunding that has plagued this population for the previous 2 centuries. ■

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### Contributors

Both of the authors made mutual contributions to the article.

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Human participant protection was not needed because no human participants were involved.

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