It's Hard Out Here for an American Indian: Implications of the Patient Protection and Affordable Care Act for the American Indian Population

Alex Dyste†

Introduction

And us mothers and grandmothers, we don't understand why if we in the treaties . . . gave all our land, [and] our land in the United States of America is worth so much right now. [W]e feel like how come if we gave all that up, why isn't our health care, why hasn't it gone up as well.[1]

The storied and often turbulent relationship the United States shares with the nation's indigenous population is tainted with broken promises and marked by indifference.[2] Tracing its origins to initial European contact with the tribes in the late 1400s,[3] federal Indian law is complex, inconsistent, and largely defined by the anomalous trust relationship the federal government maintains with the tribes.[4] The boundaries of the

---

†. B.A. Michigan State University, 2011; J.D. Candidate University of Minnesota Law School, 2014. I would like to thank the editors and staff of *Law and Inequality: A Journal of Theory and Practice* and extend my deepest gratitude to Professor Joan Howland for her immense support and insight.

1. U.S. COMM'N ON CIVIL RIGHTS, BROKEN PROMISES: EVALUATING THE NATIVE AMERICAN HEALTH SYSTEM 21 (Sept. 2004) [hereinafter BROKEN PROMISES] (quoting Rebecca Ortega, a member of the Pueblo Santa Clara).

2. *See, e.g.*, WINONA LADUKE, LAST STANDING WOMAN 33 (Michael Dregni ed., 1997); D'ARCY MCNICKLE, THEY CAME HERE FIRST 199 (1975); GEORGE E. SAURMAN, WE'VE DONE THEM WRONG: A HISTORY OF THE NATIVE AMERICAN INDIANS AND HOW THE UNITED STATES TREATED THEM 34 (2012) (illustrating the history of federal-tribal relations in Minnesota).

3. *See* DAVID H. GETCHES ET AL., CASES AND MATERIALS ON FEDERAL INDIAN LAW 44–73 (West Publ'g Co., 6th ed. 1993) (describing the European doctrine of discovery and the legal ideas applied by the Europeans in their contact with the Native population).

4. Vine Deloria, Jr., *Laws Founded in Justice and Humanity: Reflections on the Content and Character of Federal Indian Law*, 31 ARIZ. L. REV. 203, 203 (1989) ("Federal Indian law itself is a mythical creature because it is composed of badly written, vaguely phrased[,] and ill-considered federal statutes; hundreds of self-serving Solicitor's Opinions and regulations; and state, federal, and Supreme Court decisions which bear little relationship to rational thought and contain a fictional view of American history that would shame some of our country's best novelists.").

trust relationship are unclear.[5] Founded upon notions of international law and the sovereignty of each nation,[6] the trust doctrine obligates the United States' federal government to provide for and to protect the tribes.[7] These obligations include the provision of health care.[8]

The basis of an Indian "right" to health care derives from a quagmire of treaties, policies, and legislation.[9] A review of Indian policy reveals a pattern of shifting the responsibility for health care between different federal agencies and reflects confusion surrounding the roles that states and local entities have in providing assistance to Indians.[10] This history is further complicated by the divergent, yet simultaneous notions of tribes as both independent sovereign nations and wards of the federal government.[11] Of paramount importance to understanding the development of Indian health care are two pieces of legislation: the Indian Self-Determination and Education Assistance Act (ISDEAA)[12] and the Indian Health Care Improvement Act (IHCIA).[13] These Acts, promulgated in the 1970s, represented nationwide recognition that health care was

---

5. *Id.* There is no agreed-upon unified policy that defines the contours of the relationship between the federal government and the nation's tribes. *See also* Betty Pfefferbaum et al., *Learning How to Heal: An Analysis of the History, Policy, and Framework of Indian Health Care*, 20 AM. INDIAN. L. REV. 365, 366 (1996)[hereinafter Pfefferbaum et al., *Learning How to Heal*].

6. Sharon O'Brien, *Tribes and Indians: With Whom Does the United States Maintain A Relationship?*, 66 NOTRE DAME L. REV. 1461, 1462 (1991).

7. *Id.* This description of the federal-tribal relationship is conflicting. "Tribes are quasi-sovereigns, yet Congress possesses plenary control over Indian affairs. The government is responsible for tribal lands and resources, but it can extinguish both at will. The government asserts that it possesses a political relationship with federally recognized tribes, yet it maintains relations with a host of nonrecognized tribes . . . ." *Id.* at 1462–63.

8. U.S. COMM'N ON CIVIL RIGHTS, NATIVE AMERICAN HEALTH DISPARITIES BRIEFING: EXECUTIVE SUMMARY 3 (Feb. 2004) [hereinafter HEALTH DISPARITIES BRIEFING] ("Accordingly, the federal government has accepted many obligations, including education, construction, law enforcement, and medical services. This health care obligation requires the government to provide medical treatment to all Native Americans living in the United States.").

9. *See* Pfefferbaum et al., *Learning How to Heal*, *supra* note 5, at 367. Please note that throughout this Note, the terms "Indian," "American Indian," and "Native American" are used interchangeably.

10. *Id.* at 368–86.

11. *Id.* at 372. *See* Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1, 17 (1831) ("[Indians'] relation to the United States resembles that of a ward to his guardian.").

12. The Indian Self-Determination and Education Assistance Act of 1975, 25 U.S.C. §§ 450a–450n (2006).

13. Indian Health Care Improvement Act, Pub. L. No. 94–437, 90 Stat. 1400 (codified as amended in scattered sections of 25 U.S.C.).

becoming an issue for the entire country.[14] Despite the lofty goals set forth by these Acts,[15] the federal and tribal governments continue to struggle to provide effective health care for Native populations.[16]

The public financing of the Indian health care system is accomplished through two avenues: public health insurance programs and publicly funded health care providers.[17] The former includes programs such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[18] The latter includes the Indian Health Service (IHS) and other qualified federal health centers.[19] Common to both schemes is chronic underfunding.[20] This shortage in financing is detrimental to the upkeep of facilities, acquisition of equipment, retention of providers, and accessibility to services such as chronic care of long-term illnesses.[21]

Despite these financing difficulties, the IHCIA has largely been viewed as a success.[22] However, its last full reauthorization

---

14. *See* Pfefferbaum et al., *Learning How to Heal*, *supra* note 5, at 383.

15. 25 U.S.C. § 1602(1) (2006). The stated goal of the IHCIA is to "assure the highest possible health status for Indians and Urban Indians and to provide all resources necessary to effect that policy." *Id.*

16. Sarah Somers, *Health Care Reform for Native Americans: The Long-Awaited Permanent Reauthorization of the Indian Health Care Improvement Act*, 44 CLEARINGHOUSE REV. 365, 365 (2010). *See* BROKEN PROMISES, *supra* note 1, at 70–120.

17. Megan J. Renfrew, *The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives*, 40 COLUM. J.L. & SOC. PROBS. 173, 179 (2006).

18. *Id.*

19. *See id.* at 180.

20. *See* Margaret P. Moss, *American Indian Health Disparities: By The Sufferance of Congress?*, 32 HAMLINE J. PUB. L. & POL'Y 59, 74–75 (2010); Renfrew, *supra* note 17, at 174; Caryn Trombino, *Changing the Borders of the Federal Trust Obligation: The Urban Indian Health Care Crisis*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 129, 147 (2005); *Medicare and Medicaid Funding Challenges*, THE CONCORD COALITION, http://www.concordcoalition.org/medicare/medicare-and-medicaid-funding-challenges (last visited Nov. 13, 2012) (explaining the consistent increase in the cost of U.S. health care entitlement programs over the past forty years and its underlying causes).

21. *See* Moss, *supra* note 20, at 74.

22. *See* NAT'L INDIAN HEALTH BD., REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT: BRINGING INDIAN HEALTH SERVICES INTO THE 21ST CENTURY (2009), *available at* http://www.nihb.org/docs/IHCIA/IHCIA%20Fact%20Sheet_March%2009.pdf; Mark Trahant, Editorial, *Supreme Court's Ruling Extends American Indian Health-care Model of Progress, Innovation*, SEATTLE TIMES (July 9, 2012), http://seattletimes.com/html/opinion/2018645706_guest10marktrahant.html [hereinafter Trahant, *Supreme Court's Ruling*] ("It may be the most successful piece of legislation ever."); Mark Trahant, *ObamaCare Is a Different Debate; Indian Health Care Improvement Act Is Permanent*,

took place in 1992.[23] Between 1992 and 2010, Congress appropriated funds on an annual basis under the authority of the Snyder Act of 1921.[24] In March 2010, President Obama affirmed the permanency of IHCIA by signing the landmark legislation, the Patient Protection and Affordable Care Act (ACA).[25] The U.S. Supreme Court ruled on the constitutionality of the ACA in June 2012 in *National Federation of Independent Business v. Sebelius*.[26] By upholding the ACA's constitutionality, the IHCIA, which was included within the pages of the ACA, was legitimized as well.[27] The ACA seeks to revolutionize health care in the United States and secure affordable coverage for the middle class.[28] Though highly controversial, the ACA is the most expansive social legislation in decades, and it strives to place the United States on par with other developed countries that offer their citizens health care.[29]

This Note seeks to explore the practical implications of the ACA on the IHCIA and to demonstrate that the new works in way that is contrary to the obligation the federal-tribal trust relationship imposes. Part I details the history of Indian health policy, specifically describing the federal-tribal trust relationship and the current state of Indian health. Part II provides the

---

INDIANCOUNTRYTODAYMEDIANETWORK.COM (June 28, 2012), http://indiancountrytodaymedianetwork.com/ict_sbc/obamacare-is-a-different-debate-indian-health-care-improvement-act-is-permanent [hereinafter Trahant, *ObamaCare is a Different Debate*].

23. Moss, *supra* note 20, at 78.

24. Snyder Act of 1921, 25 U.S.C. § 13 (2004); Somers, *supra* note 16, at 366.

25. Editorial, *ACA Ruling Affirms Indian Health Care Improvement Act*, ARIZ. DAILY INDEP. (July 3, 2012), http://arizonadailyindependent.com/2012/07/03/aca-ruling-affirms-indian-health-care-improvement-act/.

26. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 ("The Affordable Care Act is constitutional in part and unconstitutional in part.").

27. *See* Editorial, *ACA Ruling Affirms Indian Health Care Improvement Act*, *supra* note 25; Levi Rickert, *Supreme Court Affirmed the Indian Health Care Improvement Act Too*, NATIVE NEWS NETWORK (June 30, 2012, 7:00 AM), http://www.nativenewsnetwork.com/supreme-court-affirmed-the-indian-health-care-improvement-act-too.html; Trahant, *Obamacare is a Different Debate*, *supra* note 22; Trahant, *Supreme Court's Ruling*, *supra* note 22.

28. Press Release, The White House, The Affordable Care Act: Secure Health Coverage for the Middle Class (June 28, 2012), http://www.whitehouse.gov/the-press-/2012/06/28/fact-sheet-affordable-care-act-secure-health-coverage-middle-class [hereinafter Press Release].

29. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, with a Flourish*, N.Y. TIMES, Mar. 24, 2010, http://www.nytimes.com/2010/03/24/health/policy/24health.html?_r=0; Cynthia Tucker, *Court Decision Might Put U.S. Healthcare on Par with Other Nations*, PORTLAND PRESS HERALD (June 30, 2012), http://www.pressherald.com/opinion/court-decision-might-put-u_s_-health-care-on-par-with-other-nations_2012-06-30.html.

statutory framework and the corresponding funding scheme it creates for the Indian health system. Part III discusses the decision in *Sebelius* and the resulting changes it created for U.S. health care. Part IV highlights the Indian-specific provisions of ACA and details their faults. Part IV also suggests remedial measures that can be taken to implement the ACA in a manner most likely to benefit the Indian population. This Note concludes that although the ACA contains potentially troubling provisions for Indians, the legislation reinforces the United States' obligations to American Indians and represents a step in the correct direction.

I. The Federal-Tribal Trust Relationship Is the Foundation for Indian Health Policy in the United States

Indians' right to health care is complicated at the outset from the distinct sovereign-to-sovereign relationship the United States shares with the tribes.[30] Indians are entitled to a unique form of dual citizenship. They derive benefits from their U.S. citizenship that are available to all U.S. citizens, while they are simultaneously entitled to rights that arise from their tribal membership.[31] These are rights grounded in centuries of case law, treaties, and statutes.[32] In general, the duty of the federal government to provide health care to the Native population arises from "the destruction of Indian civilization and the poverty and disease that followed in its wake."[33]

The landmark cases of *Worcester v. Georgia* and *Cherokee Nation v. Georgia* provided the first recognition of the federal-tribal relationship.[34] In these opinions, Chief Justice John Marshall interpreted treaty language to conclude that the tribes

30. Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 219 (1997) [hereinafter Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans*].

31. *Id.*

32. *See* FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 1 (Nell Jessup Newton ed., 2005) ("Treaties with Indian tribes are organic, quasi-constitutional, foundational documents because they create a government-to-government relationship between the tribes and United States.").

33. AMERICAN INDIAN POL'Y REV. COMM'N REP. ON INDIAN HEALTH: TASK FORCE SIX 33 (1976) [hereinafter TASK FORCE SIX]. *See* Holly T. Kuschell-Haworth, *Jumping Through Hoops: Traditional Healers and the Indian Health Care Improvement Act*, 2 DEPAUL J. HEALTH CARE L. 843, 845 (1999); Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans*, *supra* note 30, at 213.

34. Worcester v. Georgia, 31 U.S. (6 Pet.) 515 (1832); Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1 (1831).

were "domestic dependent nations" and characterized their relationship as one in which the tribal nations "claim[ed] and receive[d] the protection of one more powerful: not that of individuals abandoning their national character, and submitting as subjects to the laws of a master."[35] Treaties were used as a means to exercise formal dealings with the tribes concerning issues of trade, alliance, and land.[36] However, in executing these treaties, Indians moved from a position of equal power to an inferior level.[37] Their status in relation to the federal government has been analogized to that of a "ward to his guardian," with the tribes "in a state of pupilage."[38]

While the federal government's responsibility to provide health care to Indians is generally accepted, the specific duties and the rights associated with that responsibility are unclear.[39] Moreover, the trust responsibility in itself cannot form the basis of a legal claim against the United States.[40] Still, providing social services is one of the defining characteristics of the trust relationship.[41] Accordingly, the United States, as the fiduciary of the trust and in exchange for the deprivation it caused, must provide for the tribes' resulting dependencies.[42]

A. Current State of Indian Health Care

The deficiencies of the Indian health system are well-documented.[43]

---

35. *Worcester*, 31 U.S. at 555.

36. GETCHES ET AL., *supra* note 3, at 74. Utilizing the treaty method itself recognized the tribes' status as an independent nation. *Id.*

37. COHEN, *supra* note 32, at 26.

38. *Cherokee Nation*, 30 U.S. at 17. *See* United States v. Kagama, 118 U.S. 375, 383 (1886).

39. Pfefferbaum et al., *Providng for the Health Care Needs of Native Americans*, *supra* note 30, at 219.

40. Gila River Pima-Maricopa Indian Comm. v. United States, 427 F.2d 1194, 1198 (Ct. Cl. 1970). The court explains that the trust relationship alone, minus any "[l]anguage in a treaty, agreement, or statute spelling out such a relationship" merely "resembles" such a legal relationship and is without any legal force. *Id. But see* Lone Wolf v. Hitchcock, 187 U.S. 553, 565, 567 (1903); *Kagama*, 118 U.S. at 379; *Cherokee Nation*, 30 U.S. (5 Pet.) 1, 17 (1831) (illustrating that the United States' obligations to the tribes arise out of course of dealings, not express statutory language supporting a fiduciary duty).

41. The other two defining criteria are land and self-governance. *See* U.S. COMM'N ON CIVIL RIGHTS, A QUIET CRISIS: FEDERAL FUNDING AND UNMET NEEDS IN INDIAN COUNTRY 3 (July 2003) [hereinafter A QUIET CRISIS], *available at* http://www.usccr.gov/pubs/na0703/na0204.pdf.

42. *See* Trombino, *supra* note 20, at 137.

43. For a comprehensive overview of the deficiencies and associated problems in the Native American Health Care System, see BROKEN PROMISES, *supra* note 1,

> Today, Native Americans continue to experience significant rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries. Native Americans are 770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents, and 52 percent more likely to die from pneumonia or influenza than other Americans, including white and minority populations. As a result of these increased mortality rates, the life expectancy for Native Americans is 71 years of age, nearly five years less than the rest of the U.S. population. . . . Additionally, . . . seven of the top 10 causes of the high morbidity and mortality rates are directly related to, or significantly affected by individual behavior and lifestyle choices.[44]

There are five recognized factors contributing to the above disparities: limited access to appropriate health facilities; poor access to health insurance, including Medicaid, Medicare, and private insurance; insufficient federal funding; quality of care issues; and disproportionate poverty and poor education.[45] Racial discrimination also is cited as a cause.[46] These factors are not mutually exclusive, and within each are overlapping subcomponents.[47]

IHS has been given primary responsibility for eliminating these disparities, and in many areas their efforts have been successful.[48] Still, insufficient funding remains the paramount challenge in solving the Indian health care crisis.[49]

---

at 7–25 and A QUIET CRISIS, *supra* note 41, at 34–48.

44. *See* HEALTH DISPARITIES BRIEFING, *supra* note 8, at 5–6.

45. *Id.* at 15. *See also* Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans*, *supra* note 30, at 245–46 ("Access to health care is difficult to define and measure. It implies, at the very least, four aspects of health care coverage: (1) availability of care as indicated by the provision of staff and facilities and measured, for example, by the ratio of providers to population; (2) accessibility or usability as indicated by the provision of insurance, eligibility for and/or entitlement to care, and ease of service utilization; (3) affordability as indicated by the ability to purchase insurance or care; and (4) acceptability as indicated by a perception of value associated with obtaining care and of the care obtained. All four aspects of coverage—availability, usability, affordability, and acceptability—have been and continue to be issues of concern in the provision of health services to Indians.").

46. HEALTH DISPARITIES BRIEFING, *supra* note 8, at 14.

47. *Id.* at 15 ("For example, a person may arrive at a health facility only to find that lack of funding has prevented the facility from providing the necessary services or that there is an extended waiting period before services will be available.").

48. *Id.* at 5.

49. *See* HEALTH DISPARITIES BRIEFING, *supra* note 8, at 51; Jerilyn DeCoteau, *Access of Urban Indians to Health Care*, 20 CLEARINGHOUSE REV. 402, 404 (1986) ("Severely inadequate funding of IHS creates the majority of the access and quality

II. Statutory Framework & Structure of Indian Health Systems

A. Statutory Framework

The evolution of Indian health policy in this country follows a path familiar to that of other developed nations with Indigenous populations.[50] "Three stages in the development of health policy have been identified: (1) public apathy and reliance on charity; (2) public provision of services when not adequately provided by the private sector; and (3) replacement of private and charitable programs by public services and public financing."[51] The concept of an Indian "right" to health care began garnering attention in the 1920s.[52] Prior to this time, the federal government's role in health care was minor.[53] While medical inadequacies were acknowledged, they were primarily noted only within the context of Indian schools.[54]

The Snyder Act of 1921 and the IHCIA provide the basic framework of the Indian health care system.[55] Codified with the purpose of "direct[ing], supervis[ing], and expend[ing] such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians . . . [f]or relief of distress and conservation of health,"[56] the Snyder Act directed the Bureau of Indian Affairs (BIA) to administer programs for the conservation of the tribes' health.[57] Just a few years later, Congress passed the Indian Citizenship Act of 1924,[58] expanding Indians' citizenship and, thereby, their eligibility for benefits available to all U.S. citizens.[59]

The IHS was created in 1955 as a division of the Public Health Service (PHS) (later the Department of Health and Human

---

issues.").

50. *See* Pfefferbaum et al., *Learning How to Heal*, *supra* note 5, at 389.

51. *Id.*

52. *Id.* at 376.

53. *Id.* at 374 (noting the integral role the Great Depression and World War II had in revolutionizing health care because these events undermined people's beliefs in their ability to control their own lives and for the first time demonstrated the government's recognition of a right to public services).

54. *Id.*

55. Snyder Act of 1921, 25 U.S.C. § 13 (1994); Indian Health Care Improvement Act of 1976, Pub. L. No. 94-437, 90 Stat. 1400 (codified as amended in scattered sections of 25 U.S.C.).

56. Snyder Act of 1921, 25 U.S.C. § 13.

57. *See* COHEN, *supra* note 32, at 1377.

58. Indian Citizenship Act of 1924, ch. 233, 43 Stat. 253 (repealed 1952).

59. *See* Pfefferbaum et al., *Learning How to Heal*, *supra* note 5, at 376.

Services).[60] It was at this time that PHS assumed legal responsibility for Indian health care.[61] As the Termination Era ended and congressional Indian policy shifted into the Self-Determination Era,[62] the tribes received the encouragement and support of the federal government to exercise greater self-sufficiency and control over their programs and practices.[63]

Congress passed the Indian Self-Determination and Education Assistance Act of 1975,[64] providing for the transfer of programs traditionally controlled by the BIA and the IHS to tribal governments.[65] "The Act reflects a fundamental philosophical change concerning the administration of Indian affairs: tribal programs are funded by the federal government, but the programs should be planned and administered by the tribes themselves; federal 'domination' should end."[66] Congress subsequently passed the IHCIA in 1976.[67] Comprehensive in scope, it represents the first legal and moral recognition of Congress' duty to provide health care to Indians.[68] While the Snyder Act of 1921 codified Congress' responsibility to administer health services, it only required Congress to do so "from time to time" as was deemed appropriate.[69] On the other hand, the IHCIA mandated that the federal government administer health resources continuously.[70] This bill sought to fill the voids left by prior Indian health legislation and to better define the vague nature and extent of the federal commitment to Indian health care.[71]

---

60. *Id.* at 382.

61. *Id.*

62. *See* GETCHES ET AL., *supra* note 3, at 217. Ironically, termination, fueled by the government's desire for assimilation and designed to detribalize American Indians, had the opposite effect. *Id.* The threat of termination spurred a "supratribal consciousness" that drew Indian groups together in a concerted effort to quash the termination policy. *Id.* President Nixon's confirmation of the failures of termination served as a catalyst into the Self-Determination Era. *Id.* at 219.

63. *Id.* at 218–19.

64. The Indian Self-Determination and Education Assistance Act of 1975, 25 U.S.C. §§ 450a–450n (2006).

65. *See* Pfefferbaum et al., *Learning How to Heal*, *supra* note 5, at 384. *See also* GETCHES ET AL., *supra* note 3, at 220 (describing the most important features of the Act).

66. GETCHES ET AL., *supra* note 3, at 220.

67. *See* BROKEN PROMISES, *supra* note 1, at 24.

68. *Id.*

69. *See* Pfefferbaum et al., *Learning How to Heal*, *supra* note 5, at 386.

70. *See id.* at 385–86.

71. *See* TASK FORCE SIX, *supra* note 33, at 33–37 (providing a historical overview of Indian health care and noting that "almost no legislative or legal definition of the nature or extent" of the federal obligation to provide special health programs to Indians exists).

B. Dual Funding Schemes

The bifurcated system of financing for Indian health care arises from the tribes' dual entitlement to medical services.[72] U.S. citizenship and treaty rights authorize Indians to receive care from both public health insurance programs and publicly funded health care providers.[73] The funding schemes are separate because the services offered through the Center for Medicare/Medicaid Services (CMS) are available to the U.S. population at large.[74]

1. Public Health Insurance Programs

CMS is the second largest provider of health care for Native Americans.[75] Though second to IHS, due to the abject poverty among this population, these public services remain an important source of medical care.[76] It is estimated that forty percent of the Indian population enrolls in a publicly funded program.[77] Though CMS operates them all, there are fundamental differences between Medicare, Medicaid, and the CHIP.

Medicare is a government insurance program primarily designed for individuals sixty-five years and older.[78] Though highly criticized when signed in 1965, it has grown to be one of the government's most popular and costliest programs, covering well over forty million Americans.[79] Medical bills are paid through a trust funded by monthly payments from beneficiaries.[80] Because it is a federal program, Medicare operates essentially the same in each state.[81]

---

72. *See* Renfrew, *supra* note 17, at 179.

73. *See* Pfefferbaum et al., *Learning How to Heal*, *supra* note 5, at 386; Renfrew, *supra* note 17, at 179.

74. *See* A QUIET CRISIS, *supra* note 41, at 35.

75. *Id.*

76. Andy Schneider & JoAnn Martinez, *Native Americans and Medicaid: Coverage and Financing Issues—Report*, HENRY J. KAISER FAMILY FOUNDATION (Dec. 30, 1997), http://kff.org/disparities-policy/report/native-americans-and-medicaid-coverage-and-financing-2.

77. *Id.*

78. Ctrs. for Medicare & Medicaid Servs., *Medicare Program—General Information*, CMS.GOV, http://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html (last modified Aug. 27, 2013, 9:49 AM).

79. Jonathan Oberlander, *The Politics of Medicare Reform*, 60 WASH. & LEE L. REV. 1095, 1099–100 (2003).

80. U.S. Dep't of Health & Human Servs., *What is the difference between Medicare and Medicaid?*, HHS.GOV, http://answers.hhs.gov/questions/3094 (last updated Dec. 20, 2012).

81. *Id.*

In contrast, Medicaid and its counterpart, the CHIP, operate through a federal-state partnership.[82] Medicaid is a publicly funded insurance program that caters primarily to low-income Americans.[83] All states are required to offer coverage to the blind and disabled, low-income elderly, and some low-income parents and children.[84] They also have the option to provide coverage to additional populations.[85] Though subject to ultimate approval by CMS because of varying budgetary and political calculations among states, each state has wide discretion in the administration of its program.[86] The CHIP is similarly funded on a federal-state basis, but it provides coverage for children whose families earn too high an income for Medicaid and yet cannot afford private insurance.[87]

2. Indian Health Service Is the Primary Publicly Funded Health Care Provider

The mission of IHS is "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."[88] The IHCIA and its 1992 amendments outlined a number of new initiatives to serve as models for public health and a national health agenda.[89] The legislation also specified the following goals for IHS: (1) to assure Indians access to high-quality comprehensive health services in accordance with need; (2) to assist tribes in developing the capacity to staff and manage their own health programs and to provide opportunities for tribes to assume operational authority for IHS programs in their communities; and (3) to advocate for Indians with respect to health matters and to assist them in accessing programs to which they are entitled.[90]

IHS delivers health services to approximately 1.9 million American Indians and Alaska Natives who are members of 566 federally recognized tribes in thirty-five states.[91] Once eligibility

82. *Id.*

83. *See* Renfrew, *supra* note 17, at 180.

84. *Id.*

85. *Id.*

86. *Id.* at 180–81.

87. Ctrs. For Medicare & Medicaid Servs., *Children's Health Insurance Program*, MEDICAID.GOV, http://www.medicaid.gov/CHIP/CHIP-Program-Information.html (last visited Nov. 13, 2012).

88. *About IHS*, INDIAN HEALTH SERVICE, http://www.ihs.gov/aboutihs/ (last visited Oct. 27, 2013).

89. *See* Pfefferbaum, *Learning How to Heal*, *supra* note 5, at 386.

90. *Id.* at 385–86

91. *About IHS*, *supra* note 88.

criteria are satisfied, a patient does not need to demonstrate economic need to receive treatment.[92] IHS services are administered in three ways: direct IHS services, tribal services, and Urban Indian Health Programs.

IHS is the largest federally funded program for American Indian health care.[93] Congress provides appropriations for IHS's annual budget, which is augmented through funds acquired by billing private and public insurance for services supplied to insured Indians.[94] IHS services operate as a provider of last resort.[95] This residual role means that those who are insured in Medicare, Medicaid, or private insurance are to use those services first.[96] Although IHS has received praise for the work it performs with limited funding,[97] the severity of the underfunding is critical.[98] One estimate suggests that in 2005, IHS's annual budget of approximately three billion dollars was underfunded by half.[99] While other programs within the Department of Health and Human Services (HHS) provide limited services for Native Americans, their Native American expenditures are equal to 0.5% of IHS funding for Native Americans.[100] This equates to less than twenty million dollars.[101] In fiscal year 2010, the appropriation was $4,052,375,000.[102]

Prior to the signing of ACA in 2010, IHCIA was last fully reauthorized by the Indian Health Amendments of 1992,[103] extending Congressional appropriations through 2000.[104] In 2000, appropriation authorization was extended through 2001.[105] Since then, Congress continued to appropriate funds for IHCIA on an

92. BROKEN PROMISES, *supra* note 1, at 48.

93. Renfrew, *supra* note 17, at 182.

94. *Id.*

95. Trombino, *supra* note 20, at 143.

96. *Id.*

97. *Id.*

98. *See, e.g.*, BROKEN PROMISES, *supra* note 1, at 87–120; *see also*, A QUIET CRISIS, *supra* note 41, at 42–48.

99. Renfrew, *supra* note 17, at 183.

100. HEALTH DISPARITIES BRIEFING, *supra* note 8, at 33.

101. *Id.*

102. DEP'T OF HEALTH & HUMAN SERVS., INDIAN HEALTH SERVICE FISCAL YEAR 2012 JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES 1 (2012), *available at* http://www.hhs.gov/about/FY2012budget/fy_2012_budget_justification_revised.pdf.

103. *See* ELAYNE J. HEISLER & ROGER WALKE, CONG. RESEARCH SERV., INDIAN HEALTH CARE IMPROVEMENT ACT PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), at 2 (2010).

104. *Id.*

105. *Id.*

annual basis[106] under the Snyder Act, which provides permanent authority for the appropriation of funds for Indian health.[107] Congress had been contemplating IHCIA reauthorization since 1999.[108] In the 112th Congress, IHCIA reauthorization bills were introduced in the House and Senate within health care reform bills.[109]

III. Patient Protection & Affordable Care Act Secures the Indian Health Care Improvement Act

On March 23, 2010, President Obama signed new health insurance reform legislation, H.R. 3590, the ACA.[110] Included within the ACA was a permanent reauthorization of IHCIA.[111] Congress enacted the ACA with the goals of increasing health insurance coverage for lower and middle-class Americans and decreasing the overall cost of health care.[112] An estimated thirty-two million Americans will benefit from the health insurance this program provides.[113]

Indian policymakers had long advocated for reauthorization of IHCIA.[114] Though the Snyder Act permitted Congress to continue appropriations, IHCIA needed reauthorization to provide

---

106. *Id.*

107. NAT'L INDIAN HEALTH BD., REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT (IHCIA): BRINGING INDIAN HEALTH SERVICES INTO THE 21ST CENTURY 1 (2009) [hereinafter REAUTHORIZATION].

108. *See* HEISLER & WALKE, *supra* note 103, at 3.

109. *Id.*

110. *See* HEISLER & WALKE, *supra* note 103, at 1 (explaining the legislative process of passing the ACA).

111. *Patient Protection and Affordable Care Act Title X–Strengthening Quality, Affordable Health Care for All Americans, Subtitle B, Part III, Section 10221: Indian Health Care Improvement Act Section-by-Section Summary*, BINGAMAN SENATE 1 (2012), web.archive.org/web/20120905142135/http://www.bingaman.senate.gov/policy/ppaca_ihcia.pdf (last archived Sept. 5, 2012) [hereinafter *Title X*]. The Indian Health Care Improvement Reauthorization and Extension Act, S. 1790, was a "cut-and-bite bill," which means that it updated pertinent provisions of IHCIA, without restating the bill in its entirety within ACA. *Id.*

112. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2571 (2012).

113. *See Title X*, *supra* note 111, at 1.

114. News Release, U.S. Dep't of Health & Human Servs., Indian Health Care Improvement Act Made Permanent (Mar. 26, 2010), http://www.hhs.gov/news/press/2010pres/03/20100326a.html [hereinafter News Release] ("Since 2000, tribes and tribal organization[s] have been strongly advocating for the updating and reenacting of the IHCIA. . . . The provision of health care services to American Indians and Alaska Natives is a key component of the federal government's trust responsibility, and the updating and permanent authorization of the IHCIA helps to fulfill this responsibility." (quoting Yvette Roubideaux)).

the underlying authority for direct health care to the Indian population.[115] Moreover, the American health care system had undergone extensive adjustments to changing times since 1992, while the Indian health care system remained outdated.[116] Comprehensive in scope, the ACA not only expands health insurance coverage to Americans but also augments reimbursements to providers, strengthens patient protections, includes incentives for the recruitment and retention of health care providers, and provides grants for programs in service areas such as prevention, health disparities, and improved access.[117] Native Americans are included within the reform's reach.[118] They are eligible to participate in Medicaid and the state insurance exchanges, and Indian health programs may utilize the reforms available to providers, including grant initiatives.[119] Accordingly, Indian health advocates praised President Obama for his support in helping to remedy the Indian health care crisis.[120]

In practice, the law increases coverage largely by expanding Medicaid and providing federal subsidies to aid Americans in purchasing private insurance.[121] States may create insurance exchanges that will serve as a "one stop shop" for individuals and small business owners to create individualized private health plans.[122] These exchanges are designed on a state-by-state basis and prohibit insurers from denying coverage to those with preexisting conditions.[123] In addition, the individual mandate, a central feature of the ACA, requires individuals who can afford health insurance to purchase some minimally comprehensive

115. *See* REAUTHORIZATION, *supra* note 107, at 1.

116. *Id.*

117. *See Title X*, *supra* note 111, at 1.

118. *Id.*

119. *Id.*

120. *See* News Release, *supra* note 114, at 1 ("We are grateful to President Obama for his unwavering and longstanding support for the enactment of the Indian Health[C]are Improvement Act, which is critical to modernizing and improving the health care we provide to American Indians and Alaska Natives. This administration is intent on honoring the obligations of our government-to-government relationship with American Indian tribes, including the promise of adequate health care." (quoting Kathleen Sebelius)).

121. *See* Sara Rosenbaum, *The Patient Protection and Affordable Care Act: Implications for Public Health Policy and Practice*, 126 PUB. HEALTH REPS. 130, 130–31, 132 (2011), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3001814/pdf/phr126000130a.pdf.

122. *See* Press Release, *supra* note 28.

123. *Id.*

care.[124] Failure to comply imposes a fee that is to be filed with an individual's tax returns.[125]

The day that President Obama signed the ACA, fourteen state attorneys general filed suit claiming that the law's controversial individual mandate was unconstitutional.[126] Arguing that the individual mandate was beyond the federal government's Commerce Clause power, the states contended that if the government could require individuals to buy health insurance, it could compel them to buy anything.[127] In defense, the government argued that the mandate was within its Commerce Clause power "because the failure to buy insurance shifts the costs of health care for the uninsured to health[ ]care providers, insurance companies, and everyone who does have health insurance."[128] To address this problem, the ACA provides a cost-shifting solution.[129] For the legislation to work economically, health insurance companies need a guaranteed pool of customers.[130] The individual mandate was the administration's mechanism for supplying such a group of guaranteed premium-payers.[131] Justices surmised that members of Congress would not have supported the law if it did not include the mandate.[132]

---

124. 26 U.S.C. § 5000A(a) (2010).

125. 26 U.S.C. § 5000A(b).

126. Ezra Klein, *Unpopular Mandate: Why Do Politicians Reverse Their Positions?*, NEW YORKER (June 25, 2012), http://www.newyorker.com/reporting/2012/06/25/120625fa_fact_klein.

127. *See* Rosenbaum, *supra* note 121. This gave rise to the popular broccoli analogy coined by Justice Antonin Scalia in oral arguments during *Sebelius*. *See, e.g.*, James B. Stewart, *How Broccoli Landed on Supreme Court Menu*, N.Y. TIMES (June 13, 2012), http://www.nytimes.com/2012/06/14/business/how-broccoli-became-a-symbol-in-the-health-care-debate.html (discussing Justice Scalia's analogy to broccoli during oral arguments).

128. Amy Howe, *Today's Health-Care Decision: In Plain English*, SCOTUS BLOG (June 28, 2012 6:07 PM), http://www.scotusblog.com/2012/06/todays-health-care-decision-in-plain-english/. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2585 (detailing how, to recover losses they suffer as a result of providing care for the insured, hospitals pass the cost on to those who are insured, at an estimated one thousand dollars per year).

129. Lyle Denniston, *Don't Call It a Mandate—It's a Tax (UPDATED)*, SCOTUS BLOG (June 28, 2012 11:07 AM), http://www.scotusblog.com/2012/06/dont-call-it-a-mandate-its-a-tax/.

130. *Id.* The government reasoned that the mandate was critical to the operation of the reform because it allowed its other provisions to function, and was necessary to ensure that both the healthy and sick would enroll for coverage. *See* Adam Liptak, *On Day 3, Justices Weigh What-Ifs of Health Ruling*, N.Y. TIMES, Mar. 28, 2012, at A1.

131. *See* Liptak, *supra* note 130.

132. *Id.*

The U.S. Supreme Court also considered the "Medicaid coercion" issue.[133] The ACA requires that states provide health care coverage for virtually all of their citizens under the age of sixty-five or risk losing the funding they receives from the federal government.[134] The states maintained that this expansion was unconstitutional because they are so heavily dependent on federal funding that to potentially lose it was equivalent to putting "a gun to [their] head[s]."[135] This proposed change in Medicaid represented a fundamental shift in its structure.[136] Originally enacted as a program to care for the neediest Americans, it is now understood as "an element of a comprehensive national plan to provide universal health insurance coverage."[137]

The Court found the government's Commerce Clause argument unpersuasive.[138] Chief Justice Roberts viewed the mandate as creating commerce rather than regulating it.[139] To uphold the mandate under this power would permit the government to regulate virtually anything, Roberts explained.[140] However, the Court did not rest its decision on the Commerce Clause. Instead, Justice Roberts interpreted the mandate as a tax, and found that the government's taxing power is sufficient to sustain the ACA's individual mandate.[141] Under Congress' taxing power, it has the ability to encourage people to buy something.[142] "Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness."[143] Simply put, the law gives an individual a lawful choice to do or not do a certain act.[144] If one is willing to pay the tax, the Government is without power to compel any further action.[145] By upholding the constitutionality of the ACA, IHCIA was affirmed.[146] This long-

133. *See* Howe, *supra* note 128.

134. *Id.*

135. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2604 (2012).

136. *Id.* at 2606.

137. *Id.*

138. *Id.* at 2587 (explaining that commerce power precedent regulates *existing* commercial activity rather than compelling individuals to become active).

139. *Id.* The Commerce Clause grants Congress the power to "regulate Commerce," which assumes that there is commerce present to regulate. *See id.* at 2586.

140. *Id.*

141. *Id.* at 2600.

142. *Id.* at 2599.

143. *Id.* at 2600.

144. *Id.*

145. *Id.*

146. Editorial, *ACA Ruling Affirms Indian Health Care Improvement Act*, ARIZ. DAILY INDEP. (July 3, 2012), http://arizonadailyindependent.com/2012/07/03/aca-

awaited reauthorization allowed Indian Country[147] to move forward in ensuring and improving health care for the nearly two million people served by IHS.[148]

IV. The ACA's Faults Act as a Barrier to Successful Coverage for the American Indian Population as a Whole

The ACA's budget designates $5.5 billion for IHS improvements in its federal, tribal, and urban programs.[149] Because the ACA reauthorized the IHCIA permanently, it appropriated funds for fiscal year 2010 (and each year thereafter) to remain available until exhausted.[150] This funding will be used to uphold the United States' goal of "[p]rovid[ing] 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 health disparities between Indians and the general population" and to "[p]ermit the health status of Indians to be raised to the highest possible level . . . ."[151] Despite these admirable goals, the intricate design of the ACA, together with the patchwork financing of Indian Country, creates a complex scheme that may ultimately create more problems than solutions.[152] The scheme reveals three shortcomings: a gap of the

---

ruling-affirms-indian-health-care-improvement-act/.

147. COHEN, *supra* note 32, at 134–35 ("Three basic definitions within Indian law set the general boundaries for the field in terms of political units, individuals, and territory. These key terms are 'Indian tribe' or 'Indian nation,' 'Indian,' and 'Indian country.' None of these terms has had a single, all-purpose federal definition that has operated consistently across time. . . . For federal purposes, the terms 'Indian tribe' or 'Indian nation' refer to an [I]ndigenous North American group with which the United States has established a legal relationship. The term 'Indian' refers either to a member of such a tribe or a person with some specified relationship to such a tribe. And the term 'Indian country' refers to the territory set aside for the operation of special rules allocating governmental power among Indian tribes, the federal government, and the states.").

148. Rickert, *supra* note 27 ("This is an important step for health[ ]care in Indian Country; the permanence of the Indian Health Care Improvement Act has been affirmed and NCAI [National Congress of American Indians] will stay focused on working with all members of Congress to uphold the trust responsibility to tribes. Moving forward, we are focused on improving health care for Indian Country, while ensuring the Indian Health Care Improvement Act remains protected and implemented as enacted." (quoting Jefferson Keel)).

149. OFFICE OF MGMT. & BUDGET, FISCAL YEAR 2013 BUDGET OF THE U.S. GOV'T 110 (2012).

150. *See* HEISLER & WALKE, *supra* note 103, at 3.

151. 25 U.S.C. § 1601 (2006).

152. *See* Mark Trahant, *ObamaCare Is a Different Debate*, *supra* note 22; *Indian Health Care Improvement Act Is Permanent*, INDIAN COUNTRY TODAY MEDIA NETWORK (June 28, 2012),

population left without coverage due to the expiration of Maintenance of Effort requirements; exemption from the Individual Mandate for American Indians; and the absence of a cultural competency requirement.[153]

A. Medicaid Expansion Provisions

At the heart of the ACA is the state Medicaid expansion.[154] The ACA requires state programs to provide Medicaid care to adults with incomes up to 133% of the federal poverty level.[155] In 2012, this translated to roughly $30,000 for a family of four.[156] This differs from the previous Medicaid coverage which permitted states to only cover adults with children if their income was considerably lower, and to exclude childless adults completely.[157] Additionally, the ACA adds the CHIP to IHCIA reimbursement requirements.[158] Prior to the ACA, the IHCIA required that the federal government pay one hundred percent of the cost of all Medicaid services billed.[159] This requirement is still in place, but expands government reimbursement to tribes and tribal organizations for all services provided by Medicare, Medicaid, the CHIP, or any third-party payer.[160] Also, reimbursements from Social Security Administration (SSA) health benefit programs are not to be taken into consideration when determining IHS appropriations.[161]

The problem with the Medicaid expansion provisions is two-fold: first, mandatory Maintenance of Effort requirements will be

---

http://indiancountrytodaymedianetwork.com/ict_sbc/obamacare-is-a-different-debate-indian-health-care-improvement-act-is-permanent (explaining that each state's individual set of Medicaid rules complicates the process).

153. NAT'L INDIAN HEALTH BD., SUMMARY OF THE INDIAN HEALTH CARE IMPROVEMENT ACT AND INDIAN SPECIFIC PROVISIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 13, 15 (2010).

154. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2572 (2012).

155. *Id.*

156. *Medicaid Expansion*, AM. PUB. HEALTH ASS'N, http://www.apha.org/advocacy/Health+Reform/ACAbasics/medicaid.htm (last visited Oct. 19, 2013).

157. *See Sebelius*, 132 S.Ct. at 2572.

158. *See* HEISLER & WALKE, *supra* note 103, at 7.

159. Medicaid is a shared federal-state partnership that is funded through a combination of federal and state funds. The federal government reimburses states for services provided to Medicaid-enrolled patients based on the Federal Medical Assistance Percentage (FMAP). The state is responsible for covering the difference between the FMAP and the total cost of services rendered. This difference generally translates to between twenty-four and fifty percent of the total cost. *See* Renfrew, *supra* note 17 at 181.

160. *See* HEISLER & WALKE, *supra* note 103, at 7.

161. 25 U.S.C. § 1641(a) (2009).

discontinued in 2014, leaving many Indians without coverage.[162] Second, for a variety of reasons, Native Americans historically do not enroll in public programs such as Medicare and Medicaid.[163]

1. The Maintenance of Effort Expiration Creates a Void Leaving Many Native Americans Without Coverage

Until 2014, states are required to comply with Maintenance of Effort stipulations, which prevent states from adopting eligibility standards, methodologies, or procedures under their Medicaid and CHIP programs that are narrower than those in place when the ACA was enacted.[164] At that time, new nationwide criteria for Medicaid will take effect.[165] For children, current Maintenance of Effort standards will remain in place through 2019.[166] Estimates for Medicaid expansion vary greatly among the states.[167] For example, expansion estimates range from just two percent in Massachusetts to eighty-eight percent in Nevada.[168] Despite this variance, enrollment will almost certainly decrease with the elimination of Maintenance of Effort requirements after 2014,[169] and the effect will be detrimental for the American Indian population.[170] With the Maintenance of Effort's expiration, states will almost certainly decide to lower their existing Medicaid

---

162. ED FOX, HEALTH CARE REFORM: TRACKING TRIBAL, FEDERAL, AND STATE IMPLEMENTATION 24 (2011), *available at* http://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSHealthCareReform5202011.pdf.

163. *See* RALPH FORQUERA, URBAN INDIAN HEALTH 13 (2001), *available at* http://www.kff.org/minorityhealth/loader.cfm?url=/commonspot/security/getfile.cfm&pageid=13909.

164. HENRY J. KAISER FAMILY FOUND., UNDERSTANDING THE MEDICAID AND CHIP MAINTENANCE OF EFFORT REQUIREMENTS (2012), *available at* http://www.kff.org/medicaid/upload/8204-02.pdf. These requirements ensure that states cannot restrict those seeking to enroll nor drop current enrollees. Such conditions were deemed necessary because of states' histories of enacting administrative barriers such as extensive paperwork for beneficiaries to apply or renew their eligibility. *See* Evie Lalangas & Ruth Ehresman, *Maintenance of Effort Requirements Ensure Health Insurance During Tough Economic Times*, THE MISSOURI BUDGET PROJECT (Aug. 4, 2011), http://www.mobudget.org/files/MOE_Requirements_Ensure_Health_Insurance_During_Tough_Economic_Times-8-4-2011.pdf.

165. Sarah Lueck, *Medicaid Maintenance-of-Effort Provisions Do Not Stop States from Fighting Fraud*, CTR. ON BUDGET & POLICY PRIORITIES 1 (Apr. 24, 2012), http://www.cbpp.org/files/6-6-11health.pdf.

166. *Id.*

167. *See* FOX, *supra* note 162, at 24.

168. *Id.*

169. *Id.*

170. *See* FOX, *supra* note 162, at 25.

requirements to transfer enrollees to the state health exchanges in order to preserve their budget.[171] States are not likely to choose to maintain coverage for those with a higher income since these individuals are likely entitled to subsidies in the health exchange programs.[172] The elimination of Maintenance of Effort requirements will disproportionately hurt the Indian population because their participation in the state exchanges is predicted to be low due to their exemption from the individual mandate.[173] By reducing their threshold for coverage, presumably to the 133% minimum, only the most indigent of Indians will remain covered.[174]

2. Native Americans Historically Decline to Use Public Programs

The Medicaid expansion also overlooks the fact that many American Indians are reluctant to enroll in public programs.[175] Some believe that due to their unique trust relationship with the United States they are entitled to health care and should not have to register for programs directed towards the population at large.[176] This perspective stems from American Indians' view that they purchased health care at the lofty cost of 400 million acres of land, and the cumbersome Medicare and Medicaid registration and enrollment processes are not a burden they bargained for.[177] Some are intimidated and confused by the enrollment procedure, or feel the process is too intrusive.[178] Others choose not to enroll because of transportation, literacy, and language barriers.[179] Past injustice and fear that has created distrust in the government has proven to be a deterrent for some.[180] Yet others cite mistreatment by social workers and staff as a barrier to the service.[181] For urban Indians

171. *Id.* at 24.

172. *Id.*

173. *Id.* at 24–25.

174. *Id.* at 25.

175. *See* FORQUERA, *supra* note 163, at 12–13.

176. *Id.*

177. *See* HEALTH CARE DISPARITIES BRIEFING, *supra* note 8, at 29.

178. URBAN INDIAN HEALTH COMM'N., INVISIBLE TRIBES: URBAN INDIANS AND THEIR HEALTH IN A CHANGING WORLD 9 (2007) [hereinafter INVISIBLE TRIBES], *available at* http://www.uihi.org/wp-content/uploads/2009/09/UIHC_Report_FINAL.pdf. For example, tribal members often indicate concerns that their property will be seized or their assets confiscated. This apprehension is likely rooted in the historical mistreatment of their property. *Id.*

179. *Id.*

180. *Id. See also id.* at 12 (describing how historical trauma intersects with poverty and discrimination to produce a fear and mistrust of Whites).

181. *See* FORQUERA, *supra* note 163, at 13; *see also* Gwendolyn Roberts Majette,

in particular, ignorance of resources is also a factor.[182] Stigma surrounding public programs is also an issue.[183] The perception of public program beneficiaries as lazy and undeserving welfare recipients has not only contributed to low enrollment, but also adversely affects how health care providers treat recipients once they are enrolled.[184]

To combat American Indians' reluctance to participate in public programs, aggressive public education and outreach efforts must be undertaken to establish eligibility and facilitate enrollment.[185] Geographic challenges, specifically the remoteness and inaccessibility of reservations, have long been recognized as barriers to the administration of health services.[186] Urban Indians represent an even more transient and dispersed population than reservation communities.[187] These structural barriers demonstrate the need for localized outreach efforts informing Native communities about the resources available for their use. Such efforts should be coordinated with local and state planning councils charged with implementing the ACA reforms.[188] Developing strategic partnerships is important to generating discussions with critical state and regional actors on how they intend to address health reform for the American Indian population.[189]

Community services are another tool to aid in outreach initiatives.[190] Such programs may "transmit cultural communications about upcoming pow-wows, health events or other group activities," as well as offer referrals to medical services.[191] Tribally operated facilities have proven to be more effective at increasing enrollment in and collections from public insurance programs than federally run facilities.[192] Understandably,

---

Access to Health Care: What a Difference Shades of Color Make, 12 ANNALS HEALTH L. 121, 136 (2003) (specifying bias or prejudice, stereotyping, and uncertainty in communication and clinical decision-making as the three causes of discriminatory treatment in health care delivery).

182. *See* DeCoteau, *supra* note 49, at 406.

183. *See* HEALTH CARE DISPARITIES BRIEFING, *supra* note 8, at 29–30.

184. *Id.*

185. *See* BROKEN PROMISES, *supra* note 1, at 145–46.

186. *Id.* at 70–71.

187. *See* URBAN INDIAN HEALTH INST., ACTUALIZING HEALTH CARE REFORM FOR URBAN INDIANS: AN ACTION PLAN FROM THE URBAN INDIAN HEALTH SUMMIT 16 (2011) [hereinafter ACTUALIZING HEALTH CARE REFORM].

188. *Id.* at 20.

189. *Id.*

190. *Id.*

191. *Id.* at 16.

192. *See* HEALTH DISPARITIES BRIEFING, *supra* note 8, at 29.

American Indians are more inclined to release private information to other Indians.[193] Tribally run providers should work in conjunction with community organizations to educate and improve access to public services.

A number of programs serve as models for success. The most important feature of these programs is their emphasis on culturally appropriate care.[194] Engaging the Native community in innovative and health-oriented activities has spurred awareness and encouraged the adoption of healthier lifestyles.[195] For example, the Indian Walk-In Center located in Salt Lake City has organized health fairs that combine traditional pow-wow dancing, basketball tournaments, and a diabetes awareness "fun run."[196] It also refers attendees to local health clinics that the Indian Walk-In Center has contracts with that use patient data for future studies on Native American health.[197] In another example, in an effort to demystify the bewildering medical bureaucracy, the Native American Cancer Research Corporation, in partnership with local urban Indian organizations and the Los Angeles-based American Indian Clinic, has created and implemented programs that train female Indian volunteers ("Native Sisters") to teach the Native community about the intricacies of the medical system.[198] One of Nike's philanthropic endeavors includes their collaboration with the Urban Inter-Tribal Center of Dallas to provide custom-made orthopedic shoes for Native diabetes patients.[199]

B. Exemption from the Individual Mandate Undermines the Government's Trust Responsibility

Studies estimate that 43.8 million Americans will be insured through the state health exchanges, which act as a counterpart to the Medicaid expansion.[200] Sixteen million of these Americans will gain health coverage through the individual mandate.[201] Though critical to the functioning of the ACA, various exemptions from the

193. *Id.*
194. *See* INVISIBLE TRIBES, *supra* note 178, at 21.
195. *Id.*
196. *Id.*
197. *Id.*
198. *Id.* at 21–22.
199. *Id.* at 21.
200. *See* FOX, *supra* note 162, at 26.
201. Margaret Steele, *Analysts Debate Importance of the 'Individual Mandate' to Health-Reform Law*, HEALTH (Mar. 22, 2012), http://news.health.com/2012/03/22/analysts-debate-importance-of-the-individual-mandate-to-health-reform-law/.

mandate will be granted for financial hardship, religious objections, American Indians, undocumented immigrants, and others.[202] This exemption, based on one's status as Indian,[203] undermines the purpose of the ACA, which is to ensure increased access to health care for the United States' most vulnerable populations.[204]

1. The Individual Mandate Is Critical In Reducing American Indian Health Disparities

The individual mandate is vital if the goals of the ACA are to be fully realized.[205] The individual mandate is designed to prevent adverse selection, a situation in which high-risk individuals do not purchase health insurance until they are sick.[206] A risk pool with a high proportion of unhealthy individuals prevents insurance companies from providing coverage to the greatest amount of people because of increased premiums.[207] In addition to being crucial to the infrastructure of the reform, participation in the individual mandate guarantees access to basic services mandatory for all providers offering coverage through the state exchanges.[208] Qualified health providers are required to offer "essential health benefits" in ten enumerated categories.[209] Among these categories are emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; and pediatric services, including oral and vision care.[210] Native Americans are the most at risk or among the most at risk populations for services in each of these areas.[211]

---

202. HENRY J. KAISER FAMILY FOUND., SUMMARY OF THE AFFORDABLE CARE ACT 1 (2011), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf.

203. 26 U.S.C. § 5000A(e)(3) (2010).

204. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S.Ct. 2566, 2580, 2582 (2012).

205. Editorial, *Why the Mandate Holds the Key to Health-Care Reform*, WASH. POST (Mar. 26, 2012), http://www.washingtonpost.com/opinions/why-the-individual-mandate-matters-so-much/2012/03/23/gIQA8zCacS_story.html.

206. *A Lesson from Massachusetts: The Importance of the Individual Mandate*, NAT'L COAL. ON HEALTH CARE, web.archive.org/web/20120511204938/http://nchc.org/massachusetts/news/lesson-massachusetts-importance-individual-mandate (last archived May 11, 2012).

207. *Id.*

208. *Building the Health Insurance Marketplace*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/issues-research/health/american-health-benefit-exchanges.aspx#ehbs (last updated Aug. 21, 2013).

209. *Id.*

210. *Id.*

211. *See* HEALTH DISPARITIES BRIEFING, *supra* note 8, at 5–14; David A. Nash & Ron J. Nagel, *Confronting Oral Health Disparities Among American Indian/Alaska*

Moreover, the 2009 rate of non-insured American Indians was 29.2%, nearly double the national non-insured rate for all races.[212] Clearly, American Indians' utilization of the state-based exchanges is imperative to increased access to health care.

2. Indian Status Exemption Contradicts the Federal-Tribal Trust Relationship

An estimated twenty-four million Americans are exempt from the individual mandate.[213] This group includes those who cannot afford insurance, members of certain religious groups, undocumented immigrants, and the tribes.[214] Native Americans' exemption from the individual mandate is rooted in their recognized status as independent nations.[215] The tribes' inherent sovereignty arises from their special government-to-government relationship with the U.S.[216] Because they are sovereign nations, the federal government cannot coerce the tribes into compliance with the ACA.[217] At the same time, it is because of their dependent status on the federal government that the U.S. has an obligation to provide tribes with health care in the first place.[218] The United States' promise of health care is a fundamental element of its trust responsibility.[219] Accordingly, the federal government is obligated to fulfill that promise.[220]

Native Children: The Pediatric Oral Health Therapist, 95 AM. J. PUB. HEALTH 1325, 1325 (2005).

212. *See* FOX, *supra* note 162, at 8.

213. *See* Sarah Kliff & Ezra Klein, *Individual Mandate 101: What It Is, Why It Matters*, WONKBLOG (Mar. 27, 2012, 10:35 AM), http://www.washingtonpost.com/blogs/wonkblog/post/individual-mandate-101-what-it-is-why-it-matters/2011/08/25/gIQAhPzCeS_blog.html.

214. *Id.*

215. *See* KELLY O'DONNELL, THE IMPACT OF FEDERAL HEALTH CARE REFORM ON INDIGENT HEALTH CARE IN BERNALILLO COUNTY 12 (2011), *available at* http://conalma.org/wp-content/uploads/2012/10/10-Impact-of-Federal-Healthcare-Reform-on-Indigent-Health-Care-in-Bernalillo-County.pdf. *See, e.g.*, TASK FORCE SIX, *supra* note 33, at 134 (describing the principle of self-determination as providing the tribes with the option to exercise control over their policies and practices).

216. The government-to-government interpretation of the federal-tribal relationship has been predominant since the late twentieth century. *See* Trombino, *supra* note 20, at 136. The government's fiduciary duty arises from European colonization of America. *See* GETCHES ET AL., *supra* note 3, at 79–81.

217. *See* O'DONNELL, *supra* note 215, at 12.

218. *See* Kuschell-Haworth, *supra* note 33, at 845. ("The Federal government's earliest goals were to prevent disease and to speed Native American assimilation into the general population by promoting Native American dependence on Western medicine . . . .").

219. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans*, *supra* note 30, at 213 ("Destruction of traditional civilization, along

Exempting Native Americans from compliance with the ACA undermines that obligation and potentially deprives tribal members of the benefits of universal health care. While sovereignty is integral to the growth and future of Indian tribes,[221] the critical state of tribal health outweighs the potential undermining of sovereignty in this instance.[222] It is clear that the ACA was not designed with Native American concerns in mind,[223] but the applicable Indian-specific provisions should be implemented in a manner that will yield the best outcomes for this population. Because of Native Americans' historically low rates of utilizing public programs,[224] and because they are likely to be disproportionately impacted by the expiration of Maintenance of Effort requirements,[225] exempting Native Americans is inconsistent with that goal.

The ACA contains special incentives for American Indians to participate in the insurance exchanges.[226] Individuals who are exempted from the individual mandate are not prohibited from purchasing insurance if they choose to do so.[227] The ACA eliminates all cost-sharing for Indians under 300 percent of the federal poverty level[228] and requires special monthly enrollment periods for Indians.[229] Cost-sharing, the unreimbursed amount participants are required to pay as a cost of receiving services, has become an increasingly popular feature of insurance programs due to rising costs.[230] Because of this expense, some low-income populations have been deterred from obtaining health care.[231] Even though these incentives are included, barriers to tribal participation still exist. Native Americans are reluctant to utilize

---

with poverty and disease that followed, and subsequent treaty-based agreements, created a fundamental government responsibility for provision of health, and other, services to Indians.").

220. *See* BROKEN PROMISES, *supra* note 1, at 23.

221. *See* Scott C. Idleman, *Multiculturalism and the Future of Tribal Sovereignty*, 35 COLUM. HUM. RTS. L. REV. 589, 590, 659 (2004).

222. *See* FOX, *supra* note 162, at 8.

223. *Id.* at 5.

224. *See* discussion in Part IV.A.2, *supra*.

225. *See* FOX, *supra* note 162, at 24–25.

226. *Id.* at 27.

227. 25 U.S.C. § 1642 (2010).

228. 42 U.S.C. § 18071(d) (2010).

229. 42 U.S.C. § 18031(c)(6).

230. HENRY J. KAISER FAMILY FOUND., COST-SHARING FOR HEALTH CARE: FRANCE, GERMANY, AND SWITZERLAND 1–2 (2009), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7852.pdf.

231. *Id.*

public services,[232] the conflicting definitions of Indian used by agencies may be problematic,[233] and studies indicate that Native Americans are less likely to participate in the insurance exchanges than the Medicaid expansion.[234] With these concerns in mind, subjecting Native Americans to the mandate is consistent with the federal government's trust obligation and offers this population the best opportunity for increased access to health care.

There are three reasons why compliance with the individual mandate is not overly burdensome to the tribes: first, the individual mandate applies to the nation at large, as opposed to the tribes in isolation,[235] thereby eliminating the bright line demarcation of Indians and non-Indians that characterizes much of Indian Law; second, tribal consultation procedures outlined in the ACA[236] are in accordance with the principle of public freedom; and third, such conformance is consistent with an emerging vision of tribal sovereignty based on international law concepts and a burgeoning human rights culture.[237]

i. The Individual Mandate's Comprehensive Application Is in Contrast to the "Measured Separatism" that Characterizes Much of Indian Law

The treaties entered into between the federal government and Indian tribes are the legal cornerstone for the federal-tribal relationship and more generally, provide the basis for tribal sovereignty.[238] However, early treaties between the nations did not envision incorporation of American Indians into U.S. citizenship, and later treaties only granted such status to those sufficiently "detribalized."[239] Indeed, a desire for measured separatism is reflected in the words and structure of original Indian laws and treaties.[240] For years, Congress has vacillated between two

232. *See* discussion in Part IV.A.2, *supra*.

233. *See* ACTUALIZING HEALTH CARE REFORM, *supra* note 187, at 12. Particularly with regard to urban Indians, differences in the political versus legal definitions of an Indian may create confusion that harms or benefits a person's eligibility for coverage and the financing organizations receive. *Id.*

234. *See* FOX, *supra* note 162, at 27.

235. 42 U.S.C. § 18071 (2010).

236. 45 C.F.R. § 155.130(f) (2012).

237. *See* Angela R. Hoeft, *Coming Full Circle: American Indian Treaty Litigation From an International Human Rights Perspective*, 14 LAW & INEQ. 203, 268 (1995).

238. *See* FRANK POMMERSHEIM, BRAID OF FEATHERS: AMERICAN INDIAN LAW AND CONTEMPORARY TRIBAL LIFE 40 (1995).

239. *See* DANIEL MCCOOL ET AL., NATIVE VOTE 1–7 (2007).

240. *See* POMMERSHEIM, *supra* note 238, at 16; CHARLES F. WILKINSON,

incongruent views: self-determination and self-government for tribes, and assimilation into greater U.S. culture.[241] Regardless of the prevailing notion at the time, "[i]n the continuing conflict between the claims and rights of non-Indian American citizens and the Indian tribes . . . there is no question but that Congress has heavily favored non-Indian citizens . . . ."[242] A review of the record of American Indians and the federal legislative branch reflects ignorance and ambivalence, and in some instances, raises questions about the constitutionality of some congressional initiatives as invalid exercises of the plenary power.[243] In commending the small number of Congressmen who worked astutely on Indian legislation, former Indian Commissioner Francis Leupp noted:

> When it is remembered that all laws and appropriations are passed by the votes, or the silent consent, of more than five hundred members of the two houses of Congress, that probably not more than one-fifth of these know anything at all about Indians, and that, of this small group, it is doubtful whether a dozen know anything of tribes outside of the borders of their own States respectively, it argues pretty well for the industry and interest of a few men that we obtain any Indian legislation of real value.[244]

Federal Indian policy has long been built upon Eurocentric undertones and assumptions of Indian incompetence.[245] Still, the societal vestiges of mistreatment are felt now in the ostensible era

---

AMERICAN INDIANS, TIME, AND THE LAW: NATIVE SOCIETIES IN A MODERN CONSTITUTIONAL DEMOCRACY 14 (1987).

241. *See* CHARLES WILKINSON, AM. INDIAN RES. INST., INDIAN TRIBES AS SOVEREIGN GOVERNMENTS 1 (2d ed. 2004).

242. *See* VINE DELORIA, JR. & DAVID E. WILKINS, TRIBES, TREATIES, AND CONSTITUTIONAL TRIBULATIONS 45 (1999); *see also* MARKKU HENRIKSSON, THE INDIAN ON CAPITOL HILL 259 (1988) (describing the non-consensual management and representation of Indian affairs in Congress); POMMERSHEIM, *supra* note 238, at 37 ("From the very beginning of this republic, the federal government has sought economic and political advantage in its dealings with Indian tribes."); WILKINSON, *supra* note 240, at 53 ("To be sure, tribes are subject to the overriding power of Congress.").

243. *See* DELORIA & WILKINS, *supra* note 242, at 45.

244. *Id.* at 46. The authors observe, "[b]ecause legislators and the legislative process are so inconsistent in fulfilling the constitutional mandate to tribal nations, it seems somewhat problematic that the federal courts would use the phrase 'wisdom of Congress' and try to determine congressional intent when examining and interpreting federal statutes." *Id.* at 50.

245. *See* Hoeft, *supra* note 237, at 214; *see also* Bruce E. Johansen, *Introduction*, *in* ENDURING LEGACIES: NATIVE AMERICAN TREATIES AND CONTEMPORARY CONTROVERSIES, at xiii, xiv (Bruce E. Johansen ed., 2004) (describing a speech given by Vine Deloria, Jr. in which Deloria described the legal definition of sovereignty itself as Eurocentric).

of self-determination.[246] Federal-tribal relations remain to be tainted with racism and discrimination.[247] Defended on the basis that such treatment is "benignly generic or genuinely ennobling," federal Indian policies continue to perpetuate paternalism.[248] Since the U.S. Supreme Court's decision in *Morton v. Mancari*,[249] federal classifications that distinguish American Indians for purposes of distinctive treatment have been upheld.[250] In *Mancari*, the Court characterized a BIA hiring preference as flowing from the trust relationship: Justice Blackmun stated that such preferences were not racial; instead, he classified such preferences as political.[251] In justifying its decision, the *Mancari* Court noted that the federal government has treated Native Americans uniquely since our country's first dealings with the tribes.[252] The *Mancari* principle, intended as a benevolent mechanism to enhance tribal autonomy, has instead been reduced to a one-line analysis: if the demarcation is based on tribes or tribal membership, it will be upheld.[253] This construction has failed to discern between discriminatory, oppressive government action and desirable action in furtherance of the tribe's development.[254]

The answer to the challenges facing tribes in the realms of social and economic development can be found, from Pommersheim's perspective, in the creation of a new ethic and sense of solidarity between Indians and non-Indians.[255] This unity does not necessarily erase the differences between majoritarian society and Native Americans, but uses them to the advantage of each.[256] The individual mandate, the ACA's "linchpin," is an

246. *See* Idleman, *supra* note 221, at 632; O'Brien, *supra* note 6, at 1463.

247. *See* Idleman, *supra* note 221, at 631.

248. *Id.* at 632.

249. 417 U.S. 535 (1974).

250. *See* Sarah Krakoff, *Inextricably Political: Race, Membership, and Tribal Sovereignty*, 87 WASH. L. REV. 1041, 1054 (2012).

251. *See Mancari*, 417 U.S. at 553 n.24.

252. *See* Krakoff, *supra* note 250, at 1056. Authorization for differential treatment is rooted in the Constitution, in history, and in international law concepts used to advance European colonization and the manifest destiny expansion of the United States. *Id.*

253. *See id.* at 1059.

254. *Id.*

255. *Id.*

256. POMMERSHEIM, *supra* note 238, at 200 ("[T]he point is not to find the new, true perspective; the point is to strive for impartiality by admitting our partiality. The perspective of those who are labeled 'different' may offer an important challenge to those who impose the label, but it is a corrective lens, another partial view, not the absolute truth. It is the complexity of our reciprocal realities and the conflict between the realities that constitute us which we need to understand." (quoting MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION,

example of this solidarity.[257] The individual mandate is integral, if the legislation is to succeed, in confronting and solving "a 'profound and enduring crisis' in the health care industry" and in the achievement of universal health care.[258] In enacting this legislation, Congress sought "a reformed system, [in which] more Americans will get the care they need, regardless of their race, ethnicity, or primary language, and the quality of care will improve."[259] The ACA represents a deracialized effort to achieve a true sense of balance and an ethic of mutual understanding among *all* races. Requiring American Indians to comply with the mandate is within the scope of tribal sovereignty and attempts to rectify the government's past shortcomings in the deliverance of health care. Such a scheme recognizes that the future of Indians and non-Indians is inextricably tied and attempts to shed historical animosity in favor of a shared agenda.[260]

ii. The ACA's Tribal Consultation Procedures Align with the Principle of Public Freedom

The ACA requires states that contain federally recognized tribes to consult and collaborate with tribes and tribal officials on exchange policies that have tribal implications.[261] This stipulation is consistent with the principle of public freedom and, in turn, fosters development.[262]

Participation in local government is an inherently democratic concept. Simply put, participatory democracy allows individuals to participate in formulating the laws they must obey.[263] This enduring American value, pervasive in political discourse, allows individuals to have a meaningful role in the societal decisions that impact their lives.[264] Significantly, the notion of public freedom encompasses full inclusion in the life of society.[265] Indian tribes

---

AND AMERICAN LAW 376 (1991))).

257. *See* Jenna L. Kamiat, *PPACA and the Individual Mandate: A Healthy Approach to Severability*, 80 FORDHAM L. REV. 2237, 2250 (2012).

258. *Id.* at 2238.

259. *Goal 1: Strengthen Health Care*, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://www.hhs.gov/secretary/about/goal1.html (last visited Mar. 31, 2013).

260. *See* POMMERSHEIM, *supra* note 238, at 30.

261. 45 C.F.R. § 155.130(f) (2012).

262. Goals of development are broadly defined as economic growth, more jobs, and a better standard of living. *See* POMMERSHEIM, *supra* note 238, at 166.

263. *See* Christiana Ochoa, *The Relationship of Participatory Democracy to Participatory Law Formation*, IND. J. GLOBAL LEGAL STUD. 5, 7 (2008).

264. *See* HARVARD LAW REVIEW ASS'N, *Rethinking the Trust Doctrine in Federal Indian Law*, 98 HARV. L. REV. 422, 432 (1984).

265. *Id.*

cannot have sincere public freedom without corresponding tribal sovereignty.[266] Such autonomy affords tribal members an active role in shaping the policies and rules that intimately affect their people, such as universal health care.[267] The ACA's consultation procedures involve tribal leaders and form the basis of a federal-tribal partnership that is in pursuit of tribal advancement.[268] Admittedly, under this framework the government is not relinquishing its plenary control of Indian affairs, but it seeks to incorporate the substantive values and vision of tribal bodies.

iii. Compliance with the Individual Mandate Is Compatible with Emerging Conceptions of Native Sovereignty

Due to transformations fueled by the expansion of globalization, impressions of sovereignty are evolving.[269] As the imperialistic conventional view declines, there has been an analogous rise in a view of sovereignty that embraces citizens' rights and emphasizes the interrelationship between citizens, the government, and the international community.[270] This nascent understanding of sovereignty draws on human rights norms that require more from the government as citizens' expectations grow, thereby increasing the government's scope and responsibilities as citizens seek more from it, often framing their requests within the rhetoric of "rights."[271] Thus, a focus on individual human rights is now a recognized component of sovereignty.[272]

Today, tribes are influenced by the majoritarian culture perhaps more than ever before, and struggle to reconcile their traditional existence with modernity.[273] Tribes have long lived exclusive of the dominant culture, but now increasingly desire to

---

266. *Id.*

267. *Id.*

268. *See, e.g.*, *MNsure Tribal Consultation Policy*, MNSURE 1 (2013), http://www.mnsure.org/images/Bd-2013-09-11-TribalConsultationPolicy-final.pdf (detailing the importance of involving Indian tribes in developing federal and state health care policies in order to improve tribal members' lives).

269. *See* Angela R. Riley, *Good (Native) Governance*, COLUM. L. REV. 1049, 1057 (2007).

270. *See* Helen Stacy, *Relational Sovereignty*, 55 STAN. L. REV. 2029, 2043 (2003).

271. *See id.* at 2050. The sovereign's duties toward its citizens continue to expand, incorporating more than just civil and political rights, but also social, economic, and cultural rights. *Id.* at 2048. This conception embraces the fluid logic that the sovereign's duty to protect its citizens should follow the citizens, instead of limiting the sovereign's duties to its borders. *Id.*

272. *See* Riley, *supra* note 269, at 1059.

273. *Id.* at 1089.

participate in shaping the policies executed by national and international institutions that affect their cultural and political existence.[274] Part of this shift in identity is traced to American Indians' understanding of their role in a contemporary world, particularly in relation to other sovereigns.[275] Tribes have long understood the value of interdependence and know that in some instances, the best decision for their community may be to pair with other sovereigns in pursuit of increased self-governance.[276]

Globalization and technological advancements have allowed tribes to successfully incorporate modern tools into their development and dealings to increase tribal functioning and cohesion.[277] The ACA is an example of a social policy that has the potential to effectuate development and consequently reduce long-term dependency. It represents a means by which tribal members can seek to hold the government accountable for redressing the harms perpetrated against them.[278] Years of mistreatment in the realm of health care[279] can finally be rectified. The key point is that we now live in a human rights culture.[280] "[H]uman rights have become the language with which people, groups, and even nation states, frame their requests for better treatment from others—whether those others are citizens, governments, international capital, or neighbors."[281] The ACA is consistent with twentieth-century human rights theory and with a benevolent conception of the government's obligations towards its citizens.[282] Requiring tribal compliance with the individual mandate creates a commitment on behalf of the federal government and establishes an attendant state obligation to continue its expected conduct of providing health care.[283] This strategic convergence between two

---

274. *Id.* at 1090.

275. *Id.* at 1091.

276. *Id.* "After all, many Indian nations formed confederacies and alliances in pre- and post-contact America to facilitate their survival and continued existence." *Id.* at 1092. *See* WILKINSON, *supra* note 240, at 54 ("Ultimately, during the modern era the tribes have used their sovereign status in numerous pragmatic ways to rise from the termination era and gain a place . . . in the community of governments in the United States.").

277. *See* Riley, *supra* note 269, at 1101.

278. *See Exchange Primer: Native Americans*, N.M. HEALTH INS. EXCH. ADVISORY TASK FORCE 1, http://www.edfoxphd.com/NMNative_American_Work_Group_Primer_copy.pdf.

279. *See* HEALTH DISPARITIES BRIEFING, *supra* note 8, at 14–15.

280. *See* Stacy, *supra* note 270, at 2049.

281. *Id.*

282. *Id.* at 2050.

283. *See id.* at 2052.

sovereigns contemplates a purpose for both tribal governments and the larger state.[284] In other words, it is a cultural match.

> In sum, it is clear that contemporary governments–tribal or otherwise–cannot ignore the human rights of their members. *Sovereignty should not be used as a shield to justify the denial of basic rights and liberties.* All sovereigns should thus, in some sense, strive to be "good." At the same time, however, the obligations of tribal governments to their members must be contemplated in the context of the concomitant duties owed to tribes by the larger, dominant regime in conjunction with the goal—deeply embedded in international human rights law—of preserving the continuation and existence of minority cultures . . . .[285]

iv. Proponents of Sovereignty Argue that Mandated Compliance Undermines Tribal Autonomy

> *Perhaps the most basic principle of all Indian law, supported by a host of decisions . . . is the principle that* those powers 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. *Each tribe begins its relationship with the federal government as a sovereign power, recognized as such in treaty and legislation.*[286]

What sovereignty signifies for Native Americans is clear: "[a]t the end of a century dominated by anti-colonial nationalist struggles for sovereignty and independence, we can hardly help but see national independence as almost synonymous with dignity, freedom, and empowerment."[287] Tribal sovereignty is a foundational concept.[288] Indian tribes possess a right to grow and

---

284. *See* Riley, *supra* note 269, at 1124.

285. *Id.*

286. WILKINSON, *supra* note 241, at 31 (quoting Felix S. Cohen).

287. Thomas Biolsi, *Imagined Geographies: Sovereignty, Indigenous Space, and American Indian Struggle*, 32 AM. ETHNOLOGIST 239, 239 (2005) ("Our people have exercised inherent sovereignty, as nations, on the Columbia Plateau for thousands of years, since time immemorial. . . . We . . . hereby declare our national sovereignty. We declare the existence of this inherent sovereign authority—the absolute right to govern, to determine our destiny, and to control all persons, land, water, resources and activities, free of all outside interference—throughout our homeland." (quoting the Declaration of Sovereignty of the Confederated Tribes of the Warm Springs Reservation)).

288. POMMERSHEIM, *supra* note 238, at 50.

evolve; they are not static.[289] The tribes are permanent fixtures in the American political system.[290]

The application of the concept of sovereignty to American Indians has undergone extensive scholarly debate and has been the subject of heated controversy.[291] Evolving in scope and definition, the term continues to be employed, though it has proven rather elusive in practice.[292] The doctrine of sovereignty is fragmented and ambiguous, paradoxical, and theoretically incoherent, especially in recent decades.[293] Still, Cohen's articulation that inherent tribal sovereignty is "perhaps the most basic principle of all Indian law" is true.[294]

Critics of Indian sovereignty argue that Indian governments operate in a separate sphere at odds with legal and political values that ought to transcend racial or cultural distinctions.[295] In response, tribal advocates stress that the imposition of and forced compliance with the majoritarian political values threatens the very fabric of tribal communities, and "assumes by implication the moral superiority of [W]estern moral and political values."[296] This behavior, some contend, is congruous with Western imperialism and reminiscent of the colonial "civilizing missions" of European nations.[297] In other words, this behavior mistakenly assumes that all societies desire the same forms of development.[298] In this view, compliance with the individual mandate could be perceived as culturally insensitive and encouraging the federal homogenization of Indian affairs. Such a perspective would be consistent with a

289. *See* WILKINSON, *supra* note 240, at 53.

290. *Id.*

291. *Id.* at 55.

292. *See* POMMERSHEIM, *supra* note 238, at 50.

293. *Id.* at 51.

294. WILKINSON, *supra* note 240, at 62. Professor Cohen, arguably the most influential Indian lawyer and scholar of all time, defined tribal sovereignty as adhering to three fundamental elements: (1) an Indian tribe retains, in the first instance, all the powers of a sovereign state; (2) conquest subjects the tribe to the legislative power of the United States and, in substance, eliminates its external sovereignty (for example, its ability to enter into treaties with foreign nations), but does not by itself affect a tribe's internal sovereignty, that is, its capacity to self-govern; (3) these powers are subject to qualification by treaties and express legislation of Congress, but, save those explicitly qualified, absolute powers of internal sovereignty remain with the Indian tribe and in their duly constituted instruments of government. *See* POMMERSHEIM, *supra* note 238 at 51–52.

295. *See* Patrick Macklem, *Distributing Sovereignty: Indian Nations and Equality of Peoples*, 45 STAN. L. REV. 1311, 1314 (1993).

296. *Id.* at 1341.

297. *See* Riley, *supra* note 269, at 1060.

298. *Id.*

vision of the tribes' existence as only at the hands of Congress, paralyzed within the confines of limited tribal sovereignty.[299]

Still, in the face of an opportunity for the tribes to finally receive the type of health care this population has so long deserved, it is a mistake to permit optional compliance. This is not an instance which mimics the assimilative or oppressive practices so prevalent in the history of federal-tribal relations.[300] This is not a Eurocentric imperialistic measure designed to detribalize American Indians or a policy aimed to socially, politically, economically, or religiously burden this population.[301] It is true that Indigenous societies are structured around values and beliefs that are foreign to liberal democratic political systems,[302] but the imposition of this particular, arguably Western, policy, will allow Indian nations to advance and grow on par with the rest of the nation. In this view, requiring that American Indians comply is part of a broader guarantee that strives to ensure long-term self-governance and diminished reliance. While in many aspects the dominant culture continues to encroach on Native sovereignty, the ACA furthers shared goals between the federal government and the Indian tribes and effectuates the continued existence of tribal communities. At the end of the day, the benefits that the ACA can realize are too tremendous to risk. Similar to other examples of tribal reform, the ACA can be viewed as "an essential first step in strengthening government stability, exercising greater political sovereignty, and enhancing prospects for increased political and economic development."[303] Ultimately, compliance does not undermine the legitimacy of sovereignty in this case because it is an authentic effort on behalf of the federal government to improve health and quality of life, despite the differences that have tainted the trust relationship for years.

---

299. *See* POMMERSHEIM, *supra* note 238, at 49. Tribal sovereignty is a highly emotional issue. *See* Deloria, *supra* note 4, at 217. During the rallies of the Trail of Broken Treaties in the 1970s, thousands of Indian activists stormed Washington, D.C. demanding the recognition of its virtues in a series of hundreds of protests and demonstrations. *Id.* For a collection of emotional media content detailing the Trail of Broken Treaties, see AKWESASNE NOTES, B.I.A. I'M NOT YOUR INDIAN ANY MORE 2 (1973). At the time, the violent occupation of the BIA office was one of the most serious attacks upon the U.S. on its own soil since the War of 1812. *Id.* at iv.

300. *See* Macklem, *supra* note 295, at 1317, 1319.

301. *See id.* at 1312–13 (discussing the impact of European settlement of North America on defining Indians' identities).

302. *See* Macklem, *supra* note 295, at 1340–41.

303. Riley, *supra* note 269, at 1082 (quoting Eric Lemont, *Overcoming the Politics of Reform: The Story of the Cherokee Nation of Oklahoma Constitution Convention, in* AMERICAN INDIAN CONSTITUTIONAL REFORM AND THE REBUILDING OF NATIVE NATIONS 288 (Eric D. Lemont ed., 2006)).

C. The ACA's Minimal Cultural Competency Requirement Represents a Critical Flaw in the Western Medical Model

The last patient of the day is a tribal leader. Her daughter just committed suicide that morning, left two little kids behind and her husband. . . . She couldn't say a word. There was no point in interviewing her. I just held her in my arms and sang her one of my traditional songs, and prayed hard. . . . No, they don't teach that in medical school.[304]

Section 199A of the ACA prohibits the Federal Tort Claims Act from assuming liability for traditional health care practices conducted within the Indian health care system.[305] This means that the government is exempt from liability for any injury that arises from traditional healing methods, a fundamental and culturally competent service.[306] Frequently discussed, but largely misunderstood, "traditional" Indian medicine is often perceived as antithetical to Western medicine.[307] This exclusion reflects this misperception and is contrary to the stated purpose of the ACA.[308]

Traditionally, Native Americans endorse a holistic view of health,[309] and their cultural views are likely foreign to non-Native health professionals. "The basing of American medicine on scientific and experimental observation has provided enormous success and advancement in a variety of fields."[310] However, "[t]his movement has been emphasized at the expense of other approaches to truth, which have suffered as a result of the emphasis on scientism."[311]

Urban Indians, who already find themselves in a foreign environment, are often frustrated by language difficulties, fragmented services, and medical personnel that are "usually completely ignorant of or insensitive to cultural differences,

304. INVISIBLE TRIBES, *supra* note 178, at 13 (quoting an unidentified Native family physician).

305. *See Title X*, *supra* note 111, at 13.

306. *Id.*

307. *See* TASK FORCE SIX, *supra* note 33, at 74.

308. 25 U.S.C. § 1601 (2006).

309. Many tribes believe that health is comprised of four factors: physical, mental, emotional and spiritual. *See* INVISIBLE TRIBES, *supra* note 178, at 14. Some include a social component in their health outlook as well. *Id.* To achieve total body wellness, all components must be balanced. *Id.* One becomes "ill" when one aspect has been ignored. *Id.*

310. *See* TASK FORCE SIX, *supra* note 33, at 74.

311. *Id.*

community resources, and special Indian needs."[312] Traditional Native American beliefs regarding wellness and medicine vary drastically from the Westernized model utilized in training health care providers.[313] The success of any health care service is affected by the underlying beliefs of the patient.[314] In this context, strictly subjecting Native Americans to a Western medical model reflects a sense of imperialism and superiority, given the lack of available alternatives for this population.[315]

The importance of culturally competent services in the medical profession is generally acknowledged.[316] Cultural competence is defined as:

> The demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy.... [P]erhaps the most significant aspect of this concept is the inclusion of and integration of the three areas that are usually considered separately when they are considered at all.[317]

Minimal federal standards exist for culturally appropriate services in the medical profession.[318] Lack of cultural competency and sensitivity has repeatedly been cited as an issue in the provision of health care to Indians.[319] The ACA requires qualified health plans operating inside the health exchanges to complete basic criteria for certification.[320] Among these requirements is "the implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings."[321] This

---

312. DeCoteau, *supra* note 49, at 406.

313. "My rage came mainly from the frustration caused by the way I feel about Western medicine, the way it generally dehumanizes patients." Pfefferbaum et al., *Learning How to Heal*, *supra* note 5, at 366 (quoting Cherokee Chief Wilma Mankiller).

314. *See* Kuschell-Haworth, *supra* note 33, at 854.

315. *Id.* IHCIA authorizes medical services strictly under the Western medical model, excluding traditional forms of Native American medicine. *Id.*

316. *See* HEALTH CARE DISPARITIES BRIEFING, *supra* note 8, at 42.

317. *Id.*

318. *See National Standards on Culturally and Linguistically Appropriate Services (CLAS)*, OFFICE OF MINORITY HEALTH, U.S. DEPT. OF HEALTH & HUMAN SERVS., http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 (last modified Apr. 12, 2007, 3:04 PM) [hereinafter *National Standards on CLAS*].

319. *See* INVISIBLE TRIBES, *supra* note 178, at 13–14.

320. BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R41269, PPACA REQUIREMENTS FOR OFFERING HEALTH INSURANCE INSIDE VERSUS OUTSIDE AN EXCHANGE (2010).

321. 42 U.S.C. § 18031(g)(1)(E) (2006).

minimal criterion is the only mention of cultural training throughout the ACA.[322]

IHS concludes that culturally competent care is not an issue for their services because they employ a high proportion of Native Americans within their system.[323] However, studies indicate that when IHS refers its patients to contracted health care providers, cultural insensitivity, bias, and a lack of knowledge concerning traditional medicine are an issue.[324]

To address cultural competency issues, HHS should require providers participating inside the state exchanges to demonstrate their ability to supply culturally appropriate services. This could be accomplished through the mandatory satisfaction of the Culturally and Linguistically Appropriate Services in Health Care (CLAS) Standards offered through the Office of Minority Health.[325] These standards provide a framework for organizations seeking to provide culturally and linguistically appropriate services.[326] Currently, only four CLAS criteria are required for providers that receive federal funding.[327] Moreover, the compulsory standards are limited to linguistically appropriate services.[328] Stricter guidelines for the implementation of the "activities" mentioned in the ACA should be promulgated in order to ensure that providers are educated and trained. Guidelines should quantify a number of minutes that each provider must meet to satisfy the standards.

Central to a certification program for providers in the state exchanges should be education on traditional medicine. The lack of diversity of cultural backgrounds interferes with cooperative programs of mutual support.[329] The recommendation of cooperation between traditional medicine men and physicians is not a new concept, having been originally introduced in the 1940s.[330] Today's education should highlight the commonalities

322. 42 U.S.C. § 18031(i)(3)(E) (specifying that providers are to "provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges," but again this stipulation refers to linguistically appropriate services).

323. During the study, when asked for information pertaining to IHS training and policy implementation efforts for culturally appropriate services, IHS was unable to produce monitoring mechanisms, training initiatives, or specific funding for culturally competent delivery. *See* BROKEN PROMISES, *supra* note 1, at 35–36.

324. *Id.* at 35.

325. *See National Standards on CLAS*, *supra* note 318.

326. *Id.*

327. *Id.*

328. *Id.*

329. *See* TASK FORCE SIX, *supra* note 33, at 80.

330. *Id.* at 82.

between Indian and non-Indian medicine[331] and should incorporate Indian practitioners to offer a comprehensive view of supplying traditional medicine in a modern context.

Conclusion

Public health in the United States reflects a balancing of scientific advancement and social values.[332] These values, combined with political factors, reflect the interests of the elite[333] and account for the differential treatment and status of Indians in comparison to the general population.[334] Throughout the history of federal-tribal relations, it is clear that these dominant views have existed to diminish the political status and health status of the tribes.[335] Though the Self-Determination Era was designed to relinquish federal control of tribal policy and strengthen Indians' autonomy, it has led to mixed results.[336] To remain true to the central goal of raising Indians' health status to the highest possible level, the federal government must strike a balance between fulfilling its role as "guardian" and tribal self-governance.

Unfortunately, the concept of dual entitlement has provided Congress with a built-in excuse to shift responsibility for health care to other parties and services.[337] This concept of dual entitlement is legitimate, but trammels the trust responsibility's purpose in the realm of health care.[338] "Defeasance of, versus maintaining and strengthening, sovereignty is arguably the

331. *Id.* at 83 ("There is a striking universality of healing practices among Indian tribes and between Indians and non-Indians. This includes such characteristics as seriousness of benevolent intentions; establishment of diagnosis; a concept of causality; a relatively long period of preparation; reward to the healer involving a payment of a fee. In most areas, the Indian concept is considerably more comprehensive and holistic than that possessed by European-American 'scientific' medicine.").

332. *See* Pfefferbaum et al., *supra* note 5, *Learning How to Heal*, at 389.

333. *See* Moss, *supra* note 20, at 59; *see also* Majette, *supra* note 181, at 122 ("[T]he United States health care system is based on a [W]hite male paradigm. This paradigm explicitly highlights race, ethnicity[,] and sex, and implicitly economic status, due to the dominance of [W]hite males in employment positions of power and high compensation.").

334. *See* Pfefferbaum et al., *supra* note 5, *Learning How to Heal*, at 389–90.

335. *Id.*

336. *See* Pfefferbaum et al., *supra* note 30, *Providing for the Health Care Needs of Native Americans*, at 239.

337. *See* TASK FORCE SIX, *supra* note 33, at 137.

338. *See* Pfefferbaum et al., *supra* note 5, *Learning How to Heal*, at 390 ("[T]he contradiction inherent in federal responsibilities compared to tribal sovereignty continues to dominate, and sometimes confuse, policy development and implementation.").

number one issue in Indian Country."[339] Access to health care is arguably the second. The conflicting political status of the tribes has resulted in their standing as America's most regulated population,[340] but the ACA represents a step in the right direction. The weaknesses the ACA contains—the void in coverage created by the expiration of the Maintenance of Effort requirements, the Individual Mandate exemption for Natives, and the lack of cultural competency requirements—will no doubt present tribal communities with challenges as they continue to struggle in navigating the ever-changing medical world. The sheer complexity of the legislation may act as a barrier to success itself as well. However, by fostering a more direct relationship between the tribes and those responsible for the implementation of the ACA, the best outcomes will be actualized.

339. *See* Moss, *supra* note 20, at 59–60

340. *See* Moss, *supra* note 20, at 60.