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From the Desks of Kofi Ampaabeng, Bobbi Herzberg, and Jordan K. Lofthouse

January 31, 2022

Healthy Future Task Force Security Subcommittee
2112 Rayburn House Office Building
Washington, DC 20515

cc: Molly Brimmer
Andrew Keyes
Shane Hand

Dear Representatives Hudson, Banks, and Cole:

We are pleased to respond to the request for information (RFI) by the Healthy Future Task Force Security Subcommittee for policy recommendations focusing on pandemic preparedness, public health, supply chains, and medical independence from China. The Mercatus Center at George Mason University is dedicated to advancing knowledge relevant to current policy debates. Toward this end, its scholars conduct independent, nonpartisan analyses and propose policy solutions grounded in peer-reviewed literature. With that in mind, this comment does not represent the views of any affected party or special interest group.

The subcommittee is seeking feedback on several policy issues under three focus areas. We concentrate on two policy options under the public health focus area:

- Bolstering Americans' confidence in public health institutions (question 15 in the RFI)
- Improving the quality of healthcare services to Native Americans (question 19 in the RFI)

Bolstering Americans' Confidence in Public Health Institutions
The management of public health during the pandemic has been controversial at best, and lawmakers should review and draw lessons from the public health decision-making process that has operated during the public health emergency, especially regarding nonpharmaceutical interventions (NPIs) such as lockdowns, mask mandates, vaccine mandates, and eviction moratoria. Conducting a review and implementing the lessons of such review into future emergency response plans would help build trust between Americans and their public health officials.

In response to an RFI by the Republican Study Committee, Mercatus scholars made four recommendations to improve public health. This response is attached, and we summarize the recommendations here. Generally, Congress should review laws that permit public health agencies to impose certain restrictions. Specifically, Congress should do the following:

- Conduct a full cost-benefit or cost-effectiveness analysis of NPIs recommended and implemented during the COVID-19 pandemic, taking into account individual autonomy and method sustainability in the analysis, as officials do in Sweden.
- Use the laboratory of federalism to catalog pandemic policies according to their effectiveness and net benefit. Such a catalog could provide a starting point for future public health crises. A broad set of experts should contribute to the creation of the catalog, making special note of past policy failures so that future policymakers do not repeat those mistakes.
- Examine how the federal response to the COVID-19 pandemic has altered the power balance between federal, state, and local public health policymakers. Doing so would allow Congress to consider how any such alteration affects the future development of effective, robust, and resilient public health policies.
- Review section 361 of the Public Health Service Act of 1944, which grants broad powers to health agencies to take necessary actions during a public health emergency, with the aim of narrowing the scope of actions agencies can take.

Improving Quality of Healthcare Services to Native Americans

Native Americans have long experienced higher rates of health problems than the general American population and other racial and ethnic minority groups. In addition, Native Americans have been disproportionately affected by COVID-19 in part because of poorer underlying health conditions, which are risk factors for COVID-19 mortality. The contributors to Native American health outcomes are complex and multifaceted. Two of the leading contributors to Native American health problems are pervasive poverty and shortcomings within the Indian Health Service (IHS). In a series of recently released policy briefs (see attached),[1] one of us (Lofthouse) discusses these problems and proposes solutions to address them. The main problems discussed in the briefs are (a) inadequate funding for the IHS, (b) managerial inefficiencies within the IHS, and (c) broader institutional inefficiencies that impede economic growth for Native Americans living on reservations.

Our recommendations range from small-scale policy changes to large-scale institutional changes that could rearrange governance structures in ways that improve the IHS and the broader institutions that affect Native American economic growth. We make three main recommendations for improving the health outcomes for Native Americans:

- Increase funding to the IHS.
- Increase accountability within the IHS.
- Remove institutional barriers to economic growth on Native American reservations.

Increase funding to the IHS. The IHS, which is charged with improving the health of Native Americans, has been chronically underfunded since its creation in 1955. For example, the Government Accountability Office (GAO) reports that, in 2017, per capita spending for the 1.6 million Native Americans eligible for service from the IHS was $4,078, compared with $8,109 for

1. Jordan K. Lofthouse, "Improving Accountability and Performance in the Indian Health Service" (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, January 2022); Jordan K. Lofthouse, "Increasing Funding for the Indian Health Service to Improve Native American Health Outcomes" (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, January 2022); Jordan K. Lofthouse, "Reducing Poverty to Improve Native American Health Outcomes" (Mercatus Policy Brief, Mercatus Center at George Mason University, Arlington, VA, January 2022).

Medicaid beneficiaries.[2] Although the IHS is the payer of last resort, per capita expenditures that are half those of Medicaid and the Federal Bureau of Prisons are unlikely to yield good outcomes.[3]

Unlike many other federal healthcare programs such as Medicare and Medicaid, the IHS is funded mainly through discretionary appropriations. In 2020, Congress appropriated $6 billion to the IHS. These funds were used for both clinical services to the eligible population and maintenance of IHS facilities. These appropriated funds have been insufficient. As a result, the IHS experiences significant staffing shortages, lack of equipment for on-site services, and long wait times, among other problems.[4]

The amount appropriated to the IHS is determined by base funding (from prior years) with adjustments for inflation and population increase. Congress should reset the base funding to, at a minimum, ensure parity with Medicaid in per capita terms. In addition, as it has done for the US Department of Veterans Affairs, which provides healthcare to veterans through the Veterans Health Administration, Congress can grant the IHS advance appropriation authority, which would make funds available to the IHS at the beginning of the fiscal year to prevent funding lapses. As the Congressional Research Service notes, the IHS has received its regular appropriation at the start of the fiscal year only once in the past 25 years.[5] This means that the IHS has very often been subjected to funding constraints caused by delay in appropriations via continuing resolutions. Funding via continuing resolutions imposes significant constraints on the activities of the IHS and its ability to adequately provide healthcare to Native Americans.

Increase accountability within the IHS. The GAO and the US Department of Health and Human Services Office of Inspector General have documented several managerial shortcomings at the IHS. As one of us (Lofthouse) notes, the IHS has long-standing issues with mismanagement that go beyond ordinary bureaucratic inefficiencies[6]—the healthcare services have been substandard, and staff do not adequately follow administrative policies. An increase in funding without robust measures of accountability or improved organizational structures could lead to boondoggles, continued substandard healthcare quality, or other unintended consequences. Although the IHS has established a new strategic plan, the Quality Framework, the Accountability Dashboard for Quality, and a new credentialing system in recent years to improve access, quality, and management within the agency, Congress should institute measures that would improve the accountability within the IHS and ensure compliance with existing regulations.

One way to improve accountability in the IHS is to reform institutional structures so that they better align the incentives of the officials, doctors, and other employees with the desired outcomes. Incentives to improve accountability might include a system of rewards for good performance or rewards for discovery of innovations. What good performance means, what constitutes an innovation, or what a system of rewards involves depends on context. Because IHS employees have local and tacit knowledge about the institutional details and incentives of the agency, they have the best knowledge about how to align incentives for the desired outcomes. Therefore, any potential reforms should include consultation with IHS employees at every level so that reforms incorporate knowledge of the people they are meant to help.

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2. Government Accountability Office, "Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs" (report no. GAO-19-74R, Government Accountability Office, Washington, DC, December 10, 2018).
3. Government Accountability Office, "Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs" (report no. GAO-17-379, Government Accountability Office, Washington, DC, June 2017).
4. Lofthouse, "Increasing Funding."
5. Elayne J. Heisler and Kate P. McClanahan, "Advance Appropriations for the Indian Health Service: Issues and Options for Congress" (report no. R46265, Congressional Research Service, Washington, DC, March 11, 2020).
6. Lofthouse, "Improving Accountability and Performance."

Remove institutional barriers to economic growth. The third policy option is more complex and would require sustained effort. Chronic poverty among Native Americans can be attributed to lack of sustained economic growth within reservations. Economic development is heavily dependent on formal and informal institutions, such as legislation, regulations, social norms, and civic groups. When institutions, both formal and informal, facilitate entrepreneurship and innovation, a society can experience unimpeded economic growth. However, if a society's institutions hamper exchange and entrepreneurship, that society will experience relatively slow economic growth and poverty. There is a well-established direct relationship between poverty and poor health outcomes. Long-term solutions to Native American health problems must include institutional reforms that ensure economic growth.

The federal government's legal relationship with tribes means that many institutions are similar across most, if not all, tribes. Three important institutional channels impede entrepreneurship and economic development on many reservations: the federal land trust, a dual federal-tribal bureaucracy, and legal and political uncertainty. Those three channels make it more difficult for people to engage in mutually beneficial exchange, to become entrepreneurs, and to discover innovations. Such barriers hamper economic growth, thereby leaving people poorer than they would be otherwise.[7]

Federal policymakers can improve governance institutions by streamlining the policies governing how trust land can be sold, leased, or developed. In addition, federal officials can remove unnecessary red tape that affects Native American economic life. Finally, federal officials can reform laws and regulations to mitigate the uncertainty and complexity regarding taxation schemes, judicial jurisdiction, incorporation codes, and access to capital markets.

Conclusion

In this comment, we propose actions Congress could take to ensure that public health is more effectively managed during pandemics and to improve health outcomes for Native Americans. Concerning public health, Congress should conduct a full review of the cost-effectiveness of NPI recommendations; consider how the federal response to the pandemic has altered the balance of power between federal, state, and local policymakers; and assess the comparative effectiveness of the various state policy responses to the pandemic. In addition, Congress should review laws that give broad powers to agencies to regulate public health.

Concerning Native American health outcomes, the funding for the IHS should be increased to match expenditure on other similar programs, and the IHS should also be granted advanced appropriation authority. In addition, Congress should improve accountability within the IHS management to ensure quality care for Native Americans. Finally, the long-term improvements to Native American health require economic growth, which reduces poverty. We recommend that Congress review and streamline policies that govern the federal land trust and reform regulations that contribute to complexity and uncertainty.

7. Lofthouse, "Reducing Poverty."

Sincerely,

Kofi Ampaabeng

Bobbi Herzberg

Jordan K. Lofthouse

Attachments (4)
"Healthcare Quality, Insurance Coverage, Pandemic Policy, and Competition: Four Areas for Reform" (Response to Questions for the Record)
"Increasing Funding for the Indian Health Service to Improve Native American Health Outcomes" (Mercatus Policy Brief)
"Improving Accountability and Performance in the Indian Health Service" (Mercatus Policy Brief)
"Reducing Poverty to Improve Native American Health Outcomes" (Mercatus Policy Brief)

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From the Desk of Kofi Ampaabeng, Bobbi Herzberg, and Elise Amez-Droz

January 7, 2022

RSC Health Care Task Force
Republican Study Committee
1725 Longworth House
Washington, DC 20515

Chair Banks and members of the Republican Study Committee:

We are pleased to respond to the request by the Republican Study Committee (RSC) for policy recommendations to contribute to the Health Care Freedom Commitment to America initiative. The Mercatus Center at George Mason University is dedicated to advancing knowledge relevant to current policy debates. Toward this end, its scholars conduct independent, nonpartisan analyses and propose policy solutions grounded in peer-reviewed literature. With that in mind, this comment does not represent the views of any affected party or special interest group.

The RSC is seeking input on several policy areas. We focus on four: expanding insurance coverage options, ensuring access to quality care and portable insurance, reforming public health policy in the wake of the COVID-19 pandemic, and increasing competition in healthcare. Key to our approach to healthcare reform is the promotion of individual agency in the provision and delivery of healthcare and in the creation of public health laws. Our assumption, grounded in economic theory, is that people make more informed choices when they control more of their healthcare dollars and that the market responds accordingly by delivering better value. We further assume that public health is best safeguarded when the people who are subjected to and benefited by public health laws all have a voice in the policymaking process, because decentralization and individual agency promote general welfare. Finally, we assume that physicians can take care of patients better when not faced with heavy paperwork requirements or barriers to reimbursement for hospital services. On the basis of these assumptions, we propose practical policy solutions to empower patients, physicians, and interdisciplinary experts to transform healthcare.

Expand Insurance Coverage Options

Since the Great Depression, healthcare in the United States has been financed mainly through private or public health insurance. However, there are other ways of financing healthcare, including direct primary care (DPC), association health plans (AHPs), and healthcare sharing ministries (HCSMs), which continue to grow in popularity despite unfavorable treatment by regulations. Nevertheless, the dominance of health insurance means that policy reforms are often centered on it to the detriment of other means of financing healthcare. The use of insurance to finance healthcare creates moral hazard well recognized by scholars. This hazard, which involves overuse of care caused by the third-party payment, has led policymakers to consider alternative

funding arrangements, such as consumer-directed healthcare, that give consumers more control over their healthcare decisions.

One of the most common tools of consumer-directed healthcare is the combination of health savings accounts (HSAs) with high-deductible health plans. However, many restrictions limit the consumer empowerment that this combination was intended to deliver. For example, HSAs, which were introduced in 2003 as part of the Medicare Prescription Drug, Improvement, and Modernization Act, cannot be used to pay for the fees or premiums of a DPC, AHP, or HCSM plan. Congress can rectify the unfavorable treatment of alternative healthcare financing arrangements by including them as eligible HSA medical expenses.

Since their introduction, HSAs have been very popular among Americans to fund their medical expenses. We expect that, as more Americans gain more control over their healthcare expenses, providers will respond by offering competitively priced, quality services. According to a 2021 survey of employers by the Plan Sponsor Council of America (PSCA), 58 percent of employees who have the option to enroll in an HSA choose to do so. After the introduction of HSAs, it soon became evident that the annual contribution limits—initially set at $2,600 for an individual and $5,150 for a family[1]—were too low to allow Americans to accumulate sufficient funds. President George W. Bush proposed laws to increase the contribution limits and remove other restrictions but was ultimately unsuccessful.[2]

For HSAs to have a meaningful effect on healthcare spending and use, more Americans must have access to them, and Americans must be allowed to contribute more to accumulate sufficient funds to cover future expenses, especially during years when they spend little on healthcare. A 65-year-old American couple retiring in 2022 will need $300,000 to finance medical expenses during retirement, and accumulating that amount in an HSA takes many couples at least 25 years.[3]

We propose three specific policies to increase and improve the use of HSAs:

- Expand the list of eligible healthcare expenses.
- Allow more people to open HSAs.
- Encourage Americans to accumulate more funds in their HSAs.

Expand the list of eligible healthcare expenses. The IRS determines what expenses can be financed by an HSA. These expenses do not include premiums, whether for private insurance plans, Medicare plans, or noninsurance health plans such as DPC, AHPs, HCSMs, and short-term limited-duration insurance (STLDI) plans. Expanding the list of qualified expenses to cover both premiums for health plans and STLDIs would enhance the appeal of HSAs.

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[1] Internal Revenue Service, "Internal Revenue Bulletin" (Bulletin no. 2004-2, Internal Revenue Service, Washington, DC, January 12, 2004).
[2] Michael F. Cannon, "Health Savings Accounts: Do the Critics Have a Point?" (Policy Analysis no. 569, Cato Institute, Washington, DC, May 30, 2006).
[3] This result assumes that the couple "contributes the maximum, withdraws 50% each year to pay for current qualified medical expenses, but leaves the remaining 50 percent invested, also earning an average 7% return." Fidelity Investments, "Fidelity's 20th Annual Retiree Health Care Cost Estimate Hits New High: A Couple Retiring Today Will Need $300,000 to Cover Medical Expenses, an 88% Increase since 2002," press release, May 7, 2021, https://sponsor.fidelity.com/bin-public/06_PSW_Website/documents/Cost_of_healthcare-in_ret_Fidelity_2021_RHCCE_NR.pdf.

Recent history has shown that legislatively expanding the list of qualified expenses is possible. For example, the Coronavirus Aid, Relief, and Economic Security (CARES) Act expanded qualified HSA expenses temporarily to include menstrual care products and over-the-counter drugs.[4] Congress could go further and add expenses for health-enhancing activities such as gym memberships, exercise equipment, and wellness programs. The research is clear that physical activity has long-term health benefits, which would lead to lower healthcare spending, all other things equal.[5]

If and when Congress instructs the IRS to expand the list of HSA-eligible expenses, it should also limit the regulatory burden that may arise from those expansions. Healthcare is already one of the most regulated industries. Paperwork requirements arising from the Social Security Act, Patient Protection and Affordable Care Act (PPACA), Employee Retirement Income Security Act, Health Insurance Portability and Accountability Act, Health Information Technology for Economic and Clinical Health Act, and many other acts of Congress now cause doctors and other providers to spend over half of their working hours filing paperwork instead of treating patients.

A growing number of doctors are choosing to exit the (public and private) insurance system and open DPC clinics, a new healthcare model that eliminates insurance and regulatory paperwork. Patients of DPC practices get extensive access to their doctors for a monthly fee of usually well below $100.[6] They enjoy discounted labs and wholesale-priced drugs, and physicians can take care of their patients instead of focusing on paperwork. This model relies entirely on the fact that no third-party payers are involved. Although it would be desirable for patients to be able to use their HSAs to pay for DPC memberships, visits, labs, and drugs, the introduction of regulations governing what types of DPC-related expenses are eligible for HSA expensing risks compromising the model's effectiveness. For instance, the IRS proposed a rule in 2020 that would have classified DPC as insurance, which would have opened the door to the regulation of DPC as an insurance product, instead of as a service. The IRS did so even though 32 states have enacted legislation defining DPC as a medical service and not an insurance product. Additionally, the proposed rule would have explicitly banned people who benefit from a DPC membership from having an HSA: "An individual generally is not eligible to contribute to an HSA if that individual is covered by a direct primary care arrangement."[7] Congress can and should ensure that the IRS does not regulate DPC as an insurance product and ban DPC patients from having an HSA.

The risk is also great when the Centers for Medicare and Medicaid Services (CMS) seeks to copy the model. It did so in 2018, when it issued a request for information to try to implement a DPC model within Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[8] The potential problem is like what can readily be observed with the Supplemental Nutrition Assistance Program (SNAP). Stores that accept SNAP as payment are subject to regulations by the Food and Nutrition Service that make stores undergo a complex application process and abide by extensive program integrity rules. If DPC doctors were to accept Medicaid, Medicare, and CHIP

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[4] Coronavirus Aid, Relief, and Economic Security Act, H.R. 748, 177th Cong. (2020).
[5] Miriam Reiner et al., "Long-Term Health Benefits of Physical Activity—a Systematic Review of Longitudinal Studies," *BMC Public Health* 13, no. 1 (December 2013): 813; Darren E. R. Warburton, Crystal Whitney Nicol, and Shannon S. D. Bredin, "Health Benefits of Physical Activity: The Evidence," *Canadian Medical Association Journal* 174, no. 6 (2006): 801–9.
[6] Gina Roberts-Grey, "What Is Direct Primary Care? A Patient's Guide to DPC," GoodRx, May 19, 2020, https://www.goodrx.com/insurance/health-insurance/direct-primary-care.
[7] Internal Revenue Service, Certain Medical Care Arrangements, 85 Fed. Reg. 35398 (June 10, 2020).
[8] Centers for Medicare and Medicaid Services, "Direct Provider Contracting Models—Request for Information," updated January 4, 2022, https://innovation.cms.gov/innovation-models/direct-provider-contracting.

beneficiaries, they would risk being subject to the paperwork they sought to escape by setting up their clinic.

Allow more Americans to open HSAs. HSAs were intended to be available to all Americans for any medical expense.[9] However, HSAs as implemented include several restrictions that persist to this day. Currently, HSAs are available only to people who are enrolled in high-deductible health plans and do not meet some other requirements.[10] Congress's intent in creating HSAs was to allow people who faced high out-of-pocket costs to save up for those costs. But given the growth of healthcare costs, most Americans face high out-of-pocket costs, even if they are not enrolled in high-deductible plans. That group includes traditional Medicare beneficiaries, whose coinsurance is 20 percent of the price of the services they incur, and many Medicare Advantage beneficiaries, who often owe copays for services.

Congress should allow any willing American to fund and use an HSA to pay for healthcare-related expenses. Young people, especially, would benefit from a lifelong accumulation of healthcare funds through HSAs, and Congress should allow and encourage young people to open and actively fund HSAs. Current laws allow young adults ages 18–26 to be covered by their parents' health insurance, but they cannot have HSAs, even though they can use their parents' HSAs to fund eligible medical expenses. Young people should be allowed to accumulate funds in their HSAs, especially because their healthcare expenses tend to be low.

Encourage Americans to accumulate more funds in their HSAs. Currently, individuals fund their HSAs through pretax deductions and contributions from employers through cafeteria plans. Annual contribution limits apply regardless of the funding source. Federal law allows the IRS to adjust the annual contribution limits of HSAs to account for inflation. Therefore, the current HSA contribution limits of $3,650 for individuals and $7,300 for families for the year 2022 largely reflect cost-of-living adjustments since 2004, when the original limits were determined. After two decades of existence, the benefits of HSAs are clear, and, as scholars have noted, the success of HSAs depend partially on the annual contribution limits set by the IRS.[11]

To help Americans accumulate more funds in their HSAs, Congress could increase the annual contribution limits or set the limit as the larger of current limits and a percentage of adjusted gross income.[12]

In addition to raising the limits, Congress could allow other contribution sources for HSAs. For example, whereas surviving spouses can inherit HSAs without incurring any tax penalties, children cannot. Given that the intent of HSAs is to save for current and future medical expenses, the tax benefits should be able to be passed on to children. Another potential source of funding for HSAs is unspent Flexible Savings Account (FSA) balances. Currently, unspent FSA balances are forfeited if not used for qualified expenses within 15 months. The CARES Act temporarily allows such funds to roll over into the following year. Congress could build on this provision by allowing unspent FSA balances to roll over into HSAs.

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[9] PeopleKeep Team, "History of Health Savings Accounts—MSAs to HSAs," accessed January 4, 2022, https://www.peoplekeep.com/blog/bid/143476/history-of-health-savings-accounts-msas-to-hsas.
[10] Internal Revenue Service, "Health Savings Accounts and Other Tax-Favored Health Plans" (publication no. 969, Internal Revenue Service, Washington, DC, February 11, 2021).
[11] Juergen Jung and Chung Tran, "The Macroeconomics of Health Savings Accounts" (CAEPR Working Paper no. 2007-023, Center for Applied Economics and Policy Research, Bloomington, IN, April 11, 2008).
[12] "Definition of Adjusted Gross Income," Internal Revenue Service, last updated December 10, 2021, https://www.irs.gov/e-file-providers/definition-of-adjusted-gross-income.

Ensure Access to Quality Care and Portable Insurance

Access to quality care is not inherently dependent on access to insurance coverage, as demonstrated by the example of DPC. But disruptions in coverage can lead to unpredictable costs and exposure to bankruptcy risk. Disruptions are more likely to occur among working-age people and their families, the majority of whom are in an employer-sponsored insurance plan. The most straightforward way of ensuring portability of coverage is to dissociate health insurance from employment, which is currently beyond the realm of the politically feasible. Thus, we propose the legislation of recent executive rules on STLDI plans, which allow Americans on employer-sponsored plans to remain privately insured between jobs.

Before the PPACA and subsequent regulations severely curtailed STLDI plans, Americans used these plans to remain insured between jobs and avoid a health insurance coverage gap. Although employees can continue coverage from a previous employer under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the premium tends to be high. In 2021, for example, the average annual premium for continuation of coverage was $5,969 for individuals and $22,221 for families.[13] According to one study, only 23 percent of COBRA-eligible employees take advantage of coverage continuation.[14] The rest choose to use STLDI plans, Medicaid, or they remain uninsured. All states except California, Massachusetts, New Jersey, and New York allow the sale of STLDI plans, and some states limit either the term or the duration of STLDI plans.[15]

Recognizing these challenges, the Trump administration implemented rules to allow individuals to purchase STLDI plans for a term of up to 12 months and renew over the following 36 months. Before that, coverage under STLDI plans was limited to three months and not renewable.[16] Congress should enact the rule in statute to minimize the uncertainty that comes from frequent rule changes. In addition, Congress could also allow HSAs to cover premiums for STLDI plans, as they allow with COBRA premiums.[17]

Reform Public Health, Especially in Light of the Successes and Failures of the Response to COVID-19

Decision-making during a pandemic represents one of the most difficult situations for policymakers and politicians, but it is one of the most important situations to get right. Doing so means acting quickly with the best scientific evidence available but still recognizing that constituent values and interests vary. Although public health professionals are knowledgeable, their values may not match those of society generally,[18] and their recommendations during a pandemic should therefore be evaluated in a larger context. COVID-19 brought to the fore the ingenuity of scientists, as seen in the rapid development of tests, vaccines, and various effective treatments. However, managing public health during the pandemic has proven controversial. The

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[13] Gary Claxton et al., "Health Benefits In 2021: Employer Programs Evolving in Response to the COVID-19 Pandemic," *Health Affairs* 40, no. 12 (2021): 1961–71.
[14] Ryan J. Rosso, "Health Insurance Continuation Coverage Under COBRA" (report no. R40142, Congressional Research Service, Washington, DC, updated August 13, 2021), 16.
[15] Dania Palanker, Maanasa Kona, and Emily Curran, *States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans* (Washington, DC: Commonwealth Fund, 2019), 17.
[16] Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38212 (August 3, 2018).
[17] Internal Revenue Service, "Health Savings Accounts and Other Tax-Favored Health Plans."
[18] This mismatch may be the result of both framing effects and ideological imbalance. L. J. Leininger and Harold Pollack, "Opinion: We're Public Health Experts. We Need to Do a Better Job of Talking to Conservatives," *Washington Post*, October 12, 2020; Elizabeth A. DeVilbiss et al., "Assessing Representation and Perceived Inclusion among Members of the Society for Epidemiologic Research," *American Journal of Epidemiology* 189, no. 10 (2020): 998–1010.

pandemic focused a spotlight on the public health profession's normal ways of making science-led policy, and it is critical that society examines what worked and what failed, especially given the new broad-based use of nonpharmaceutical interventions (NPIs) such as lockdowns, mask mandates, etc.

The effects of NPIs stretch well beyond health to every facet of life—economic, social, and political. As society reviews the effectiveness of COVID-19 policies, it is critical that decision makers incorporate input from all stakeholders, not simply public health experts. There is a long tradition of scholarship examining the failures associated with reliance on narrow experts in forming policy, including F. A. Hayek's work on knowledge and socialist planning and Roger Koppl's more recent work.[19]

The GRADE and DECIDE frameworks used in public health incorporate other voices,[20] but they are so skewed toward public health expertise that they do not balance the various interests of the members of a democratic society. Politicians can achieve better balance of interests by consulting other members, but only if those members are not dismissed as unscientific or nonexpert. They simply reflect other expertise and perspectives.

Some recent public health work incorporates outside perspectives and expertise. For example, Karin Gulbrandsson, Nils Stenstöm, and Regina Winzer, in a 2016 study in Sweden, adapt the DECIDE framework to include individual autonomy and method sustainability as specific Swedish values of importance. This could explain why Sweden has taken a different route than virtually every other country with the COVID-19 pandemic. Public health officials incorporated Swedish values into the policy framework to improve its application in their community. A similar approach that recognizes additional values is critical for the US context.[21]

Given the limited information that policymakers have, it is critical that, when creating new policy, they continually evaluate the policy's effects and introduce corrective measures. This is what happens naturally in a federalist system, where individual states learn from each other but also reflect the specific knowledge they have of their own constituencies. America should be using this diversity to determine best policies and not get caught in political battles over federal consolidation. Recognizing which aspects of public health are best addressed at the national level (for example, vaccine development) and which are best addressed at the state or local levels (for example, most NPIs) will permit less costly solutions.

Before the next pandemic, America should develop a policy process that takes into account broad input from many areas, especially those outside healthcare. Such a process would permit policymakers to move quickly in the face of the next crisis, without as many accusations of partisanship or calls for one type of expertise to be considered to the exclusion of all others. If NPIs are to be a viable part of public health strategy, then the type of experts required to make such policy must include economists, business leaders, educators, religious leaders, and others.

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[19] F. A. Hayek, "The Use of Knowledge in Society," *American Economic Review* 35, no. 4 (1945): 519–30; Roger Koppl, *Expert Failure* (Cambridge, UK: Cambridge University Press, 2018).

[20] GRADE = Grading of Recommendations, Assessment, Development, and Evaluations; DECIDE = Define, Extrapolate, Consider, Incorporate, Develop, and Evaluate.

[21] Karin Guldbrandsson, Nils Stenström, Regina Winzer, "The DECIDE Evidence to Recommendation Framework Adapted to the Public Health Field in Sweden," *Health Promotion International* 31, no. 4 (2016): 749–54.

It is important that Congress reviews the various laws that permit public health agencies to impose certain restrictions. Specifically, we recommend that Congress do the following:

- Conduct a full cost-benefit or cost-effectiveness analysis of the NPIs recommended during the COVID-19 pandemic. Take into account individual autonomy and method sustainability in the analysis, as officials do in Sweden.
- Use the laboratory of federalism to catalog pandemic policies according to their effectiveness and net benefit. Such a catalog could provide a starting point for future public health crises. A broad set of experts should contribute to the creation of the catalog, making special note of past policy failures so that future policymakers do not repeat those mistakes.
- Examine how the federal response to the COVID-19 pandemic has altered the balance between federal, state, and local public health policymakers. Doing so would allow Congress to consider how any such alteration affects the future development of effective, robust, and resilient public health policies.
- Review section 361 of the Public Health Services Act of 1944, which grants broad powers to health agencies to take necessary actions during a public health emergency, with the aim of narrowing the scope of actions agencies can take.

Increase Competition in the Healthcare Industry

The growth of healthcare regulations in recent decades has made the healthcare industry less competitive by increasing the cost of compliance, hindering entrepreneurship, and fostering consolidation. But in some cases, Congress has acted directly to reduce competition in the sector. One particularly egregious example is section 6001 of the PPACA, which prevents new hospitals owned by physicians from receiving reimbursements from Medicare.

Congress started implementing restrictions on physician-owned hospitals (POHs) in 1992 under pressure from the hospital industry, which claimed that doctors' simultaneous owning and operating of hospitals represents a conflict of interest. The restrictions on POHs came to a head in 2010, when CMS forbade new and existing POHs from participating in Medicare. Medicare beneficiaries represent almost a fifth of all American patients, effectively making the restriction a ban on POHs. Indeed, there are just 200 POHs in the country (compared with 6,000 nonprofit and investor-owned hospitals), the same number as when the ban came into effect.[22] A new peer-reviewed study reviewing over 30 years of research finds that the quality of POHs is equivalent to other hospitals—and superior in some cases. Physician-owned community hospitals have similar costs and quality of care as nonprofit and for-profit community hospitals. Specialty POHs—i.e., hospitals that focus on certain medical specialties, such as cardiology or orthopedic surgery—have higher quality and lower or similar costs.[23] Restrictions on POHs are restrictions on private enterprise and innovation by physicians, stifling the efforts and ideas of some of the brightest and best-educated Americans. For these reasons, Congress should consider allowing POHs to participate in Medicare, like they did in the past.

Conclusion

In this comment, we propose policy solutions in four areas. First, we offer ways to expand insurance coverage options by changing the rules on HSAs to ensure that more Americans can use them for current healthcare expenses while also accumulating funds for future use. We propose

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[22] Brian J. Miller and Jesse Ehrenfeld, "Covid-19 Has Revealed the Hazards of Blocking Physician-Owned Hospitals," *STAT*, September 30, 2021.

[23] Ted Cho et al., *Cost and Quality of Care in Physician-Owned Hospitals: A Systematic Review* (Arlington, VA: Mercatus Center at George Mason University, 2021), 23.

the relaxation of current restrictions on HSAs and other cafeteria spending plans to allow Americans to spend their tax-advantaged funds on other innovative payment mechanisms. In suggesting those relaxations, we stress the caution that Congress should take to avoid creating policies that increase the already extensive involvement of the government in healthcare decisions. To forestall such an occurrence, laws by Congress should communicate their intent clearly to rulemaking agencies. Second, we explain that portability issues arise from employer-sponsored insurance but acknowledge that, in the short term, an overhaul of the employer-sponsored system would be challenging. We therefore suggest that, in lieu of such an overhaul, Congress prioritize the legislation of executive actions that have expanded access to STLDI plans. Third, we go on to point out that the creation and implementation of public health policy requires the involvement of many types of experts, not only public health experts, and we offer recommendations for diversifying the voices that influence public health laws. And fourth, noting the complex reasons underlying the lack of competition in today's healthcare system, we highlight a particularly egregious law that bans POHs from participating in Medicare and suggest that Congress overturn that law.

Sincerely,

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POLICY BRIEF

Increasing Funding for the Indian Health Service to Improve Native American Health Outcomes

Jordan K. Lofthouse

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For many decades, Native Americans have experienced higher rates of health problems than the general American population and other racial minority groups.[1] Today, the average Native American dies five and a half years sooner than the average American.[2] In the recent past, Native Americans have suffered disproportionately from the COVID-19 pandemic. During the first year of the COVID-19 pandemic, Native Americans faced the highest rates of infection, hospitalization, and death due to COVID-19 when compared with any other race or ethnicity in the United States.[3]

At least two important causes are behind the poorer health outcomes that Native Americans experience. First, the Indian Health Service (IHS), a healthcare system funded and managed by the federal government, has struggled chronically with underfunding and bureaucratic shortcomings. Second, the pervasive poverty that many Native Americans experience has contributed to poor health outcomes. Institutions that raise transaction costs of economic development and innovation perpetuate poverty, contributing to worse health outcomes.

Improving Native American health will require both immediate, small-scale policy changes and long-term, large-scale institutional reforms. In terms of small-scale policy changes, Congress could increase funding for the IHS, which is an immediate and practical solution for delivering more healthcare to more individuals. However, increasing IHS funding will not solve the underlying management problems in the IHS or the institutional problems contributing to widespread poverty. This brief focuses on the shortest-term solution—increasing IHS funding. Other briefs in this series tackle larger, longer-term changes to IHS management and reforms to broader governance institutions on reservations.

UNDERFUNDING IN THE IHS

The roughly 70-year history of the IHS has been characterized by significant resource constraints. Many scholars have argued that the IHS is severely underfunded, and some believe that the IHS receives only half of what it needs to provide adequate service.[4] Since the federal government became involved in Native American healthcare, it has allocated smaller proportions of money per capita to the IHS than any other federally funded healthcare program.[5] Medicare, Medicaid, the Veterans Health Administration (VHA), and federal prisons receive two to three times as much federal funding per person. The Government Accountability Office (GAO) finds that in 2017, IHS per capita spending was $4,078, as compared with $8,109 for Medicaid, $10,692 for the VHA, $13,185 for Medicare, and $8,600 for federal prisoners.[6]

Compared with other federal direct providers (e.g., the VHA) or public insurers (e.g., Medicare and Medicaid), the IHS spends much less annually and serves a much smaller number of individuals. In 2017, the IHS spent a total of $6.68 billion, which represents less than 10 percent of the VHA's spending and roughly 1 percent of spending by either Medicare or Medicaid. Also in 2017, the IHS served about 1.6 million individuals, which is about one-quarter of the number of individuals that the VHA serves and less than 3 percent of the number served by Medicare or Medicaid.[7]

However, it is important to note that the IHS, the VHA, Medicare, and Medicaid significantly differ in many ways, including their design, structure, funding, population needs, and services provided. Thus, such differences make it difficult to do an accurate apples-to-apples comparison of these federal programs. Despite the difficulty in making interprogram comparisons, the widespread scholarly consensus is that the IHS is underfunded, and the continued poor health outcomes for IHS recipients support this consensus.

The IHS receives the bulk of its funding through congressional appropriations (mainly discretionary), as well as collections from reimbursement, including Medicare, Medicaid, the State Children's Health Insurance Program, the US Department of Veterans Affairs, and private insurance.[8] The IHS Division of Budget Formulation prepares and manages the annual IHS budget justification to Congress, in which it makes the case to Congress for certain budgetary allocations. For fiscal year (FY) 2021, the IHS requested $6.4 billion for all its operations.[9] Congressional appropriations to the IHS have been growing incrementally over the past few years, from $4.8 billion in FY 2016 to $6.0 billion in FY 2020.[10] IHS funds are directed to many different programs, such as facility maintenance, clinical services, and preventive health measures.[11] The IHS is the only major federal healthcare provider whose funding comes solely through regular, annual congressional appropriations.[12]

The IHS is a payer of last resort, and its facilities seek reimbursement from third-party insurers when applicable, including Medicare and Medicaid, meaning that the actual government spending per capita is somewhat higher than just IHS spending per capita. For example, roughly 23 per-

cent of Native Americans using Medicare also list the IHS as a source of coverage.[13] Calculating a straightforward number of healthcare-related government spending per Native American is difficult because multiple factors and funding sources need to be considered, but each of those factors and funding sources does not necessarily apply to all Native Americans. Despite this difficulty, IHS funding levels are especially important for the segment of the Native American population that relies solely or largely on the IHS for its healthcare.

EFFECTS OF INSUFFICIENT FUNDING

In the IHS system, less immediate health issues are often neglected due to funding shortages or the lack of staff or equipment for on-site services, leading to relatively long wait times for routine healthcare services and gaps in ancillary services. The IHS has chronically struggled to provide adequate services in a timely manner, especially in poor, rural areas. Additionally, staffing vacancies and aging infrastructure and equipment have increased the wait times in many IHS facilities. In a 2005 GAO study of 13 randomly selected IHS facilities, four facilities reported that patients routinely had to wait more than a month for some types of primary care. In some cases, wait times in the IHS ranged from two to six months, especially for women's healthcare, general physicals, and dental care. Such long wait times exceed the standards of other federally operated healthcare systems. For example, policies in the US Department of Veterans Affairs dictate that nonurgent outpatient appointments should be completed within 30 days for eligible veterans with high priority. Within the US Department of Defense's managed care program, routine appointments should be completed in 7 days and routine specialty care appointments in 30 days.[14]

More than a decade after that 2005 study, a 2016 GAO investigation found that wait times were still long. This study found that the IHS "has not conducted any systematic, agency-wide oversight of the timeliness of primary care provided in its federally operated facilities and, as a result, cannot ensure that patients have access to timely primary care," which does not comply with federal internal control standards.[15] Despite ongoing problems, IHS officials in various area offices have been attempting to solve the problems. In the Great Plains Area, some facilities have expanded their daily hours to 7 a.m. through 11 p.m. to better serve IHS patients. In the Phoenix Area, some IHS facilities now schedule "nursing only" visits where a doctor is not required, such as vaccinations.[16]

Mental healthcare is also in short supply. The GAO has reported that roughly one-quarter of IHS outpatient mental healthcare services do not have the capacity to meet the demand for mental healthcare. For example, managers at one facility stated that two to three times the amount of psychiatric care was needed.[17]

The GAO has also found frequent gaps in diagnosing and treating nonemergency medical conditions that cause pain or some degree of disability.[18] Thus, the agency's funding constraints have made it difficult to respond to the fluctuating needs of the population in a given year.[19]

Federal agencies, such as the Centers for Medicare and Medicaid Services, have suggested that individual Native Americans should consider getting health insurance because the IHS's funding limitations generally prohibit Native Americans from receiving all the healthcare they may need or want.[20] Like other Americans, Native Americans may purchase their own private health insurance to cover healthcare expenses that the IHS does not or cannot fund. However, owing to the combination of no-cost IHS services, high rates of poverty, and low employment rates, Native Americans lack health insurance at rates higher than national averages.[21] Approximately 36 percent of Native Americans have private health insurance coverage. Because of high rates of poverty, Medicaid covers roughly 34 percent of nonelderly Native Americans, leaving the remaining 30 percent of Native Americans to rely completely on IHS services or to pay out of pocket. For comparison, 62 percent of the overall nonelderly population in the United States has private health insurance.[22] Health insurance could provide more access to healthcare that Native Americans do not receive under the status quo in the IHS. However, the realities of poverty and unemployment cause Native Americans to face, on average, some of the largest barriers to accessing health insurance.

Similarly, financial constraints have meant that IHS facilities can provide and pay for only a limited range of services. The IHS often runs out of funding for specialty services that are contracted out within their fiscal year, leaving many patients to pay fully out of pocket, use health insurance, or go without care.[23] The IHS provides services to eligible patients at no direct out-of-pocket costs, but it is not an entitlement program, like Medicare or Medicaid, or an insurance program. When congressional funds are exhausted in a given fiscal year, the IHS must limit the services it directly provides or the services it pays for through Purchased/Referred Care (PRC) at non-IHS facilities.

If a Native American patient receives services at a non-IHS facility, there is no guarantee that the IHS will pay for any services through the PRC program. Patients must meet several requirements to have the IHS pay for PRC services, including residency requirements, notification requirements, medical priority, and use of alternate resources. Additionally, authorization to use PRC funds is allowed only when an IHS beneficiary has exhausted all other healthcare resources available, such as private insurance, state health programs, and Medicaid. Thus, many Native Americans are left with unmet healthcare needs, especially those with limited access to private insurance, Medicare, or Medicaid.[24]

The IHS must engage in healthcare rationing because it does not have enough funding to pay for all the medical needs of eligible Native Americans, meaning that IHS officials have no choice but to prioritize who receives care and what kind of treatments they will receive. Regulations and guidance for making rationing decisions can be found in the *Code of Federal Regulations*, especially title 42, sections 136.23, 136.24, and 136.61, as well as Indian Health Manual, part 2, chapter 3: manual exhibit 2-3-B. Depending on resources and local demands for care, imaging for preventable cancers such as colon, breast, and cervical cancers are not always available. Similarly, diabetic eye

exams to prevent loss of vision are rare, despite many Native American populations having some of the highest rates of type II diabetes in the world.[25]

Related to the problem of underfunding is a problem of understaffing. Across the IHS system, hospitals and health centers are having trouble retaining staff members. A 2019 *New York Times* analysis and a 2018 GAO report have found that roughly one-quarter of all medical positions within the IHS are vacant. In some locations, the vacancy rate is roughly 50 percent.[26] In recent years, IHS hospital administrators have expressed concerns about the inability to recruit and retain staff members, which leads to a dependence on temporary personnel, acting personnel, and contracted providers.

The GAO has found that IHS facilities lack enough permanent doctors or nurses to provide quality and timely healthcare. Although the IHS has taken steps to recruit and retain providers, such as offering financial incentives and housing, vacancies remain a problem. The GAO has found that the IHS cannot usually match local market salaries and does not have enough housing to meet its demand for IHS healthcare providers. Thus, the IHS has become reliant on hiring temporary providers, which can be problematic because (a) it may be more costly on some margins, and (b) it may result in lower quality patient care over time.[27]

THE BIGGER PICTURE OF REFORM

Increased funding will not solve the IHS's underlying institutional problems or other socioeconomic factors that contribute to the generally poorer health of many Native Americans. However, increased funding will likely solve some of the problems that the IHS faces, such as healthcare rationing, deteriorating physical facilities, aging medical equipment, and a shortage of trained medical staff. The question of how much funding Congress should appropriate to the IHS is difficult because policymakers must find the margin of funding that (a) reasonably allows the IHS to fulfil its legal obligations without being wasteful and (b) is democratically acceptable.

Because IHS funding comes through Congress's annual fiscal year appropriations cycle, delays in the appropriations process lead to uncertainty and disruption for the IHS's operations. To partially resolve this problem, Congress could grant the IHS advance appropriation authority. This appropriation system has already been implemented in the VHA, which is currently the only federal agency that receives advance appropriations for its healthcare program. Congress granted the VHA advance appropriation authority for specified medical care accounts in 2009.[28] If Congress were to consider granting the IHS advance appropriation authority, it could use the VHA system as a template and modify the details as necessary to fit the IHS's unique context.

Increasing the IHS's funding or changing the system of appropriations are only small steps in improving Native American health outcomes. Policymakers can set the stage for Native Americans

to flourish by increasing IHS funding, reforming IHS policies, and removing barriers to entrepreneurship and innovation.

Ultimately, policymakers can and should develop a more ideally constituted set of institutions for Native Americans that both improve the IHS and help resolve the underlying causes of poverty. The relatively low levels of funding limit preventive care for many Native Americans, who outpace other minority groups in deaths from preventable diseases. Increasing IHS funding is a practical, short-term way to deliver more healthcare to individuals. However, this recommendation should not be construed as providing an excuse to neglect tackling deeper institutional issues in the IHS or the roots of poverty.

The IHS is a highly imperfect healthcare system, and long-term solutions must focus on institutional reforms. For example, Congress and IHS policymakers could institute better mechanisms of internal accountability and communications within the IHS. Congress and IHS policymakers could also consider reducing barriers to healthcare-related innovations, such as telemedicine. Such reforms could increase the supply of healthcare to Native Americans.

At the largest scale, institutional reforms must remove barriers to innovation and entrepreneurship. Because poverty and poorer health are interrelated, improving health outcomes for Native Americans will require addressing the underlying causes of poverty, including the formal institutions on reservations that impose high costs on potential entrepreneurs.

ABOUT THE AUTHOR

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NOTES

1. Donna E. Shalala et al., *Regional Differences in Indian Health, 1998–99* (Rockville, MD: Indian Health Service, 1999); Joseph P. Kalt et al., *The State of the Native Nations: Conditions under U.S. Policies of Self-Determination* (New York: Oxford University Press, 2007); Karen Chartier and Raul Caetano, "Ethnicity and Health Disparities in Alcohol Research," *Alcohol Research & Health* 33, no. 1-2 (2010): 152–60; Indian Health Service, *Indian Health Disparities*, October 2019.
2. Indian Health Service, *Indian Health Disparities*.
3. "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity," Centers for Disease Control and Prevention, last updated November 22, 2021, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

4. Michelle Sarche and Paul Spicer, "Poverty and Health Disparities for American Indian and Alaska Native Children: Current Knowledge and Future Prospects," *Annals of the New York Academy of Sciences* 1136, no. 1 (2008): 126–36; Kalt et al., *The State of the Native Nations*, 222–24; Donald Warne and Linda B. Frizzell, "American Indian Health Policy: Historical Trends and Contemporary Issues," *American Journal of Public Health* 104, no. S3 (2014): S263–S267; Abraham B. Bergman et al., "A Political History of the Indian Health Service," *Millbrook Quarterly* 77, no. 4 (1999): 572; Thomas Sequist et al., "Trends in Quality of Care and Barriers to Improvement in the Indian Health Service," *Journal of General Internal Medicine* 26, no. 5 (2011): 480–86.
5. Warne and Frizzell, "American Indian Health Policy," S263.
6. Government Accountability Office, "Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs" (report no. GAO-19-74R, Government Accountability Office, Washington, DC, December 10, 2018); Government Accountability Office, "Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs" (report no. GAO-17-379, Government Accountability Office, Washington, DC, June 2017).
7. Government Accountability Office, "Indian Health Service: Spending Levels."
8. Congressional Research Service, "The Indian Health Service (IHS): An Overview" (report no. R43330, Congressional Research Service, Washington, DC, January 12, 2016).
9. US Department of Health and Human Services, *Indian Health Service: Justification of Estimates for Appropriations Committees*, February 5, 2020.
10. Indian Health Service, *IHS Profile*, August 2020.
11. US Department of Health and Human Services, *Indian Health Service: Justification of Estimates*.
12. Congressional Research Service, "Advance Appropriations for the Indian Health Service: Issues and Options for Congress" (report no. R46265, Congressional Research Service, Washington, DC, March 11, 2020).
13. Cristina Boccuti, Christina Swoope, and Samantha Artiga, *The Role of Medicare and the Indian Health Service for American Indians and Alaska Natives: Health, Access and Coverage* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2014).
14. Government Accountability Office, "Indian Health Service: Health Care Services Are Not Always Available to Native Americans" (report no. GAO-05-789, Government Accountability Office, Washington, DC, August 2005), 4.
15. Government Accountability Office, "Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times" (report no. GAO-16-333, Government Accountability Office, Washington, DC, March 2016), 13.
16. Government Accountability Office, "Indian Health Service: Actions Needed," 19.
17. Government Accountability Office, "Indian Health Service: Health Care Services," 18.
18. Government Accountability Office, "Indian Health Services: Health Care Services," 19.
19. Peter J. Cunningham, "Access to Care in the Indian Health Service," *Health Affairs* 12, no. 3 (1993): 224–33; Sequist et al., "Trends in Quality of Care," 480.
20. Centers for Medicare and Medicaid Services, "10 Important Facts about Indian Health Service and Health Insurance" (CMS ICN No. 909322-N, Centers for Medicare and Medicaid Services, Washington, DC, August 2016).
21. Stephen Zuckerman et al., "Health Service Access, Use, and Insurance Coverage among American Indians/Alaska Natives and Whites: What Role Does the Indian Health Service Play?," *American Journal of Public Health* 94, no. 1 (2004): 53–59.
22. Samantha Artiga, Rachel Arguello, and Philethea Duckett, *Health Coverage and Care for American Indians and Alaska Natives* (Menlo Park, CA: Henry J. Kaiser Family Foundation, 2013).
23. Donald Warne, Judith Kaur, and David Perdue, "American Indian/Alaska Native Cancer Policy: Systemic Approaches to Reducing Cancer Disparities," *Journal of Cancer Education* 27, no. S1 (2012): S18–S23

24. "For Patients, Frequently Asked Questions," Indian Health Service, accessed December 3, 2021, https://www.ihs.gov/forpatients/faq/; "Purchased/Referred Care (PRC)," Indian Health Service, accessed December 3, 2021, https://www.ihs.gov/prc/; Congressional Research Service, "The Indian Health Service (IHS): An Overview"; Indian Health Service, *Can PRC Pay for Your Referral Medical Care? Find Out in 3 Stages*, n.d., https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/PRC-ProcessHandout.pdf.

25. Sequist et al., "Trends in Quality of Care," 483.

26. Mark Walker, "Fed Up with Deaths, Native Americans Want to Run Their Own Health Care," *New York Times*, October 15, 2019; Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies" (report no. GAO-18-580, Government Accountability Office, Washington, DC, August 2018).

27. Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges"; US Department of Health and Human Services, Office of Inspector General, "Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care" (report no. OEI-06-14-00011, US Department of Health and Human Services, October 2016).

28. Congressional Research Service, "Advance Appropriations"; Government Accountability Office, "Indian Health Service: Considerations Related to Providing Advance Appropriation Authority" (report no. GAO-18-652, Government Accountability Office, Washington, DC, September 2018).

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POLICY BRIEF

Improving Accountability and Performance in the Indian Health Service

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For many decades, Native Americans have experienced higher rates of health problems than the general American population and other racial minority groups.[1] Today, the average Native American dies five and a half years sooner than the average American.[2] During the first year of the COVID-19 pandemic, Native Americans faced the highest rates of infection, hospitalization, and death due to COVID-19 when compared with any other race or ethnicity in the United States.[3]

At least two important causes are behind the poorer health outcomes that Native Americans face. First, the Indian Health Service (IHS), a healthcare system funded and managed by the federal government, has struggled chronically with underfunding and bureaucratic shortcomings. Second, the pervasive poverty that many Native Americans experience has contributed to poor health outcomes. Institutions that raise transaction costs of economic development and innovation perpetuate poverty, contributing to worse health outcomes.

Improving Native American health will require both immediate, small-scale policy changes and long-term, large-scale institutional reforms. Increasing IHS funding will likely help improve health outcomes to a degree, but more funding will not solve the underlying management problems in the IHS or the institutional problems contributing to widespread poverty.

One of the most important ways to improve Native American health outcomes is to reform the IHS to resolve many of its management problems. As currently constituted, the IHS is a highly imperfect healthcare system. Long-term solutions must focus on institutional reforms that (a) align the incentives of IHS workers with improved performance and (b) increase accountability of decision makers in the IHS.

BUREAUCRATIC SHORTCOMINGS AND MISMANAGEMENT IN THE IHS

The IHS is subject to the same kinds of inefficiencies and shortcomings that all government bureaucracies face. However, the IHS also appears to have long-standing issues with mismanagement that go beyond ordinary bureaucratic inefficiencies. Acknowledging such problems in a bureaucracy does not imply that the individuals who work in the bureaucracy are inherently unknowledgeable, nefarious, or inept.

Bureaucrats in the IHS and all other bureaucracies face incentive problems; that is, they have weak motivations to provide quality goods and services in cost-effective ways. All people respond rationally to their institutional incentives, implying that an agency's particular institutional rules are very important for eliciting "desirable" kinds of behavior. The institutional rules that govern an agency can pose problems if those rules incentivize individual bureaucrats to shirk their responsibilities, obfuscate information, or generate pessimism, among myriad other potential problems.[4]

In general, all bureaucrats, no matter the agency, face similar incentives. Unlike private firms, bureaucrats are not residual claimants, meaning that they do not personally benefit from improving quality or reducing costs. Excessive costs or subpar services do not jeopardize the existence of a government agency. Overspending does not personally affect an individual bureaucrat's take-home pay. Additionally, bureaucrats are not rewarded for responsible, prudent spending. In fact, bureaucrats may be punished for spending money more prudently because Congress is likely to shrink an agency's future budget if that agency demonstrates it can fulfill its responsibilities with less funding. Thus, individual bureaucrats in the IHS, like those in all government agencies, face perverse incentives for spending efficiently and eliminating waste.[5]

IHS employees respond rationally to the institutional incentives they face. For example, IHS hospitals and health centers are having trouble retaining staff members because the IHS cannot usually match local market salaries and does not have enough housing to meet the demand of potential IHS healthcare providers. Thus, the IHS has become reliant on hiring temporary providers, which can cause problems because (a) it may be more costly on some margins and (b) it may result in lower-quality patient care over time.[6] A 2019 *New York Times* analysis and a 2018 Government Accountability Office (GAO) report find that roughly a quarter of all medical positions in the IHS are vacant. In some locations, the vacancy rate is roughly 50 percent.[7] Whereas the IHS has taken some steps to recruit and retain providers, such as offering financial incentives and housing, vacancies remain a problem.

Because of the current institutional incentives and constraints, mismanagement and poor performance are widespread in IHS headquarters, area offices, and service units. The US Department of Health and Human Services Office of Inspector General and the GAO have identified several forms of mismanagement, such as providing substandard healthcare services and inadequately following administrative policies. In a 2019 audit, the OIG identifies three broad categories of

institutional problems in the IHS system: (a) a lack of clarity and understanding regarding the IHS's formal structure, policies, and roles; (b) a lack of information on hospital performance and problems; and (c) a lack of confidence in the IHS's ability to succeed.[8]

First, the structural problems are rooted in the lack of transparency and clarity in the hierarchy of the bureaucracy. IHS officials have said that the most common negative issue they face is "the lack of a solid organizational structure regarding management of IHS hospitals, including policies that would direct the work of IHS headquarters, area offices, and hospitals, and distinguish their respective responsibilities."[9] The obscurity and vagueness of policies and administrative structures, as well as a high turnover rate, have caused widespread confusion in the agency, leading to poor performance on multiple margins.

Second, because of this lack of clarity with structure and policy, IHS employees have said that there is no clear view about what constitutes good performance or how to go about solving problems. A lack of communication in the agency compounds the problems of the obscurity and vagueness of policies and administrative structures. Bureaucrats in the IHS headquarters often lack knowledge of what is going on in the area offices. Workers in area offices and hospitals have reported that they "received poor or incomplete information about operations, and that they did not feel that anyone in IHS HQ had a comprehensive view of Area Offices and hospitals."[10] In the audit, several IHS officials articulate a "tendency to avoid conflict and frank discussion and feedback" and acknowledge that administrative meetings "did not include practical discussions about operations and problems."[11] This combination of uncertainty and a lack of communication has caused confusion and discord at all levels regarding the IHS's goals and ability to solve problems.

Third, the persistent internal and external criticisms of the IHS have led to a widespread pessimism in the managers and the medical staff. IHS officials have openly questioned the IHS's efficacy as an agency because of "protracted bureaucratic processes; lack of a clear vision for how to meet goals; lack of trust within IHS; and lack of trust between IHS and the broader beneficiary community."[12] In the 2019 audit, several IHS officials say that "they could not recall any celebrations of success" in the agency.[13] IHS employees have said that a change in the organization's culture is necessary to overcome the widespread sense of defeatism.[14]

In addition to the administrative problems mentioned previously, hospitals and healthcare centers, run by both the IHS or tribes, have often failed to meet federal and tribal standards for health, safety, and quality, which potentially puts patients in jeopardy. Substandard healthcare services have been compounded by the underlying organizational and management problems that affect the entire IHS system.

OIG investigations find that IHS-run hospitals have a relatively high rate of patient harm. In fiscal year 2017, roughly 13 percent of patients in IHS hospitals experienced patient harm events during their stays. Smaller hospitals in the IHS system often had higher rates of harm. In IHS hospitals

with fewer than 1,000 admissions in fiscal year (FY) 2017, 19 percent of patients experienced patient harm events; in IHS hospitals with more than 1,000 admissions in FY 2017, 9 percent of patients experienced patient harm events. The OIG has found that more than half of the instances of patient harm were related to the use of medication. Pediatric patients had the lowest rate of patient harm (5 percent), whereas the highest rates were seen among elderly patients (30 percent) and patients delivering children (21 percent). The OIG has found that an estimated 7 percent of all IHS patients experienced instances of harm that could have been prevented if the patients had been given better care.[15] In reality, patient harm numbers might be significantly higher owing to missing records and other inadequacies with IHS data.

In a 2020 review, the OIG finds that 56 percent of labor and delivery patients had some aspect of care that did not follow national clinical guidelines, did not use best practices for blood-loss estimation, or both. Although postpartum hemorrhage affects only about 1 to 3 percent of births in the entire United States, 33 percent of the OIG's sample of labor and delivery patients experienced a postpartum hemorrhage.[16]

IHS hospitals do not always follow their own protocols, even with dangerous drugs. In 2019, the OIG found that IHS hospitals do not consistently follow the Indian Health Manual or other IHS policies and procedures when prescribing and dispensing opioids.[17] In particular, its review finds that many IHS hospitals do not always "review the course of patient treatment and causes of pain within required timeframes," "perform the required urine drug screenings within recommended time intervals," "review patient health records before filling a prescription from a non-IHS provider," or "maintain pain management documents to support that the provider had performed his or her responsibilities."[18]

In addition to providing substandard healthcare services and causing suffering because of organizational issues, the IHS and tribal offices have, as repeatedly found by the OIG, inadequately followed administrative policy on many margins, including hiring practices and use of funds, which have sometimes been improper or illegal. For example, in 2020 the OIG found that tribal health programs in the IHS system do not always follow established protocols for conducting background checks for people working with children. The OIG concluded that this noncompliance increased the risk that an individual with a disqualifying criminal history could have regular contact with children. The OIG is currently working with the IHS and these tribes to make plans for compliance.[19]

Illegal or noncompliant uses of funds have been found throughout the IHS system, including in federally run and tribally run entities. For example, the OIG has found that the IHS does not follow its own protocols for purchased and referred services, which can directly affect how and when patients receive services.[20] Investigations have also found the improper use or inadequate monitoring of the IHS Loan Repayment Program, which allows the IHS to pay for education loans for health professionals who join the IHS.[21] Relatedly, the IHS's travel-card and purchase-card pro-

grams also have relatively high rates of noncompliance with federal requirements and the IHS's own policies. OIG officials have concluded that purchase-card errors occur because policies for monitoring and educating cardholders are not adequate.[22] Even in some tribally administered parts of the IHS system, compliance with funding policies has been problematic. In an OIG report from 2016, inspectors find that the Rocky Boy Health Board of Montana's Chippewa Cree Indians of the Rocky Boy's Reservation had incurred and paid unallowable salary and benefit expenses using IHS money. The OIG concludes that these noncompliant payments occurred for two reasons: (a) the Rocky Boy Health Board had inadequate internal controls and (b) the Rocky Boy Health Board staff was not adequately trained in accordance with federal requirements, the tribe's policies, and the health board's policies.[23]

REFORMS TO IMPROVE ACCOUNTABILITY AND PERFORMANCE IN THE IHS

The IHS has taken steps in recent years to improve management and organizational accountability. In 2016, the IHS launched the Quality Framework, which implements telehealth consultation in some areas, and also created an Accountability Dashboard for Quality. In 2017, the IHS implemented policies to enhance recruitment and retention of staff, and in 2018, the IHS began using a new credentialing system to enhance the screening of people before they are hired. In 2019, the IHS established the Office of Quality and released the *IHS Strategic Plan FY 2019–2023*, which outlines new goals to improve access, quality, and management in the agency.[24]

It remains to be seen how effective these recent initiatives will be in improving IHS hospital quality and management. More drastic steps are likely necessary to overcome the pervasive failures in communication, accountability, and healthcare quality.

The difficult problem of public administration reform is developing new policies that are accompanied by as little waste and as few unintended consequences as possible. The fundamental problem with making or reforming policies in a complex system is that unintended consequences inevitably arise. In theory, policymakers can take steps to minimize the likelihood and magnitude of unintended consequences, but doing so requires that they be flexible and willing to make changes when a particular policy or institutional rule produces undesirable results. There is no simple solution to problems embedded in complex systems. A common pitfall for policymakers is to acknowledge that they are working with complex systems, yet still engage in simplistic, linear thinking when making decisions.[25]

Perhaps the best and most effective policy recommendation to improve the IHS is to better align the incentives of IHS employees at every level with the interests of Native Americans. The incentives that individual employees face also must align with the goals of the agency. Otherwise, individuals will not be motivated to contribute to the achievement of the agency's goals. Thus, one way to improve accountability and communication in the IHS is to reform institutional structures to better align the incentives of the officials, doctors, and other employees with the desired outcomes.

Incentives to improve accountability might include a system of rewards for good performance or rewards for discovering innovations. What good performance means, what constitutes an innovation, or what a system of rewards looks like depends on the local conditions and internal culture of the IHS. Outside observers face a problem in knowing exactly what the institutional incentives are and knowing which reward systems are likely to be effective. Because IHS employees have local and tacit knowledge about the institutional details and incentives of the agency, they have the best knowledge about how to align incentives for the desired outcomes. Therefore, any potential reforms should include consultation with IHS employees at every level so that reforms incorporate knowledge of the very people they are meant to help.

Another important policy recommendation is to focus on effective constraints so that instances of noncompliance with established standards and policies are minimized. As the OIG has already determined, employees of the IHS have disregarded administrative policies, including by improperly hiring personnel and by improperly using funds. The repeated disregard of administrative policies at various levels of the IHS is evidence that employees do not view their institutional constraints as especially binding. More stringent punishments for violations of federal and tribal policies could constrain unproductive behavior, such as hiring unqualified employees and using IHS funds in unauthorized ways.

Moving toward a system of more effective incentives and constraints would improve the effectiveness and efficiency of the IHS. No single reform will solve all the problems of the IHS, and policymakers should be wary of purported panaceas. The use of panaceas has a track record of repeated failures in various forms of governance.[26] It is difficult to improve the incentives and constraints of a complex government agency. Such reforms require trial and error to find a workable set of incentives and constraints that accommodate the differences at the various levels of the agency and in various communities. Thus, as the IHS moves forward with institutional reforms, officials at all levels require humility. Proposed reforms would require intensive, context-specific analysis and an awareness of the complexities of social life.[27]

Policymakers can and should develop a more ideally constituted set of institutions that improve the IHS's performance. The IHS bureaucratic system suffers from many shortcomings, and long-term solutions must focus on implementing better methods of internal accountability and communications in the IHS.

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NOTES

1. Donna E. Shalala et al., *Regional Differences in Indian Health: 1998–99* (Rockville, MD: Indian Health Service, 1999); Joseph P. Kalt et al., *The State of the Native Nations: Conditions under U.S. Policies of Self-Determination* (New York: Oxford University Press, 2007); Karen Chartier and Raul Caetano, "Ethnicity and Health Disparities in Alcohol Research," *Alcohol Research & Health* 33, no. 1-2 (2010): 152–60; Indian Health Service, *Indian Health Disparities*, October 2019.
2. Indian Health Service, *Indian Health Disparities*.
3. "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity," Centers for Disease Control and Prevention, last updated November 22, 2021, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.
4. *The Selected Works of Gordon Tullock*, ed. Charles Rowley, vol. 6, *Bureaucracy* (Indianapolis: Liberty Fund, 2005); James M. Buchanan, "Politics without Romance: A Sketch of Positive Public Choice Theory and Its Normative Implications," in *The Logical Foundations of Constitutional Liberty*, ed. Geoffrey Brennan, Hartmut Kliemt, and Robert D. Tollison, vol. 1, *The Collected Works of James M. Buchanan*, ed. Geoffrey Brennan, Hartmut Kliemt, and Robert D. Tollison (Indianapolis: Liberty Fund, [1979] 1999), 45–59.
5. Christopher J. Coyne, *Doing Bad by Doing Good: Why Humanitarian Action Fails* (Stanford, CA: Stanford University Press, 2013); William A. Niskanen Jr., *Bureaucracy and Representative Government* (Chicago: Aldine, Atherton, 1971).
6. Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies" (report no. GAO-18-580, Government Accountability Office, Washington, DC, August 15, 2018); US Department of Health and Human Services, Office of Inspector General, "Indian Health Service Hospitals: Longstanding Challenges Warrant Focused Attention to Support Quality Care" (report no. OEI-06-14-00011, US Department of Health and Human Services, Washington, DC, October 2016).
7. Mark Walker, "Fed Up with Deaths, Native Americans Want to Run Their Own Health Care," *New York Times*, October 15, 2019; Government Accountability Office, "Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies."
8. US Department of Health and Human Services, Office of Inspector General, "Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals" (report no. OEI-06-16-00390, US Department of Health and Human Services, Washington, DC, August 2019).
9. US Department of Health and Human Services, Office of Inspector General, "Organizational Challenges," 11.
10. US Department of Health and Human Services, Office of Inspector General, 15.
11. US Department of Health and Human Services, Office of Inspector General, 16.
12. US Department of Health and Human Services, Office of Inspector General, 19.
13. US Department of Health and Human Services, Office of Inspector General, 20.
14. US Department of Health and Human Services, Office of Inspector General, 20.

15. US Department of Health and Human Services, Office of Inspector General, "Incidence of Adverse Events in Indian Health Service Hospitals" (report no. OEI-06-17-00530, US Department of Health and Human Services, Washington, DC, December 2020).

16. US Department of Health and Human Services, Office of Inspector General, "Instances of IHS Labor and Delivery Care Not Following National Clinical Guidelines or Best Practices" (report no. OEI-06-19-00190, US Department of Health and Human Services, Washington, DC, December 2020).

17. "Indian Health Manual," Indian Health Services, accessed December 20, 2021, https://www.ihs.gov/ihm/pc/.

18. US Department of Health and Human Services, Office of Inspector General, "IHS Needs to Improve Oversight of Its Hospitals' Opioid Prescribing and Dispensing Practices and Consider Centralizing Its Information Technology Function" (report no. A-18-17-11400, US Department of Health and Human Services, Washington, DC, July 2019), 11.

19. US Department of Health and Human Services, Office of Inspector General, "Tribal Health Programs: Concerns about Background Verifications for Staff Working with Indian Children" (report no. A-01-20-01500, US Department of Health and Human Services, Washington, DC, August 28, 2020).

20. US Department of Health and Human Services, Office of Inspector General, "Most Indian Health Service Purchased/Referred Care Program Claims Were Not Reviewed, Approved, and Paid in Accordance with Federal Requirements" (report no. A-03-16-03002, US Department of Health and Human Services, Washington, DC, April 2020); Government Accountability Office, "Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs" (report no. GAO-19-74R, Government Accountability Office, Washington, DC, December 10, 2018).

21. US Department of Health and Human Services, Office of Inspector General, "Audit of the Indian Health Service's Internal Controls over Monitoring of Recipients' Compliance with Requirements of the Loan Repayment Program" (report no. A-09-10-01005, US Department of Health and Human Services, Washington, DC, December 2010).

22. US Department of Health and Human Services, Office of Inspector General, "The Indian Health Service's Controls Were Not Effective in Ensuring That Its Travel Card Program Complied with Federal Requirements and Its Own Policy" (report no. A-07-16-05091, US Department of Health and Human Services, Washington, DC, April 2018).

23. US Department of Health and Human Services, Office of Inspector General, "Expenses Incurred by the Rocky Boy Health Board Were Not Always Allowable or Adequately Supported" (report no. A-07-15-0422, US Department of Health and Human Services, Washington, DC, March 2016).

24. US Department of Health and Human Services, Office of Inspector General, "Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals" (report no. OEI-06-16-00390, US Department of Health and Human Services, Washington DC, August 2019).

25. Coyne, *Doing Bad by Doing Good*, 147–65.

26. Elinor Ostrom, Marco A. Janssen, and John M. Anderies, "Going Beyond Panaceas," *Proceedings of the National Academy of Sciences* 104, no. 39 (September 2007): 15176–78.

27. Stefanie Haeffele and Anne Hobson, eds., *The Need for Humility in Policymaking: Lessons from Regulatory Policy* (Lanham, MD: Rowman & Littlefield International, 2019).

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POLICY BRIEF

Reducing Poverty to Improve Native American Health Outcomes

Jordan K. Lofthouse

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For many decades, Native Americans have experienced higher rates of health problems than the general American population and other racial minority groups.[1] Today, the average Native American dies five and a half years sooner than the average American.[2] During the first year of the COVID-19 pandemic, Native Americans faced the highest rates of infection, hospitalization, and death due to COVID-19 when compared with any other race or ethnicity in the United States.[3]

At least two important causes are behind the poorer health outcomes that Native Americans experience. First, the Indian Health Service (IHS), a healthcare system funded and managed by the federal government, has struggled chronically with underfunding and bureaucratic shortcomings. Second, the pervasive poverty that many Native Americans experience has contributed to poor health outcomes. Institutions that raise transaction costs of economic development and innovation perpetuate poverty, contributing to worse health outcomes.

Improving Native American health will require both immediate, small-scale policy changes and long-term, large-scale institutional reforms. In terms of small-scale policy changes, Congress could increase funding for the IHS, which is an immediate and practical solution for delivering more healthcare to more individuals. However, increasing IHS funding will not solve the underlying management problems in the IHS or the institutional problems contributing to widespread poverty. This brief focuses on long-term, large-scale changes to the governance institutions on reservations that contribute to poverty. Other briefs in this series tackle the smaller, more immediate changes to IHS policies and performance.

Perhaps the most important policy reforms are those that remove barriers to entrepreneurship and economic growth. Through alleviation of poverty and increased economic growth, health outcomes for Native Americans are likely to improve, even without other institutional changes to the IHS.

ECONOMIC GROWTH AS A REMEDY FOR HEALTH PROBLEMS

Scholars have identified a relationship between poverty and poor health outcomes.[4] Economic growth appears to improve health outcomes because people with more wealth are likely to have better nutrition and more access to healthcare providers. Additionally, economic growth increases the number of resources for governments to put toward public health services and complementary goods and services for healthcare, such as improved transportation infrastructure.[5] Conversely, improved health outcomes seem to improve economic growth because healthier people are more productive and accumulate more human capital.[6]

INSTITUTIONAL BARRIERS TO ECONOMIC GROWTH ON RESERVATIONS

Many Native American reservations are islands of poverty within the United States. Despite decades of federal and tribal initiatives, economic development and health outcomes on reservations have consistently lagged behind other places in the United States.[7] Removing barriers to economic growth and alleviating poverty will likely result in a healthier Native American population.

Economic development is heavily dependent on formal and informal institutions, which are the rules of the game according to which human action takes place. Formal institutions, such as legislation and regulations, directly affect the way that economic development takes place. Informal institutions, such as social norms and civic groups, also influence how economic action unfolds. When institutions, both formal and informal, facilitate entrepreneurship and innovation, a society can experience economic growth and higher standards of living over time. However, if a society's institutions hamper exchange and entrepreneurship, that society will experience relatively slow economic growth and, in the worst cases, economic decline.

Scholars and policymakers have pointed to several formal and informal institutions that have contributed to poverty on many reservations.[8] This institutionally caused poverty inhibits reservation residents from successfully coping with both chronic medical problems and new problems such as pandemics.

Because tribes have some autonomy and self-governance under the federal government's self-determination policies, formal institutions can and do vary from reservation to reservation. However, the federal government's legal relationship with tribes means that many institutions are similar across most, if not all, tribes. At least three institutional channels impede entrepreneurship

and economic development on many reservations. These three channels make it more difficult for people to engage in mutually beneficial exchange, become entrepreneurs, and discover new innovations:[9]

- Property rights and the federal land trust
- Dual federal–tribal bureaucracy
- Legal and political uncertainty

In the following subsections, we give a brief overview of these three channels, but this discussion is not exhaustive. Many complex issues contribute to poverty on Native American lands, and the three channels discussed here are only some of those issues.

Property Rights and the Federal Land Trust

Economists largely agree that well-defined and well-enforced private property rights are a prerequisite for sustained economic growth. However, the federal trust system makes on-reservation property rights more ill defined and convoluted than those elsewhere. The trust system, started in the late 19th century, allows the federal government to hold in trust the title for parcels of land owned by a tribal government or by individual Native Americans.

The complexity of property rights under the modern federal land trust means that Native Americans face higher transaction costs for buying, selling, renting, or using property. Therefore, they also face higher costs of engaging in entrepreneurship and private enterprise, which limits economic growth.

Trust land is subject to various constraints over alienation, leasing, and encumbrance. Individual Native Americans and tribal governments who own land held in trust cannot sell their land without the express permission of the Bureau of Indian Affairs (BIA). In addition to permitting the sale of trust land, BIA officials must grant permission to change land uses, make capital improvements, or lease trust lands, which can be a time-consuming process.

Another barrier posed by the trust system is the difficulty of using land as loan collateral. Many banks choose not to lend to individuals or tribal governments with trust land because it is unlikely that banks can repossess the land in the event of a default, which subsequently restricts access to capital markets that are necessary for private enterprise.[10]

Furthermore, the bureaucratic oversight of trust lands imposes significant costs on reservation residents through red tape that does not apply to nonreservation private property. For example, trust lands owned by individuals are subject to federal environmental regulations because trust land has a similar legal status to other federal land, such as national parks and national forests. The BIA must apply the provisions of the National Environmental Policy Act (NEPA), the Archaeo-

logical Resources Protection Act, and other federal laws and regulations.[11] Compliance with these laws and regulations increases the time and monetary costs of engaging in economic enterprises, even if those enterprises are small. The environmental assessments and environmental impact statements required under NEPA can be a time-consuming and financially expensive process for those who are least equipped to cope with such costs.

In addition to bureaucratic issues and compliance costs, fractionation is another major issue affecting trust lands. Fractionation occurs when many individuals co-own a parcel of land. Under the land trust, these individuals own a percentage share of the land instead of a distinct area. Today, hundreds or thousands of people may co-own the same parcel of land, which creates difficulty in using the land because the co-owners must agree on whether to use the land or to sell or lease it. Across the United States, approximately 100,000 fractionated tracts of land are owned by more than 243,000 landowners.[12] Fractionation is a significant barrier to entrepreneurial activity because it raises the transaction costs of using trust land, especially leasing the land for any kind of economic development.

The federal trust system is a proverbial double-edged sword. One of the current goals of the federal government is to bring more land into the trust, and the trust system is generally popular with Native Americans. Over the course of American history, tribes have lost the vast majority of their homeland and their sovereignty, but the federal land trust essentially allows tribes and individual Native Americans to "keep Indian lands in Indian hands."[13] Bringing more land into the trust is an understandable goal, especially because Native Americans lost tens of millions of acres that were originally set aside for them in the mid- to late-1800s. Over the past several decades, millions of acres have been returned to the trust system, allowing tribes to regain some of the land that was lost. Despite the desire to "keep Indian lands in Indian hands," the federal trust system has significant tradeoffs that must be considered. Thus, a trust system that promotes socially beneficial entrepreneurship, as opposed to inhibiting that goal, will require major policy reforms that make it much less costly for individuals and tribes to use, sell, or lease trust land and the associated natural resources. If the BIA and tribal agencies do not remove costly red tape, entrepreneurship and innovation are likely to remain low, leading to slow rates of economic growth.

Dual Federal–Tribal Bureaucracy

The complex relationship between tribal bureaucracies and federal bureaucracies is often ill defined and convoluted. Nominally, the federal government and tribes have a government-to-government relationship, but the federal agencies have the power to create public policies, even if the policies go against tribal leaders' wishes. Therefore, both federal and tribal bureaucracies have broad discretion to oversee and regulate economic enterprises directly as well as through more indirect means. Sometimes, these two sets of bureaucracies do not agree on public policies, and there can be tension and even contradictions between the policies. Thus, the federal–tribal

relationship has led to a unique form of public administration that sometimes leads to socially unproductive features, such as negative forms of political entrepreneurship, erosion of the rule of law, and impediments to private enterprise.[14]

On reservations, both federal officials in many agencies and tribal officials have the power to oversee how land is used, what type of labor is allowed, which types of businesses are allowed, who receives government allocations of money, how business is regulated, and so on. Because two independently functioning bureaucracies can make public policies on the same topic, reservation residents face relatively large amounts of bureaucratic red tape that increase the costs of engaging in market enterprises, entrepreneurship, and innovation.

One additional complicating factor is that tribal governments function as both firms and governments. Many tribes run business ventures, including tourism, gaming, energy, agriculture, forestry, manufacturing, and telecommunications, while they also have the coercive powers of government to tax, legislate, and regulate.[15] These tribally owned businesess are often some of the largest employers on reservations. Additionally, tribally owned businesses are often the largest source of revenues for tribal governments because reservations have a limited tax base and grants from the federal government are scarce.

Although tribally owned businesses provide many benefits to the members of these tribes, the mixture of government and business often leads to unintended consequences. In many cases, the policymakers who run the business are the same people as or have direct connections to the people who regulate economic activity on reservations. Maintaining the separation between day-to-day business decisions and tribal politics is often difficult for tribal officials because enterprises are overseen or influenced by elected officials and bureaucrats. Thus, on some reservations, the institutional arrangements do not provide for a distinct separation between day-to-day business decisions and tribal politics, leading to an environment with a high potential for rent-seeking and corruption. In the case of many tribal enterprises, a culture of rent-seeking has emerged where political leaders, who are simultaneously business leaders, discover and exploit opportunities that enrich themselves at the expense of their constituents.[16] Despite some problems, many tribes have succeeded in creating governance institutions that effectively separate business management from political decisions.[17] To improve economic development, tribal governments can focus on reforming the governance institutions to insulate tribal businesses from direct and indirect political influences.

Legal and Political Uncertainty

Owing to the unique structure of formal institutions on reservations, legal and political uncertainty has been one of the greatest barriers to economic development. This uncertainty is also related to the complexity of understanding how property rights work on reservations and navigating the labyrinth of tribal and federal policies created by the dual bureaucracies. Uncertainty and com-

plexity regarding taxation schemes, judicial jurisdiction, incorporation codes, and access to capital markets create barriers to potential Native American entrepreneurs as well as to off-reservation entrepreneurs who wish to enter reservation markets.[18] Thus, the complexity of Native American governance systems creates confusion and uncertainty for people who may want to do business on a reservation and, in turn, creates significant barriers to economic development. Potential entrepreneurs may be uncertain about how government actions will affect their decisions, and this uncertainty hampers the ability of entrepreneurs to engage in socially beneficial actions that create wealth on reservations.

A tribal government's ownership of a business can also lead to uncertainty in some cases. Owing to the common-law sovereign-immunity doctrine, tribes are immune from suit unless Congress gives authorization. Sovereign immunity is not limited to just a tribal government proper; courts have extended such immunity to entities that are directly related to tribes, such as tribally owned businesses, even if the businesses' operations take place off the reservation. Off-reservation entrepreneurs or potential entrepreneurs may be hesitant to engage in economic enterprises directly with tribes or tribally owned businesses because they may not be able to bring a suit if a contract is breached. It is often uncertain who can be sued if a tribal entity violates a contract and which court has jurisdiction. Such uncertainty is a large disincentive to engaging in economically beneficial action.[19]

However, tribal leaders can choose to waive immunity on a case-by-case basis, or they can choose to negotiate limited waivers. In recent years, many tribal officials have chosen to waive immunity from suit for business purposes of enforcement of commercial contracts or leases. Waiving immunity can be controversial. Some tribal government leaders are hesitant to waive immunity because they see it as an abandonment of the progress made in securing sovereign status. By contrast, other officials see the ability to waive immunity, either limited or in full, as the full expression of tribal sovereignty and self-determination. By partially or fully waiving immunity, tribal leaders can signal that they are trustworthy and reliable to engage in economic activity. Off-reservation entrepreneurs and investors have historically been hesitant to use tribal courts because they did not perceive the courts as impartial. However, many tribes have successfully reached commercial agreements by innovatively using neutral arbitration provisions. For example, when entering into these provisions, each party selects a party arbitrator, and the party arbitrators select a third neutral arbitrator to adjudicate.[20] If tribal officials want to increase mutually beneficial exchanges with off-reservation businesses, they should consider the use of immunity waivers and arbitration agreements.

INSTITUTIONAL REFORMS TO AID ECONOMIC GROWTH

Institutional problems demand institutional solutions. Although reservations face institutional barriers to entrepreneurship and economic growth, many tribal and federal leaders are aware

of the problems. Tribal and federal officials across the United States have enacted institutional reforms and new policies to facilitate economic growth, with many successes. Tribal leaders can learn from one another and experiment with their own policies based on the experiences of other tribes. Federal officials can facilitate this mutual learning and experimentation by giving tribes the freedom and resources necessary to devise reforms that are tailored to their unique contexts.

Many tribal governments have shown that they are willing and capable of reforming their institutions to facilitate economic development. For example, several tribal governments have successfully streamlined legal processes, provided resources for tribal members to more easily navigate complex legal institutions, and provided tribal members easier access to capital markets.[21] Tribal officials can learn from these successes, and they can consider other reforms that will reduce barriers to entrepreneurship and economic growth. Some of the more important reforms might include updating the policies for the use of tribal trust land, insulating tribal businesses from direct and indirect political influences, and expanding the use of immunity waivers and arbitration agreements. If more tribal policymakers work to reform problematic institutions to promote socially productive entrepreneurship, reservations would likely experience higher rates of economic growth and lower rates of poverty. Resolving the problem of chronic poverty may help make Native American populations more robust against current and future health crises.

Like their tribal counterparts, federal policymakers have been making some institutional reforms, such as fixing the worst parts of the fractionation problem.[22] Before the 1990s, leasing fractionated trust land required the co-owners' unanimous consent.[23] Over the past 30 years, however, Congress has partially addressed the problem of fractionation by passing the American Indian Agricultural Resource Management Act of 1993 (AIARMA), the Indian Land Consolidation Act Amendments of 2000 (ILCA Amendments), and the American Indian Probate Reform Act of 2004 (AIPRA). The AIARMA and the ILCA Amendments changed the requirements of unanimous consent so that owners of fractionated land could more easily lease their land. In many cases, owners of fractionated land can make decisions with just a simple majority, but some cases still require 90 percent of owners to agree. The AIPRA has helped limit new fractionation through federally assisted estate planning so that further splintering does not occur when a landowner passes away without a will. Despite marginal improvements through these three acts, owners of fractionated trust land still face relatively high transaction costs.[24]

Further federal-level reforms are necessary to reduce economic barriers, facilitate economic growth, and reduce poverty. For example, simplifying the processes and regulations for using, selling, or leasing trust land would reduce the transaction costs facing individual tribal members and tribal governments. Removing or reducing other forms of red tape would more easily allow both individual entrepreneurs and tribal businesses to have more opportunities for economic success. Without continuing the reforms that lower transaction costs, Native Americans are likely to remain impoverished and suffer from higher rates of health problems.

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NOTES

1. Donna E. Shalala et al., *Regional Differences in Indian Health, 1998–99* (Rockville, MD: Indian Health Service, 1999); Joseph P. Kalt et al., *The State of the Native Nations: Conditions under U.S. Policies of Self-Determination* (New York: Oxford University Press, 2007); Karen Chartier and Raul Caetano, "Ethnicity and Health Disparities in Alcohol Research," *Alcohol Research & Health* 33, no. 1-2 (2010): 152–60; Indian Health Service, *Indian Health Disparities*, October 2019.
2. Indian Health Service, *Indian Health Disparities*.
3. "Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity," Centers for Disease Control and Prevention, last updated November 22, 2021, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.
4. Adam Wagstaff, "Poverty and Health Sector Inequalities," *Bulletin of the World Health Organization* 80, no. 2 (2002): 97–105; Gopal K. Singh and Mohammad Siahpush, "Widening Socioeconomic Inequalities in US Life Expectancy, 1980–2000," *International Journal of Epidemiology* 35, no. 4 (2006): 969–79; David R. Williams et al., "Race, Socioeconomic Status, and Health: Complexities, Ongoing Challenges, and Research Opportunities," *Annals of the New York Academy of Sciences* 1186 (2010): 69–101; Gary Bloch, Linda Rozmovits, and Broden Giambrone, "Barriers to Primary Care Responsiveness to Poverty as a Risk Factor for Health," *BMC Family Practice* 12, no. 1 (2011): 62.
5. Simon Lange and Sebastian Vollmer, "The Effect of Economic Development on Population Health: A Review of the Empirical Evidence," *British Medical Bulletin* 121, no. 1 (2017): 47–60.
6. Alok Bhargava et al., "Modeling the Effects of Health on Economic Growth," *Journal of Health Economics* 20, no. 3 (2001): 423–40; David N. Well, "Accounting for the Effect of Health on Economic Growth," *Quarterly Journal of Economics* 122, no. 3 (2007): 1265–306.
7. Rachel L. Mathers, "The Failure of State-Led Economic Development on American Indian Reservations," *Independent Review* 17, no. 1 (2012): 65–80.
8. Fred S. McChesney, "Government as Definer of Property Rights: Indian Lands, Ethnic Externalities, and Bureaucratic Budgets," *Journal of Legal Studies* 19, no. 2 (1990): 297–335; Stephen Cornell and Joseph P. Kalt, "Successful Economic Development and Heterogeneity of Government Form on American Indian Reservations" (report no. PRS-95-4, Harvard Project on American Economic Development, Harvard University, Cambridge, MA, March 1995); Terry L. Anderson and Dominic P. Parker, "Sovereignty, Credible Commitments, and Economic Prosperity on American Indian Reservations," *Journal of Law and Economics* 51, no. 4 (2008): 641–66; Terry L. Anderson and Dominic P. Parker, "Economic Development Lessons from and for North American Indian Economies," *Australian Journal of Agricultural and Resource Economics* 53, no. 1 (2009): 105–27; Shawn E. Regan and Terry L. Anderson, "The Energy Wealth of Indian Nations," *LSU Journal of Energy Law and Resources* 3, no. 1 (2014): 195–223; Jordan K. Lofthouse, "Institutions and Economic Development on Native American Lands," *Independent Review* 24, no. 2 (2019): 227–48; Jordan K. Lofthouse, "Liberty versus Bureaucracy on Native American Lands," *Journal of Private Enterprise* 34, no. 1 (2019): 87–101.
9. Lofthouse, "Institutions and Economic Development."
10. Anderson and Parker, "Economic Development Lessons"; Anderson and Parker, "Sovereignty, Credible Commitments"; Lofthouse, "Institutions and Economic Development."

11. Bureau of Indian Affairs, "Indian Affairs National Environmental Policy Act (NEPA) Guidebook" (document no. 59 IAM 3-H, Bureau of Indian Affairs, Washington, DC, August 2012); Bureau of Indian Affairs, "Indian Affairs Manual" (document no. 59 IAM 8, Bureau of Indian Affairs, Washington, DC, October 16, 2012), https://www.bia.gov/sites/bia.gov/files/assets/public/raca/manual/pdf/idc-024939.pdf.

12. "Fractionation," US Department of the Interior, accessed December 3, 2021, https://www.doi.gov/buybackprogram/fractionation.

13. Indian Land Tenure Foundation (website), accessed December 3, 2021, https://iltf.org/.

14. Lofthouse, "Institutions and Economic Development"; Lofthouse, "Liberty versus Bureaucracy."

15. Karen J. Atkinson and Kathleen M. Nilles, *Tribal Business Structure Handbook* (Washington, DC: Office of Indian Energy and Economic Development, 2008).

16. Jordan K. Lofthouse, "Culture and Native American Economic Development," *Journal of Entrepreneurship and Public Policy* 9, no. 1 (2020): 21–39; Seung G. Choi and Virgil H. Storr, "A Culture of Rent Seeking," *Public Choice* 181, no. 1 (2019): 101–26.

17. Miriam Jorgensen and Jonathan B. Taylor, "What Determines Indian Economic Success? Evidence from Tribal and Individual Indian Enterprises" (report no. PRS 003, Harvard Project on American Indian Economic Development, Cambridge, MA, June 2000).

18. Lofthouse, "Institutions and Economic Development"; Lofthouse, "Liberty versus Bureaucracy."

19. Lofthouse, "Institutions and Economic Development"; Lofthouse, "Culture and Native American Economic Development."

20. Harvard Project on American Indian Economic Development, *On Improving Tribal-Corporate Relations in the Mining Sector: A White Paper on Strategies for Both sides of the Table* (Cambridge, MA: Harvard University, 2014).

21. One helpful source of information regarding new and innovative tribal programs is the Harvard Project on American Indian Economic Development. The project keeps a list of tribal programs and practices that it identifies as improving tribal governance. Harvard Project on American Indian Economic Development, *Honoring Nations: Directory of Honored Programs, 1998–2018* (Cambridge, MA: Harvard University, 2018).

22. Michael A. Heller, "The Tragedy of the Anticommons: Property in the Transition from Marx to Market," *Harvard Law Review* 111, no. 3 (1998): 621–88.

23. Lofthouse, "Institutions and Economic Development"; Jessica A. Shoemaker, "No Sticks in My Bundle: Rethinking the Indian Land Tenure Problem," *Kansas Law Review* 63, no. 2 (2015): 383–450.

24. Shoemaker, "No Sticks in My Bundle"; Diane K. Lautt, "The American Indian Probate Reform Act: A Five-Year Review," *Washburn Law Journal* 51, no. 1 (2011): 105–30; Jacob Russ and Thomas Stratmann, "Missing Sticks: Property Institutions and Income Dissipation in Indian Country" (GMU Working Paper in Economics No. 15-22, George Mason University, Fairfax, VA, December 2014).