



Public Health Law

Office for State, Tribal, Local and Territorial Support
Centers for Disease Control and Prevention

Tribal Epidemiology Centers Designated as Public Health Authorities Under the Health Insurance Portability and Accountability Act

In 2010, Congress enacted the Patient Protection and Affordable Care Act (ACA),¹ which permanently reauthorized the Indian Health Care Improvement Act (IHCIA).² Originally passed in 1976 and subsequently amended, IHCIA declares that “it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”³ IHCIA established the legal and programmatic structure for providing health services to American Indian and Alaska Native populations (AI/AN).⁴

IHCIA’s 2010 reauthorization included a provision designating tribal epidemiology centers (TECs) as public health authorities under the Health Insurance Portability and Accountability Act (HIPAA) and authorizing TEC access to data held by the US Department of Health and Human Services (HHS).⁵ This issue brief describes TECs and explains the impact of their designation as public health authorities under HIPAA.

About Tribal Epidemiology Centers

IHCIA’s 1992 amendments authorized the establishment of TECs to serve each Indian Health Service region.⁶ TECs perform a variety of functions “[i]n consultation with and on the request of Indian tribes, tribal organizations, and urban Indian organizations” to elevate the health status of tribal and urban Indian communities, including

1. Collecting and monitoring data on the health status objectives of the Indian Health Service, Indian tribes, tribal organizations, and urban Indian organizations;

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

25 U.S.C.A. § 1602



2. Evaluating delivery and data systems that impact Indian health;
3. Assisting tribes, tribal organizations, and urban Indian organizations to determine health status objectives and services needed to meet those objectives;
4. Making recommendations of services to assist Indian communities;
5. Making recommendations to improve Indian healthcare delivery systems;
6. Providing technical assistance to tribes, tribal organizations, and urban Indian organizations to develop local health priorities and disease incidence and prevalence rates; and
7. Providing disease surveillance and promoting public health.⁷

Access to AI/AN public health data is a continuing issue facing TECs, yet is essential towards the successful performance of these functions. To secure AI/AN health data, TECs often collaborate with other jurisdictions, including state, local, and federal agencies.⁸ Data-sharing agreements make some of these data requests possible.⁹ However, state and local jurisdictions do not always have data-sharing agreements with TECs, which can create delay. Further, some jurisdictions require fees to acquire the data.¹⁰

An additional issue affecting TECs is their difficulty securing relevant data, fostered by concern from state and local jurisdictions and private entities about release of identifiable health data,¹¹ as well as by state laws limiting access to certain health data.¹²

Tribal Epidemiology Centers (TECs)



There are 12 TECs located throughout the United States. For a list, visit the [Indian Health Service website](#). Map Credit: [Indian Health Service](#)

IHCIA Reauthorization of 2010

IHCIA's 2010 reauthorization included provisions to facilitate TEC data access, including designating TECs as public health authorities under HIPAA and authorizing TEC access to HHS data.

TEC Designation as Public Health Authorities Under HIPAA

IHCIA's reauthorization designated TECs as public health authorities for the purposes of HIPAA.¹³ Per IHCIA, "[a]n epidemiology center . . . shall be treated as a public health authority . . . for purposes of the Health Insurance Portability and Accountability Act."¹⁴ Public health authorities are defined as

[A]n agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.¹⁵

Under HIPAA, health information is defined as any information that

- (A) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.¹⁶

"Individually identifiable" health information is considered protected under HIPAA's Privacy Rule.¹⁷ Covered entities, such as health plans, healthcare clearinghouses, and certain healthcare providers, must comply with the Privacy Rule.¹⁸

The Privacy Rule authorizes public health authorities' access to protected health information "for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions."¹⁹

As public health authorities under IHCIA's reauthorization, TECs now have access to this protected health information. However, the Council of State and Territorial Epidemiologists has found that state law as well as misinterpretation of the HIPAA Privacy rule by covered entities can still prevent or limit a TEC's ability to access relevant data:

Seeking to adhere to the Rule, covered entities may mistakenly refuse to share [protected health information] with public health authorities despite the Rule's allowance for the sharing of such information. Some covered entities use the Rule as a shield to reject requests for [protected health information] from public health authorities, even if they have typically provided such data in the past before implementation of the Rule.²⁰

Additionally, state privacy laws often establish additional rules for protected health information, thus creating another barrier for TECs in accessing data.²¹

TECs and HHS

In addition to designating TECs as public health authorities, IHCA allows TECs access to data held by the secretary of HHS. IHCA states that the secretary “shall grant to each epidemiology center . . . access to use of the data, data sets, monitoring systems, delivery systems, and other protected health information in the possession of the Secretary.”²² It also directs the director of the Centers for Disease Control and Prevention (CDC) to provide technical assistance to TECs in performing the functions outlined in ICHIA.²³

Conclusion

Access to quality public health data remains a priority for TECs and the AI/AN populations they serve. For additional information on TECs and data quality and access issues, visit—

- [Best Practices in American Indian & Alaska Native Public Health: A Report from Tribal Epidemiology Centers 2013.](#)
- James G. Hodge, Jr., Torrey Kaufman, and Craig Jacques, [Legal Issues Concerning Identifiable Health Data Sharing Between State/Local Public Health Authorities and Tribal Epidemiology Centers in Selected US Jurisdictions](#), COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS (Nov. 8, 2011).

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¹ The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010).

² 25 U.S.C. §§ 1601-1683.

³ Indian Health Amendments of 1992, Pub. L. No. 102-573, §§ 101, 106 Stat. 4526 (1992) (codified at 25 U.S.C. §§ 1601 et seq.).

⁴ *Id.*

⁵ 25 U.S.C.A § 1621m(e)(1).

⁶ Pub. L. No. 102-573, 106 Stat. 4526 § 214(a)(1).

⁷ 25 U.S.C.A. § 1621m(b).

⁸ *Best Practices in American Indian & Alaska Native Public Health: A Report From Tribal Epidemiology Centers 2013*, 125, available at http://itcaonline.com/wp-content/uploads/2014/03/TEC_Best_Practices_Book_2013.pdf.

⁹ *Id.*

¹⁰ *Id.*

¹¹James G. Hodge, Jr., Torrey Kaufman, and Craig Jacques, *Legal Issues Concerning Identifiable Health Data Sharing Between State/Local Public Health Authorities and Tribal Epidemiology Centers in Selected US Jurisdictions*, COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, 1 (Nov. 8, 2011), available at <http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/PDFs/LegalIssuesTribalJuris.pdf>.

¹²*Id.* at 14–5.

¹³25 U.S.C.A. § 1621m(e)(1).

¹⁴*Id.*

¹⁵45 C.F.R. § 164.501.

¹⁶42 U.S.C.A. § 1320d(4).

¹⁷45 C.F.R. § 160.103.

¹⁸*Id.* §§ 160.102, 164.500.

¹⁹*Id.* § 164.512(b)(1)(i).

²⁰Hodge at 11.

²¹*Id.* at 14–5.

²²25 U.S.C.A. § 1621m(e)(2).

²³*Id.* § 1621m(c).