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HIPPA and Patient Privacy: Tribal Policies as Added Means for Addressing Indian Health Disparities

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HIPAA AND PATIENT PRIVACY: TRIBAL POLICIES AS ADDED MEANS FOR ADDRESSING INDIAN HEALTH DISPARITIES

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Introduction

> *[T]he HIPAA privacy rule will improve the quality of care and access to care by fostering patient trust and confidence in the health care system. People will be encouraged to more fully participate in their own care, and . . . [o]nce fully. . . implemented, we believe the HIPAA privacy regulation will improve the quality of health care and broaden access to health care services.*[1]

The Department of Health and Human Services (DHHS) published final privacy standards for the protection of individually-identifiable health information on August 14, 2002. The privacy standards are part of the regulations promulgated under the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.[2] The HIPAA regulations set forth standards and administrative requirements that must be in place to protect the confidentiality of medical records and to limit disclosures of such protected information.[3] These HIPAA privacy protections raise some interesting questions for Indian health care programs

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1. Testimony of Janlori Goldman, Director, Health Privacy Project, Before the Subcommittee on Privacy and Confidentiality, National Committee on Vital and Health Statistics, Regarding the HIPAA Privacy Regulation: Implementation, Compliance, and Impact on Health Care 9 (Nov. 19, 2003), *available at* http://www.healthprivacy.org/usr_doc/ncvhs testfin.pdf.

2. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936. The privacy regulations are codified at 45 C.F.R. pts. 160, 164 (2005).

3. 45 C.F.R. pts. 160, 164 (2005).

regarding privacy and tribal governmental provision of health care, disclosures related to cultural differences or varied governmental structures, and the health and safety of Indian people.

This article explores the emerging importance of health care privacy in tribal health care facilities. Part I presents a brief background of Indian health care and the need to address health disparities. Part II provides an overview of the Indian Self-Determination and Education Assistance Act (ISDEAA) and tribal agreements with the Indian Health Service (IHS) for operating programs, functions, services and activities of the IHS and providing health care to tribal people. Part III discusses the applicability or inapplicability of HIPAA to Indian tribes and tribal organizations that provide health care to Indians under the ISDEAA and also provides a basic background on the HIPAA privacy regulations. Part IV examines tribal authority to develop and implement privacy requirements suited to the particular needs of Indian communities. Finally, Part V concludes that tribes can use their governmental authority to develop their own privacy policies and laws for increased flexibility to best meet the health needs of their respective tribal communities, and thereby provide another critical layer of self-governance in tribal health care as tribes continue to strive to erase health disparities between the tribes and the general population.

I. Background of Indian Health Care

Indian health care is a longstanding subject of importance in Indian country and has a solid history under federal law. While the federal government entered treaties with many tribes, and promised in those treaties to provide health care to tribal members in exchange for tribes turning over vast tracts of land, the first major federal legislation to address the federal government's ongoing responsibility to provide health care to Native Americans did not arise until Congress enacted the Snyder Act in 1921.[4] The Snyder Act authorizes federal appropriations for Indian tribes, and initially required the Bureau of Indian Affairs to "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians . . . for relief of distress and conservation of health."[5] In 1934, Congress authorized the Secretary of the Interior to contract with states and political subdivisions of states, as well as private and public entities, to provide

4. Snyder Act of 1921, ch. 115, 42 Stat. 208 (codified as amended at 25 U.S.C. § 13 (2000)).

5. 42 Stat. at 208.

health care to Indians.[6] In 1955, Congress transferred the responsibilities for Indian health care from the Bureau of Indian Affairs to the Division of Indian Health (later re-named "Indian Health Service") under the Public Health Service.[7]

Twenty years later, in 1975, Congress enacted the ISDEAA.[8] Under the authority of the ISDEAA, as amended, tribes and tribal organizations across the country have contracted with the IHS to operate IHS or tribally-owned outpatient clinics and inpatient hospital facilities ranging from very small operations to full-blown hospitals. The ISDEAA made it possible for many tribes to take over the responsibility of providing health care to their own people in their own Indian communities.

In 1976, Congress also enacted the Indian Health Care Improvement Act (IHCIA),[9] which is a comprehensive statute providing for Indian health education, recruitment of health professionals to Indian country, health care facilities and sanitation, and the collection of third-party revenue and behavioral health programs. The Act authorizes appropriations for "providing the highest possible health status to Indians . . . with all resources necessary to effect that policy."[10] By recognizing that the health status of Indians is "far below that of the general population of the United States," the Act made raising the health status of Native Americans to the "highest possible level" a national goal of the United States.[11] However, this goal is still far from being met.

Health care is currently not treated as an entitlement for Native Americans, but funds are made available through discretionary spending bills. Nevertheless, through treaties, laws and statutes, the federal government has a responsibility to pay for Indian health care for certain eligible Indians, but this is not to say that tribal health programs are flush with money and that

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6. 25 U.S.C. § 452 (2000).

7. Transfer Act, 42 U.S.C. § 2001 (2000). The Office of the Surgeon General supervised Indian health care until the Office was later abolished by 80 Stat. 1610.

8. Indian Self-Determination and Education Assistance Act of 1975, Pub. L. No. 93-638, 88 Stat. 2203 (codified as amended at 25 U.S.C. §§ 450-458aaa-18 (2000)).

9. 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.). The IHCIA has been re-authorized and amended several times. The most current version of the Act expired in 2001, despite continuing efforts of tribal leaders from across the country to re-authorize the Act. *See* Indian Health Care Improvement Act Amendments of 2005, S. 1057, 109th Cong. (2005) (revised Act based on draft bill developed by the Tribal Steering Committee in 2000).

10. Indian Health Care Improvement Act of 1976, § 3, 90 Stat. at 1401.

11. 25 U.S.C. § 1601(b), (d) (2000).

Indian people are now receiving the care they need. Nothing could be farther from the truth. A report issued by the United States Commission on Civil Rights in July 2003 demonstrates the deficient status of health care for Indian people in the United States.[12] According to the report, called "A Quiet Crisis,"

> [Native Americans] have a lower life expectancy than any other racial/ethnic group and higher rates of many diseases, including diabetes, tuberculosis, and alcoholism. Yet, health facilities are frequently inaccessible and medically obsolete, and preventive care and specialty services are not readily available.[13]

The report also notes that the life expectancy of Native Americans is "nearly six years less" than other racial and ethnic groups[14] and that most Indian people must rely on the IHS for health care because they do not have any private health insurance.[15] Another report issued by the Commission on Civil Rights in 2004 stated,

> 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 the rest of the United States, including white and minority populations.[16]

The General Accounting Office recently found that IHS-owned facilities (including several operated by tribes under the ISDEAA) lack adequate health-care equipment for basic services,[17] have too few medical specialists available

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12. U.S. COMM'N ON CIVIL RIGHTS, A QUIET CRISIS: FEDERAL FUNDING AND UNMET NEEDS IN INDIAN COUNTRY (2003) [hereinafter QUIET CRISIS].

13. *Id.* at x.

14. *Id.* at 34.

15. *Id.* at x.

16. U.S. COMM'N ON CIVIL RIGHTS, BROKEN PROMISES: EVALUATING THE NATIVE AMERICAN HEALTH CARE SYSTEM 7-8 (2004) (citing *Reauthorization of the Indian Health Care Improvement Act: Hearing on S. 556 Before the S. Comm. on Indian Affairs and the H.R. Comm. of the Office of Native American and Insular Affairs*, 108th Cong. (2003) (statement of Dr. Charles Grim, Assistant Surgeon General, Interim Director, Indian Health Service)).

17. INDIAN HEALTH SERV. FACILITIES NEEDS ASSESSMENT & PRIORITIZATION CRITERIA WORKGROUP, REPORT ON FINDINGS AND RECOMMENDATIONS 15, 17-19 (2002) [hereinafter FAAB REPORT], *available at* http://www.oehe.ihs.gov/faab/workgroup/workgroupfr.pdf. For additional information on the existing IHS health facilities construction priority system, see Indian Health Service: Office of Environmental Health and Engineering, http://www.oehe.ihs.gov (last visited Nov. 9, 2006). Congress authorized the IHS to construct health

on site at the health clinics, and cannot provide adequate behavioral health care, specialty dental services, or care for non-urgent conditions such as arthritis and chronic pain.[18] Waiting times at the clinics are so backed-up due to staffing and equipment shortages that some Indians could have to wait for up to six months for an appointment.[19] Furthermore, many tribal health facilities are in great need of repair or replacement, and tribes wait for many years on the Indian health facility priority list before they receive funding.[20]

Despite these disparities and shortcomings, Congress only provides funding to the IHS for about fifty-nine percent of what is needed to address tribal health care needs.[21] The federal government spends less on the health care of Indians than it does for health care of prisoners on a per capita basis.[22] Each year, the IHS spending on Indian people is only about forty percent of what the average per person health care expenditures are across the rest of the country.[23]

Tribes thus have significant interest in improving the overall quality of care provided to tribal people. One way of doing so is to increase the amount of third-party revenues that the tribes receive for services provided at tribal clinics and hospitals, such as Medicare and Medicaid reimbursements. Privacy of health information can also play a role. One of HIPAA's major purposes is to improve the quality of health care by restoring trust in the health care system,[24] and another is to improve the efficiency and effectiveness of health care delivery through a national framework for privacy protection.[25]

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facilities for tribes through the enactment of the Snyder Act of 1921 and the IHCIA in 1976. FAAB REPORT, *supra*, at 16.

18. GEN. ACCOUNTING OFFICE, INDIAN HEALTH SERVICE: HEALTH CARE SERVICES ARE NOT ALWAYS AVAILABLE TO NATIVE AMERICANS 4 (2005).

19. *Id.*

20. FAAB REPORT, *supra* note 17.

21. QUIET CRISIS, *supra* note 12, at x (noting the IHS receives 0.5% of the overall budget for the DHHS, an amount that is a lesser proportion than what the agency previously received through the Department's discretionary budget in 1998, despite rising health care costs).

22. *Id.*

23. *Id.* at 44. Data for fiscal year 2003 shows that the IHS spent approximately $1914 per person per year for health services to Native Americans, while the federal government spent $5915 per person for Medicare beneficiaries and $3803 for federal prisoners. *Id.* at 44 fig.3.2 (showing comparisons between IHS appropriations per capita and other federal health expenditures, 2003). The U.S. per capita amount of health care coverage in fiscal year 2003 was $5065. *Id.*

24. JUNE M. SULLIVAN, AM. BAR ASS'N, HIPAA: A PRACTICAL GUIDE TO THE PRIVACY AND SECURITY OF HEALTH DATA 2 (2004).

25. *Id.*

The HIPAA privacy regulations are meant to protect a patient's health information relating to past, present or future physical and mental health conditions, the provision of health care, and any payments for health care by health care providers, health plans and healthcare clearinghouses (known under the regulations as "covered entities").[26] According to the Health Privacy Project, the absence of a national health privacy law prior to the HIPAA privacy regulations contributed to significant negative impacts on health care, where many people avoided care or lied about their health in order to avoid having their medical information used against them without their knowledge or permission.[27] Increased efficiency and effectiveness, as well as improving the quality of health care and increasing trust, are extremely important building blocks in the Indian health care system, particularly given the history of the Indian health care system and the overall lower health status of Indian people who rely on that system.

II. The ISDEAA and Indian Health Care

The Indian Self Determination Education and Assistance Act (ISDEAA) provides Indian tribes,[28] tribal organizations,[29] and tribal consortiums[30] with the right to assume responsibility for health programs provided to Indians by the United States. The ISDEAA was enacted in 1975 and signed into law by

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26. 45 C.F.R. § 160.103 (2005) (defining "covered entity" as "(1) a health plan"; "(2) a health care clearinghouse"; and "(3) a health care provider who transmits any health information in electronic form in connection with a transaction covered by [the HIPAA regulations]"). Covered entities were required to be in compliance with the HIPAA privacy standards by April 14, 2003. *Id.* § 164.534. "Small health plans" were given one additional year for compliance, until April 14, 2004. *Id.* Small health plans are those plans with annual receipts of $5 million or less. *Id.* § 160.103.

27. Goldman, *supra* note 1, at 2.

28. 25 U.S.C. § 450b(e) (2000) (defining "Indian tribe" as "any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation . . . which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians").

29. *Id.* § 450b(*l*) (defining "tribal organization" as "the recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities").

30. *Id.* § 458aaa(a)(5) (defining an "inter-tribal consortium" as a "coalition of two or more separate Indian tribes that join together for the purpose of participating in self-governance, including tribal organizations").

President Nixon.[31] The purpose of the Act is to foster self-determination of Indian tribes and improve the ability of tribes to best meet the needs of their own tribal communities:

> The Congress hereby recognizes the obligation of the United States to respond to the strong expression of the Indian people for self-determination by assuring maximum Indian participation in the direction of educational as well as other Federal services to Indian communities so as to render such services more responsive to the needs and desires of those communities.
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> . . . .
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> The Congress declares its commitment to the maintenance of the Federal Government's unique and continuing relationship with, and responsibility to, individual Indian tribes and to the Indian people as a whole through the establishment of a meaningful Indian self-determination policy which will permit an orderly transition from the Federal domination of programs for, and services to, Indians to effective and meaningful participation by the Indian people in the planning, conduct, and administration of those programs and services.[32]

Under the ISDEAA, tribes can negotiate an agreement with the United States to take over programs, functions, services and activities (PFSAs) that the United States provides on behalf of the tribes so that tribes are responsible for delivering the health care services previously provided through the IHS.[33] Under such agreements, tribes have the ability to redesign the services to best deliver health care in their own communities. The funding associated with the programs, the monetary amounts the United States would have spent to continue providing the PFSAs, is transferred to the contracting tribes. For tribes who wish to enter into an agreement for health PFSAs, the ISDEAA has two primary programs: the self-determination program under Title I of the Act,[34] and the self-governance program under Title V of the Act.[35] These are unique agreements tribes can use for improving the health care of their people.

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31. 25 U.S.C. §§ 450, 450a (2000).

32. *Id.* § 450a(a)-(b); *see also* Exec. Order No. 13,084, 63 Fed. Reg. 27,655 (May 14, 1998).

33. Cherokee Nation of Okla. v. Leavitt, 543 U.S. 631, 632 (2005).

34. 25 U.S.C. §§ 450f-450n.

35. *Id.* § 458aaa to 458aaa-18.

A. Title I Self-Determination Contracts

Tribes can enter the ISDEAA program by negotiating a contract and annual funding agreement (AFA) under Title I of the Act. All tribes have the right to participate in the Title I program, and they can initiate participation by submitting a contract proposal to the IHS, which must then approve or decline the proposal within ninety days of receipt.[36] The proposal can be declined only under certain limited reasons set forth in the statute.[37] The Secretary may decline a Title I contract only if the declination is supported by "controlling legal authority" that (1) the program or service will not be satisfactory; (2) trust resources will not be adequately protected; (3) the program or service cannot be completed or maintained under the proposed contract; (4) the amount of funds being sought is more than the amount the Secretary spends (as determined under the Act); or (5) the programs or services "cannot lawfully be carried out by the contractor."[38] If the IHS declines a Title I proposal, the tribe has the right to appeal the decision and seek a formal administrative hearing or go directly to federal court.[39] For those proposals that are approved, the IHS negotiates the contract and awards an AFA, transferring responsibilities and funding for health care to the tribe. The ISDEAA requires that certain mandatory provisions be included in the contract that promote Congress' policy of self-determination while also providing limited federal oversight of how tribes carry out the responsibilities assumed in the agreements.[40] Additional provisions must be approved by both parties.

In a Title I contract, tribes can include any of the PFSAs provided by the IHS to Indians and Alaska Natives, as well as administrative functions that support the delivery of the PFSAs, including those provided by the federal government "for the benefit of Indians because of their status as Indians without regard to the agency or office of the Department of Health and Human Services . . . within which it is performed."[41] Title I makes it possible for

36. *Id.* § 450f(a)(2).

37. *Id.*

38. *Id.* § 450f(a)(2)(A)-(E).

39. *Id.* §§ 450f(e), 450m-1(a).

40. *Id.* § 450m (providing that the Secretary may reassume a contract or grant agreement if the tribal organization's performance of the contract violates rights or endangers health, safety, welfare, or mismanages trust funds, trust lands, or interests in trust lands); *see also id.* § 458aaa-6(a)(2) (Title V self-governance) (allowing the Secretary to reassume operation of a PFSA if there is "imminent endangerment of the public health caused by an act or omission" or if there is "gross mismanagement" of funds and requires a written notice, hearing on the record, and time for the tribe to take corrective action — except in an emergency).

41. *Id.* § 450f(a)(1).

tribes to step into the shoes of the federal government and, as a result, access unique rights that other federal contractors may not have. For example, tribes that operate Title I contracts have rights to surplus and excess federal property, access to federal supply sources,[42] and protection under the Federal Tort Claims Act when performing within the scope of their contracts.[43] Tribes can redesign the services, provided the redesign satisfies the five grounds on which the IHS can decline to contract under Title I. Tribes are also entitled to be compensated for additional administrative costs they incur beyond costs paid in federal operation of the programs.[44]

B. Title V Self-Governance Compacts

The self-governance program is set forth in Title V[45] of the Act, under which tribes can enter into a compact and funding agreement[46] with the DHHS

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42. *Id.* § 450j(f); *see also id.* § 450l(c)(b)(10) (referring to the model agreement provision for the use of federal motor vehicles); *id.* § 450i(e) (referring to the right to have federal employees detailed to work at tribal health care facilities).

43. Department of the Interior Appropriations Act of 1991, Pub. L. No. 101-512, § 314, 104 Stat. 1915, 1959-60 (codified as amended at 25 U.S.C. § 450(f) (2000)) (extending the full protection and coverage of the Federal Tort Claims Act to Indian tribes, tribal organizations and Indian contractors performing functions pursuant to an ISDEAA agreement). The provision deems any Indian tribe, organization or tribal contractor to be a part of the federal government when performing duties under a contract, grant agreement or any other agreement or compact authorized by the ISDEAA for the purpose of defending claims arising during the course of performance of that agreement. *Id.* For claims asserted against such a tribe, tribal organization, Indian contractor or tribal employee after September 30, 1990, the claim is deemed to be an action against the United States. *Id.*

44. *See generally* S. Bobo Dean & Joseph H. Webster, *Contract Support Funding and the Federal Policy of Indian Tribal Self-Determination*, 36 TULSA L.J. 349 (2000) (discussing how the government's failure to pay 100% of the contract support funds owed to tribes has adversely affected tribal programs).

45. The Title V programs, which pertain to the DHHS (for programs of the IHS), were enacted by Congress and signed into law by President Clinton on August 18, 2000. Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, 114 Stat. 711 (codified as amended at 25 U.S.C. §§ 458aaa to 458aaa-18 (2000)). The 2000 amendments also enacted Title VI of the ISDEAA, which required the Secretary of the DHHS to study the feasibility of extending Title V to other agencies of the Department besides the IHS. 25 U.S.C. § 602 (2000). The report was finalized and presented to Congress in March 2003. OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., TRIBAL SELF-GOVERNANCE DEMONSTRATION FEASIBLITY STUDY (2003), *available at* http://aspe.hhs.gov/selfgovernance/Evaluation/report.htm (concluding that expanding the self-governance program to agencies within the DHHS other than the IHS was feasible and that legislation needed to be enacted to implement such a program).

46. 25 U.S.C. § 458aaa-7(b).

for all PFSAs that, just as under Title I, are "carried out for the benefit of Indians because of their status as Indians without regard to the agency or office of the Indian Health Service" where the PFSAs are performed.[47] The self-governance program uses the term "compact" instead of "contract,"[48] and the document that pertains to and transfers funding is called a "Funding Agreement" rather than an "Annual Funding Agreement," because Title V authorizes multiple year agreements.[49] Up to fifty tribes per year may be admitted into the Title V program.[50] To participate, tribes must complete a planning phase, request entry into the self-governance program, and demonstrate three years of financial stability by showing no significant or material audit exceptions in required annual audits.[51]

The self-governance program reduces federal oversight and increases tribes' ability to redesign programs and reallocate funding to better serve their patients. Tribes have the right to include any Title I provisions they wish in a Title V agreement.[52] This can sometimes result in a Title V compact or Funding Agreement being similar to a Title I contract or AFA. However, Title V includes a detailed "final offer" process, whereby a tribe can require the Secretary of the DHHS to provide a detailed finding for declining a proposed term of the contract or requested funding level.[53] The Secretary has forty-five days to make a decision on the offer, after which time it is deemed approved, unless the tribe agrees to extend the time.[54] The Secretary must put a rejection of a final offer in writing and the rejection must be based on one or more of the following grounds: the funding level requested exceeds what is due to the tribe, the requested program is an inherent federal function as defined at 25 U.S.C. § 458aaa(a)(4), the tribe cannot carry out the program without creating a risk to public health, or the tribe is not eligible to participate in the Title V program.[55] Rejections of final offers may be appealed in a hearing on the record to an administrative body or to federal district court.[56]

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47. *Id.* § 458aaa-4(b)(1).
48. *Id.* § 458aaa-7(b).
49. *Id.* For the remainder of this article, the term "AFA" will represent both Title V Funding Agreements and Title I Annual Funding Agreements.
50. *Id.* § 458aaa-2(b)(1).
51. *Id.* § 458aaa-2(c).
52. *Id.* § 458aaa-15(b).
53. *Id.* § 458aaa-6(b).
54. *Id.*
55. *Id.* § 458aaa-6(c)(1).
56. *Id.* § 458aaa-6(c)(1)(C).

Like Title I, Title V also provides tribes with rights to surplus and excess federal property and access to federal supply sources,[57] except that Title V makes certain provisions mandatory that are permissive under Title I, such as tribes' ability to use existing school buildings, hospitals, and other facilities.[58] In addition, Title V makes Secretarial acquisition of excess or surplus property mandatory if that property is appropriate for use by a tribe in connection with the execution of an authorized self-governance compact or funding agreement.[59] Also like Title I, Title V provides tribes protection under the Federal Tort Claims Act when performing within the scope of their agreements.[60]

C. Unique Agreements for Improving Indian Health Care

Agreements negotiated under the ISDEAA are different from other types of government-related contracts or federal procurement agreements, and are based on the federal and tribal government-to-government relationship.[61] The ISDEAA protects tribal compactors and contractors from having to comply with burdensome administrative requirements, such as extensive reporting,[62] and prohibits the imposition of agency policies or rules unless agreed to by the tribes.[63]

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57. *Id.* § 458aaa-11(c).

58. *Cf. id.* § 450j(f).

59. *Id.* § 458aaa-11(c)(3).

60. *Id.* § 458aaa-15(a) (making application of § 314 of Pub. L. No. 101-512 mandatory in Title V agreements); *see supra* text accompanying note 43 (discussing FTCA coverage under Title I of the ISDEAA).

61. Cherokee Nation of Okla. v. Leavitt, 543 U.S. 631 (2005). These government-to-government contracts, while different from typical federal procurement contracts that impose a multitude of regulatory burdens on the contractor, are still binding, enforceable contracts with available remedies for government breach. *Id.* at 632.

62. Title I only requires the submission of an annual audit report under the Single Audit Act. 25 U.S.C. § 450(c) (2000) (citing Single Audit Act, 31 U.S.C. §§ 7501 (2000)). The Single Audit Act also applies to tribes under Title V of the ISDEAA. *Id.* § 458aaa-5(c). Title V agreements must also include a provision requiring tribes to "report on health status and service delivery" under certain circumstances, *id.* § 458aaa-6(a)(1), and progress reports and financial information are due twice per year with respect to construction activities, *id.* § 458aaa-8(f).

63. 25 U.S.C. § 458aaa-16(e) ("Unless expressly agreed to by the participating Indian tribe in the compact or funding agreement, the participating Indian tribe shall not be subject to any agency circular, policy, manual, guidance, or rule adopted by the Indian Health Service, except for the eligibility provisions of section 450j(g) and the regulations promulgated under this section.").

Tribal contractors and compactors also have the right to re-design any non-construction program that is included in their AFAs.[64] However, there is a difference in how this redesign authority works between Titles I and V. Under Title I, the Secretary of the DHHS must be notified of the tribe's intention to redesign a program.[65] The Secretary then evaluates the proposal under the declination criteria.[66] Under Title V, by contrast, tribes may reallocate funding "in any manner which the Indian tribe deems to be in the best interest of the health and welfare of the Indian community being served," but only if the action does not result in denying eligibility for services to persons who would be eligible under federal law.[67] There is no right of Secretarial review of a redesign request under Title V.

Certain funds provided under an AFA can also be reallocated to different programs "to meet matching or cost participation requirements under other federal and non-federal programs."[68] Tribes thus have flexibility to use federal funding to redesign PFSAs to increase the cultural relevance and effectiveness of the services they provide.[69]

Determining what funding a tribe receives under an ISDEAA AFA can be a complex process, but the basic funding elements are as follows: Tribes are entitled to no less than what the Secretary would have spent on a PFSA (for example, the direct costs required to provide dental services), without any regard to the organizational level within the DHHS at which the DHHS

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64. *Id.* § 450j(j).

65. *Id.*

66. *Id.* § 450f.

67. *Id.* § 458aaa-5(e).

68. *Id.* § 450j-1(j). This provision is mandatory in Title V agreements as well. *Id.* § 458aaa-15(a); *see also id.* § 458aaa-11(d) ("All funds provided under compacts, funding agreements, or grants made pursuant to this subchapter, shall be treated as non-Federal funds for purposes of meeting matching or cost participation requirements under any other Federal or non-Federal program.").

69. The agreements must also include a promise by the United States to continue to uphold its trust responsibility to tribes. *See* Model Agreement, 25 U.S.C. § 450(c)(d) (2000); *id.* § 458aaa-6(g). For a good overview of the federal trust responsibility, see generally Professor Mary Christina Wood's "Trust Trilogy," as follows: Mary Christina Wood, *Indian Land and the Promise of Native Sovereignty: The Trust Doctrine Revisited*, 1994 UTAH L. REV. 1471 (1994); Mary Christina Wood, *Protecting the Attributes of Native Sovereignty: A New Trust Paradigm for Federal Actions Affecting Tribal Lands and Resources*, 1995 UTAH L. REV. 109 (1995); Mary Christina Wood, *Fulfilling the Executive's Trust Responsibility Toward the Native Nations on Environmental Issues: A Partial Critique of the Clinton Administration's Promises and Performance*, 25 ENVTL. L. 733 (1995).

operates the PFSA.[70] The Secretary must then add to that amount enough funding for overhead and administrative costs, known as "contract support costs."[71] Contract support costs

> consist of an amount for the reasonable costs for activities which must be carried on by a tribal organization as a contractor to ensure compliance with the terms of the contract and prudent management, but which (A) normally are not carried on by the respective Secretary in his direct operation of the program; or (B) are provided by the Secretary in support of the contracted program from resources other than those under contract.[72]

Contract support must include the cost of reimbursing a contractor for reasonable and allowable costs of direct program expenses and related administrative expenses.[73] The contract support costs paid to tribal contractors is thus for direct and indirect contract support.[74] Tribes are also entitled to any mandatory increases appropriated by Congress for the IHS, such as cost of living increases, that are related to the programs or administrative functions being performed under the ISDEAA agreement.[75]

The number of tribes participating in the ISDEAA programs to conduct health care operations and run health facilities has dramatically increased over time. As of 1994, the IHS had entered into only fourteen self-governance compacts and AFAs with as many tribes and tribal organizations for a total of $51 million, which was just over two percent of the IHS budget that fiscal year.[76] By 2004, the number of self-governance compacts rose to sixty-five

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70. 25 U.S.C. § 450j-1(a)(1). Tribes are also entitled to "start-up" costs in the first year that a tribe takes over a PFSA. *Id.* § 450j-1(a)(5).

71. *Id.* § 450j-1(a)(2).

72. *Id.*

73. *Id.* § 450j-1(a)(3).

74. *See* Contract Support Costs, IHS Circular 2004-03 [hereinafter IHS Circular 2004-03] (providing guidance to both tribal and IHS personnel in the preparation and negotiation of requests for contract funding in support of new and continuing ISDEAA contracts and compacts negotiated in FY 2005 and thereafter); *see also* Title V of the ISDEAA, 25 U.S.C. § 458aaa-7(c).

75. 25 U.S.C. §§ 450j-1(a), 458aaa-4(b)(1). However, tribes cannot contract or compact for funding associated with what are known as "Inherent Federal Functions," which Title V defines to be "those Federal functions which cannot legally be delegated to Indian tribes." *Id.* § 458aaa(a)(4).

76. Office of Tribal Self-Governance, Indian Health Serv., FY 2004 Self-Governance Data Table (Sept. 15, 2004) [hereinafter FY 2004 Self-Governance Data Table]. These agreements were entered into under the self-governance demonstration program, through Title III of the

and the IHS had entered into eighty-five AFAs.[77] The total amount of funding included in the Title V AFAs for fiscal year 2004 was $917.8 million, which was thirty-one percent of the IHS' fiscal year 2004 budget.[78] A total of 292 tribes and tribal organizations participated in the tribal self-governance program in 2004.[79]

Tribal operation and ownership of health clinics and hospitals under the ISDEAA has greatly contributed to turning tribal management of health care over to the tribes, who are best suited to determining what community-based approaches work for their patients. As one Indian health policy analyst recognized, "As Indian people are taking control of the management of their own health care delivery systems, they are achieving some remarkable results in reducing costs, while increasing the scope of benefits and improving the quality of care."[80] The ISDEAA has thus been a critically important step toward improving the health status of tribal people while recognizing the benefits that can be gained through tribal governmental authority and tribal decision-making over health care. Through such authority, the privacy of health information can also contribute to these recognized benefits.

III. HIPAA Privacy Rules and Applicability to Tribes

The DHHS published regulations to implement the privacy standards required by HIPAA for the confidentiality of medical records.[81] The privacy regulations address the following requirements, among others: (1) use of personal health information for treatment, payment and operations;[82] (2) patient authorizations for certain disclosures;[83] (3) mandatory disclosure of certain health information;[84] (4) research;[85] (5) marketing;[86] (6) use and

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ISDEAA, which was replaced by the permanent Title V program in 2000. Tribal Self-Governance Amendments of 2000, Pub. L. No. 106-260, 114 Stat 711 (codified as amended at 25 U.S.C. § 450 (2000)).

77. FY 2004 Governance Data Table, *supra* note 76.

78. *Id.* The amounts do not include non-appropriated funds, such as Medicare and Medicaid collections, or non-IHS appropriated funds.

79. *Id.* This number represents fifty-two percent of all federally-recognized tribes.

80. MIM DIXON, AM. PUBLIC HEALTH ASS'N, MANAGED CARE IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES x (1998).

81. 45 C.F.R pts. 160, 164 (2006).

82. 45 C.F.R. § 164.506.

83. *Id.* § 164.510.

84. *Id.* § 164.512.

85. *Id.* § 164.508(b)(3).

86. *Id.* § 164.508(a)(3).

disclosure by business associates;[87] (7) notice of privacy practices;[88] and (8) administrative requirements, such as designation of a privacy official and implementation of a compliance mechanism.[89] HIPAA also sets forth certain requirements for transaction standards and code sets of electronically transmitted information and security of electronic health information,[90] which have different compliance deadlines and requirements.[91]

HIPAA requirements also provide the basis for establishing a National Provider Identifier as the standard unique health identifier for health care providers.[92] After implementation of the NPI, providers will no longer have to keep track of multiple numbers to identify themselves in standard transactions with one or more health plans.[93]

A. HIPAA's Applicability to Indian Tribes

HIPAA's applicability to Indian tribes, tribal organizations and tribal consortiums depends on two related questions: First, whether HIPAA applies generally to Indian tribes, and second, whether HIPAA applies to a particular tribal health provider.

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87. *Id.* § 164.502(e)(1).

88. *Id.* § 164.520.

89. *Id.* § 164.530.

90. *Id.* § 164.300-18. The HIPAA Security Rule identifies standards and implementation specifications with which covered entities must comply. *Id.* § 164.318(a)(1). While the HIPAA rule applies to all protected health information regardless of form (oral, written, electronic), the Security standards apply only to that protected health information that is created, received, maintained or transferred in electronic form. *See id.* § 164.302. The general requirements of the rule are as follows: ensure confidentiality, integrity, and availability of all electronic protected health information (ePHI) that the covered entity creates, receives, maintains or transmits; protect against reasonably anticipated threats or hazards to the security or integrity of ePHI; protect against reasonably anticipated uses or disclosures of ePHI that are not permitted or required; and ensure compliance by staff. *Id.* § 164.306.

91. *Id.* § 164.532, 164.534.

92. *Id.* § 162.406. The National Provider Identifier (NPI) is a ten-digit identifier number that will identify health care providers in all standard transactions. *Id.* The NPI is part of an initiative undertaken by CMS, beginning in 1993, to develop a health care provider identification system to meet the needs of the Medicare and Medicaid programs and, ultimately, the needs of a national identification system for all health care providers. 69 Fed. Reg. 3434 (Jan. 23, 2004). Congress incorporated the NPI in HIPAA through subtitle F of Title II of the Administrative Simplification provisions of HIPAA. *Id.*

93. Once NPI is implemented, "legacy" identification numbers, such as UPIN, Blue Cross Blue Shield numbers, CHAMPUS and Medicaid numbers, will no longer be permitted. *See id.*

1. Overall Applicability to Indian Tribes

Nowhere in HIPAA's statutory provisions on patient health information does the Act specifically state that it applies to Indian tribes. The regulations promulgated under HIPAA likewise lack a specific statement of applicability, and DHHS' published HIPAA guidance provides little to illuminate the agency's or Congress' position on this question. The summary set forth in the final privacy rule may be one indication of the DHHS intent that HIPAA applies to tribal health care providers. In the summary, the Department states that it engaged in "required consultations" on HIPAA, which included the National Congress of American Indians and the National Indian Health Board, as well as a "representative of the self-governance Tribes."[94]

Dr. Trujillo, then Director of the IHS, first communicated with tribes about HIPAA when he sent a "Dear Tribal Leader" letter in May 2001, alerting tribes that the IHS had formed a HIPAA Compliance Team.[95] In addition to notifying tribes of the IHS HIPAA Compliance Team, the letter also stated, "Health care programs will be required to comply with HIPAA to be eligible for third party collections, which generate significant revenue for the Indian health care system. The Indian health care system's challenge will be to achieve uniformity in instituting HIPAA-compliant measures throughout health care programs."[96] Dr. Grim, the current Director of the IHS, thereafter issued a letter to tribal leaders and tribal health directors on March 4, 2003, updating them on the IHS preparation for HIPAA compliance and letting tribes know they may use IHS compliance forms as guidance for their own compliance.[97] Dr. Grim later sent another letter to tribal leaders stating the IHS view that HIPAA requirements apply to tribes, tribal organizations and urban Indian programs that have agreements with the IHS under the ISDEAA.[98] He further stated that the IHS believes HIPAA applies to tribal health care providers whether or not they operate an IHS program under the ISDEAA, "tribal sovereignty notwithstanding."[99] The IHS Office of General

94. 65 Fed. Reg. 82,462, 82,474 (Dec. 28, 2000).

95. Letter from Michael Trujillo, Director of IHS, to Tribal Leaders (May 7, 2001), *available at* http://www.ihs.gov/TribalLeaders/triballetters/2001_letters/27737-01_HIPAA_team.pdf.

96. *Id.*

97. Letter from Charles Grim, Director of IHS, to Tribal Leaders (Mar. 4, 2003), *available at* http://www.ihs.gov/tribalLeaders/triballetters/2003_Letters/03-04-2003_Letter.pdf.

98. Letter from Charles Grim, Director of IHS, to Tribal Leaders (May 13, 2003), *available at* http://www.ihs.gov/tribalLeaders/triballetters/2003_Letters/05-13-2003_Letter.pdf.

99. *Id.*

Counsel has also indicated that the agency's attorneys have concluded that HIPAA applies to Indian tribes, but the agency has not released copies of such legal advice.[100] Thus, while the agency thinks HIPAA applies to tribes, there is no clear legal guidance in any of these statements from the DHHS or the IHS regarding HIPAA's specific application to tribes.

Some arguments are available under the ISDEAA that contractors or compactors are not subject to the HIPAA regulations unless tribes explicitly agree otherwise. Several provisions of the ISDEAA place limits on the application of federal regulations to programs operated under the ISDEAA. For example, Title I contracts are not subject to federal contracting or cooperative agreement laws, including any regulations, except to the extent such laws expressly apply to Indian tribes.[101] However, the Title I regulations require that a proposal submitted by an Indian tribe to contract under Title I include a

> statement that the Indian tribe or tribal organization will implement procedures appropriate to the programs, functions, services or activities proposed to be contracted, assuring the confidentiality of medical records and of information relating to the financial affairs of individual Indians obtained under the proposal contract, or as otherwise required by law.[102]

The Title V regulations also specify, "[A] Tribe must consider the potential application of Tribal, Federal and state law and regulations that may apply to requests for access to Tribal patient records."[103] While these provisions do not specifically state that HIPAA or other federal or state privacy regulations apply to Title I contracts or Title V compacts, they do demonstrate Congress' intent that tribes and tribal organizations take medical privacy issues into account when making health care services available to patients. They may, however, also be interpreted to mean that tribes, at least when operating under Title V of the ISDEAA, need not do so exactly as HIPAA directs.

HIPAA's applicability to tribes also involves the question of whether laws generally applicable to a class of persons do or do not apply to Indian tribes. There is a split in the way in which federal courts have approached this

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100. Jocelyn Beer, Senior IHS Attorney, Remarks at Spring Self-Governance Conference, Meeting of IHS Lead Negotiators (Apr. 2003).

101. 25 U.S.C. § 450j(a)(1) (2000); *see also id.* § 458aaa-16(e) (making agency circulars, policies, manuals, guidance documents and regulations inapplicable to Title V agreements, except for certain eligibility restrictions and the Title V regulations).

102. 25 C.F.R. § 900.8(m) (2006).

103. 42 C.F.R. § 137.180 (2006).

question. For example, the Tenth and the Eighth Circuit Courts of Appeals follow well-established principles of tribal sovereignty and tribal self-governance, requiring a specific congressional pronouncement or clear legislative intent before holding that statutes of general applicability apply to Indian tribes.[104] In contrast, the Ninth, Seventh, and Second Circuits have done just the opposite and adopted an approach that creates a presumption that when Congress passes a statute of general applicability, Congress intends that law to apply to Indian tribes unless the statute specifically excludes Indian tribes.[105] This latter approach is known as the "*Tuscarora* approach," which is based on Supreme Court dicta in *Federal Power Commission v. Tuscarora Indian Nation*,[106] in which the Supreme Court wrote, "general acts of Congress apply to Indians as well as to all others in the absence of a clear expression to the contrary."[107]

The Eleventh Circuit, which includes Alabama, Georgia and Florida, relied on that dicta to hold that a law of general applicability will apply to tribes unless Congress clearly indicates its intention that the law *not* apply to tribes, and in a few other circumstances:[108]

> [A]s we recognized in *Florida Paraplegic Association Inc. v. Miccosukee Tribe of Indians of Florida*, a Congressional statute of general applicability presumptively applies to Indian tribes absent some clear indication that Congress did not intend for tribes to be subject to the legislation. 166 F.3d 1126 (11th Cir. 1999) (citing *Federal Power Comm'n v. Tuscarora Indian Nation*, 362 U.S. 99 (1960)). Review of the cases on Indian sovereign immunity shows that courts will only rule that a generally applicable statute does not govern an Indian tribe when the statute would "(1) abrogate rights guaranteed under an Indian treaty, (2) interfere with purely

104. Donovan v. Navajo Forest Prod. Indus., 692 F.2d 709, 712 (10th Cir. 1982) (regarding the Occupational Safety and Health Act); EEOC v. Fond du Lac Heavy Equip. & Constr. Co., 986 F.2d 246, 249 (8th Cir. 1993) (regarding the Age Discrimination in Employment Act).

105. *See generally* Donovan v. Coeur d'Alene Tribal Farm, 751 F.2d 1113, 1117 (9th Cir. 1985) (regarding the Occupational Safety and Health Act); Smart v. State Farm Ins. Co, 868 F.2d 929, 932 (7th Cir. 1989) (regarding ERISA); Reich v. Mashantucket Sand & Gravel, 95 F.3d 174, 179(2nd Cir. 1996) (regarding the Occupational Safety and Health Act). A majority of federal labor and employment laws are considered laws of general applicability.

106. 362 U.S. 99, 120 (1960).

107. *Id.*

108. Taylor v. Ala. Intertribal Council Title IV J.T.P.A., 261 F.3d 1032, 1034-35 (11th Cir. 2001).

> intramural matters touching [on an Indian tribe's] exclusive rights of self-government, or (3) contradict Congress's intent."[109]

The Ninth Circuit Court of Appeals, which includes California, Oregon, Washington, Arizona, Montana, Idaho, Nevada, Alaska and Hawaii, took a similar position in *Lumber Industry Pension Fund v. Warm Springs Forest Product Industries*.[110] In *Warm Springs*, the court held that laws of general applicability — that do not specifically mention Indian tribes — apply to tribes unless: (1) the law touches exclusive rights of self-governance in purely intramural matters; (2) the law would abrogate a treaty right; or (3) the legislative history demonstrates that Congress did not intend the law to apply to tribes.[111] While the last two exceptions are more easily demonstrated with factual evidence, the self-governance exception is more difficult to contemplate, as it applies "only in those rare circumstances where the immediate ramifications of the conduct are felt primarily within the reservation by members of the tribe and where self-government is clearly implicated."[112]

For those Indian tribes with ISDEAA contracts or compacts within the Ninth, Seventh and Eleventh Circuits, and those under the jurisdiction of any other courts that choose to follow the Supreme Court's dicta in *Tuscarora*, HIPAA will likely be regarded as a law of general applicability that applies to tribes, because HIPAA does not contain any language clearly exempting tribes from its application. Tribes in these jurisdictions will be subject to the HIPAA privacy standards unless the facts in a specific case make it possible to successfully invoke the self-government or treaty right exceptions set forth in the case law. Thus, many tribes would be independently subject to compliance with HIPAA whether providing health services under the ISDEAA or otherwise.

While HIPAA does not contain any *express* Congressional intent that the privacy requirements were meant to apply to Indian tribes, nor do the HIPAA regulations *expressly* mention Indian tribes in the definition of "covered entities," Indian tribes that provide or pay for health care may be included

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109. *Id.*

110. 939 F.2d 683 (9th Cir. 1991).

111. *Id.* at 685; *see also* Donovan v. Coeur d'Alene Tribal Farm, 751 F.2d 1113, 1116 (9th Cir. 1985); Snyder v. Navajo Nation, 371 F.3d 658 (9th Cir. 2004) (examining actions filed against the Navajo Nation and the United States under the Fair Labor Standards Act (FLSA), 29 U.S.C. §§ 201-219 (2000) and concluding that the FLSA's silence on its application to tribes would make the FLSA generally applicable to tribes under the *Tuscarora* rule and finding that none of the three exceptions apply).

112. *Snyder*, 371 F.3d at 661.

within the classes of covered entities known as a "health plan" or a "health care provider," as discussed further below.

2. Applicability to Individual Tribal Health Providers

Even if HIPAA is a law of general applicability that extends to Indian tribes generally, one must still examine whether particular tribal programs are actually subject to the HIPAA privacy regulations. At least two classes of covered entities might include Indian tribal health programs that provide or pay for health care, depending on their particular circumstances: Health plan and health care provider.

HIPAA defines a "health plan" as "an individual or group plan that provides, or pays the cost of, medical care" as defined in the Public Health Service Act, as well as the Indian Health Service program under the Indian Health Care Improvement Act.[113] Indian tribes and tribal organizations that enter into agreements under the ISDEAA take over the functions of the IHS and therefore may fall under the definition of a health plan. The term "health plan" also includes any other individual or group plan, or combination of individual or group plans, which provides or pays for the cost of "medical care."[114] The term "medical care" refers to diagnosis, treatment and prevention of disease.[115] Many tribal health care programs are designed to perform this function and thus would be covered under this definition. Furthermore, tribes and tribal organizations do not seem to fall within the definition of what is *excluded* from being a health plan, though it may depend on a tribe's particular circumstances.[116]

For example, tribes and tribal organizations might, at least to some degree, fall within an exclusion of what is considered a health plan as a government-

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113. 45 C.F.R. § 160.103 (2003).

114. *Id.*

115. 42 U.S.C. § 300gg-91(a)(2) (2000) (defining "Medical care"); 45 C.F.R. § 160.103(3) (incorporating into HIPAA regulations).

116. 45 C.F.R. § 160.103 (2006). The definition of "health plan" states,

> *Health plan* excludes: (i) Any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in section 2791(c)(1) of the [Public Health Service] Act, 42 U.S.C. 300gg-91(c)(1); and (ii) a government-funded program (other than one listed in paragraph (1)(i)-(xvi) of this definition): (A) Whose principle purpose is other than providing, or paying the cost of, health care; or (B) Whose principle activity is: (1) The direct provision of health care to persons; or (2) The making of grants to fund the direct provision of health care to persons.

Id.

funded program whose principal activity is the direct provision of health care or the making of grants to fund the direct provision of health care.[117] However, the government-funded program would have to be one "other than" the IHS program under the Indian Health Care Improvement Act.[118] The exception may thus technically apply to certain portions of a tribe's programs (such as, alcohol programs funded by a grant from the DHHS Substance Abuse and Mental Health Administration), but not to other programs (such as, health programs funded under an ISDEAA contract or compact). The likely practical result would be that HIPAA is extended to all aspects of the tribe's health programs.

If a tribe is not a health plan, it is likely covered by HIPAA's definition of "health care provider," which is much broader and focuses on the activities being performed by the provider. Health care providers include hospitals, outpatient clinics, and providers of medical or health services such as physician services or rural health clinic services.[119] The regulations also include in the definition of "health care provider" any other organization "who furnishes, bills, or is paid for health care in the normal course of business."[120] HIPAA's privacy requirements then apply to any health care provider "who transmits any health information in electronic form in connection with a transaction covered by this subchapter."[121] An "electronic form" encompasses the use of electronic storage media such as computer hard drives, removable disks, digital memory cards, and transmission media, such as the internet, extranet, private networks, or dial-up lines.[122] Such transactions include, but are not limited to, the following:

- Health care claims or similar encounter information involving (1) a request for payment (and necessary accompanying information), made from a health care provider to a health plan, for health care purposes; or (2) the transmission of encounter information for the purpose of reporting health care, but only if there is no direct claim because the reimbursement contract is based

117. *Id.*

118. 45 C.F.R. § 160.103 (2006) (defining health care exclusions).

119. *Id.* (defining "health care provider").

120. *Id.*

121. *Id.* § 164.104. The transactions for which the Secretary has promulgated standards are set forth at 45 C.F.R. § 162.923 (2006). If a health care provider uses another entity to conduct such covered transactions in electronic form on its behalf, the health care provider is considered for the purposes of the regulations to be conducting the transactions in electronic form. *Id.*

122. *Id.* § 160.103 (defining "electronic media" and "transmission media").

on a mechanism other than charges or reimbursement rates for specific services.[123]

- Eligibility inquiries "from a health care provider to a health plan" to determine eligibility to receive health care under the health plan; "[c]overage of health care under the health plan"; or the "benefits associated with the plan".[124]
- Requests for the review of health care to obtain an authorization for the care.[125]
- Requests to obtain authorization for referring an individual to another health care provider.[126]
- Inquiries and responses about the status of a health care claim.[127]
- Enrollment or disenrollment in a health plan.[128]

Additionally, the Administrative Simplification Compliance Act (ASCA), as it operates in the context of HIPAA, requires that Medicare claims be submitted electronically.[129] As the DHHS explains, "Section 3 of the ASCA, thus, in general has the effect of requiring Medicare providers that are not already covered entities to conduct a covered transaction (the health care claim transaction) electronically and, thereby, become covered entities."[130] Most health care providers thus get bootstrapped into HIPAA applicability if they bill for Medicare. However, small providers with fewer than twenty-five full-time equivalent employees, which could include some tribes, are not required to submit Medicare claims electronically,[131] but, if such small providers choose to bill Medicare electronically, or if they only submit paper claims but check a patient's Medicare eligibility through electronic means, such providers will come under the purview of being a covered entity under HIPAA.[132]

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123. *Id.* § 162.11019(b).
124. *Id.* § 162.1201(a)(1)-(3).
125. *Id.* § 162.1301(a).
126. *Id.* § 162.1301(b).
127. *Id.* § 162.1401(a),(b).
128. *Id.* § 162.1501.
129. Administrative Simplification Compliance Act, Pub. L. No. 107-105, § 3, 115 Stat. 1003, 1006-07 (codified as amended at 42 U.S.C. § 1395y (Supp. III 2003)). The Medicare program is a "health plan" under HIPAA and thus is a covered entity that is required to conduct standardized transactions. Medicare Program, Electronic Submission of Medicare Claims, 68 Fed. Reg. 48,805, 48,806 (Aug. 15, 2003) (to be codified at 42 C.F.R. pt. 424).
130. 68 Fed. Reg. at 48,806.
131. Administrative Simplification Compliance Act § 3, 115 Stat. at 1006-07.
132. CTRS. FOR MEDICARE & MEDICAID SERVS., ARE YOU A COVERED ENTITY? 5 (HIPAA Information Series No. 2, 2003).

A tribe whose health care transactions are *all* conducted by paper, telephone or dedicated facsimile (not facsimile by computer) is probably not subject to HIPAA.[133] There may be small tribal providers who operate under such circumstances. However, a tribe or tribal organization that transmits health information electronically, and operates a hospital or an outpatient clinic, would fall within the class of providers covered by HIPAA.

Finally, the definition of "health care provider" expressly makes HIPAA applicable to Federally Qualified Health Centers (FQHCs) and designated rural health care providers.[134] Tribes that operate ISDEAA agreements may qualify for FQHC status,[135] and some tribes have opted for FQHC status in order to receive direct payments from the Centers for Medicare and Medicaid Services for providing covered health care services to eligible beneficiaries.[136] Rural health clinics are those clinics located in an area designated as rural by the Bureau of the Census and designated as being "medically underserved" by the Secretary of the DHHS.[137] Like FQHCs, rural health providers can receive a direct reimbursement at one inclusive rate for covered health services provided to eligible beneficiaries.[138] For any tribes or tribal organizations that have FQHC or rural health provider status, HIPAA certainly applies to them.

3. Strong Policy Favoring Privacy Protection

Patient privacy is an important issue in Indian country, as it is elsewhere in the United States, and there is a strong federal policy of protecting health privacy.[139] Based on the significant push toward protecting patient privacy, the

133. The term "electronic" typically does not include transmissions by paper, facsimile, voice or telephone where the information being transmitted was not in electronic form before the transmission. 45 C.F.R. § 160.103 (2006).

134. *See id.* (cross-referencing 42 U.S.C. § 1395x(s)(2000), which in turn references rural health and FQHCs, which specifically includes, in another cross-reference, FQHCs operated by a tribe or tribal organization under the ISDEAA).

135. CTRS. FOR MEDICARE & MEDICAID SERVS., FACT SHEET: FEDERALLY QUALIFIED HEALTH CENTER 1 (2004).

136. *Id.* The statutory requirements outlining eligibility for FQHC status are at section 1861(aa)(4) of the Social Security Act.

137. CTRS. FOR MEDICARE & MEDICAID SERVS, MEDICAL CLAIMS PROCESSING MANUAL ch. 9, § 10.1 (2004).

138. *Id.* ch. 9, § 20.1.

139. 65 Fed. Reg. 82,462, 82,468 (Dec. 28, 2000) ("The absence of strong national standards for medical privacy has widespread consequences. Healthcare professionals who lose trust of their patients cannot deliver high-quality care."); *see also* United States v. Sutherland, 143 F. Supp. 2d 609 (W.D. Va. 2001) (using HIPAA privacy rules as guidance even though not yet in effect and recognizing strong federal policy to protect privacy of patient medical records).

remainder of this article proceeds under the presumption that HIPAA applies to most, if not all, tribal health care programs and providers. In the event that HIPAA does not apply to a particular tribe, it is still important to keep in mind that the requirement for the protection of patient medical information can be much broader than HIPAA.

B. The Basics of HIPAA's Privacy Protections

The HIPAA privacy regulations require covered entities to protect the confidentiality of the patient's personal health information unless HIPAA specifically allows the information to be disclosed. Information that is covered by the HIPAA privacy regulations is known as "protected health information" (PHI). PHI is any health information relating to past, present or future mental health or the condition of the individual, the provision of health care to the individual, or the past, present or future payment for the individual's health care.[140] HIPAA prescribes when a covered entity can use or disclose PHI without patient consent, when patient authorization is required, or when disclosure is mandatory. HIPAA also contains several important patient rights and places administrative responsibilities on covered entities.

1. Uses and Disclosures

In general, HIPAA allows a covered entity to use or disclose PHI for its own treatment, payment, or health care operations[141] without prior consent or authorization from the patient.[142] Health care providers can thus use PHI for their own treatment purposes, and HIPAA specifies that such information can be disclosed for the treatment activities of another health care provider.[143] A covered entity can also use PHI for that entity's payment activities or share

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140. 45 C.F.R. § 160.103 (2006) (defining "health information"). To be covered under HIPAA, the PHI must also have been created or received by a covered entity, be individually-identifying or present a reasonable basis for believing that the information could be used to identify an individual. *Id.* (defining "individually identifiable health information"). PHI can be in any medium — written, oral or electronic. *Id.* (defining "health information" and "protected health information").

141. *Id.* § 164.501, 164.506(c)(1) (defining "Health Care Operations").

142. *Id.* § 164.506(a).

143. *Id.* § 164.501 (authorizing use or disclosure for "the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another."); *id.* § 164.506(c)(2).

such information with another covered entity or health care provider for the payment activity of the entity that receives the information.[144]

HIPAA allows PHI to be shared between covered entities for certain limited health care operations of the entity receiving the information, but only if that entity has or had a relationship with the patient who is the subject of the personal health information being shared.[145] Such operations include fraud and abuse detection or compliance;[146] quality assessment and improvement-type activities; review of the competence or qualifications of health care professionals or provider performance; certain training programs; and accreditation, certification, licensing or credentialing activities.[147]

A patient's permission is not required for the release of PHI in certain circumstances where the information is essential for public purposes or for the operation of the health care system. For example, a covered entity can disclose PHI without patient authorization for public health activities and purposes, such as prevention of communicable disease or child abuse.[148] Disclosures can be made to law enforcement about victims of abuse, neglect, domestic violence[149] or other crime.[150] HIPAA also allows disclosures to a health

144. *Id.* § 164.506(c)(3). Payment activities include actions taken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care, or determinations of eligibility for coverage and adjudication or subrogation of health benefit claims, as well as review of coverage for medical necessity or appropriateness of care. *Id.* § 164.501 (defining "payment"). "Payment" also includes risk adjustment of amounts due to health status and demographic characteristics; billing, claims management, or collection activities; and obtaining payment under a contract for reinsurance and related health care data processing. *Id.*

145. *Id.* § 164.506(c)(4).

146. *Id.* § 164.506(c)(4)(ii).

147. *Id.* § 164.506(c)(4)(i); *id.* § 164.501 (defining "Health Care Operations"). Information-sharing for the other types of health care operations included in HIPAA, such as underwriting, premium rating, or business planning and development, or for exchanges that fall outside of treatment or payment, would not be allowed absent a business associate agreement (BAA). *See id.* §§ 164.502(e)(1), 164.504(e). Business associates include lawyers and accountants, and any other entity or person who performs a function or activity on behalf of (or provides a service to) the covered entity that involves the creation, use or disclosure of protected health information. *Id.* § 160.103 (defining "business associate"). Covered entities can even be business associates of other covered entities. *Id.* § 160.103(3). HIPAA not only requires the covered entity and its business associate to enter a BAA, but additional protections must be provided in certain circumstances.

148. *Id.* § 164.512(b)(1)(i)-(ii).

149. *Id.* § 164.512(c).

150. *Id.* § 164.512(f)(3). Patient permission is not required for disclosures to law enforcement for certain limited activities, such as limited information for identification and

agency for oversight activities[151] and in response to a subpoena when accompanied by certain assurances or a court order.[152] The HIPAA privacy rule permits these types of disclosures, but the covered entity is not required to make the disclosure, unless some other law or policy makes disclosure mandatory.

For other disclosures, HIPAA requires that the patient be given an opportunity to agree or object. For example, patients must be given an opportunity to object to being listed in a facility directory or patient census[153] or to having his or her name released to clergy.[154] A covered entity can disclose PHI to family members, close personal friends, or other persons identified by the patient if the information is directly related to the person's involvement in the patient's care or payment for that care.[155] When the patient is incapacitated or otherwise not available to agree or object, providers have flexibility to exercise professional judgment to release information to persons involved in the patient's care if the provider believes it is in the patient's best interests to do so.[156] Providers can also disclose PHI to notify or assist in notifying a family member, personal representative or other person responsible for the individual's care regarding the individual's location, general condition, or death, and may do so based on a reasonable inference that the individual does not object to the disclosure.[157] Disclosures can be made freely if the patient's PHI is de-identified.[158]

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location purposes, in response to a request about a person suspected to be a victim of crime, about decedents for the purpose of alerting law enforcement if the covered entity suspects that the person's death resulted from criminal conduct, information the covered entity believes in good faith constitutes commission of a crime on the covered entity's premises, or to report a crime in a medical emergency.

151. *Id.* § 164.512(d).

152. *Id.* § 164.512(e). For further information on disclosures pursuant to subpoena or court order, see *infra* text accompanying notes 172-76.

153. 45 C.F.R. § 164.510(a). HIPAA allows a hospital or covered health care provider to maintain the following in a public directory: individual's name, location in the facility, health condition in general terms, and religious affiliation. *Id.* § 164.510(a)(1)(i)(A)-(D). This information can only be disclosed to clergy or persons who ask for the individual by name. *Id.* § 164.510(a)(1)(ii).

154. *Id.* § 164.510(a)(1)(ii)(A).

155. *Id.* § 164.510(b).

156. *Id.* § 164.510(b)(3).

157. *Id.*

158. *Id.* § 164.514. HIPAA sets forth two alternative methods for covered entities to de-identify PHI. First, a covered entity may apply "generally acceptable statistical and scientific principals and methods for rendering information not individually identifiable." *Id.* § 164.514(c). Second, a covered entity may use HIPAA's "safe harbor" method for de-

If a covered entity wishes to disclose PHI for a purpose that is not otherwise permitted or required under HIPAA, the covered entity must obtain a patient's voluntary and informed authorization in writing before using or disclosing the PHI.[159] HIPAA also requires a covered entity to obtain a valid authorization before disclosing psychotherapy notes[160] and when PHI is to be used for marketing purposes.[161] To be valid, authorization forms must be in plain language, and contain the following: a specific and meaningful description of the information to be used or disclosed; the name or specific identification of the entity authorized to make the disclosure; the name or specific identification of the entity to whom the disclosure is being made; a description of the purpose of the requested disclosure; the expiration date of the authorization; a statement of the patient's right to revoke the authorization (along with exceptions and instructions); and the patient signature and date.[162] Authorizations generally cannot be combined with other forms that seek permission to use or disclose PHI,[163] and HIPAA prohibits covered entities from conditioning treatment, payment or eligibility for benefits or enrollment on obtaining such an authorization.[164]

Finally, HIPAA requires covered entities to make reasonable efforts to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose.[165] The minimum necessary standard does not apply to disclosures based on a valid patient authorization, to a provider for treatment, to DHHS or for HIPAA enforcement, to disclosures required by law or to the individual patient.[166] Certain incidental uses and disclosures are also permitted, so long as the covered entity has applied reasonable safeguards and implemented the minimum necessary standard where applicable.[167] For

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identification, which requires a covered entity to remove certain identifiers such as name, street address, social security number, and birth date. *Id.* § 164.514(b).

159. *Id.* § 164.508(a)(1). Patients have a right to revoke authorizations at any time in writing, with a couple of limited exceptions. *Id.* § 164.508(c)(2)(i).

160. *Id.* § 164.508(a)(2).

161. *Id.* § 164.508(a)(3).

162. *Id.* § 164.508(c)(1)-(3).

163. *Id.* § 164.508(b)(3).

164. *Id.* § 164.508(c)(2)(ii).

165. *Id.* § 164.502(b) (stating such disclosures are also exempt from HIPAA's requirement to account for disclosures).

166. *Id.*

167. *Id.* § 164.502(a)(1)(iii). An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a result of another use or disclosure that is permitted by the HIPAA privacy rules. OFFICE OF CIVIL RIGHTS, HIPAA PRIVACY GUIDANCE: INCIDENTAL USES AND DISCLOSURES 1 (2003 rev.).

example, disclosures made by calling out a patient's name in a waiting room or conversations overheard in semi-private rooms would not violate the HIPAA privacy rule. The minimum necessary standard is a reasonableness standard that is intended to be flexible, though covered entities may need to make certain adjustments to their facilities in order to minimize access or to provide additional security.

2. Patient Rights and Administrative Requirements

Patients have several rights under HIPAA regarding the use of and access to their PHI. For example, patients have a right to inspect and copy their own health records;[168] to request restrictions on the use of their health information;[169] and to request that amendments be made to their health records,[170] though the covered entity does not have to agree to any requested restrictions or amendments.[171]

Covered entities must keep an accounting of the disclosures made of a patient's protected health information for purposes other than treatment, payment and health care operations,[172] and patients have a right to receive a listing of those disclosures made in the preceding six years.[173] Additionally, patients can make complaints to the covered entity or may file a complaint with the Secretary of the DHHS if he or she believes that the entity is not complying with the privacy rules.[174]

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168. 45 C.F.R. § 164.524.

169. *Id.* § 164.522(a)(1).

170. *Id.* § 164.526(a)(2).

171. *Id.* §§ 164.522(a)(1)(ii), 164.526(a)(2) (allowing denial of the request for amendment if the covered entity determines that the PHI was not created by the covered entity, is not part of a designated record set, is not available for inspection (such as psychotherapy notes), or is otherwise "accurate and complete").

172. *Id.* § 164.528(a)(1). The U.S. Government Accountability Office (GAO) has expressed concern about the "burden of accounting for [mandatory] disclosures to public health authorities." GEN. ACCOUNTING OFFICE, HEALTH INFORMATION: FIRST YEAR EXPERIENCES UNDER THE FEDERAL PRIVACY RULE 3 (2004). The GAO fears that the administrative burden placed on covered entities to account for such disclosures will serve as a disincentive for the entities to voluntarily respond to requests from public health agencies for reports. *Id.* at 13. The GAO recommends that reporting to public health authorities be exempted from the HIPAA accounting requirements, and the DHHS is reportedly taking this recommendation into consideration. *Id.* at 21.

173. 45 C.F.R. § 164.528(a). The accounting must include the date of each disclosure, the name and address of the entity to whom the disclosure was made (if known), a description of the information disclosed and a statement describing the reason the disclosure was made. *Id.* § 164.528(b).

174. *Id.* § 164.530(d). The Department's Office of Civil Rights (OCR) is responsible for

In order to implement all of these requirements and inform patients about their rights under HIPAA, covered entities are required to have in place a Notice of Privacy Practices, which must describe how the covered entity can use or disclose the patient's health information and what rights the patient has in regards to his or her own PHI.[175] A provider must make a good faith effort to secure an acknowledgement from the patient that he or she has received the provider's Notice.[176] Covered entities are also required to follow certain administrative requirements, such as designating a privacy officer to handle all HIPAA complaints and to manage the entity's HIPAA compliance efforts.[177]

The HIPAA privacy rule thus constitutes a series of complex and detailed regulations, the parameters of which are not thoroughly clarified because HIPAA involves a relatively new set of laws and the privacy rule has not yet been subjected to extensive litigation to solidify guidelines on how to interpret language in particular regulatory provisions.[178] The Office of Civil Rights and

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investigating complaints received by the Secretary from health care consumers. Penalties will not be imposed if "the failure to comply was due to reasonable cause and not to willful neglect," so long as corrective action is taken within thirty days after the failure to comply is (or should have been) known. 42 U.S.C. § 1320d-5(b)(3) (2000). Additionally, no civil penalty will be imposed if it is "established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person violated the provision." *Id.* § 1320d-5(b)(2). Penalties will be waived "to the extent that payment of such penalty would be excessive relative to the compliance failure involved." *Id.* § 1320d-5(b)(4). The regulations also provide, "The Secretary will, to the extent practicable, seek the cooperation of covered entities in obtaining compliance . . . ." 45 C.F.R. § 160.304. The Preamble to the original regulations likewise suggests that the federal government will be willing to work with covered entities to bring them into compliance. *See* 64 Fed. Reg. 60,002 (Nov. 3, 1999). Finally, even if there would be a formal finding of noncompliance with HIPAA, the OCR has available to it the possibility of using informal resolution without imposing penalties. *Id.* Civil monetary penalties can include fines of $100 per violation up to $25,000 per year for all violations of an identical requirement. 42 U.S.C. § 1320d-5(a)(1); Delegation to Impose Civil Monetary Penalties, 65 Fed. Reg. 82,381 (Dec. 28, 2000). Criminal penalties include fines up to $250,000 and imprisonment up to ten years for intent to sell or use PHI for personal gain or harm. 42 U.S.C. § 1320d-6.

175. 45 C.F.R. § 164.520.

176. *Id.* § 164.520(c)(2)(ii) (recognizing that providing notice and obtaining an acknowledgment is not practical during emergency treatment situations).

177. *Id.* § 164.530(a).

178. A handful of cases over the last few years involve the HIPAA regulations, but have not shed much light on specific HIPAA privacy regulations. *See, e.g.*, United States v. Sutherland, 143 F. Supp. 2d 609 (W.D. Va. 2001) (first HIPAA-related case involving court's perception of strong federal policy to protect patient privacy); Citizens for Health v. Thompson, No. Civ.A. 03-2267, 2004 WL 765356 (E.D. Pa. Apr. 2, 2004) (upholding HIPAA under the Administrative Procedures Act); Law v. Zuckerman, 307 F. Supp. 2d 705 (D. Md. 2004) (finding a violation

DHHS have issued several guidance documents, but covered entities will likely continue to struggle over the next several years on how to properly implement HIPAA. Many ISDEAA tribal providers face similar challenges, but Indian tribes and tribal organizations may also experience unique issues in privacy implementation due to their governmental status, and their difference from other government entities who provide or pay for health care.

IV. Tribal Privacy Policies

When determining what is best for their own patients and the Indian community being served, one approach that can be particularly beneficial to ISDEAA contractors and compactors, and to tribes in general, is to address patient privacy through tribal law. Tribal health providers have the unique ability to self-govern, not only as entities that contract or compact with the IHS under the ISDEAA, but also as tribal governments or instrumentalities of tribal governments.[179]

Tribes are sovereign nations with inherent sovereign authority to make their own laws and govern health care matters for their members. Tribes are "distinct, independent political communities qualified to exercise powers of self-government, not by virtue of any delegation of powers, but rather by reason of their original tribal sovereignty."[180] The United States Supreme Court recognizes that such authority is retained unless otherwise divested by Congress through treaty or statute.[181]

Therefore, tribes retain their inherent sovereignty to the extent that the federal government has not limited or extinguished tribal power. Congress clearly divested tribes of certain rights, such as the ability to alienate land freely[182] and the power to enter into formal relations with foreign governments.[183] Tribes otherwise apply their powers of self-government to internal matters ranging from the development of rules for a tribal court

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of HIPAA based on *ex parte* discussions and finding that HIPAA applies to oral records); N.W. Mem'l Hosp. v. Ashcroft, 362 F.3d 923 (7th Cir. 2004) (holding that HIPAA regulations do not impose state evidentiary privileges on litigation to enforce federal law).

179. Tribal organizations or consortiums that compact or contract under the ISDEAA may also exercise inherent tribal authority in the health care area if such authority is delegated to the tribal organization or consortium by its member tribes. *See, e.g.*, Armstrong v. United States, No. A00-31-CV(JWS), 2004 WL 2595931 (D. Alaska Apr. 14, 2003).

180. FELIX COHEN'S HANDBOOK OF FEDERAL INDIAN LAW 232 (Rennard Strickland et al. eds., 1982) (footnotes omitted).

181. United States v. Wheeler, 435 U.S. 313, 323 (1978).

182. *See generally* Johnson v. McIntosh, 21 U.S. (8 Wheat.) 543 (1823).

183. *See generally* Cherokee Nation v. Georgia, 30 U.S. (5 Pet.) 1 (1831).

system, to the regulation of land and water resources, to the control of liquor,[184] to the ability to tax[185] and other local government functions.

Health care is an important tribal governmental function.[186] The regulations that implement Title V of the ISDEAA, regarding self-governance agreements with the IHS for health care programs and services, acknowledge tribes' inherent sovereign authority to adopt health privacy laws, by providing that a tribe must consider the potential application of "*Tribal*, Federal and state law and regulations that may apply to requests for access to Tribal patient records . . . ."[187]

Tribes are thus, by virtue of their inherent sovereign authority, in a position of determining what they want their privacy policies to provide, so long as that authority is not otherwise constrained. HIPAA does not entirely preempt non-federal regulation of health privacy, but instead allows states to exercise their authority to adopt privacy rules that are not "contrary" to HIPAA and are "more stringent than" HIPAA.[188] HIPAA does not specifically include Indian tribes in this provision, but case law demonstrates that tribal exercise of sovereign authority places tribes on the same footing as state governments in terms of their rights to enact laws. In *NLRB v. Pueblo of San Juan*,[189] for example, the Tenth Circuit Court of Appeals held that a tribe could be considered equivalent to a state or territory for purposes of enacting a right-to-work law under an allowance for such laws in the National Labor Relations Act.[190] The Court reasoned that, while Indian tribes are not states for constitutional purposes, all statutes must be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit,[191] and that there was no indication in the National Labor Relations Act that Congress intended to divest tribes of their rights to enact laws as states are able to do under the Act.[192]

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184. Rice v. Rehner, 463 U.S. 713, 726 (1983).

185. Merrion v. Jicarilla Apache Tribe, 455 U.S. 130, 141 (1982) (holding that tribes retain "inherent power necessary to tribal self-government and territorial management").

186. *See, e.g.*, Ransom v. St. Regis Mohawk Educ. & Cmty. Fund, 658 N.E. 2d 989, 992 (N.Y. Ct. App. 1995) (discussing governmental functions as furthering governmental objectives, such as providing housing, *health* and welfare services) (citing Weeks Constr., Inc. v. Oglala Sioux Housing Auth., 797 F.2d 668, 670-71 (8th Cir. 1986)).

187. 42 C.F.R. § 137.180 (2006) (emphasis added).

188. 45 C.F.R. § 160.202 (2006).

189. 276 F.3d 1186 (10th Cir. 2002).

190. *Id.* at 1200.

191. *Id.* at 1195 (internal citations omitted).

192. *Id.* at 1200.

HIPAA does not provide any evidence that Congress wished to divest tribes of authority to enact their own privacy or other laws. The same reasoning as that applied by the Tenth Circuit Court of Appeals in *Pueblo of San Juan*, can easily be extended to the health privacy context to show that tribes should at least have the same authorities as states under HIPAA to adopt privacy policies that are not contrary to HIPAA and which offer equal or greater privacy protections than what HIPAA provides.

HIPAA defines a law as being contrary, as follows: "(1) A covered entity would find it impossible to comply with both the State [read "tribal"] and federal requirements; or (2) the provision of State [read "tribal"] law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of [the Act]."[193] HIPAA then defines a "more stringent" use or disclosure as follows: "With respect to a use or disclosure, the law prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted under this subchapter."[194] Therefore, when adopting or modifying their own privacy policies, under the reasoning above, tribes could include protections that are different from or additional to what HIPAA requires, if those protections are consistent with HIPAA's purposes and are equal to or more stringent than HIPAA.

For example, HIPAA allows a covered entity to disclose PHI in the course of a judicial proceeding not only in response to a court order, but also in response to a subpoena, discovery request or other lawful process without a court order if the requesting party has provided satisfactory assurances that he or she has requested the information from the patient or given notice of the request, or has made efforts to secure a qualified protective order.[195] While disclosure without a court order is permissive under HIPAA, an Indian tribe may decide that it will not release any of its health records on the mere basis of a subpoena. For instance, typical records requests received by the tribe might involve drug or alcohol treatment records that a tribe by law cannot release without a court order[196] and the tribe does not want to routinely

193. 45 C.F.R. § 160.202 (defining "contrary").

194. *Id.* (defining "more stringent"). The definition contains the following exceptions: (1) when HIPAA makes disclosure mandatory to the Secretary to determine whether a covered entity is in compliance with HIPAA, or (2) when HIPAA makes disclosure mandatory to the individual patient who is the subject of the PHI. *Id.* § 160.202(1)(i)-(ii).

195. *Id.* § 164.512(e)(1)(i)-(iv).

196. Tribes or tribal organizations that contract or compact with the IHS under the ISDEAA are subject to separate federal regulations governing the confidentiality of alcohol and drug abuse patient records. 42 C.F.R. pt. 2 (2006) ("Part 2 regulations"). There are thus numerous occasions when a tribe will be asked to release such patient records under HIPAA, such as in

distinguish between types of records; or a particular tribe may have agreed in its ISDEAA agreement with the IHS to follow federal Privacy Act procedures, which requires a court order for releasing medical records;[197] or the tribe may just feel uncomfortable releasing records without a court order. Some tribes may have concerns about recognizing the jurisdictional authority of a state court or fail to recognize subpoenas in general.

For whatever reason, a tribe may decide that it wishes to require a court order before releasing any patient medical information in a court of law. Such a policy would not run afoul of HIPAA, for two reasons: First, the HIPAA provision allowing disclosure of patient information based on a subpoena is permissive rather than mandatory, and HIPAA specifically provides that documents may be released on the basis of a valid court order,[198] so the tribe's restriction would not conflict with HIPAA or create an obstacle to HIPAA's purpose of protecting patient confidentiality. Second, the tribe's privacy policy of prohibiting a disclosure otherwise allowed by HIPAA, by finding a subpoena insufficient for the release of patient information, meets the definition of being a "more stringent" requirement. A tribe exercising the same authorities as a state under HIPAA to adopt privacy policies that are not contrary to HIPAA and which offer equal or greater privacy protections than what HIPAA provides, can adopt a privacy policy that requires a court order before releasing any patient medical information.[199]

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a child protective custody case under the Indian Child Welfare Act of 1978, 25 U.S.C. §§ 1901-1963 (2000). The DHHS issued a guidance document in June 2004 construing HIPAA and the Part 2 regulations in harmony. SUBSTANCE ABUSE AND MENTAL HEALTH SERV. ADMIN., DHHS, THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS REGULATION AND THE HIPAA PRIVACY RULE: IMPLICATIONS FOR ALCOHOL AND SUBSTANCE ABUSE PROGRAMS (2004). In general, the DHHS recommends following the more restrictive Part 2 rule and not disclose the information until the provider can obtain the patient's authorization or point to an exception that permits disclosure. *Id.* at 5. Thus, if HIPAA allows a disclosure, but Part 2 prohibits it, then the records cannot be disclosed. If disclosure is allowed by the Part 2 regulations, then the entity must still ensure that the disclosure is also allowed by HIPAA.

197. 45 C.F.R. § 5b.9(b)(11).

198. *Id.* § 164.512(e)(1)(i).

199. Whether tribal privacy protections that are more stringent than HIPAA would apply in state or federal court, in cases brought under state or federal law, may be open to debate, but at least one federal court determined that a more stringent state law applied in a case involving a purely federal matter. Nat'l Abortion Fed'n v. Ashcroft, No. 04 C 55, 2004 U.S. Dist. LEXIS 1701, at *8 (N.D. Ill. Feb. 5, 2004) (finding that Illinois privacy protections for PHI are more stringent than HIPAA and relying on those protections to quash a subpoena served on a hospital).

However, unless HIPAA does not apply to a particular tribe, a tribal privacy policy should not contain any *less* protective provisions than what HIPAA requires, even when doing so may satisfy an important governmental interest. For example, a tribal government may wish to address a growing problem of teenage pregnancy and related social issues pertaining to young mothers and their children. The tribe may wish to take a community and cultural-based approach and require the tribal health clinic to disclose the names of teenaged patients who seek pregnancy tests or services to a designated member of the tribal council, who can then intervene with the teenager to provide guidance or other non-treatment support. While the teenager's parent or guardian may have a right to the teenager's PHI,[200] or reporting to law enforcement may be permitted if a crime is involved,[201] none of the HIPAA provisions allowing a use or disclosure absent patient authorization or requiring disclosure would allow a tribal health provider to disclose the teenager's PHI for this purpose. HIPAA requires the patient's authorization before the information could be released.[202] The tribal health clinic would thus find it impossible to comply with the tribal law requiring disclosure without patient consent and the HIPAA requirement that the clinic obtain the patient's authorization before disclosing PHI, which makes the tribal law "contrary" to HIPAA as defined above. Additionally, the requirement to disclose PHI when HIPAA otherwise prevents disclosure without patient authorization would be a less stringent use or disclosure than what HIPAA allows. In these circumstances, HIPAA would preempt the tribal law. Following the tribal law rather than HIPAA could result in the tribe being subject to a HIPAA complaint, investigation, and possibly even penalties imposed by the federal government.[203]

However, a different answer may arise in the context of a tribal law requiring reporting for law enforcement activities. For example, the illegal sale of prescription pain medication, by patients to whom it has been legitimately prescribed, is a growing problem in the United States and in Indian country. In order to curb dangerous and illegal activities, an Indian tribe may wish to pass a tribal law allowing the disclosure of a patient's name to local law enforcement or to the Drug Enforcement Administration when the

200. 45 C.F.R. § 164.502(g)(3).

201. *Id.* § 164.512(b)(1)(ii).

202. *Id.* § 164.502(a), 164.508(a).

203. *See supra* note 174 (discussing civil and criminal penalties under HIPAA). Tribal sovereign immunity does not protect tribes from lawsuits filed against them by the United States. *See, e.g.*, United States v. Yakima Tribal Court, 806 F.2d 853, 861 (9th Cir. 1986); United States v. Red Lake Band of Chippewa Indians, 827 F.2d 380, 383 (8th Cir. 1987).

tribal health clinic becomes aware that the patient is abusing, fraudulently obtaining or selling a prescribed pain-management medication.

A covered entity may not voluntarily disclose patient medical information, such as the fact that a patient has been prescribed a particular type of medication, to law enforcement unless HIPAA specifically allows the entity to do so. HIPAA provides that PHI can be disclosed to law enforcement when the covered entity has been asked for the information by law enforcement officials for the purposes of identifying or locating a "suspect, fugitive, material witness, or missing person."[204] Thus, if a tribal, state or federal law enforcement official asks the tribe about the patient's prescriptions, HIPAA would not prohibit the disclosure of certain identifying information.[205] However, law enforcement must generally request the information before it can be released, except in special circumstances,[206] none of which seem to apply to the type of scenario described in the pain medication hypothetical.

However, HIPAA does allow covered entities to report PHI to law enforcement when "otherwise required by law" to do so.[207] A tribally-enacted law that requires a tribal health provider or entity to disclose suspected diversions of prescription drugs could fall under this provision. HIPAA also recognizes that some state laws require health care providers to report incidents of gunshot or stab wounds, or other violent injuries, but uses the word "including" in the regulatory language.[208] This indicates that the DHHS

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204. 45 C.F.R. § 164.512(f)(2). Disclosures can also be made on law enforcement request "about an individual who is or is suspected to be a victim of a crime" if the officer "represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim," or if the officer represents that waiting for patient authorization would "materially and adversely affect" the law enforcement activity. *Id.* § 164.512(f)(3)(ii)(A)-(B). HIPAA also provides that covered entities can respond to an administrative subpoena or investigative demand when accompanied by certain assurances. *Id.* § 164.512(f)(1)(ii)(C).

205. *Id.* § 164.512(f)(2)(i)(A)-(H).

206. *Id.* §§ 164.512(f)(5), (6)(i)(A)-(C); *see also id. §* 164.512(f)(1)(ii)(A)-(B) (allowing releases to comply with a court ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena); *id.* §§ 164.502 (j)(2), 164.512(j)(1)(ii)(A), (j)((2)-(3), 164.512(f)(4); *see also id.* § 164.512(j)(1)(ii)(B) (to apprehend an individual who appears to have escaped from lawful custody); *id.* § 164.512(k) (specialized governmental purposes); *id.* § 164.512(j)(1)(i)(A)-(B) (permitting disclosures to "prevent or lessen a serious and imminent threat to the health or safety of a person or the public").

207. *Id.* § 164.512(f)(1)-(6).

208. *Id.* § 164.512 (f)(1)(i) ("As required by law including laws that require the reporting of certain types of wounds or other physical injuries, except for laws subject to paragraph (b)(1)(ii) or (c)(1)(i) of this section [HIPAA provisions relating to child abuse or neglect or other victims of abuse, neglect or domestic violence].").

intends for covered entities to be able to rely on other laws to release information to law enforcement. Therefore, when an Indian tribe passes a law or adopts a privacy policy that requires disclosure of patient information to law enforcement whenever a patient is suspected of abusing pain medication (or for other non-physical/non-injury law enforcement purposes), such a law or policy would be less restrictive than HIPAA by allowing a disclosure that is otherwise prohibited by HIPAA, but should be allowable because HIPAA recognizes governmental authority to require certain reporting in order to curb or address criminal activity.

Other rules or policies that allow disclosures and are less restrictive than HIPAA, outside of the law enforcement context, would not be permissible under HIPAA. While the tribe may have the community's best interests in mind, the law or policy should be consistent with HIPAA to avoid the risk that the tribe's employees would violate HIPAA and become subject to civil or criminal penalties.[209]

When a policy is designed to curb dangerous or counterproductive behaviors, but could run afoul of HIPAA as being a less stringent requirement or contrary to HIPAA, tribes can often exercise their governmental authorities in ways other than through disclosure of patient information. For example, in the teenage pregnancy scenario, tribes could ask health providers to tell patients about available tribal programs that the patient could thereafter voluntarily attend or otherwise conduct educational or outreach campaigns that do not require disclosure of PHI. In this manner, tribes can continue to make governmental decisions in their members' best interests and pursue important governmental objectives while also observing the parameters of HIPAA and the tribes' patients' privacy.

One other way in which a clearly developed tribal privacy policy can really help a tribe, tribal organization or tribal consortium, is to smooth-out any potential problems with the use and disclosure of information within the tribal organizational structure. For some tribes, where the tribal council is closely and regularly involved in the management and oversight of the tribal health clinic, some tribal council members may want access to a particular patient's PHI when a problem or complaint arises. Some tribes may experience uncertainties when a patient or a patient's family member reveals PHI during a tribal council meeting and thereafter the tribal council needs to discuss that information at a different session involving potential disclosure to other tribal members. In addition, a tribal department may need PHI from the tribal clinic

209. *See supra* note 174 (discussing penalties).

for billing, health oversight, auditing or other business-related purposes. Some tribes may just have general concerns about whether inter-departmental sharing of PHI would violate patient privacy.

Most tribes should be able to freely exchange information internally, but the extent to which a tribe can use and disclose information between the tribal health clinic and other components of the tribe depends on many factors particular to the tribe and to the type of information being shared. First, some information may not actually be PHI covered by HIPAA, so would not be subject to HIPAA's restrictions. For example, employment records held by a covered entity in its role as an employer are excluded from the definition of "protected health information."[210] Second, the tribal government's structure and how the tribal health clinic is organized could affect whether the tribe as a whole (including the health clinic) is one covered entity, or whether different components of the tribe would be considered separate covered entities (or the health clinic a covered entity and another component of the tribe a business associate). Third, a covered entity can use and disclose PHI for its own treatment, payment and health care operations.[211] One covered entity may even share PHI with another covered entity for the "payment activities of the entity that receives the information"[212] or for certain limited health care operations, as discussed previously. Most of the uses and disclosures that occur within a tribe tend to fall under the treatment, payment and health care operations allowance, though tribes may wish to be cognizant of uses or requested disclosures that are unusual. Disclosures that fall outside of treatment, payment or operations should be carefully considered under HIPAA's other provisions to determine whether disclosure can be made absent patient authorization. Finally, tribal contracts or compacts under the ISDEAA, grant agreements or other contractual arrangements may place additional privacy requirements or restrictions on a tribe.

These various allowances and restrictions can sometimes lead to confusion and a hesitancy to release needed and disclosable information. Indian tribes can adopt a clear privacy policy that outlines how patient PHI can or cannot be used and disclosed within the tribal organizational structure so that employees and tribal staff clearly understand the boundaries they must observe and allowances in which they can engage. The policy should help tribal employees who might be reluctant to share PHI for fear of violating HIPAA, and also head-off potential political pressures to release information when it

210. 45 C.F.R. § 164.501.
211. *Id.* § 164.506(a).
212. *Id.* § 164.506(c)(3).

should otherwise not be released. Tribal privacy policies could also take into account culturally-sensitive ways to provide assurances to patients who may be more willing to seek health care if they do not have to fear unauthorized disclosures of their health information within their tribal communities. Tribes should also keep in mind that, when using or disclosing PHI in accordance with the policy, HIPAA requires covered entities to make reasonable efforts to limit the disclosure of PHI to the "minimum necessary" to accomplish the intended purpose of the use or disclosure.[213]

Tribes have sovereign authority to develop their own privacy policies to govern the use, disclosure and safeguards of patient health information. Under the analysis above, tribal providers can adopt tribal privacy policies which contain standards and protections that do not conflict with HIPAA and which are stricter than HIPAA for protecting privacy. A tribe's ability to enact a policy that allows the release of information that is less stringent than HIPAA would depend on whether HIPAA applies to that particular tribe and the circumstances of the potential disclosures. Each tribe will likely need to consider how it wishes to proceed for its particular situations, and may wish to consult with their legal counsel to review the potential applicability of HIPAA to the tribe, whether the tribe voluntarily follows the federal Privacy Act, and other related issues, so that the tribe can make an informed decision about how it wishes to address patient privacy to best meet the tribe's particular needs for its patient demographics and circumstances.

Conclusion

Tribes and tribal people continue to experience a lack of adequate resources for health care and disparate health status compared to the general population in the United States. Over the last thirty years, however, the tribally-driven self-determination and self-governance programs under the ISDEAA, and the tribal sovereignty exercised within and through those and other health programs and policies, have made significant inroads to raising the health status of native people. As Wilma Mankiller, former Principal Chief of the Cherokee Nation, astutely explained,

> The federal policy of Self-Governance has enabled tribal governments to develop a range of innovative projects from language immersion to health care, housing, natural resource management and justice programs. These inspiring stories and

213. *Id.* § 164.502(b)(1).

> images of tribal people illustrate to the general public what we have known for a very long time: Tribal Self-Governance works. Tribal governments perform better when they are able to chart their own courses, allocate their own resources and establish priorities based on local needs.[214]

Tribal decisions and control over the protection of patient privacy by ISDEAA contractors and compactors can add to the progress being made. Exercise of sovereign authority to address health privacy in a manner best suited to each tribe's particular circumstances, patient needs, cultural differences and governmental structure can go a long way toward increasing the empowerment of that tribe within the overall Indian health care system and the American health system in general. Privacy breaches in small communities can have large impacts on adequacy of care. Clear-cut privacy rules, understood by a tribe's staff, management, and patients can increase overall confidence in the tribal health system so that patients are willing to seek the health care they need, and increased patient trust can lead to better patient/physician relationships and improved health status overall.

Recognizing and appreciating tribal sovereign authority in this area, as it relates to tribes' authorities under the ISDEAA and exercise of governmental power to enact privacy rules that are consistent with or more stringent than the HIPAA privacy protections, is part of the nation's responsibility to honor the federal government's commitment to protect and promote the health status of Indians. Tribal control over health privacy, as related to tribal sovereign authority and the HIPAA privacy rule, is an added means for addressing health disparities and making improved health care a reality for Native American communities.

214. Wilma Mankiller, *Forward* to BRENT SIMCOSKY & CYNDI HOLMES, SELF-GOVERNANCE COMMUNIC'N & EDUC. PROJECT, PROUD NATIONS 9 (2005).