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IMPACT OF THE CORONAVIRUS AND FEDERAL RESPONSES ON INDIGENOUS PEOPLES' HEALTH, SECURITY, AND SOVEREIGNTY

*Libby Smith**

COVID-19 has ravaged the United States since the first confirmed American diagnosis in January 2020.¹ By December 2020, there were 19,663,976 diagnosed cases and 341,199 deaths attributed to the disease in the United States alone.² In June 2021, a year and a half after the first American diagnosis, the CDC reported 33,283,781 total cases of COVID-19 and 597,195 deaths caused by the disease.³ Increased governmental regulations, economic shutdowns, and overwhelmed healthcare providers have impacted the lives of millions of people worldwide. Additionally, this pandemic has revealed long-standing systematic inequalities and injustices putting minorities at a greater risk of contracting COVID-19 and developing more severe cases of the disease.

In the United States, minority communities are disproportionately impacted by COVID-19.⁴ Latinos and African Americans are three times more likely to be infected than their white counterparts.⁵ American Indians and Alaska Natives are also more likely to contract the disease.⁶ The Centers for Disease Control and Prevention (CDC) reported that lab-confirmed coronavirus cases in American Indian and Alaska Natives were 3.5 times that among non-Hispanic white persons.⁷ In fact, the Navajo

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1. Erin K. Stokes et al., *Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 759, 760 (2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm#:~:text=The%20first%20laboratory%2Dconfirmed,January%2022%2C%202020>.

2. *United States COVID-19 Cases and Deaths by State*, CDC (Dec. 31, 2020), <https://stacks.cdc.gov/view/cdc/99750>.

3. *United States COVID-19 Cases, Deaths, and Laboratory Testing (NAATs) by State, Territory, and Jurisdiction*, CDC (June 13, 2021), <https://perma.cc/H4M6-XX2J>.

4. See Richard A. Opiel Jr. et al., *The Fullest Look Yet at the Racial Inequity of Coronavirus*, N.Y. TIMES (July 5, 2020), <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html>.

5. *Id.*

6. Stokes et al., *supra* note 1.

7. Sarah M. Hatcher et al., *COVID-19 Among American Indian and Alaska Native Persons — 23 States, January 31–July 3, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1166, 1167 (2020), <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6934e1-H.pdf>.

Nation, which encompasses parts of Utah, Arizona, and New Mexico,⁸ surpassed New York, the epicenter of the American outbreak, for per capita confirmed cases in May 2020.⁹ At the height of the pandemic, the Navajo Nation had 2,304.41 confirmed cases of COVID-19 per 100,000 people—the highest in the United States—while New York had 1,806 cases per 100,000 people.¹⁰

The increased rate of transmission in Native American communities can be attributed in large part to historical inequalities in wealth and access to health care. The poverty rate for Native Americans is greater than twenty-five percent, which is more than double that of the general population.¹¹ The CDC explains that factors related to wealth, such as “reliance on shared transportation, limited access to running water, [and] household size” contributed to the rapid spread of coronavirus in tribal communities.¹²

The heightened rate of both virus transmission and severe COVID-19 cases is also attributable to the lack of access to preventive medicine in Native American communities. People with preexisting conditions, such as cancer, diabetes, and obesity, are the most at-risk for developing severe cases of the disease.¹³ American Indians and Alaska Natives are more likely than the general population to have preexisting conditions;¹⁴ they are 4.6 times more likely to die of chronic liver disease and cirrhosis, 3.2 times more likely to die of diabetes, 1.8 times more likely to die of influenza and pneumonia, 1.5 times more likely to die of kidney disease, and 1.1 times more likely to die of heart disease.¹⁵ This increased rate of preexisting conditions among Native Americans puts them at a greater risk of developing a severe case of COVID-19, and the lack of adequate medical

8. *History*, NAVAJO NATION, <https://www.navajo-nsn.gov/history.htm> (last visited June 13, 2021).

9. Hollie Silverman et al., *Navajo Nation Surpasses New York State for the Highest Covid-19 Infection Rate in the US*, CNN (May 18, 2020), <https://www.cnn.com/2020/05/18/us/navajo-nation-infection-rate-trnd/index.html>.

10. *Id.*

11. U.S. COMM’N ON CIVIL RIGHTS, *BROKEN PROMISES: CONTINUING FEDERAL FUNDING SHORTFALL FOR NATIVE AMERICANS 156-57* (Dec. 2018), <https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf>.

12. Hatcher et al., *supra* note 7, at 1167.

13. See *COVID-19: People with Certain Medical Conditions*, CDC, <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html> [<https://perma.cc/CH4Q-AEBA>] (May 12, 2021).

14. *Disparities*, INDIAN HEALTH SERV. (Oct. 2019), <https://www.ihs.gov/newsroom/factsheets/disparities/>.

15. U.S. COMM’N ON CIVIL RIGHTS, *supra* note 11, at 66.

facilities available to tribal communities means that severe cases of the disease are even more dangerous. The Indian Health Service posits that “[l]ower life expectancy and . . . disproportionate disease burden” in Native communities “exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences.”¹⁶

This Comment focuses on the systematic issues in the United States that led to the disparate impact of COVID-19 on Native communities and the long-term effects the disease will have on those communities. First, Part I discusses the Indian Health Service’s inadequate funding, which contributes to a lower standard of medical care for American Indians and Alaska Natives. Part II then examines the federal response to COVID-19 and the distribution of aid to American Indian and Alaska Native tribes. Part III of this Comment analyzes the economic impact of COVID-19 on tribes and how decreased tribal income inhibits these communities from supplementing federal funds to fund tribal governments. Finally, Part IV concludes this Comment by challenging the federal government to formulate solutions for these pressing issues in Native American health, education, and poverty.

I. Federal Indian Law and Funding

The relationship between the United States government and Native Americans has been turbulent since the founding of our country. Native Americans established independent governments long before the first European settlers came to America.¹⁷ When the U.S. Constitution was enacted, Article I, Section 8 granted Congress the power “to regulate Commerce . . . with the Indian tribes” as a government-to-government relationship between sovereign nations.¹⁸ The tumultuous policies later enacted by the federal government regarding tribes, however, created a cycle serving to perpetually impair Native Americans’ quality of education,

16. *Disparities*, *supra* note 14.

17. Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance Under the Indian Self-Determination and Education Assistance Act*, 39 AM. INDIAN L. REV. 1, 6 (2014-2015).

18. U.S. CONST. art. I, § 8, cl. 3.

health, and employment.¹⁹ Native Americans continue to rank near the bottom of all Americans in these areas.²⁰

A. Historic Policies and Legislation

The United States has a long history of mistreatment toward American Indians and Alaska Natives. Before the Indian Self-Determination and Education Assistance Act was enacted in 1975, the federal government implemented various policies to strip tribes of their land rights, sovereignty, and cultures.²¹ A brief study of this history helps to explain the disadvantages Native people have long faced and how the federal government caused many of them.

Immediately after the American Revolution, the United States recognized the desire of Indian tribes to remain an independent people; the relationships between the United States and the tribes were stable, if not respectful.²² Although the United States considered Native American peoples inferior, it honored the government-to-government relationship described in our Constitution.²³

In the 1800s, however, as conflicts between settlers and Indians grew and the idea of Manifest Destiny spread through the United States, a trio of Supreme Court decisions—known as the Marshall trilogy—began the slow process of stripping tribes of their rights.²⁴ Simultaneously, the Executive Branch, under Andrew Jackson, implemented the Indian Removal Policy.²⁵ Through the Indian Removal Act of 1830, most of the eastern tribes were forced to relocate to Indian Territory in Oklahoma.²⁶

Although this period began a series of abusive federal Indian policies, the cases making up the Marshall trilogy—*Johnson v. M'Intosh*, *Cherokee Nation v. Georgia*, and *Worcester v. Georgia*—“preserve[d] important tribal rights, including tribes' limited sovereignty and right to self-

19. NAT'L ACADS. OF SCIS., ENG'G & MED., COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 508-09 (2017) [hereinafter PATHWAYS TO HEALTH EQUITY], https://www.ncbi.nlm.nih.gov/books/NBK425848/pdf/Bookshelf_NBK425848.pdf.

20. U.S. COMM'N ON CIVIL RIGHTS, *supra* note 11, at 1.

21. *See* Strommer & Osborne, *supra* note 17, at 3–8.

22. *Id.* at 6.

23. *Id.* at 6–7.

24. *Id.* at 8.

25. *Id.* at 12.

26. *Id.* at 13.

governance, while legitimizing . . . the expropriation of Indian lands.”²⁷ These cases established the grounds for a trust relationship between the United States and Indian tribes by holding that tribes are “domestic dependent nations”; “[t]heir relation to the United States resembles that of a ward to his guardian.”²⁸ This trust relationship later established many legal obligations, including medical care, owed by the United States to tribes.

As the United States continued to expand westward, Indian removal was no longer feasible. The federal government then adopted policies for the assimilation of tribes into American life. The Assimilation Era was defined by the General Allotment Act of 1887 (Dawes Act) and the implementation of a boarding school system designed to strip the customary Native American traditions from children and integrate them into white society.²⁹ The Dawes Act broke up tribal lands into individual family plots, which in turn led to the stripping of millions of acres of land away from Native Americans.³⁰ This era also saw the decline of individual tribal governments and rise of the Bureau of Indian Affairs (BIA).³¹ The Snyder Act, passed in 1921, gave the BIA authority to fund health care, education, and employment on reservations.³²

The Indian Reorganization Act of 1934, designed to develop tribal economies and promote self-determination, began a positive, though brief, era.³³ The Indian Reorganization Act reversed allotment, allowing the BIA to take Indian lands into trust.³⁴ Additionally, the Act provided procedures for establishing formal tribal constitutions, tribal corporations, and membership enrollment.³⁵ This positive era was short-lived, and the federal government quickly reverted back to policies that negatively affected tribes.

In the 1950s, the Termination Era took hold.³⁶ The United States stripped many tribes of their reservations and statuses as federally recognized

27. *Id.* at 8; *see also* *Johnson v. M'Intosh*, 21 U.S. (8 Wheat.) 543 (1823); *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1 (1831); *Worcester v. Georgia*, 31 U.S. (6 Pet.) 515 (1832).

28. *Strommer & Osborne*, *supra* note 17, at 11 (citing *Cherokee Nation v. Georgia*, 30 U.S. at 521–22).

29. *PATHWAYS TO HEALTH EQUITY*, *supra* note 19, at 508.

30. *The Dawes Act*, NAT'L PARK SERV., <https://www.nps.gov/articles/000/dawes-act.htm> (Nov. 10, 2020).

31. *Strommer & Osborne*, *supra* note 17, at 14.

32. 25 U.S.C. § 13.

33. *PATHWAYS TO HEALTH EQUITY*, *supra* note 19, at 509.

34. *Strommer & Osborne*, *supra* note 17, at 14–15.

35. *Id.* at 15.

36. *PATHWAYS TO HEALTH EQUITY*, *supra* note 19, at 509.

tribes.³⁷ The federal government then forced these tribes to relocate to urban areas.³⁸ The goal of this era was “to end federal supervision and control over the Indian ‘wards,’ weaken tribal governments, and assimilate individual Indians.”³⁹ Once again, the federal government sought to weaken tribal bonds and disempower tribal members.

Finally, in the 1960s, the United States began to promote Indian self-determination. Congress passed the Indian Civil Rights Act in 1968, ensuring that the guarantees in the Bill of Rights were given to Indian tribes.⁴⁰ In 1970, President Nixon asked Congress to “renounce, repudiate and repeal the termination policy” in favor of tribal self-determination.⁴¹ Ultimately, in 1975, Congress passed the Indian Self-Determination and Education Assistance Act (ISDEAA), which reestablished the tribes as nations and recognized the value of tribal self-determination and self-governance.⁴² While Congress enacted the ISDEAA to promote tribal independence, the Act did not initially accomplish this goal.⁴³ It was not until Congress amended the Act in 2000 that it truly enabled tribes to achieve self-determination.⁴⁴ By then, after centuries of abuse and neglect, American Indian tribes faced overwhelming difficulties caused by pervasive cycles of substandard education, poor health, and low economic opportunity.

B. Current Policies and Legislation

The ISDEAA promotes tribal self-determination and allows tribes to contract with federal agencies to assume control over and administer programs, services, activities, and funding previously controlled by those federal agencies.⁴⁵ Management by individual tribes allows programs and services to be responsive to the specific needs of individual communities. It also builds leadership and administrative skills within the community. A primary way that tribes exercise self-determination under the ISDEAA is through health care.

37. *Id.*

38. *Id.*

39. Strommer & Osborne, *supra* note 17, at 15–16.

40. *Id.* at 16.

41. *Id.* at 17 (quoting President Nixon's Message to Congress Transmitting Recommendations for Indian Policy, H.R. DOC. No. 91-363, at 3 (1970)).

42. Anna Lindrooth, *Discretionary Deaths in Indian Country: Ensuring Full Funding for Tribal Health*, 26 FED. CIR. B.J. 277, 281 (2017).

43. Strommer & Osborne, *supra* note 17, at 29–30.

44. *See id.* at 41.

45. *Id.* at 29.

American Indians and Alaska Natives are two of the only groups in the United States with a legal right to health care.⁴⁶ In recognition of the forfeiture of Native American lands, the federal government acknowledges a trust responsibility and legal obligation to federally recognized American Indian and Alaska Native tribes, which “requires the government to protect tribal lands, assets, resources, treaty rights, and health care, in addition to other responsibilities.”⁴⁷ This legal relationship, formed through treaties, court decisions, statutes, regulations, and executive orders, creates a legal obligation for federally funded health care.⁴⁸

The Snyder Act of 1921 authorizes funding “for the benefit, care, and assistance of [] Indians.”⁴⁹ The Indian Health Care Improvement Act of 1979 (IHCIA) implements the federal responsibility for the care and education of Indians by improving services and facilities and encouraging the maximum participation of Indians.⁵⁰ These Acts work together to form the legislative authority for the Indian Health Service (IHS), which provides health services to Native Americans and Alaska Natives.⁵¹ Congress declared that, in fulfillment of its trust responsibility, it prioritizes “ensur[ing] the highest possible health status for Indians and urban Indians and . . . provid[ing] all resources necessary to effect that policy[.]”⁵²

The ISDEAA was intended to promote tribal independence and self-determination when it was enacted in 1975.⁵³ However, a struggle over the balance between tribal self-determination and federal oversight meant that contracting under the ISDEAA was impracticable until the 2000s.⁵⁴ Within the federal government, many believed that extreme oversight regarding Indian contracts was necessary, but that oversight actually impaired self-determination policies from achieving success.⁵⁵

In 2010, Congress permanently reauthorized the IHCIA, putting greater emphasis on funding and self-determination for tribal health care.⁵⁶ The

46. See U.S. COMM’N ON CIVIL RIGHTS, *supra* note 11, at 61–62.

47. PATHWAYS TO HEALTH EQUITY, *supra* note 19, at 507.

48. U.S. COMM’N ON CIVIL RIGHTS, *supra* note 11, at 61.

49. 25 U.S.C. § 13.

50. 25 U.S.C. § 1601(3).

51. PATHWAYS TO HEALTH EQUITY, *supra* note 19, at 509–10.

52. 25 U.S.C. § 1602(1).

53. Strommer & Osborne, *supra* note 17, at 20–21.

54. See Strommer & Osborne, *supra* note 17, at 19–33.

55. *Id.* at 29–32.

56. *Summary of Indian Health Care Improvement Act Provisions Passed in the Patient Protection and Affordable Care Act (P.L. 111-148)*, WASH. ST. LEG. 1, http://www.npaih.org/images/resources_docs/weeklymailout/2010/april/week1/IHCIA%20summary.pdf.

goals of the IHCA were to increase the number of medical professionals within tribal communities, expand the services offered, update facilities, make health care more accessible, and ensure more adequate funding.⁵⁷ While many of these goals were not met to the degree desired, the IHCA helped pave the way for tribes to take advantage of self-determination policies and empowered tribes to contract without the excessive oversight in the earlier ISDEAA years. By “1991, only seven tribes entered self-governance agreements with the BIA[.]”⁵⁸ By 2013, only three years after the IHCA was reauthorized, 254 tribes and tribal consortia entered into funding agreements.⁵⁹

Contracts between the IHS and tribes jumped even more. In 1994, only fourteen tribes had self-governance agreements, totaling \$51 million.⁶⁰ But, by 2015, the IHS had executed eighty-nine compacts and 114 funding agreements, totaling \$1.6 billion.⁶¹ Over one-third of the IHS’s total appropriations went directly to tribes and tribal organizations.⁶²

C. Federal Funding

Although self-governance agreements and tribal self-determination have grown tremendously since the reauthorization of the IHCA, a lack of adequate funding has hindered the ability of tribes to provide adequate health care for their members.⁶³ This lack of funding is a violation of the United States’ trust obligations to provide health care to tribes.⁶⁴

The IHS, which is under the umbrella of the Department of Health and Human Services (HHS), provides the majority of health care to Native Americans and Alaska Natives.⁶⁵ In 2019, approximately 2.6 million American Indians and Alaska Natives received their health care from the IHS either directly or through facilities and programs operated by tribes or tribal organizations (I/T/U systems) under self-determination contracts and self-governance compacts authorized in the ISDEAA.⁶⁶ According to the

57. *Id.*

58. Strommer & Osborne, *supra* note 17, at 48.

59. *Id.*

60. *Id.* at 49.

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.* at 51–52.

65. ELAYNE J. HEISLER, CONG. RSCH. SERV., IN11333, COVID-19 AND THE INDIAN HEALTH SERVICE 1 (2020), https://www.everycrsreport.com/files/20200414_IN11333_35302f2c30ee2c927573a3dec71052db501516de.pdf.

66. *Id.*

United States Census Bureau, approximately 2.9 million people identify as American Indian or Alaska Native, meaning ninety percent of all Native Americans and Alaska Natives receive their health care through the IHS.⁶⁷

Although American Indians and Alaska Natives have a legal right to health care provided by the federal government, their health is generally much poorer than the average American's.⁶⁸ This is because the IHS is chronically underfunded and the needs of the facilities funded through the IHS are often not met, resulting in less access and substandard care for tribal members.⁶⁹

The IHS serves approximately 2.6 million American Indians and Alaska Natives,⁷⁰ but “the Federal Government spends less per capita on Indian healthcare than” it does for any other group that receives federal health care funding.⁷¹ In fact, 2018 records show that the IHS's per capita medical care expenditure was \$3,779 while Medicare's was \$13,257, the Veterans Health Administration's was \$9,574, and Medicaid's was \$8,093.⁷² In 2019, the IHS per capita expenditure was \$4,078, compared to U.S. National Health expenditure, per person, of \$9,726.⁷³ This disparity means that medical centers funded by the IHS often lack the equipment, facilities, and staff required to give Native Americans standard health care.⁷⁴ In 2020, the federal government appropriated six billion dollars to the IHS to fund health care.⁷⁵ However, tribal leaders estimate a total of \$12.759 billion needed to fully fund the IHS in fiscal year 2022.⁷⁶

The IHS serves Native Americans through facilities run directly by the IHS, facilities operated by tribes under contracts with the IHS, and through contracts and grants to Urban Indian Organizations.⁷⁷ The IHS numbers

67. *Tribal Population*, CDC, <https://www.cdc.gov/tribal/tribes-organizations-health/tribes/state-population.html> (Dec. 21, 2018).

68. *Disparities*, *supra* note 14.

69. *PATHWAYS TO HEALTH EQUITY*, *supra* note 19, at 511.

70. *IHS Profile*, INDIAN HEALTH SERV. (Aug. 2020), <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>.

71. Lindrooth, *supra* note 42, at 278–79.

72. NAT'L TRIBAL BUDGET FORMULATION WORKGROUP, RECLAIMING TRIBAL HEALTH: A NATIONAL BUDGET PLAN TO RISE ABOVE FAILED POLICIES AND FULFILL TRUST OBLIGATION TO TRIBAL NATIONS 10 (Apr. 2020) [hereinafter RECLAIMING TRIBAL HEALTH], https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf.

73. *IHS Profile*, *supra* note 70.

74. RECLAIMING TRIBAL HEALTH, *supra* note 72, at 22.

75. *IHS Profile*, *supra* note 70.

76. RECLAIMING TRIBAL HEALTH, *supra* note 72, at 8.

77. U.S. COMM'N ON CIVIL RIGHTS, *supra* note 11, at 64.

show 117 facilities operated directly by the IHS and 451 facilities operated by Indian tribes or tribal organizations.⁷⁸ Since the Indian Self-Determination and Education Act (ISDEAA) was enacted in 1975, the government recognized the desire of Indian people “to control their relationships both among themselves and with non-Indian governments, organizations, and persons.”⁷⁹

Over sixty percent of the IHS appropriation is administered by tribes through contracts under the ISDEAA.⁸⁰ However, the federal government consistently fails to fully compensate tribal contractors operating these facilities.⁸¹ Funding shortages result in “severe offsetting reductions in patient care and in other essential governmental services for the most underserved populations in America—American Indians and Alaska Natives—who already receive fewer health services than even federal prisoners.”⁸²

The federal government’s failure to provide funds for Contract Support Costs (CSC)—“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”—is a consistent disincentive for tribes to form self-governance agreements.⁸³ A lack of funding for CSC means that funds initially allocated to programs and services providing medical care must be used for administrative costs, lowering the level of care tribal members receive.⁸⁴ Although the funding deficiencies for CSC has been addressed in both the legislature⁸⁵ and the judiciary,⁸⁶ the BIA continually fails to provide sufficient funds. In 1987, Congress amended the ISDEAA to require full funding of CSC.⁸⁷ However, in 2010, the BIA still paid only seventy-five percent of required CSC and the IHS paid only 81.5% of CSC.⁸⁸

78. *See IHS Profile*, *supra* note 70.

79. 25 U.S.C. § 5301.

80. *IHS Profile*, *supra* note 70.

81. Strommer & Osborne, *supra* note 17, at 49–51.

82. *Contract Support Costs*, TRIBAL SELF GOV., <https://www.tribalsegov.org/wp-content/uploads/2015/04/L5A-CSC-White-Paper-Updated.pdf>.

83. Strommer & Osborne, *supra* note 17, at 49–50 (citing 25 U.S.C. § 450j-1(a)(2)).

84. *Id.* at 50.

85. *See id.*

86. *See Cherokee Nation v. Leavitt*, 543 U.S. 631 (2005); *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 194 (2012).

87. Strommer & Osborne, *supra* note 17, at 49–50.

88. *Id.*

Two Supreme Court decisions addressed CSC funding. In 2005, the Court held, in *Cherokee Nation v. Leavitt*, that the IHS was liable for failing to provide sufficient funding for CSC in the years before Congress capped CSC spending.⁸⁹ This outcome meant that the IHS could have allocated any of its general funding to CSC.⁹⁰ However, lower courts continued to hold that, after Congress capped CSC expenditures, agencies were protected from liability.⁹¹

Then, in the 2012 case of *Salazar v. Ramah Navajo Chapter*, the Supreme Court held that the government “cannot back out of its contractual promise to pay each Tribe’s full contract support costs,” even if Congress failed to allocate sufficient funds.⁹² This decision sought to ensure that the government would repay tribes the administrative costs incurred by running their own health care under the ISDEAA.⁹³ However, tribes still face shortages in their funding.⁹⁴ Thus, tribes cut indirect costs, use program funding for their indirect costs, or supplement federal funding with tribal resources.⁹⁵

Although Congress recognizes its duty to fully fund tribally operated facilities by providing funds to them not less than those operated by the IHS, it has consistently failed to allocate enough funds to compensate tribal contractors.⁹⁶ Funding for Indian health care is made available through discretionary spending bills.⁹⁷ Tribal leaders request mandatory appropriations, arguing that “[t]he discretionary nature of the federal budget that systemically fails to fulfill Trust and Treaty obligation[s] is a legal, ethical, and moral violation of the greatest order.”⁹⁸

Additionally, Congress does not provide advance budgets for the IHS.⁹⁹ Therefore, tribes cannot appropriately plan how to invest their money.¹⁰⁰ Uncertain budgets make it difficult for the IHS-funded facilities to recruit, retain, and train staff.¹⁰¹ Such budgets also make planning to build or

89. 543 U.S. at 637–38.

90. Strommer & Osborne, *supra* note 17, at 52.

91. *Id.*

92. 567 U.S. 182, 194 (2012).

93. Strommer & Osborne, *supra* note 17, at 53–54.

94. *Id.* at 55.

95. *Id.* at 51.

96. 25 U.S.C. § 1602(7).

97. RECLAIMING TRIBAL HEALTH, *supra* note 72, at 8.

98. *Id.* at 3.

99. U.S. COMM’N ON CIVIL RIGHTS, *supra* note 11, at 70.

100. *Id.*

101. *Id.*; RECLAIMING TRIBAL HEALTH, *supra* note 72, at 12.

renovate facilities and investing in the future of the program challenging.¹⁰² Currently, contract support costs, current services, and a small amount of targeted funding for certain programs are the only budgetary elements Congress is required to provide.¹⁰³

D. Consequences of Long-Term Underfunding

This consistent lack of funding directly impacts a tribe's ability to respond to the sweeping coronavirus pandemic. In addition to the generally weaker health of Native Americans, putting them at greater risk for severe cases of COVID-19, tribal communities and medical facilities were grossly unequipped to handle a substantial wave of patients.¹⁰⁴ Persistent underfunding of Native American and Alaska Native health care has resulted in substandard facilities, insufficient staff, and equipment shortages.¹⁰⁵

The IHS system services 2.6 million Native Americans and Alaska Natives.¹⁰⁶ It is comprised of 46 hospitals, 330 health centers, 59 Alaska village clinics, 103 health stations, and 18 school health centers.¹⁰⁷ Of these medical facilities, about eighty percent are operated by tribes or tribal organizations through self-determination agreements under the ISDEAA.¹⁰⁸ The IHS system is often described as the I/T/U system, with the letters representing the distinction between the IHS facilities, tribal run programs, and urban health centers.¹⁰⁹ Although all I/T/U facilities are operated differently, each one is funded by the IHS and faces challenges common to all facilities.¹¹⁰

The IHS-funded facilities were not equipped to face the COVID-19 pandemic. The IHS reported a "significant need for expansion or replacement" of facilities.¹¹¹ "[T]he average age of hospitals nationwide is 10 years."¹¹² But IHS buildings have "an average age of 47 years . . . [and]

102. RECLAIMING TRIBAL HEALTH, *supra* note 72, at 12.

103. *Id.* at 3.

104. Mark Walker, *Pandemic Highlights Deep-Rooted Problems in Indian Health Service*, N.Y. TIMES (Sept. 29, 2020), <https://www.nytimes.com/2020/09/29/us/politics/coronavirus-indian-health-service.html>.

105. *Id.*

106. *IHS Profile*, *supra* note 70.

107. *Id.*

108. *Id.*

109. HEISLER, *supra* note 65, at 1–2.

110. *Id.*

111. U.S. COMM'N ON CIVIL RIGHTS, *supra* note 11, at 86.

112. RECLAIMING TRIBAL HEALTH, *supra* note 72, at 15.

have ‘surpassed their useful lives,’ and are ‘grossly undersized’ for their user populations, often resulting in ‘crowded, even unsafe, conditions’ for patients and staff.”¹¹³ The National Tribal Budget Formulation Workgroup reports that, based on current levels of funding, “if a new [IHS] facility was built today, it would not be replaced for 400 years.”¹¹⁴

In the midst of a pandemic, it is clear that the IHS is unequipped to serve Native Americans and Alaska Natives. The IHS has only 625 hospital beds to serve the members of 574 tribes.¹¹⁵ In the Navajo Nation, the vacancy rate, the percentage of unoccupied positions, for doctors is more than twenty-five percent and, for nurses, forty percent.¹¹⁶ During the pandemic, fifty-five percent of facilities serving Native Americans indicated that they do not have the capacity to isolate patients presumed to have coronavirus.¹¹⁷ Months after the federal government recognized the threat of COVID-19, eighty-seven percent of facilities had not received personal protective equipment and eighty-three percent had not received durable medical equipment from the federal government.¹¹⁸ The CEO of the Seattle Indian Health Board, Esther Lucero, reported receiving body bags from the government in response to a request for additional COVID-19 testing kits.¹¹⁹ Not only did the government fail to prepare tribal communities for medical emergencies, but it additionally failed to respond when there was one.

In addition to poor conditions within the medical facilities, many tribes do not have the infrastructure needed to slow the spread of coronavirus. In Indian Country, the “IHS plays a vital role in the construction and maintenance of water supply and sanitation facilities.”¹²⁰ Yet, thirteen percent of Native American homes still do not have safe drinking water or adequate waste disposal systems.¹²¹ Less than one percent of homes nationwide lack these systems.¹²² Many Native Americans must prioritize drinking water over hand-washing and many must travel into towns to buy

113. U.S. COMM’N ON CIVIL RIGHTS, *supra* note 11, at 86.

114. RECLAIMING TRIBAL HEALTH, *supra* note 72, at 37.

115. *The Indian Health Service & Coronavirus*, NAT. RES. COMM., https://naturalresources.house.gov/imo/media/doc/InfoGraphic_%20IHS%20and%20coronavirus.pdf (last visited June 13, 2021) (graphic).

116. Walker, *supra* note 104.

117. *The Indian Health Service & Coronavirus*, *supra* note 115.

118. *Id.*

119. *Id.*

120. U.S. COMM’N ON CIVIL RIGHTS, *supra* note 11, at 85.

121. *Id.*

122. *Id.* at 85–86.

water in bulk, increasing their risk of exposure to the virus.¹²³ A lack of adequate infrastructure also means many Native Americans are living in multi-generational homes, increasing the risk that the elderly, who are most susceptible to the disease, will be exposed.¹²⁴

Urban Indians, Indians who live in urban areas, face unique challenges in combatting the COVID-19 pandemic. Data indicates that urban Indians, which comprise about seventy percent of Native Americans, have even more acute health problems than those living in Indian Country.¹²⁵ Native Americans living in urban areas do not have access to the IHS or tribal health facilities.¹²⁶ Although the IHS contracts with thirty-four non-profit urban Indian organizations, only one percent of the IHS budget serves urban Indian health care.¹²⁷ IHS funding does not reflect the demographic shift of American Indians away from reservations and towards urban areas.¹²⁸ Funding for urban Indian health care is only at twenty-two percent of what is needed to serve this population.¹²⁹

This chronic underfunding of the Indian Health Service harms native communities and is not conducive to Congress' proclaimed goal for Indians to reach the "highest possible health status."¹³⁰ Fewer health care facilities and services are available to Native Americans than are needed. Without proper access to preventive medicine, American Indians are more likely to suffer from preexisting conditions. They are, therefore, more likely to experience detrimental health outcomes after a COVID-19 diagnosis.¹³¹

II. Federal Response to COVID-19

COVID-19 has shaken the nation, leaving businesses, families, and hospitals in dire need of emergency funds. The federal government quickly passed several bills in an attempt to meet that need throughout the last half of 2020. Tribal health facilities and governments were included in the relief with special allocations, but they were still at a disadvantage. Until federal

123. Walker, *supra* note 104.

124. *Id.*

125. U.S. COMM'N ON CIVIL RIGHTS, *supra* note 11, at 73.

126. *Id.*

127. *Id.*

128. *Id.*

129. *Id.* at 74.

130. 25 U.S.C. § 1602(1).

131. See U.S. COMM'N ON CIVIL RIGHTS, *supra* note 11, at 65.

funding arrived in May 2020, tribes depended on their own resources and donations to provide extra care to their members.¹³²

A. Federal Funding

The Coronavirus Preparedness and Response Supplemental Appropriations Act, signed by the President on March 6, 2020, was the first legislative response to the pandemic.¹³³ In total, the Act provided \$8.3 billion in pandemic relief.¹³⁴ Congress designated \$6.7 billion for the domestic response and \$1.6 billion for international relief.¹³⁵ The Act required that the CDC set aside at least \$40 million to be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes.¹³⁶ Despite delays, the CDC eventually distributed \$80 million to tribal facilities and HHS transferred an additional \$70 million to the IHS.¹³⁷

The second coronavirus relief package, the Families First Coronavirus Response Act, was signed into law on March 18, 2020.¹³⁸ This Act designated another \$64 million to the IHS.¹³⁹ Congress directed an additional \$10 million to Grants for Indian Programs within the Older Americans Act, which provides nutrition and other direct support services to American Indian, Alaska Native, and Native Hawaiian elders.¹⁴⁰ The Act also provided coronavirus testing at no cost to American Indians and Alaska Natives and expanded food assistance and unemployment benefits through September 2020.¹⁴¹

132. Arlyssa Becenti, *CARES Act Funding Received by Tribe, Official Says*, NAVAJO TIMES (May 7, 2020), <https://navajotimes.com/coronavirus-updates/cares-act-funding-received-by-tribe-official-says/>.

133. Stephanie Oum et al., *The U.S. Response to Coronavirus: Summary of the Coronavirus Preparedness and Response Supplemental Appropriations Act*, KFF (Mar. 11, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/the-u-s-response-to-coronavirus-summary-of-the-coronavirus-preparedness-and-response-supplemental-appropriations-act-2020/>.

134. *Id.*

135. *Id.*

136. HEISLER, *supra* note 65, at 2.

137. *Id.*

138. *H.R. 6201 – Families First Coronavirus Response Act, 2020*, NAT'L CONG. OF AM. INDIANS, <https://www.ncai.org/Covid-19/legislative-updates/hr-6201> (last visited June 13, 2021).

139. *Id.*

140. *Id.*

141. *Id.*

Next, on March 27, 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).¹⁴² This Act allocated \$150 billion “for payments by Treasury to States, tribal governments, and certain local government” to address the impacts of the COVID-19 pandemic.¹⁴³ The National Congress of American Indians wrote that the CARES Act “included an unprecedented level of investment in and resources for tribal response and recovery efforts.”¹⁴⁴ The CARES Act provided that \$8 billion from the Coronavirus Relief Fund must be apportioned to tribal nations for expenses due to COVID-19.¹⁴⁵ It also provided just over \$1 billion for the IHS, with a requirement that \$450 million of that amount be transferred to facilities operated by tribes.¹⁴⁶

The CARES Act also required the following figures to be provided to facilities run by tribes: at least \$15 million from the funds provided to the Substance Abuse and Mental Health Services Administration; at least \$15 million of funds provided to the Health Resources and Services Administration; and at least \$125 million from the CDC.¹⁴⁷ However, many of these funds were delayed, and tribes had to fund efforts against COVID-19 with their own resources.¹⁴⁸

The COVID-19 crisis is ongoing. Therefore, more funding for tribal communities may become available. Tribes face more acute risks caused by COVID-19 than the general public. A lack of adequate medical care and basic virus fighting measures means additional funding is needed—especially in the smaller, poorer tribal communities.

B. Litigation

The widespread need for emergency funding has given rise to litigation, as tribes fight for their share of the \$8 billion earmarked for tribes in the CARES Act.¹⁴⁹ Most of the disputes challenge the way that the Department

142. *H.R. 748 – Coronavirus Aid, Relief, and Economic Security (CARES) Act*, NAT’L CONG. OF AM. INDIANS, <https://www.ncai.org/Covid-19/legislative-updates/hr-748> [hereinafter *H.R. 748*].

143. Coronavirus Relief Fund for States, Tribal Governments, and Certain Eligible Local Governments, 86 Fed. Reg. 4182 (Jan. 15, 2021).

144. *H.R. 748*, *supra* note 142.

145. *Id.*

146. HEISLER, *supra* note 65, at 2.

147. *Id.* at 3.

148. Becenti, *supra* note 132.

149. Emily Cochrane & Mark Walker, *Tribes in a Battle for Their Share of Virus Stimulus Money*, N.Y. TIMES (June 19, 2020), <https://www.nytimes.com/2020/06/19/us/politics/tribes-coronavirus-stimulus.html>.

of the Treasury counted tribal populations, which determined the amount of funding tribes would receive in the first wave of payments.¹⁵⁰ Before the first wave of payments from the CARES Act went out, tribes submitted information about tribal enrollment to the Treasury Department.¹⁵¹ However, the department did not use that data to allocate funds.¹⁵² Instead, the Treasury Department used population data from the Department of Housing and Urban Development's Indian Housing Block Grant program, which ties population data to a geographical region.¹⁵³

The population data is based on how many Native Americans reside in a geographic area. This measurement means that many tribes without designated reservations were counted as having a population of zero and received only the minimum allocation of \$100,000.¹⁵⁴ For example, the Shawnee Tribe was counted as having a population of zero based on this data and received only \$100,000.¹⁵⁵ However, the Tribe actually has more than 3,000 members and should have received closer to \$12 million, according to its Chief, Ben Barnes.¹⁵⁶

A lawyer for the Prairie Band Potawatomi Nation said the Treasury Department's "methodology is not rationally related to the distribution of COVID-related expenses because tribal governments have a responsibility far beyond their actual geographic reservation."¹⁵⁷ Additionally, a policy brief by the Harvard Project on American Indian Economic Development found that the "Treasury's decision to use racial population data from [the Department of Housing and Urban Development's Indian Housing Block Grant] dataset demonstrably produces arbitrary and capricious allocations of CARES Act funds across tribes."¹⁵⁸ The study showed that many tribal HUD populations used by the Treasury Department were grossly lower than

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. RANDALL K.Q. AKEE ET AL., NATIVE NATIONS INST., POLICY BRIEF NO. 2, DISSECTING THE US TREASURY DEPARTMENT'S ROUND 1 ALLOCATIONS OF CARES ACT COVID- 19 RELIEF FUNDING FOR TRIBAL GOVERNMENTS (2020), https://ash.harvard.edu/files/ash/files/2harvard_nni_dissection_of_treasury_allocation_w_appendix_05_18_2020_vf_in_for_dist_2_.pdf.

their enrolled population, meaning those tribes received less funding under the CARES Act than promised.¹⁵⁹

Two lawsuits—one filed by the Shawnee Tribe of Oklahoma and the other by the Prairie Band Potawatomi Nation—alleged that the Treasury Department grossly miscalculated tribal populations and arbitrarily withheld funds from tribes.¹⁶⁰ However, neither lawsuit was successful, and both cases were dismissed.¹⁶¹ The case filed by the Shawnee Tribe was dismissed after the judge ruled that the dispute was not reviewable under the Administrative Procedure Act.¹⁶² Similarly, the case filed by the Prairie Band Potawatomi Nation was voluntarily dismissed after the judge denied the tribe's request for a preliminary injunction.¹⁶³

The judges in these cases prioritized the need to distribute the funding over ensuring that tribes receive a fair portion.¹⁶⁴ Judge Amit P. Mehta, who dismissed the Shawnee Tribe's lawsuit, issued a statement, writing that Congress "imposed an incredibly short time limit to distribute those dollars The 80 days they have waited, when Congress intended receipt of emergency funds in less than half that time, is long enough."¹⁶⁵ Despite the controversy caused by the Treasury Department's population calculations, some tribes are just happy that funds were finally going to be released. Jonathan Nez, the president of the Navajo Nation, said, "There's a timeline on this. We need to get those dollars to all the tribes across the country so they can help their citizens."¹⁶⁶

Another controversy, and resulting lawsuit, asks whether Alaska Native Corporations (ANCs) should receive a share of the funding designated for tribes in the CARES Act.¹⁶⁷ In *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, the District of Columbia Circuit Court of Appeals held that Alaska Native Corporations (ANCs) are not "Indian Tribes" within the meaning of the CARES Act or the ISDA; so, they are not eligible

159. *Id.*

160. *DC Judge Dismisses Shawnee Tribe's Lawsuit over CARES Funding*, NATIVE NEWS ONLINE (Sept. 11, 2020), <https://nativenewsonline.net/sovereignty/dc-judge-dismisses-shawnee-tribe-s-lawsuit-over-cares-funding>.

161. *Id.*

162. *Id.*

163. *Id.*

164. Cochrane & Walker, *supra* note 149.

165. *Id.*

166. *Id.*

167. *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, 976 F.3d 15 (D.C. Cir. 2020).

to receive funds from the CARES Act allocation to tribes.¹⁶⁸ ANCs were created by Congress to “receive land and money provided to Alaska Natives in settlement of aboriginal land claims.”¹⁶⁹ The Alaska Native Claims Settlement Act of 1971 (ANCSA) created regional ANCs and over 200 village corporations to serve the needs of Alaska Natives in perpetuity.¹⁷⁰ In the ANCSA, these corporations received forty-four million acres of land and \$962.5 million for land lost in the settlement.¹⁷¹ ANCs serve similar functions for Alaska Natives as tribes and tribal organizations do for Native Americans in the lower forty-eight states.¹⁷²

In *Chehalis Reservation*, the court determined that, under the ISDA’s definition of “Indian Tribe,” ANCs are not eligible to receive funds from the CARES Act.¹⁷³ According to the court, an ANC “cannot qualify as an ‘Indian Tribe’ under [the ISDEAA] unless it has been ‘recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.’”¹⁷⁴ Although ANCs receive Indian-related funding and benefits, they cannot be considered an “Indian Tribe” under either the ISDEAA or the CARES Act because the United States has not officially recognized a sovereign-to-sovereign relationship to them.¹⁷⁵ The court left open the question of whether this holding will disqualify ANCs from receiving future funding through the ISDEAA and other statutes that incorporate its definition of “Indian tribe.”¹⁷⁶

Many Native Alaskans are both shareholders in ANCs and members of a federally recognized tribe.¹⁷⁷ Native American tribes share the concern that because “villages and ANCs share citizens, shareholders, and land bases; improper inclusion of both villages and ANCs in the data collection would result in double and triple counting various factors in favor of Alaska.”¹⁷⁸

168. *Id.* at 28.

169. *Id.* at 17.

170. *About the Alaska Native Claims Settlement Act*, ANCSA REG’L ASS’N, <https://ancsaregional.com/about-ancsa/> (last visited June 13, 2021).

171. *Id.*

172. *Id.*

173. *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, 976 F.3d at 28; *see also About the Alaska Native Claims Settlement Act*, *supra* note 170.

174. *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, 976 F.3d at 23.

175. *Id.* at 25.

176. *Id.* at 28.

177. Acee Agoyo, *Alaska Native Corporations in Line for Billions in Coronavirus Relief Promised to Tribes*, INDIANZ.COM (Apr. 14, 2020), <https://www.indianz.com/News/2020/04/14/alaska-native-corporations-in-line-for-b.asp>.

178. *Id.*

Tribes are concerned that Alaska Natives will receive more than their share of the funds, depriving tribes in the lower forty-eight states of their fair share of the funds.¹⁷⁹ However, not all Alaska Natives are enrolled both in a tribe receiving CARES Act funding and a shareholder of an ANC.¹⁸⁰ Thus, Alaska Natives that are only shareholders in an ANC will be left without COVID-19 assistance based on the court's decision in *Chehalis Reservation*.¹⁸¹

In a concurrence to the *Chehalis Reservation* decision, Judge Henderson expressed her dissatisfaction with the decision, stating that “[i]t is indisputable that the services ANCs provide to Alaska Native communities—including healthcare, elder care, educational support and housing assistance—have been made only more vital due to the pandemic.”¹⁸² However, she continued, “Nonetheless it is not this court's job to soften . . . Congress' chosen words whenever we believe those words lead to a harsh result.”¹⁸³ The holding in this case may have lasting effects beyond the CARES Act funding, as many other statutes incorporate the ISDEAA definition of “Indian tribe” in their own language.¹⁸⁴

Apart from the \$162 million apportioned to ANCs, which was not distributed due to an injunction by the court,¹⁸⁵ tribes began to receive emergency funding in May 2020.¹⁸⁶ The Department of the Treasury distributed the first sixty percent, or \$4.8 billion, based on tribal population.¹⁸⁷ In North Dakota, the Standing Rock Sioux Tribe received \$21 million, the Turtle Mountain Band of Chippewa Indians received \$44 million, and the Spirit Lake Nation received \$12 million.¹⁸⁸ The Navajo Nation—one of the tribes hit hardest by COVID-19—reportedly received

179. *Id.*

180. *Id.*

181. *Alaska Native Corporations and the CARES Act*, ANCSA REG'L ASS'N, <https://ancsaregional.com/cares-act/> (last visited June 13, 2021).

182. *Confederated Tribes of the Chehalis Reservation v. Mnuchin*, 976 F.3d 15, 29 (D.C. Cir. 2020) (Henderson, J., concurring).

183. *Id.* at 30 (internal quotations omitted).

184. *Id.* at 29–30.

185. *Id.* at 20.

186. Becenti, *supra* note 132.

187. *Hoeven: Treasury Announces Initial Allocation from \$8 Billion of Historic Cares Act Funds to Indian Country*, U.S. SENATE COMM. ON INDIAN AFFAIRS (May 5, 2020), <https://www.indian.senate.gov/news/press-release/hoeven-treasury-announces-initial-allocation-8-billion-historic-cares-act-funds> [hereinafter *Hoeven: Treasury Announces Initial Allocation*].

188. *Id.*

\$600 million of the \$8 billion ensured to tribes.¹⁸⁹ The remaining forty percent, which was dispersed by the Department of the Treasury in June, was distributed to pay employees working for tribes prior to the COVID-19 pandemic and to cover expenses incurred since March 2020.¹⁹⁰

C. Vaccine

The most recent example of federal assistance comes in the form of the COVID-19 vaccine, which the United States government prioritized in “Operation Warp Speed.”¹⁹¹ The IHS issued its COVID-19 vaccine plan on November 20, 2020, planning for a vaccine to become available to tribes in December 2020.¹⁹² The plan followed three phases according to CDC guidelines: during Phase One initial doses of the vaccine were to be distributed to priority populations; during Phase Two a large number of doses were to be available and distributed to the general population; and during Phase Three the IHS would develop a routine vaccination strategy once there was unrestricted access to the vaccine.¹⁹³ The IHS estimated that 2,056,347 tribal members would need a COVID-19 vaccine.¹⁹⁴ This number included 43,783 health care workers, 120,671 other essential workers, 76,311 patients in long-term care, 374,411 elders, and 894,260 other high-risk members that needed to be vaccinated during Phase One.¹⁹⁵ Phase One was scheduled to begin in mid-December with health care workers and other essential workers receiving the vaccine, as well as those that were categorized as high-risk receiving first priority to be vaccinated.¹⁹⁶

By January 2021, 15.4 million doses of the vaccine were shipped across the country, with about 68,000 going to the IHS.¹⁹⁷ The first doses delivered

189. Becenti, *supra* note 132.

190. *The CARES Act Provides Assistance for State, Local, and Tribal Governments*, U.S. DEP’T OF THE TREASURY (June 17, 2020), <https://home.treasury.gov/policy-issues/cares/state-and-local-governments>; *Hoeven: Treasury Announces Initial Allocation*, *supra* note 187.

191. INDIAN HEALTH SERV., U.S. DEP’T OF HEALTH & HUMAN SERVS., COVID-19 PANDEMIC VACCINE PLAN 15 (Nov. 2020), https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2020_Letters/Enclosure_DTLL_DUIOLL_1118_2020.pdf.

192. *Id.* at 7.

193. *Id.* at 7–8.

194. *Id.* at 12.

195. *Id.*

196. *Id.* at 11.

197. Felicia Fonseca, *Indian Health Service Plans for COVID Vaccine Distribution*, AP (Dec. 11, 2020), <https://apnews.com/article/health-coronavirus-pandemic-native-americans-808e8b21c995849aaa9ba54efe9911aa> [hereinafter Fonseca, *COVID Vaccine Distribution*].

to the Navajo Nation, one of the tribes most impacted by COVID-19, were delivered under police escort.¹⁹⁸ The Cherokee Nation Health Services' Executive Director, Dr. R. Stephen Jones, said the Service is "administering vaccinations according to the phased distribution plan and making sure [its] most vulnerable populations, including [its] health workers, speakers and elders, receive the vaccine first."¹⁹⁹ The Cherokee Nation distributed the vaccine starting the first week of January 2021.²⁰⁰

The federal government offered tribes a choice either to receive vaccines directly from the state or through the IHS.²⁰¹ Many chose to receive vaccines through the IHS because the agency offered more flexibility in distribution plans than did the state.²⁰² However, because of the extreme need and desire for rapid distribution, some tribal leaders had only one week to decide whether their tribe would receive vaccine allocations from the state or through the IHS.²⁰³ The Seattle Indian Health Board's Chief Research Officer, Abigail Echo-Hawk, expressed dismay at the choice, stating that it "limit[s] our access to life-saving vaccines. We need as much access as possible because we have been more disproportionately impacted."²⁰⁴ Meredith Raimondi, the Director of Communications at the National Council of Urban Indian Health, had similar concerns explaining that if the tribe is forced to choose one provider and that provider fails, then the tribe is left with no vaccines; she concluded "it's a gamble at this point."²⁰⁵ For tribes that elected to receive the vaccine through IHS, the

198. *Id.*

199. *Cherokee Nation Scheduling COVID-19 Vaccinations for Elders Ages 65 and Older*, TULSA WORLD (Feb. 19, 2021), https://tulsa-world.com/community/skiatook/news/ Cherokee-nation-scheduling-covid-19-vaccinations-for-elders-ages-65-and-older/article_6ddd1f92-511a-11eb-a295-5f05c0d539e0.html.

200. *Id.*

201. Sukee Bennett, *American Indians Have the Highest Covid Vaccination Rate in the US*, NOVA (July 6, 2021), <https://www.pbs.org/wgbh/nova/article/native-americans-highest-covid-vaccination-rate-us/>.

202. *Id.*

203. Kelly Cannon, *Practical Hurdles, Cultural Distrust in Native Communities Could Hamper Vaccine Distribution*, NBC NEWS (Nov. 20, 2020), <https://www.nbcnews.com/news/us-news/practical-hurdles-cultural-distrust-native-communities-could-hamper-vaccine-distribution-n1248308>.

204. Felicia Fonseca, *Indian Health Service Plans for COVID Vaccine Distribution*, AP (Dec. 11, 2020), <https://apnews.com/article/health-coronavirus-pandemic-native-americans-808e8b21e995849aaa9ba54efe9911aa> [hereinafter Fonseca, *COVID Vaccine Distribution*].

205. Cannon, *supra* note 203.

agency planned to distribute vaccines directly to I/T/U facilities based on population.²⁰⁶

By mid-April 2021, the United States had entered Phase Two, and all adults were eligible for COVID-19 vaccines.²⁰⁷ Tribal leaders worried that the large number of tribal members requiring vaccines would pose many logistical challenges for distribution, as well as a societal challenge of convincing those who need the vaccine to get it.²⁰⁸

Before the vaccines were widely available, some communities were worried that challenges in identifying who should receive the vaccine and in administering the vaccine would make mass vaccination problematic. For the Hopi Tribe, a small tribe located in rural Arizona, transportation is of great concern.²⁰⁹ Only one-third of the Hopi population has access to reliable transportation, which limits the distance residents can travel to get vaccinated.²¹⁰ Additionally, many tribal members don't have street addresses, which makes identifying people who still need the vaccine more difficult.²¹¹ Despite these logistical challenges, by the end of June 2021, the Tribe surpassed expectations and reported that over sixty percent of the Tribe was vaccinated.²¹²

Additionally, tribal leaders worried that logistical issues with administering the vaccine would be amplified by a historic tribal mistrust and vaccine hesitancy. Jonathan Nez, the president of the Navajo Nation, warned, "There is going to be pushback to this vaccine."²¹³ In addition to a widespread distrust of the rapidly approved vaccine across the United States, some tribes face additional skepticism of health care in general.²¹⁴

206. *See id.*

207. *A Timeline of COVID-19 Vaccine Developments in 2021*, THE AMERICAN JOURNAL OF MANAGED CARE (June 3, 2021), <https://www.ajmc.com/view/a-timeline-of-covid-19-vaccine-developments-in-2021>.

208. Kelly Cannon, *Practical Hurdles, Cultural Distrust in Native Communities Could Hamper Vaccine Distribution*, NBC NEWS (Nov. 20, 2020), <https://www.nbcnews.com/news/us-news/practical-hurdles-cultural-distrust-native-communities-could-hamper-vaccine-distribution-n1248308>.

209. Cannon, *supra* note 203.

210. *Id.*

211. *Id.*

212. *Hopi Tribe Reports 62 Percent Vaccination*, NAVAJO-HOPI OBSERVER (June 29, 2021), <https://www.nhnews.com/news/2021/jun/29/hopi-tribe-reports-62-percent-vaccination/>.

213. Richard Read & Kurtis Lee, *COVID-19 Is Crushing Native American Reservations. But Distrust of the Government Makes Vaccines a Hard Sell*, L.A. TIMES (Dec. 20, 2020), <https://www.latimes.com/world-nation/story/2020-12-20/native-american-coronavirus-vaccine>.

214. *Id.*

This general medical concern stems from past research abuses such as the Havasupai case.²¹⁵ There, researchers took blood samples from members of the Tribe and distributed them to other studies without the participants' consent.²¹⁶ Similarly, in the Lummi Nation case, researchers took photos of children to study fetal alcohol syndrome but then failed to offer any ways for the Tribe to address the problem; this caused a general distrust of medical researchers on the reservation.²¹⁷ These past abuses deterred many tribal members from volunteering for vaccine trials, and tribal leaders worried they would deter Native Americans from taking the vaccine once it became more widely available.

Douglas Yankton, Sr., Chairman of the Spirit Lake Reservation in North Dakota, indicated that many of the Tribe's essential workers believe the vaccine is riskier than the virus.²¹⁸ The IHS conducted a survey where, among 8,197 of its interviewed field workers, thirty-five percent said they would "definitely" or "probably" take the vaccine while fifty percent said they would "definitely" not or "probably not" take the vaccine.²¹⁹

Although some mistrust persists in Native communities, many tribes participated in vaccine trials. The Navajo Nation welcomed the Pfizer vaccine trials on their land.²²⁰ About 125 Navajo members on the reservation volunteered.²²¹ In total, about 460 Native Americans participated in the Pfizer vaccine trials.²²² Other tribes have pursued vaccine trials with manufacturers as well and are on a path toward vaccination for all members.²²³

Moreover, many tribal leaders worked to educate their members and convince them to take the vaccine. Abigail Echo-Hawk, Director of the Urban Indian Health Institute in Seattle, expressed that tribal members may be more willing than the general public to take the vaccine.²²⁴ She cited the fact that "[p]eople in the majority population make individually based

215. *Id.*

216. *Id.*

217. Felicia Fonseca, *Fast Rollout of Virus Vaccine Trials Reveals Tribal Distrust*, ABC NEWS (Jan. 4, 2021), <https://abcnews.go.com/Lifestyle/wireStory/clarification-virus-outbreak-tribes-vaccine-trials-story-75045981> [hereinafter Fonseca, *Fast Rollout*].

218. *Id.*

219. *Id.*

220. Cannon, *supra* note 203.

221. *Id.*

222. Fonseca, *Fast Rollout*, *supra* note 217.

223. *Id.*

224. Read & Lee, *supra* note 213.

choices, while our community makes community-based choices.”²²⁵ As of June 2021, Native American and Alaska Natives lead the United States in percentage of population vaccinated with nearly forty percent of the population fully vaccinated.²²⁶

The high rate of Native American and Alaska Native vaccination and the success of Native vaccination campaigns “counter[s] longstanding assumptions about vaccine hesitancy in Indigenous communities.”²²⁷ Francys Crevier, the Chief Executive Officer of the National Council of Urban Indian Health, recognized the role community played in the high rate of vaccination among Native Americans.²²⁸

III. Impact of Tribal Enterprise Closures

In recent decades, self-determination policies have allowed tribal governments to take more control over governmental responsibilities for their citizens. However, unlike typical state and local governments, tribes do not have a traditional tax base to fund programs.²²⁹ Tribal governments are dependent on income from tribal businesses such as casinos, tourism, manufacturing, and services to finance their governmental responsibilities.²³⁰ Therefore, widespread business closures and stay-at-home orders will have a disproportionate impact on tribal communities if tribal governments cannot fund necessary governmental programs such as law enforcement, public safety, and social services.²³¹

Harvard Project researchers write that, “in their efforts to lift their citizens out of decades of poverty, replenish dilapidated infrastructure, improve housing, expand health care, and the like, tribe after tribe has had to rely on enterprise earnings as a substitute for a tax base.”²³² For the Ho-

225. *Id.*

226. *Percent of People Receiving COVID-19 Vaccine by Race/Ethnicity and Date Reported to CDC*, CDC (July 11, 2021), <https://covid.cdc.gov/covid-data-tracker/index.html#vaccination-demographics-trends>.

227. Bennett, *supra* note 201.

228. *Id.*

229. Liz Mineo, *For Native Americans, COVID-19 Is ‘the Worst of Both Worlds at the Same Time’*, HARV. GAZETTE (May 8, 2020), <https://news.harvard.edu/gazette/story/2020/05/the-impact-of-covid-19-on-native-american-communities/>.

230. *Id.*

231. See Casey Lozar et al., *COVID-19: A Deep Economic Crisis in Indian Country*, FED. RSRV. BANK OF MINNEAPOLIS (May 13, 2020), <https://www.minneapolisfed.org/article/2020/covid-19-a-deep-economic-crisis-in-indian-country>.

232. Letter from Randall Akee, Rsch. Affiliate with Harvard Project on Am. Indian Econ. Dev., et al., to the Honorable Steve Mnuchin, Sec’y of the Treasury 4 (Apr. 10, 2020),

Chunk Nation, gaming makes up more than eighty percent of its annual operating budget.²³³ Unlike state and local governments, whose tax earnings may have been damaged by the economic shutdowns, tribal governments' earnings have evaporated completely, threatening basic governmental services to Native Americans.²³⁴ The Attorney General for the Forest County Potawatomi Community said the loss of gaming forced the Community to cut its government in half, furloughing sixty percent of its workers.²³⁵ In the midst of a pandemic, tribal governments must now find funds "to increase public health resources devoted to combating COVID-19, . . . enforce stay-at-home ordinances, and even monitor[] the rush of CDC and similar information."²³⁶

Tribal gaming alone channeled over \$12.5 billion into tribal government programs in 2019, and much of that revenue will be lost due to closures caused by the pandemic.²³⁷ In a survey conducted by the Center for Indian Country Development, over sixty percent of tribal enterprises anticipated large decreases in revenues.²³⁸ The National Indian Gaming Association projected tribes would lose around \$22.4 billion from gaming closures in 2020.²³⁹ In February 2021, researchers from the Wisconsin Policy Forum found that tribal gaming payments to the state dropped 81.7% after tribes were forced to close or limit capacity in their casinos.²⁴⁰

Conversely, tribal governments experienced large increases in expenses during the pandemic, meaning fewer funds were transferred to tribal governments just as tribes needed them the most.²⁴¹ The National Indian Gaming Association's Chairman, Ernest Stevens, Jr., stated that "[g]aming for the most part is what [tribes] survive on. . . . In a lot of cases, if we don't

https://ash.harvard.edu/files/ash/files/hpaied_covid_letter_to_treasury_04-10-20_vsIGNEDvfinv02.pdf?utm_medium=Email&utm_campaign=HPAIED+COVID+Recommendations&utm_source=Press.

233. Chris Hubbuch, *Tribal Governments 'Crippled' by Lost Gambling Revenue During COVID-19 Pandemic*, WIS. ST. J. (June 22, 2020), https://madison.com/wsj/business/tribal-governments-crippled-by-lost-gambling-revenue-during-covid-19-pandemic/article_67265db9-1dfa-53c4-b78c-5e462737819e.html.

234. *Id.*

235. *Id.*

236. Letter from Randall Akee, *supra* note 232, at 5.

237. *Id.* at 1–2.

238. Lozar et al., *supra* note 231.

239. Hubbuch, *supra* note 233.

240. *Pandemic Hits Casino Revenues*, WIS. POL'Y F., (Feb. 2021), <https://wispolicyforum.org/research/pandemic-hits-casino-revenues/>.

241. Lozar et al., *supra* note 231.

have gaming we don't have dollars. We don't have a tax base."²⁴² By early April 2020, tribal enterprises in the Navajo Nation had already contributed \$2.75 million to fund efforts to combat the virus.²⁴³ However, as revenues from tribal enterprises slowed, contributions to tribal governments decreased.

Tribal enterprises and tribal governments employ around 1.1 million people nationwide.²⁴⁴ Tribal gaming alone directly employs 315,000 people—both tribal members and non-members.²⁴⁵ Without income from tribal enterprises, tribes had to lay off or furlough their employees.²⁴⁶ Thus, tribal government employees risked losing their salaries and health insurance.²⁴⁷

A loss of revenue from tribal enterprises will have a multi-layered, detrimental effect on employment in many communities where unemployment and poverty rates are already much higher than the national average.²⁴⁸ As Steven Light, co-Director of the Institute for the Study of Tribal Gaming Law & Policy at the University of North Dakota, explained: "When you have those kinds of deficits in the first place and because tribal gaming is expressly intended as a matter of public policy to mitigate those problems, COVID-19 has had a disproportionately high impact on tribal communities."²⁴⁹

Although many casinos were reopening as of early 2021, they were not operating at full capacity so as to enforce social distancing measures.²⁵⁰ Many casinos placed restrictions on their patrons, such as by requiring masks or limiting the types of games available.²⁵¹ And although casinos are reopening, they cannot recover lost revenues. Jeff Crawford, Attorney General for the Forest County Potawatomi Community, expressed that "[w]e can't tax our way out of COVID-19. We can't run a budget deficit to get us out of COVID-19. We can't print money to get out of COVID-19."²⁵²

242. Hubbuch, *supra* note 233.

243. Arlyssa Becenti, *As Tribe Waits for Funds, Enterprises Pitch In*, NAVAJO TIMES (Apr. 9, 2020), <https://navajotimes.com/coronavirus-updates/as-tribe-waits-for-funds-enterprises-pitch-in/>.

244. Letter from Randall Akee, *supra* note 232, at 6.

245. *Id.* at 5.

246. *Id.* at 2.

247. *Id.*

248. *See id.* at 8.

249. Hubbuch, *supra* note 233.

250. *Id.*

251. *Id.*

252. *Id.*

Tribal nations also recognize the need for diversification of businesses as a result of the pandemic.²⁵³

The CARES Act, signed into law in March 2020, provided some relief to tribes.²⁵⁴ Tribes, like the Navajo Nation, spent the money to continue their governmental functions.²⁵⁵ They allocated funds for projects such as expanding water and food care, purchasing medical supplies, and providing hazard or special duty pay to employees.²⁵⁶ The Navajo Nation also used the CARES Act funds to expand water and electricity access to its members.²⁵⁷ The Cherokee Nation used CARES Act funds for similar governmental functions such as funding social distancing measures in schools, funding fire and police departments, and funding food banks.²⁵⁸

The Paycheck Protection Program (PPP), established through the CARES Act, stipulates that “businesses with fewer than 500 employees are eligible for federally guaranteed loans of up to \$10 million [if] the borrowers retain their full-time employees.”²⁵⁹ However, tribal gaming enterprises were not eligible for the first round of funding through this program.²⁶⁰ The PPP provides that if the business' legal gaming revenue exceeded \$1 million in 2019, or if legal gaming made up more than fifty percent of the business' total revenue in 2019, the business is ineligible for PPP funding.²⁶¹

Three tribes—the Flandreau Santee Sioux Tribe, the Santee Sioux Nation, and the Big Sandy Band of Western Mono Indians—filed suit

253. *Id.*

254. *See supra* notes 145–48 and accompanying text.

255. *See* Arlyssa Becenti, *Hardship Checks Coming Jan. 18*, NAVAJO TIMES (Jan. 7, 2021), <https://navajotimes.com/coronavirus-updates/hardship-checks-coming-jan-18/>.

256. *Id.*

257. Austin Fast, *CARES Act Funds Bring Electric, Water Upgrades to Navajo Nation*, FRONTERAS (Feb. 23, 2021), <https://fronterasdesk.org/content/1647618/cares-act-funds-bring-electric-water-upgrades-navajo-nation>.

258. *CN Announces \$332M Plan for CARES Act Funds*, CHEROKEE PHOENIX (May 29, 2020), <https://www.cherokeephoenix.org/Article/index/134768>.

259. Casey Lozar et al., *Do Lender-Access Issues Limit Paycheck Protection Program Relief for Tribal Employers?*, FED. RSRV. BANK OF MINNEAPOLIS (May 4, 2020), <https://www.minneapolisfed.org/article/2020/do-lender-access-issues-limit-paycheck-protection-program-relief-for-tribal-employers>.

260. Dawn Stover, *Oregon Tribes' Primary Engines – Casinos – Stalled by COVID-19*, INDIANZ.COM (Apr. 23, 2020), <https://www.indianz.com/IndianGaming/2020/04/23/oregon-tribes-primary-engines-casinos-st.asp>.

261. Business Loan Program Temporary Changes; Paycheck Protection Program-Additional Eligibility Criteria and Requirements for Certain Pledges of Loans, 85 Fed. Reg. 21747, 21751 (Apr. 20, 2020) (to be codified at 13 C.F.R. pt. 120).

against the federal government after casinos were excluded from the relief program.²⁶² Although casinos were eligible for the second round of funding after an update to the Paycheck Protection Program in late April 2020, PPP was available on a first-come-first-served basis, meaning applications received for the first round of funding that were not funded received first priority.²⁶³ Small tribal gaming enterprises, therefore, may still not receive the funds needed to protect their employees.

Between 1990 and 2010, per capita income of Indians on reservations grew five times faster than the income of the average American.²⁶⁴ However, there is still a sizeable gap between living conditions for Native Americans on reservations and living conditions in the rest of the United States.²⁶⁵ The average Native American household has an income of \$39,700.²⁶⁶ This figure is forty-five percent lower than that of the average American household.²⁶⁷ Tribal enterprises are a large reason per capita income for Native Americans is on the rise.²⁶⁸ Randell Akee of the Harvard Project on American Indian Economic Development wrote “the glass is only about half full, but at least it has been filling.”²⁶⁹ Researchers, however, fear that this economic development will crash to a halt in the aftermath of the pandemic.²⁷⁰

IV. Conclusion

The ongoing COVID-19 pandemic has exposed many inequities in the United States, but none, perhaps, as profound as the treatment of Native Americans and Alaska Natives. The disparate impact the pandemic has had on Native communities revealed how decades of abuse and neglect have put Native communities at a disadvantage. However, through their responses to the COVID-19 crisis, tribes have shown their resilience, determination, and commitment to their communities. Self-determination policies have allowed tribes to begin confronting some of the inequities highlighted by the

262. Acee Agoyo, *Tribes Sue Trump Administration After Being Excluded from Coronavirus Relief Program*, INDIANZ.COM (Apr. 27, 2020), <https://www.indianz.com/IndianGaming/2020/04/27/tribes-sue-trump-administration-after-be.asp>.

263. Lozar et al., *supra* note 259.

264. Letter from Randall Akee, *supra* note 232, at 3.

265. *Id.*

266. *Id.*

267. *Id.*

268. *Id.*

269. *Id.*

270. *Id.*

pandemic, but the United States needs to prioritize the expansion of tribal authority and recognize tribes as sovereign governments with responsibilities to their citizens. The federal government must provide tribes with the support they require to enable them to prepare for recovery and meet the needs of their citizens. To start, the federal government should fully fund medical care for tribal members, and it needs to prioritize Native American health, education, and poverty reduction. During the pandemic, tribes and Native communities have demonstrated their ability and willingness to dedicate their time, resources, and energy to strengthening their communities. The federal government must honor its trust obligation and give tribes the freedom and the resources to succeed.