No. 19-10011

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE FIFTH CIRCUIT**

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STATE OF TEXAS; STATE OF WISCONSIN; STATE OF ALABAMA; STATE OF ARIZONA; STATE OF FLORIDA; STATE OF GEORGIA; STATE OF INDIANA; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF MISSISSIPPI, by and through Governor Phil Bryant; STATE OF MISSOURI; STATE OF NEBRASKA; STATE OF NORTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF SOUTH DAKOTA; STATE OF TENNESSEE; STATE OF UTAH; STATE OF WEST VIRGINIA; STATE OF ARKANSAS; NEILL HURLEY; JOHN NANTZ,

*Plaintiffs-Appellees*,

v.

UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; ALEX AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF INTERNAL REVENUE; CHARLES P. RETTIG, in his Official Capacity as Commissioner of Internal Revenue,

*Defendants-Appellants*,

STATE OF CALIFORNIA; STATE OF CONNECTICUT; DISTRICT OF COLUMBIA; STATE OF DELAWARE; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF KENTUCKY; STATE OF MASSACHUSETTS; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF NORTH CAROLINA; STATE OF OREGON; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF VIRGINIA; STATE OF WASHINGTON; STATE OF MINNESOTA,

*Intervenor Defendants-Appellants*.

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On Appeal from the United States District Court for the Northern District of Texas
No. 4:18-CV-167

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**BRIEF OF *AMICI CURIAE* 483 FEDERALLY RECOGNIZED TRIBAL NATIONS, IN SUPPORT OF INTERVENOR DEFENDANTS-APPELLANTS SEEKING REVERSAL**

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April 1, 2019

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## CERTIFICATE OF INTERESTED PERSONS

No *Amicus Curiae* on this brief has a parent corporation, and no publicly held company owns more than 10% of stock in any *Amicus Curiae* on this brief.

Pursuant to 5th Cir. R. 29.2, the undersigned counsel certifies that the following listed persons and law firms have an interest in this *amicus curiae* brief. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

***Amici Curiae*** are federally recognized Tribal Nations, Tribal Health Programs, and Tribal Organizations representing Tribal Nations and/or their interests. *Amici* are listed in Addendum A to this brief.

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April 1, 2019 /s/ John T. Kitchens
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# TABLE OF CONTENTS

**Page**

STATEMENT OF INTEREST OF *AMICI CURIAE* .......................................... 1

SUMMARY OF THE ARGUMENT ................................................................ 2

ARGUMENT AND CITATIONS OF AUTHORITY ....................................... 6

I. The IHCIA and other Indian-specific provisions have a separate genesis and purpose from the remainder of the ACA. ............................ 6

A. The purpose of the IHCIA is to carry out the federal government's trust responsibility to provide for the health and welfare of American Indian and Alaska Native people through the provision of direct services. ....................................................................... 6

B. The IHCIA has a separate legislative history from the remainder of the ACA. ........................................................................... 8

C. Other Indian-specific provisions, although enacted as part of the ACA, are likewise designed to support the Indian health system and are unconnected to the individual mandate. ................................ 11

II. The IHCIA and other Indian-specific provisions in the ACA are legally severable from the individual mandate, and should be preserved even if the individual mandate is held unconstitutional.......... 14

A. Where a statutory provision is found invalid, remaining provisions that are fully operative as law should be left intact absent clear evidence of congressional intent to the contrary. .............................. 15

B. The IHCIA and other Indian-specific provisions of the ACA are fully operative as independent law that is not related to or dependent on the individual mandate. ............................................... 18

C. There is no evidence that Congress intended for the operation of the IHCIA or other Indian-specific provisions to hinge on the validity of the individual mandate.................................................................. 19

**TABLE OF CONTENTS**
**(Continued)**

CONCLUSION ............................................................................................... 21

CERTIFICATE OF COMPLIANCE

CERTIFICATE OF SERVICE

ADDENDUM A: LIST OF *AMICI CURIAE*

ADDENDUM B: Pub. L. No. 111-148, Title X, § 10221, 124 Stat. 935 (2010)

# TABLE OF AUTHORITIES

***CASES***

*Alaska Airlines, Inc. v. Brock*,
480 U.S. 678 (1987) .......... 18

*Ayotte v. Planned Parenthood of N. New England*,
546 U.S. 320 (2006) .......... 16, 21

*Califano v. Westcott*,
443 U.S. 76 (1979) .......... 16

*Fla. ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*,
648 F.3d 1235 (11th Cir. 2011) .......... 5, 21

*Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*,
561 U.S. 477 (2010) .......... 4, 15, 17

*Hill v. Wallace*,
259 U.S. 44 (1922) .......... 17

*I.N.S. v. Chadha*,
462 U.S. 919 (1983) .......... 15, 19

*Murphy v. Nat'l Collegiate Athletic Ass'n*,
138 S. Ct. 1461 (2018) .......... 3, 15

*Nat'l Fed'n of Indep. Bus. v. Sebelius*,
567 U.S. 519 (2012) .......... *passim*

*Regan v. Time, Inc.*,
468 U.S. 641 (1984) .......... 15, 16

*Seminole Nation v. United States*,
316 U.S. 286 (1942) .......... 6

*Texas v. United States*,
340 F. Supp. 3d 579 (N.D. Tex. 2018) .......... 5, 16, 17

*Yankton Sioux Tribe v. U.S. Dep't of Health & Human Servs.*,
869 F. Supp. 760 (D.S.D. 1994) .......... 7

**TABLE OF AUTHORITIES**
**(Continued)**

***STATUTES***


25 U.S.C. § 13 .......... 7

25 U.S.C. § 1601 *et seq* .......... 1, 6

25 U.S.C. § 5301 *et seq* .......... 2, 6

26 U.S.C. § 5000A .......... 3

42 U.S.C. § 2001 .......... 7

Pub. L. No. 102-573, 106 Stat. 4526 (1992) .......... 8

Pub. L. No. 108-173, 117 Stat. 2066 (2003) .......... 13

Pub. L. No. 111-148, Title X, § 10221(a), 124 Stat. 935 (2010) .......... 4, 20

Pub. L. No. 94-437, 90 Stat. 1401 (1976) .......... 7


***REGULATIONS***


42 C.F.R. § 136.12 .......... 8

Exec. Order No. 13,175 on Consultation and Coordination With Indian Tribal Governments, 65 Fed. Reg. 67,249 (Nov. 9, 2000) .......... 6

President's Memorandum on Tribal Consultation, 74 Fed. Reg. 57,881 (Nov. 9, 2009) .......... 6


***RULES***


Fed. R. App. P. 29(a)(4)(E) .......... 1


***LEGISLATIVE MATERIALS***


154 Cong. Rec. S1155 (daily ed. Feb. 26, 2008) .......... 8

155 Cong. Rec. S10,493 (daily ed. Oct. 15, 2009) .......... 9, 12

155 Cong. Rec. S13,504 (daily ed. Dec. 19, 2009) .......... 10

**TABLE OF AUTHORITIES**
**(Continued)**

155 Cong. Rec. S13,716 (daily ed. Dec. 22, 2009) ................................................10

Cong. Research Serv., *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline* (updated Jan. 3, 2014).........................................................................................9

H.R. Rep. No. 94-1026 (1976)...........................................................................7

S. 1790, 111th Cong. (2009) ...........................................................................4

S. Comm. on Indian Affairs, 111th Cong., *Rep. on History, Jurisdiction, and Summary of Legislative Activities of the United States Senate Committee on Indian Affairs During the One Hundred Eleventh Congress* (Comm. Print 2013).....................................................................................9

S. Rep. No. 111-89 (2009) ........................................................................ 13, 14

***OTHER AUTHORITIES***

COHEN'S HANDBOOK OF FEDERAL INDIAN LAW § 22.01[3], at 1384 (Nell Jessup Newton ed., 2012) ..................................................................................6

Dep't of Health and Human Services, *Tribal Consultation Policy* (2010).......................................................................6

Indian Health Service, *Agency Overview* ..................................................................................7

Nat'l Indian Health Bd., *Brief History of the Indian Health Care Improvement Act* ....................................9

U.S. Comm'n on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans (2018)*..........................................................................................12

## STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

The 483 federally recognized Tribal Nations across the country who are *amici* or members of *amici* tribal organizations are directly affected by the District Court's decision to invalidate the Patient Protection and Affordable Care Act (ACA or Act) in its entirety. The District Court's overly broad ruling extends to a number of Indian-specific provisions of the ACA that are of critical importance to the delivery of health care services to Indian Country, including Section 10221, which amended and permanently authorized the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § 1601 *et seq.* (first enacted in 1976). None of these Indian health provisions have anything to do with the individual mandate declared unconstitutional by the District Court. If this Court agrees with the District Court that the individual mandate is invalid, the *amici* have a vital and urgent interest in ensuring that this Court properly applies established severability rules and sustains these separate and severable Indian-specific provisions.

*Amici* Tribal Nations, local and regional tribal organizations and their member Tribal Nations, and national tribal organizations are listed in Addendum A to this brief. Many of these *amici* have entered into agreements with the Secretary of Health and Human Services, acting through the Indian Health Service (IHS)

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[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), *amici curiae* state that no counsel for any party to this dispute authored this brief in whole or in part, and no person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief.

under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. § 5301 *et seq.*, to provide health care services directly to American Indian and Alaska Native people in their geographic areas. Among other things, the agreements implement provisions of the IHCIA. Individually or collectively, *amici* all either operate health care facilities and provide health care services to their citizens and other beneficiaries pursuant to the ISDEAA and the IHCIA, or they advocate on health issues affecting American Indian and Alaska Native people, or both.

*Amici* Tribal Nations and tribal organizations are thus uniquely well positioned to inform this Court on the history and operation of the IHCIA and other Indian-specific ACA provisions that are wholly unrelated to the individual mandate. *Amici* believe this brief will help the Court to understand how the District Court erred in its severability analysis, and why the IHCIA and other Indian-specific provisions of the ACA must be preserved, regardless of how this Court views the constitutionality of the individual mandate.

*Amici* submit this brief with the consent of all parties.

## SUMMARY OF THE ARGUMENT

The District Court below held that, following passage of the Tax Cuts and Jobs Act of 2017, the "individual mandate" provision of the ACA can no longer be considered a valid exercise of Congress's power to tax and is therefore

unconstitutional.[2] The District Court further held that the individual mandate is not severable from the remainder of the Act and went on to declare the Act invalid in its entirety—including Section 10221 and other Indian-specific health care provisions incorporated into the Act. While Section 10221 only represents a single page of the ACA, it incorporates by reference S. 1790, a 274-page bill that amended and permanently authorized the IHCIA.

If this Court agrees with the District Court regarding the constitutionality of the individual mandate, this appeal will raise an important question: Whether the court below correctly applied the Supreme Court's long-established severability rules when it invalidated the ACA in its entirety, including the IHCIA and certain Indian-specific provisions that are of critical importance to Tribal Nations and tribal organizations throughout the country. When a court finds a portion of a statute unconstitutional, surviving provisions that remain "fully operative as a law" should be left intact unless it is "evident" that Congress would have preferred otherwise. *See Murphy v. Nat'l Collegiate Athletic Ass'n*, 138 S. Ct. 1461, 1482 (2018); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 586–87 (2012). "[T]he normal rule is that partial, rather than facial, invalidation is the required

[2] The "individual mandate," termed "minimum essential coverage" in the Act itself, was enacted through § 1501 of the ACA, and is codified at 26 U.S.C. § 5000A(a).

course[.]" *Free Enter. Fund v. Pub. Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010).[3]

Section 10221 and other Indian-specific provisions in the Act should be preserved in accordance with this "normal rule." They provide the foundation for an independent, freestanding Indian health care system, and are "fully operative" as law without regard to the individual mandate. There is no reason to conclude that Congress would have wanted these separate, Indian-specific provisions to fall with the individual mandate. The IHCIA as amended by S. 1790 has a separate legislative genesis and history from the remainder of the ACA and, along with other Indian-specific provisions, serves an entirely separate legislative purpose. In enacting S. 1790 by way of the ACA, Congress affirmed a federal Indian health care policy "in fulfillment of [the federal government's] special trust responsibilities and legal obligations to Indians . . . ."[4] Striking down the IHCIA and other Indian health provisions on the ground that a wholly unrelated private insurance coverage mandate is constitutionally invalid would disregard those responsibilities and subvert federal Indian health care policy, without any indication that Congress had anticipated—let alone intended—such a result.

[3] Unless otherwise indicated, internal citations and quotation marks are omitted from quoted language throughout this brief, and any emphasis is added.

[4] S. 1790, 111th Cong. § 103 (2009), as enacted by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Title X, § 10221(a), 124 Stat. 935 (2010).

The District Court failed to specifically consider the relationship between the individual mandate and the IHCIA and other Indian-specific provisions of the ACA, because the court concluded that it could reach its broad ruling on severability "without marching through every nook and cranny of the ACA's 900-plus pages . . . ." *Texas v. United States*, 340 F. Supp. 3d 579, 616 (N.D. Tex. 2018).[5] Having failed to follow the "required course" of analysis, the District Court's severability ruling is overbroad, and should be reversed, at a minimum with respect to Section 10221 and other Indian-specific provisions of the Act. *See Fla. ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1327–28 (11th Cir. 2011) (reversing the district court's wholesale invalidation of the ACA and holding that the individual mandate could be severed from the remainder of the Act), *aff'd in part, rev'd in part sub nom. on other grounds, Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012).

[5] Likewise, in their abrupt change of position in this litigation, the federal Defendants-Appellants do not appear so far to have given any consideration to these provisions or to the potential impact of their new position on federal Indian health care policy.

## ARGUMENT AND CITATIONS OF AUTHORITY

### I. The IHCIA and other Indian-specific provisions have a separate genesis and purpose from the remainder of the ACA.

#### A. The purpose of the IHCIA is to carry out the federal government's trust responsibility to provide for the health and welfare of American Indian and Alaska Native people through the provision of direct services.

The IHCIA is one of many distinct and specialized federal laws designed by Congress to address the unique needs of tribal communities. These laws were enacted to carry out treaty obligations assumed by the United States in exchange for vast cessions of land and resources by Tribal Nations, and to implement the federal trust responsibility to American Indians and Alaska Natives that evolved from those and other historical dealings.[6] *See generally* COHEN'S HANDBOOK OF FEDERAL INDIAN LAW § 22.01[3], at 1384 (Nell Jessup Newton ed., 2012) ("Obligation to Provide Services").

The IHCIA was first enacted in 1976. It was crafted as a response to the deplorable health status of Indian people, the shameful condition of federal

[6] Articulated in treaties, judicial decisions, laws, regulations and policies over more than two centuries, the federal trust responsibility to Indians has been repeatedly recognized by all branches of the federal government. *See, e.g.*, *Seminole Nation v. United States*, 316 U.S. 286, 296 (1942); Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §§ 5301, 5302, 5381, 5384(a), 5385(a), 5387(g); Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §§ 1601, 1602; Exec. Order No. 13,175 on Consultation and Coordination With Indian Tribal Governments, 65 Fed. Reg. 67,249 (Nov. 9, 2000); President's Memorandum on Tribal Consultation, 74 Fed. Reg. 57,881 (Nov. 9, 2009); Dep't of Health and Human Services, *Tribal Consultation Policy* 1–2 (2010), https://www.hhs.gov/sites/default/files/iea/tribal/tribal consultation/hhs-consultation-policy.pdf.

hospitals and clinics for Indians, and inadequate or non-existent sanitation facilities on and around Indian reservations.[7] After cataloguing the conditions that imperiled Indian health, the 1976 law made a firm commitment to Indian people in its Declaration of Policy:

> The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.[8]

The IHCIA is the primary, stand-alone statutory framework for the delivery of health care services to Indian people by the United States. Along with the Transfer Act of 1954, 42 U.S.C. § 2001, and the Snyder Act, 25 U.S.C. § 13, the IHCIA provides legislative authority for the health care programs and facilities administered by the IHS, the agency housed within the Department of Health and Human Services that is responsible for providing federal health services to American Indians and Alaska Natives.[9]

The Indian health care system is unique and exists largely apart from the mainstream health care delivery system in the United States. Services to American Indian and Alaska Native people are provided directly at IHS and tribal hospitals

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[7] *See* H.R. Rep. No. 94-1026, pt. 1, at 1–17 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652–57.

[8] Indian Health Care Improvement Act, Pub. L. No. 94-437, Sec. 3, 90 Stat. 1401 (1976).

[9] *See, e.g.*, *Yankton Sioux Tribe v. U.S. Dep't of Health & Human Servs.*, 869 F. Supp. 760, 761 (D.S.D. 1994); Indian Health Service, *Agency Overview*, https://www.ihs.gov/aboutihs/overview/ (last visited Mar. 29, 2019).

and clinics and urban Indian clinics, supplemented by the purchase of contract health services where necessary and supported by annual appropriations from Congress. While these Indian health programs are authorized to collect reimbursements from Medicare, Medicaid, and private insurance when they serve Indian patients with such coverage, enrollment in an insurance plan is not a pre-requisite for receiving direct services through Indian health care providers. Eligibility for IHCIA-authorized programs is defined in federal regulations,[10] and eligible American Indian and Alaska Native patients have a right to receive care at no cost to them even when they lack any form of health coverage.

### B. The IHCIA has a separate legislative history from the remainder of the ACA.

As originally enacted, the IHCIA required periodic reauthorization. It has been reauthorized and amended a number of times, with extensive substantive amendments enacted in 1992 to strengthen its programmatic provisions.[11] In 1999, a new effort to reauthorize and make much needed improvements to the IHCIA began. In that year and throughout the ensuing decade, IHCIA bills were introduced in every Congress. Some achieved congressional committee approval, and one bill was debated on the Senate floor.[12] Congress did not enact any of these

[10] *See* 42 C.F.R. § 136.12.

[11] Indian Health Amendments of 1992, Pub. L. No. 102-573, 106 Stat. 4526 (1992).

[12] 154 Cong. Rec. S1155 (daily ed. Feb. 26, 2008).

bills, but it continued to appropriate funds for IHCIA programs through annual appropriations acts to ensure that health care services to IHS beneficiaries would not be interrupted.[13]

Finally, following a sustained effort by *amici* Tribal Nations and tribal organizations, an independent bill to amend and reauthorize the IHCIA (S. 1790) was introduced by Senator Byron Dorgan and 15 co-sponsors on October 15, 2009.[14] When introducing S. 1790, Senator Dorgan declared: "We face a bona fide crisis in health care in our Native American communities, and this bill is a first step toward fulfilling our treaty obligations and trust responsibility to provide quality health care in Indian Country."[15] Following its introduction, S. 1790 was referred to the Senate Committee on Indian Affairs, the panel with primary jurisdiction over Indian health. It was then reported favorably out of that Committee.[16]

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[13] *See* Cong. Research Serv., *The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA: Detailed Summary and Timeline* 2 (updated Jan. 3, 2014), https://crsreports.congress.gov/product/pdf/R/R41630.

[14] 155 Cong. Rec. S10,493 (daily ed. Oct. 15, 2009). *See also* Nat'l Indian Health Bd., *Brief History of the Indian Health Care Improvement Act*, https://www.nihb.org/tribalhealthreform/ihcia-history/ (last visited Mar. 29, 2019).

[15] 155 Cong. Rec. S10,493 (daily ed. Oct. 15, 2009) (statement of Sen. Dorgan).

[16] *See* S. Comm. on Indian Affairs, 111th Cong., *Rep. on History, Jurisdiction, and Summary of Legislative Activities of the United States Senate Committee on Indian Affairs During the One Hundred Eleventh Congress* 13 (Comm. Print 2013).

In contrast, H.R. 3590—which became the Senate's health care reform legislation and, eventually, the ACA—evolved on a separate track. H.R. 3590 was the product of the Majority Leader's reconciliation of health care reform measures considered and approved by the two Senate committees that have jurisdiction over all other health legislation: the Senate Finance Committee and the Health, Education, Labor and Pensions (HELP) Committee. Amending the IHCIA was completely unrelated to the efforts of those panels to craft broader health care reform bills. However, since H.R. 3590 was a moving legislative vehicle, S. 1790 was added to it as part of a Manager's package of amendments adopted by the Senate on December 22, 2009—just two days before H.R. 3590 was passed by the Senate.

Among other provisions, the Manager's amendments added a new Part III to Title X of the ACA titled "Indian Health Care Improvement."[17] Part III consisted solely of Section 10221, a single page of legislation incorporating by reference and enacting into law S. 1790, which contained over 270 pages of amendments to the IHCIA, with four alterations to the text of that measure.[18] *See* Addendum B. H.R.

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[17] 155 Cong. Rec. S13,716 (daily ed. Dec. 22, 2009); 155 Cong. Rec. S13,504–05 (daily ed. Dec. 19, 2009) (providing text of amendments to IHCIA).

[18] As incorporated into Section 10221, S. 1790 made the IHCIA a permanent federal law without an expiration date; enhanced authorities to recruit and retain health care professionals to overcome high vacancy rates; expanded programs to address diseases such as diabetes that are at alarmingly high levels in Indian Country; augmented the ability of tribal epidemiology centers to devise strategies to address local health needs; provided more equitable and innovative procedures for construction of health care and sanitation facilities; expanded opportunities for

3590, as passed by the Senate on December 24, 2009, was adopted by the House of Representatives on March 21, 2010, and signed into law by the President on March 23, 2010 as Pub. L. No. 111-148.

### C. Other Indian-specific provisions, although enacted as part of the ACA, are likewise designed to support the Indian health system and are unconnected to the individual mandate.

The ACA contains several other beneficial Indian provisions that, like the IHCIA component, were put into the Senate's health care reform bill because it was a convenient legislative vehicle—not because they were part of or related to the insurance market reforms of which the individual mandate is a part. Instead, like the IHCIA, these provisions were designed to assist in implementation of the federal trust responsibility to provide health care services to American Indian and Alaska Native people by strengthening the Indian health care system.

The need for these provisions was apparent at the time the ACA was enacted. Despite improvement in some health status measures over prior decades, Indian health disparities continued to suggest comparisons with third world countries. When introducing S. 1790 in the fall of 2009, Senator Dorgan cited but a few examples: "Native Americans die of tuberculosis at a rate 600 percent higher

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third party collections in order to maximize all revenue sources; established comprehensive behavioral health initiatives, with a particular focus on the Indian youth suicide crisis; and expressly authorized operation of modern methods of health care delivery such as long-term care and home- and community-based care, staples of the mainstream health system not previously specifically authorized for the Indian health system, among other changes.

than the general population, suicide rates are nearly double, alcoholism rates are 510 percent higher, and diabetes rates are 189 percent higher than the general population."[19] Much of this ongoing crisis was attributable to a chronic lack of funding for Indian health programs: Senator Dorgan observed in 2009 that the health care system for Native Americans is "only funded at about half of its need."[20] Even now, funding for the Indian health care system remains "inequitable and unequal," as the United States Commission on Civil Rights detailed in a recent report.[21]

Although no provision of the IHCIA or the ACA directly appropriates funding for the Indian health care system,[22] several individual provisions included in the final law were designed, among other things, to increase that system's access to additional federal and other third party resources to supplement annual appropriations. These provisions include the following:

- Section 2901 contains a critically important provision designed to protect scarce IHS resources. It makes the Indian health system the payor of last resort, which means that all other forms of payment, including Medicare, Medicaid, the

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[19] 155 Cong. Rec. S10,493 (daily ed. Oct. 15, 2009) (statement of Sen. Dorgan).

[20] *Id.*

[21] U.S. Comm'n on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* 209 (2018), https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf.

[22] The IHCIA authorizes program funding, but does not require any expenditure, and is not "paid for" by any other provision of the ACA.

VA, and private insurance must pay before the IHS will pay for a service to an eligible beneficiary.[23]

- Section 2902 amends Section 1880 of the Social Security Act, the statutory provision that authorizes IHS and tribally operated hospitals and clinics to receive reimbursements from Medicare. Section 2902 removed the "sunset" date for collection of reimbursements for Medicare Part B services that had been authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. No. 108-173, 117 Stat. 2066 (2003)).[24]

- Section 3314 corrects a problem encountered by IHS, tribal, and urban Indian organization pharmacies that provide Medicare Part D prescription drugs to their Indian patients without cost. Since the value of such drugs was not counted as out-of-pocket costs of the patient, the Indian patient was not able to qualify for the catastrophic coverage level under Part D. The Section 3314 amendment removed this barrier by directing that effective January 1, 2011, the cost of drugs borne or paid by an Indian pharmacy are to be considered out-of-pocket costs of the patient.[25]

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[23] This provision was included in the health care reform bill reported by the Finance Committee, and included in H.R. 3590 as approved by the Senate. S. Rep. No. 111-89, at 105 (2009).

[24] This provision was included in the health care reform bill reported by the Finance Committee, and included in H.R. 3590 as approved by the Senate. *Id*. at 106.

[25] This provision was added to the Finance Committee bill during mark-up, and was retained in the reconciled bill, H.R. 3590, as approved by the Senate. *Id*. at 260.

- Section 9021 amends the Internal Revenue Code to exclude from an individual tribal member's gross income the value of health benefits, care or coverage provided by the IHS or by a Tribal Nation or tribal organization to its members. The provision overrides the determination by the Internal Revenue Service that the value of health benefits provided by a Tribal Nation for its citizens constitutes taxable income to the citizen even when a Tribal Nation stepped in to provide such coverage to compensate for insufficient funding from the IHS.[26]

## II. The IHCIA and other Indian-specific provisions in the ACA are legally severable from the individual mandate, and should be preserved even if the individual mandate is held unconstitutional.

Neither the IHCIA nor any of these other Indian-specific provisions is related to or dependent upon the efficacy or validity of the individual mandate. The District Court, however, did not review any of these provisions, and did not even attempt to determine whether they were in fact dependent upon the individual mandate reforms. This was error. The IHCIA and other Indian-specific provisions of the ACA are legally severable from the individual mandate, and remain valid even if the individual mandate is deemed unconstitutional.

[26] This provision was added to the Finance Committee's health care reform bill that was reported to the Senate and was retained in the reconciled bill, H.R. 3590, approved by the Senate. *Id*. at 356.

### A. Where a statutory provision is found invalid, remaining provisions that are fully operative as law should be left intact absent clear evidence of congressional intent to the contrary.

Once a portion of a statute is found unconstitutional, the purpose of the severability rule is to separate and save those other portions of the legislation that are practically and legally independent and therefore valid. In *Free Enterprise Fund*, the Supreme Court stated:

> Generally speaking, when confronting a constitutional flaw in a statute, *we try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact*. Because the unconstitutionality of a part of an Act does not necessarily defeat or affect the validity of its remaining provisions, *the normal rule is that partial, rather than facial, invalidation is the required course*[.]

561 U.S. at 508; *see also Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) ("[A] court should refrain from invalidating more of the statute than is necessary.").

In conducting a severability analysis, a court must "ask whether the law remains 'fully operative' without the invalid provisions[.]" *Murphy*, 138 S. Ct. at 1482 (citing *Free Enter. Fund*, 561 U.S. at 509). If so, the invalid provision is "presumed severable," *I.N.S. v. Chadha*, 462 U.S. 919, 934 (1983), and what remains after severance should be sustained unless it is "evident" that Congress would have preferred the rest of the statute (or particular sections) to be invalidated along with the unconstitutional provision. *Free Enter. Fund*, 561 U.S. at 508–09; *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 586–87 ("The question here is whether Congress would have wanted the rest of the Act to stand, had it known that States

would have a genuine choice whether to participate in the new Medicaid expansion [pursuant to the Court's ruling]. Unless it is 'evident' that the answer is no, we must leave the rest of the Act intact.").

A court conducting this severability analysis "should act cautiously" because "[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people." *Regan*, 468 U.S. at 652. Since severability "is largely a question of legislative intent," *id*. at 653, a court should "strive to salvage" as much as possible of a statute so that the court does not "use its remedial powers to circumvent the intent of the legislature." *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329–30 (2006) (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979) (Powell, J., concurring in part and dissenting in part)).

Although the District Court acknowledged its duty to "refrain from invalidating more of the statute than is necessary[,]" *Texas*, 340 F. Supp. 3d at 606 (quoting *Regan*, 468 U.S. at 652), it failed to perform the analysis required to uphold that duty. Instead, the District Court relied on legislative findings, judicial precedent, and "historical context" relating specifically to health insurance coverage and market regulation to declare that the entire statute—including the Indian-specific provisions that are wholly unrelated to the health insurance market—was inseverable from the individual mandate. *Texas*, 340 F. Supp. 3d at 607–16. The court declined to "parse the ACA's provisions one by one," *id.* at

614, and simply assumed that all of them were "so interwoven" with the individual mandate that "[n]one of them can stand." *Id.* at 615 (quoting *Hill v. Wallace*, 259 U.S. 44, 70 (1922)).[27]

This assumption was error,[28] and as a result, the District Court failed to "limit the solution" to the perceived problem with the individual mandate as required by the Supreme Court's severability rules. *See Free Enter. Fund*, 561 U.S. at 508. In particular, the court did not evaluate the genesis or purpose of the IHCIA or other Indian-specific provisions in any way, and by invalidating those provisions along with the rest of the Act, the court nullified much more than was necessary to excise the effect of the individual mandate.

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[27] The court further stated:

> That is a conclusion the Court can reach without marching through every nook and cranny of the ACA's 900-plus pages because Congress plainly told the public when it wrote the ACA that "[t]he minimum coverage provision is . . . an 'essential par[t] of a larger regulation of economic activity'" and "without the provision, 'the regulatory scheme [w]ould be undercut.'"

*Texas*, 340 F. Supp. 3d at 616.

[28] As the Intervenor Defendant-Appellants argue, and *amici* argued below, the District Court's heavy reliance on legislative statements from 2010 improperly ignores the fact that Congress itself made clear its intent as to severability in 2017, when it chose to reduce the individual mandate tax penalty to $0 (thus effectively nullifying the individual mandate) *without* disturbing any other provisions of the ACA. *See* Brief for Jonathan H. Adler, *et al.* as *Amici Curiae* Supporting Intervenor-Defendants, *Texas v. United States*, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (No. 4:18-cv-00167). In any event, while health insurance reform was obviously a major goal of the ACA, even a casual reading of the Act demonstrates that not all of its provisions were related to or intended to achieve that particular goal.

### B. The IHCIA and other Indian-specific provisions of the ACA are fully operative as independent law that is not related to or dependent on the individual mandate.

The IHCIA and other Indian-specific provisions of the ACA discussed herein function as stand-alone, "fully operative" laws "in a *manner* consistent with the intent of Congress[,]" *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (emphasis in original), regardless of the individual mandate. In particular, the IHCIA existed prior to the ACA and has functioned as a freestanding and fully operative law since its original enactment in 1976. When Congress amended and permanently authorized the IHCIA by way of the ACA, it did so through simple incorporation by reference of separate legislation. Likewise, the other Indian-specific provisions discussed above are discrete statutory provisions that operate completely independently of the individual mandate.

The IHCIA and other Indian-specific provisions of the ACA serve a unique and specific purpose: they provide important authorities for the IHS and form the statutory foundation for an independent health care delivery system designed to carry out a federal responsibility to American Indian and Alaska Native people. No aspect of this system is dependent on individual health insurance coverage or the private health insurance market generally, or on the ACA's individual mandate specifically. Therefore, it should be presumed that the individual mandate can be severed from these Indian-specific ACA provisions, and the Indian-specific

provisions should be preserved unless it is "evident" that Congress would have preferred for them to be invalidated along with the individual mandate. *Chadha*, 462 U.S. at 934; *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 586–87.

### C. There is no evidence that Congress intended for the operation of the IHCIA or other Indian-specific provisions to hinge on the validity of the individual mandate.

There is no evidence in either the statutory text or legislative history that Congress intended for the IHCIA and other Indian-specific provisions to be contingent upon the validity of the individual mandate. Rather, the IHCIA's separate legislative history, its incorporation by reference into the ACA, and the separate legislative purpose served by both the IHCIA and the other Indian-specific provisions suggest that they were bundled with the insurance market reform provisions of the ACA for purposes of legislative efficiency only, not because Congress intended for them to be interdependent.

The text of the IHCIA itself further indicates that Congress would seek to preserve the IHCIA and other Indian-specific provisions that carry out the federal trust responsibility to American Indians and Alaska Natives, even if other provisions of the ACA were deemed invalid. As part of its 2010 amendments to the IHCIA, Congress again declared that "it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians" to, among other things, "ensure the highest possible health status for Indians and

urban Indians and to provide all resources necessary to effect that policy[.]"[29] It would be anomalous to conclude that Congress—without ever saying so—intended for the fulfillment of those "special trust responsibilities and legal obligations" to be contingent on otherwise unrelated private insurance market reforms.

Finally, nothing in the legislative history of the Tax Cuts and Jobs Act of 2017 indicates that Congress had changed its mind with regard to the IHCIA and other Indian-specific provisions of the ACA, or its commitment to fulfilling the federal trust responsibility, when it voted to reduce to $0 the tax penalty for failure to comply with the individual mandate. There was simply no consideration of the IHCIA or other Indian-specific ACA provisions, as those provisions are unrelated to the tax matters considered as part of the 2017 Act. The 2017 Congress's actions speak for themselves: as part of its tax reform package, Congress chose to zero out the individual mandate tax penalty, *without* altering the Indian provisions or any other portion of the ACA.

Proper application of the Supreme Court's severability rules thus compels preservation of these Indian-specific provisions of the ACA even if the individual mandate is invalidated. To strike down these provisions on the ground that they were enacted alongside the individual mandate, as the District Court has done,

[29] Pub. L. No. 111-148, Title X, § 10221(a), 124 Stat. 935 (2010) (codified at 25 U.S.C. § 1602).

would overstep the bounds of the judiciary and "circumvent the intent of the legislature." *Ayotte*, 546 U.S. at 329–30.

## CONCLUSION

Should this Court agree with the District Court's judgment that the individual mandate is unconstitutional, it should nevertheless reverse the District Court's severability holding, at a minimum with respect to the IHCIA and the other Indian-specific provisions identified above. *See Fla. ex rel. Atty. Gen.*, 648 F.3d at 1320–28 (reversing the district court's holding that the ACA's individual mandate could not be severed from the remainder of the Act, and noting: "As our exhaustive review of the Act's myriad provisions . . . demonstrates, the lion's share of the Act has nothing to do with private insurance, much less the mandate that individuals buy insurance."), *aff'd in part, rev'd in part sub nom. Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012) (reversing the underlying decision that the individual mandate was unconstitutional). These Indian-specific provisions are severable from the individual mandate and should be preserved.

Respectfully submitted this 1st day of April, 2019.

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April 1, 2019

/s/ John T. Kitchens
John T. Kitchens

*Counsel for* Amicus Curiae
*Norton Sound Health Corporation*

**CERTIFICATE OF SERVICE**

I certify that on April 1, 2019 I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I further certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

April 1, 2019

/s/ John Kitchens
John Kitchens
*Counsel for* Amicus Curiae
*Norton Sound Health Corporation*

## ADDENDUM A: LIST OF *AMICI CURIAE*

### *Amici* Federally Recognized Tribal Nations

Absentee Shawnee Tribe of Indians of Oklahoma
Alabama-Coushatta Tribe of Texas
Blue Lake Rancheria
Chemehuevi Indian Tribe of the Chemehuevi Reservation
Cherokee Nation
Cheyenne and Arapaho Tribes
Chickaloon Native Village
Chickasaw Nation
Chippewa Cree Indians of the Rocky Boy's Reservation, Montana
Choctaw Nation
Citizen Potawatomi Nation
Cloverdale Rancheria of Pomo Indians of California
Confederated Salish and Kootenai Tribes
Confederated Tribes of the Colville Reservation
Confederated Tribes of the Warm Springs Reservation of Oregon
Duckwater Shoshone Tribe
Eastern Band of Cherokee Indians
Ewiiaapaayp Band of Kumeyaay Indians
Federated Indians of Graton Rancheria
Fond du Lac Band of Lake Superior Chippewa
Forest County Potawatomi Community
Gila River Indian Community
Habematolel Pomo of Upper Lake
Iipay Nation of Santa Ysabel
Jamestown S'Klallam Tribe
Kalispel Tribe of Indians
Kickapoo Tribe of Oklahoma
The Klamath Tribes
Little River Band of Ottawa Indians
Los Coyotes Band of Cahuilla and Cupeño Indians of the Los Coyotes Reservation
Lytton Rancheria
Manchester Band of Pomo Indians
Menominee Indian Tribe of Wisconsin
Mississippi Band of Choctaw Indians
Mohegan Tribe

Muscogee (Creek) Nation
Navajo Nation
North Fork Rancheria of Mono Indians of California
Oneida Nation
Pala Band of Mission Indians
Pascua Yaqui Tribe
Pechanga Band of Luiseño Indians
Pueblo of Zuni
Puyallup Tribe of Indians
Red Lake Band of Chippewa Indians
Rincon Band of Luiseño Indians
Sac and Fox Nation
Saint Regis Mohawk Tribe
Samish Indian Nation
Santa Clara Pueblo
Seminole Tribe of Florida
Soboba Band of Luiseño Indians
Suquamish Tribe
Swinomish Indian Tribal Community
Tohono O'odham Nation
Viejas Band of Kumeyaay Indians
Wichita and Affiliated Tribes of Oklahoma

## *Amici* Local and Regional Tribal Organizations[1]

**Alaska Native Health Board** and the **Alaska Native Tribal Health Consortium**, whose members include all 227 federally recognized Tribal Nations in Alaska.

**All Pueblo Council of Governors**, whose members include:

Kewa Pueblo, New Mexico
Ohkay Owingeh, New Mexico
Pueblo of Acoma, New Mexico
Pueblo of Cochiti, New Mexico
Pueblo of Isleta, New Mexico
Pueblo of Jemez, New Mexico
Pueblo of Laguna, New Mexico

[1] Tribal Nations listed with an asterisk are not on the BIA list of federally recognized tribal entities. *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 84 Fed. Reg. 1200 (February 1, 2019).

Pueblo of Nambe, New Mexico
Pueblo of Picuris, New Mexico
Pueblo of Pojoaque, New Mexico
Pueblo of San Felipe, New Mexico
Pueblo of San Ildefonso, New Mexico
Pueblo of Sandia, New Mexico
Pueblo of Santa Ana, New Mexico
Pueblo of Santa Clara, New Mexico
Pueblo of Taos, New Mexico
Pueblo of Tesuque, New Mexico
Pueblo of Zia, New Mexico
Ysleta del Sur Pueblo
Zuni Tribe of the Zuni Reservation, New Mexico

**Arctic Slope Native Association**, whose members include:
Atqasuk Village (Atkasook)
Kaktovik Village (Barter Island)
Native Village of Barrow Inupiat Traditional Government
Native Village of Nuiqsut (Nooiksut)
Native Village of Point Hope
Native Village of Point Lay
Village of Anaktuvuk Pass
Village of Wainwright

**Bristol Bay Area Health Corporation**, whose members include:
Chignik Bay Tribal Council
Chignik Lake Village
Curyung Tribal Council
Egegik Village
Ivanof Bay Tribe
King Salmon Tribe
Knugank*
Levelock Village
Manokotak Village
Naknek Native Village
Native Village of Aleknagik
Native Village of Chignik Lagoon
Native Village of Ekuk
Native Village of Ekwok
Native Village of Goodnews Bay

Native Village of Kanatak
Native Village of Perryville
Native Village of Port Heiden
New Koliganek Village Council
New Stuyahok Village
Pilot Station Traditional Village
Platinum Traditional Village
Portage Creek Village (Ohgsenakale)
South Naknek Village
Traditional Village of Togiak
Twin Hills Village
Ugashik Village
Village of Clarks Point

**California Tribal Business Alliance**, whose members include:
Pala Band of Mission Indians
Picayune Rancheria of Chukchansi Indians of California
Torres Martinez Desert Cahuilla Indians

**California Tribal Families Coalition**, whose members include:
Bear River Band of the Rohnerville Rancheria
Big Lagoon Rancheria
Big Sandy Rancheria of Western Mono Indians of California
Bishop Paiute Tribe
Cher-Ae Heights Indian Community of the Trinidad Rancheria
Coyote Valley Band of Pomo Indians of California
Dry Creek Rancheria Band of Pomo Indians
Enterprise Rancheria of Maidu Indians of California
Federated Indians of Graton Rancheria
Fort Independence Indian Community of Paiute Indians of the Fort Independence Reservation
Habematolel Pomo of Upper Lake
Hopland Band of Pomo Indians
Ione Band of Miwok Indians of California
Jamul Indian Village of California
Karuk Tribe
Mechoopda Indian Tribe of Chico Rancheria
Morongo Band of Mission Indians
North Fork Rancheria of Mono Indians of California
Pala Band of Mission Indians

Paskenta Band of Nomlaki Indians of California
Pechanga Band of Luiseño Indians
Pit River Tribe (includes XL Ranch, Big Bend, Likely, Lookout, Montgomery Creek and Roaring Creek Rancherias)
Redding Rancheria
Redwood Valley or Little River Band of Pomo Indians of the Redwood Valley Rancheria California
Resighini Rancheria
Robinson Rancheria
Round Valley Indian Tribes, Round Valley Reservation
Shingle Springs Band of Miwok Indians, Shingle Springs Rancheria (Verona Tract)
Soboba Band of Luiseño Indians
Susanville Indian Rancheria
Tolowa Dee-ni' Nation
Wilton Rancheria
Yurok Tribe of the Yurok Reservation

**Chapa De Indian Health**, whose members include:
United Auburn Indian Community of the Auburn Rancheria of California

**Chugachmiut**, whose members include:
Native Village of Chenega (Chanega)
Native Village of Eyak (Cordova)
Native Village of Nanwalek (English Bay)
Native Village of Port Graham
Qutekcak (Seward)*
Native Village of Tatitlek
Valdez*

**Copper River Native Association**, whose members include:
Gulkana Village
Native Village of Cantwell
Native Village of Gakona
Native Village of Kluti Kaah (Copper Center)
Native Village of Tazlina

**Eastern Aleutian Tribes**, whose members include:

Adak*
Agdaagux Tribe of King Cove
Native Village of Akutan
Cold Bay*
Native Village of False Pass
Native Village of Nelson Lagoon
Qagan Tayagungin Tribe of Sand Point Village
Whittier*

**Great Plains Tribal Chairmen's Health Board**, whose members include:

Cheyenne River Sioux Tribe of the Cheyenne River Reservation, South Dakota
Crow Creek Sioux Tribe of the Crow Creek Reservation, South Dakota
Flandreau Santee Sioux Tribe of South Dakota
Lower Brule Sioux Tribe of the Lower Brule Reservation, South Dakota
Oglala Sioux Tribe
Omaha Tribe of Nebraska
Ponca Tribe of Nebraska
Rosebud Sioux Tribe of the Rosebud Indian Reservation, South Dakota
Sac & Fox Tribe of the Mississippi in Iowa
Santee Sioux Nation, Nebraska
Sisseton-Wahpeton Oyate of the Lake Traverse Reservation, South Dakota
Spirit Lake Tribe, North Dakota
Standing Rock Sioux Tribe of North & South Dakota
Trenton Indian Service Area*
Three Affiliated Tribes of the Fort Berthold Reservation, North Dakota
Turtle Mountain Band of Chippewa Indians of North Dakota
Winnebago Tribe of Nebraska
Yankton Sioux Tribe of South Dakota

**Indian Health Council**, whose members include:

Iipay Nation of Santa Ysabel
Inaja Band of Diegueño Mission Indians of the Inaja and Cosmit Reservation
La Jolla Band of Luiseño Indians
Los Coyotes Band of Cahuilla and Cupeño Indians
Mesa Grande Band of Diegueño Mission Indians of the Mesa Grande Reservation
Pala Band of Mission Indians

Pauma Band of Luiseño Mission Indians of the Pauma & Yuima Reservation
Rincon Band of Luiseño Indians
San Pasqual Band of Diegueño Mission Indians of California

**Kickapoo Tribal Health Center**

**Kodiak Area Native Association**, whose members include:
Alutiiq Tribe of Old Harbor
Native Village of Akhiok
Native Village of Karluk
Native Village of Larsen Bay
Native Village of Ouzinkie
Native Village of Port Lions
Sun'aq Tribe of Kodiak

**Maniilaq Association**, whose members include:
Native Village of Ambler
Native Village of Buckland
Native Village of Deering
Native Village of Kiana
Native Village of Kivalina
Native Village of Kobuk
Native Village of Kotzebue
Native Village of Noatak
Native Village of Point Hope
Native Village of Selawik
Native Village of Shungnak
Noorvik Native Community

**Northern Valley Indian Health**, whose members include:
Grindstone Indian Rancheria of WintunWailaki Indians of California
Kletsel Dehe Band of Wintun Indians
Mechoopda Indian Tribe of Chico Rancheria
Yocha Dehe Wintun Nation

**Northwest Portland Area Indian Health Board**, whose members include:
Burns Paiute Tribe
Coeur D'Alene Tribe
Confederated Tribes and Bands of the Yakama Nation
Confederated Tribes of Siletz Indians of Oregon

Confederated Tribes of the Chehalis Reservation
Confederated Tribes of the Colville Reservation
Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians
Confederated Tribes of the Grand Ronde Community of Oregon
Confederated Tribes of the Umatilla Indian Reservation
Confederated Tribes of the Warm Springs Reservation of Oregon
Coquille Indian Tribe
Cow Creek Band of Umpqua Tribe of Indians
Cowlitz Indian Tribe
Hoh Indian Tribe
Jamestown S'Klallam Tribe
Kalispel Tribe of Indians
The Klamath Tribes
Kootenai Tribe of Idaho
Lower Elwha Tribal Community
Lummi Tribe of the Lummi Reservation
Makah Indian Tribe of the Makah Indian Reservation
Muckleshoot Indian Tribe
Nez Perce Tribe
Nisqually Indian Tribe
Nooksack Indian Tribe
Northwestern Band of the Shoshone Nation
Port Gamble S'Klallam Tribe
Puyallup Tribe of Indians
Quileute Tribe of the Quileute Reservation
Quinault Indian Nation
Samish Indian Nation
Sauk-Suiattle Indian Tribe
Shoalwater Bay Indian Tribe of the Shoalwater Bay Indian Reservation
Shoshone-Bannock Tribes of the Fort Hall Reservation
Skokomish Indian Tribe
Snoqualmie Tribe
Spokane Tribe of the Spokane Reservation
Squaxin Island Tribe of the Squaxin Island Reservation
Stillaguamish Tribe of Indians of Washington
Suquamish Tribe
Swinomish Indian Tribal Community
Tulalip Tribes of Washington
Upper Skagit Indian Tribe

**Norton Sound Health Corporation**, whose members include:
Chinik Eskimo Community (Golovin)
Native Village of Brevig Mission
Native Village of Diomede (Inalik)
Native Village of Elim
Native Village of Gambell
Native Village of Koyuk
Native Village of Saint Michael
Native Village of Savoonga
Native Village of Shaktoolik
Native Village of Shishmaref
Native Village of Teller
Native Village of Unalakleet
Native Village of Wales
Native Village of White Mountain
Nome Eskimo Community
Stebbins Community Association

**Riverside San-Bernadino County Indian Health, Inc.**, whose members include:
Agua Caliente Band of Cahuilla Indians of the Agua Caliente Indian Reservation
Cahuilla Band of Indians
Morongo Band of Mission Indians
Pechanga Band of Luiseño Indians
Ramona Band of Cahuilla
San Manuel Band of Mission Indians
Santa Rosa Band of Cahuilla Indians
Soboba Band of Luiseño Indians
Torres Martinez Desert Cahuilla Indians

**Santa Ynez Tribal Health Clinic**

**Seattle Indian Health Board**

**Sonoma County Indian Health Project, Inc.**

**Southcentral Foundation**, whose members include:
Igiugig Village
Kokhanok Village
McGrath Native Village

Newhalen Village
Nikolai Village
Nondalton Village
Pedro Bay Village
Pribilof Islands Aleut Communities of St. Paul & St. George Islands
Takotna Village
Telida Village
Village of Iliamna

**Southeast Alaska Regional Health Consortium**, whose members include:
Angoon Community Association
Chilkat Indian Village (Klukwan)
Chilkoot Indian Association (Haines)
Craig Tribal Association
Gustavus*
Hoonah Indian Association
Hydaburg Cooperative Association
Juneau*
Ketchikan Indian Corporation
Klawock Cooperative Association
Metlakatla Indian Community, Annette Island Reserve
Organized Village of Kake
Organized Village of Kasaan
Pelican*
Petersburg Indian Association
Sitka Tribe of Alaska
Skagway Village
Thorne Bay*
Wrangell Cooperative Association

**Southern California Tribal Chairmen's Association**, whose members include:
Cahuilla Band of Indians
Campo Band of Diegueño Mission Indians of the Campo Indian Reservation
Capitan Grande Band of Diegueño Mission Indians of California (Barona Group of Capitan Grande Band of Mission Indians of the Barona Reservation; Viejas (Baron Long) Group of Capitan Grande Band of Mission Indians of the Viejas Reservation)
Chemehuevi Indian Tribe of the Chemehuevi Reservation
Ewiiaapaayp Band of Kumeyaay Indians
Iipay Nation of Santa Ysabel

Inaja Band of Diegueño Mission Indians of the Inaja and Cosmit Reservation
Jamul Indian Village of California
La Jolla Band of Luiseño Indians
La Posta Band of Diegueño Mission Indians of the La Posta Indian Reservation
Los Coyotes Band of Cahuilla and Cupeño Indians
Manzanita Band of Diegueño Mission Indians of the Manzanita Reservation
Mesa Grande Band of Diegueño Mission Indians of the Mesa Grande Reservation
Pala Band of Mission Indians
Pauma Band of Luiseño Mission Indians of the Pauma & Yuima Reservation
Rincon Band of Luiseño Indians
San Pasqual Band of Diegueño Mission Indians of California
Santa Rosa Band of Cahuilla Indians
Sycuan Band of the Kumeyaay Nation

**Tanana Chiefs Conference**, whose members include:
Alatna Village
Allakaket Village
Anvik Village
Arctic Village
Beaver Village
Birch Creek Tribe
Canyon Village Traditional Council*
Chalkyitsik Village
Circle Native Community
Evansville Village (Bettles Field)
Galena Village (Louden Village)
Healy Lake Village
Holy Cross Village
Hughes Village
Huslia Village
Kaktovik Village (Barter Island)
Koyukuk Native Village
Manley Hot Springs Village
McGrath Native Village
Medfra Traditional Council*
Native Village of Eagle
Native Village of Fort Yukon

Native Village of Minto
Native Village of Ruby
Native Village of Stevens
Native Village of Tanacross
Native Village of Tanana
Native Village of Tetlin
Nenana Native Association
Nikolai Village
Northway Village
Nulato Village
Organized Village of Grayling (Holikachuk)
Qawalangin Tribe of Unalaska Rampart Village
Shageluk Native Village
Takotna Village
Telida Village
Tok Native Association*
Village of Dot Lake
Village of Kaltag
Village of Venetie

**USET Sovereignty Protection Fund**, whose members include:
Alabama-Coushatta Tribe of Texas
Aroostook Band of Micmacs
Catawba Indian Nation (Catawba Tribe of South Carolina)
Cayuga Nation
Chitimacha Tribe of Louisiana
Coushatta Tribe of Louisiana
Eastern Band of Cherokee Indians
Houlton Band of Maliseet Indians
Jena Band of Choctaw Indians
Mashantucket Pequot Indian Tribe
Mashpee Wampanoag Tribe
Miccosukee Tribe of Indians
Mississippi Band of Choctaw Indians
Mohegan Tribe
Narragansett Indian Tribe
Oneida Nation
Pamunkey Indian Tribe
Passamaquoddy Tribe
Penobscot Nation

Poarch Band of Creeks
Saint Regis Mohawk Tribe
Seminole Tribe of Florida
Seneca Nation of Indians
Seneca—Cayuga Nation
Shinnecock Indian Nation
Tunica-Biloxi Indian Tribe
Wampanoag Tribe of Gay Head (Aquinnah)

**Yukon-Kuskokwim Health Corporation**, whose members include:
Akiachak Native Community
Akiak Native Community
Algaaciq Native Village (St. Mary's)
Anvik Village
Asa'carsarmiut Tribe
Chevak Native Village
Chuloonawick Native Village
Emmonak Village
Holy Cross Village
Iqurmuit Traditional Council
Kasigluk Traditional Elders Council
Lime Village
Native Village of Chuathbaluk (Russian Mission, Kuskokwim)
Native Village of Eek
Native Village of Georgetown
Native Village of Hamilton
Native Village of Hooper Bay
Native Village of Kipnuk
Native Village of Kongiganak
Native Village of Kwigillingok
Native Village of Kwinhagak (Quinhagak)
Native Village of Marshall (Fortuna Ledge)
Native Village of Mekoryuk
Native Village of Napaimute
Native Village of Napakiak
Native Village of Napaskiak
Native Village of Nightmute
Native Village of Nunam Iqua
Native Village of Nunapitchuk
Native Village of Paimiut

Native Village of Pitka's Point
Native Village of Scammon Bay
Native Village of Tuntutuliak
Native Village of Tununak
Newtok Village
Nunakauyarmiut Tribe
Organized Village of Grayling (Holikachuk)
Organized Village of Kwethluk
Orutsararmiut Traditional Native Council
Oscarville Traditional Village
Pilot Station Traditional Village
Shageluk Native Village
Tuluksak Native Community
Umkumiut Native Village
Village of Alakanuk
Village of Aniak
Village of Atmautluak
Village of Bill Moore's Slough
Village of Chefornak
Village of Crooked Creek
Village of Kalskag
Village of Kotlik
Village of Lower Kalskag
Village of Ohogamiut
Village of Red Devil
Village of Sleetmute
Village of Stony River
Yupiit of Andreafski

## ***Amici* National Tribal Organizations**

The **National Indian Health Board** (NIHB) is a non-profit organization representing tribal governments and their interests in health care matters. NIHB serves and represents Tribal Nations that operate their own health care delivery systems through contracting and compacting, and those that receive health care

directly from the federal Indian Health Service (IHS). NIHB provides a variety of services to Tribal Nations, the Area Health Boards, tribal organizations, federal agencies, and private foundations, including advocacy, policy development, research and training on Indian health issues, and tracking legislation and regulations.

The **National Council of Urban Indian Health** (NCUIH) is a 501(c)(3) non-profit organization founded in 1998 to support the development of quality, accessible, and culturally sensitive health care programs for American Indians and Alaska Natives living in urban communities. NCUIH serves as the national representative of the 41 urban Indian organizations providing health care services pursuant to a grant or contract with the IHS under Title V of the IHCIA.

The **National Congress of American Indians** (NCAI), founded in 1944, is the oldest, largest and most representative organization made up of American Indian and Alaska Native tribal governments and their citizens. NCAI's mission is to advocate on behalf of all Tribal Nations for the preservation of tribal lands and resources and improved federal Indian law and policy, and to inform the public and all branches of the federal government about tribal self-government, treaty rights, and a broad range of federal policy issues affecting tribal governments.

# ADDENDUM B



(2) ELIGIBILITY.—To be eligible for a grant under paragraph (1), a State Attorney General shall submit an application to the designated State agency at such time, in such manner, and containing such information, as specified by the State.

(3) TECHNICAL ASSISTANCE AND TRAINING DESCRIBED.—For purposes of paragraph (1)(B), technical assistance and training is—

(A) the identification of eligible pregnant women experiencing domestic violence, sexual violence, sexual assault, or stalking;

(B) the assessment of the immediate and short-term safety of such a pregnant woman, the evaluation of the impact of the violence or stalking on the pregnant woman's health, and the assistance of the pregnant woman in developing a plan aimed at preventing further domestic violence, sexual violence, sexual assault, or stalking, as appropriate;

(C) the maintenance of complete medical or forensic records that include the documentation of any examination, treatment given, and referrals made, recording the location and nature of the pregnant woman's injuries, and the establishment of mechanisms to ensure the privacy and confidentiality of those medical records; and

(D) the identification and referral of the pregnant woman to appropriate public and private nonprofit entities that provide intervention services, accompaniment, and supportive social services.

(4) ELIGIBLE PREGNANT WOMAN.—In this subsection, the term "eligible pregnant woman" means any woman who is pregnant on the date on which such woman becomes a victim of domestic violence, sexual violence, sexual assault, or stalking or who was pregnant during the one-year period before such date.

Definition.

(e) PUBLIC AWARENESS AND EDUCATION.—A State may use amounts received under a grant under section 10212 to make funding available to increase public awareness and education concerning any services available to pregnant and parenting teens and women under this part, or any other resources available to pregnant and parenting women in keeping with the intent and purposes of this part. The State shall be responsible for setting guidelines or limits as to how much of funding may be utilized for public awareness and education in any funding award.

Guidelines.

**SEC. 10214. APPROPRIATIONS.**

42 USC 18204.

There is authorized to be appropriated, and there are appropriated, $25,000,000 for each of fiscal years 2010 through 2019, to carry out this part.

## PART III—INDIAN HEALTH CARE IMPROVEMENT

**SEC. 10221. INDIAN HEALTH CARE IMPROVEMENT.**

(a) IN GENERAL.—Except as provided in subsection (b), S. 1790 entitled "A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes.", as reported by the Committee on Indian Affairs of the Senate in December 2009, is enacted into law.

Incorporation by reference.
25 USC 1601 *et seq.*

(b) AMENDMENTS.—

25 USC 1616*l*.

(1) Section 119 of the Indian Health Care Improvement Act (as amended by section 111 of the bill referred to in subsection (a)) is amended—

(A) in subsection (d)—

(i) in paragraph (2), by striking "In establishing" and inserting "Subject to paragraphs (3) and (4), in establishing"; and

(ii) by adding at the end the following:

"(3) ELECTION OF INDIAN TRIBE OR TRIBAL ORGANIZATION.—

"(A) IN GENERAL.—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than Alaska) in which the use of dental health aide therapist services or midlevel dental health provider services is authorized under State law to supply such services in accordance with State law.

"(B) ACTION BY SECRETARY.—On an election by an Indian tribe or tribal organization under subparagraph (A), the Secretary, acting through the Service, shall facilitate implementation of the services elected.

"(4) VACANCIES.—The Secretary shall not fill any vacancy for a certified dentist in a program operated by the Service with a dental health aide therapist."; and

(B) by adding at the end the following:

"(e) EFFECT OF SECTION.—Nothing in this section shall restrict the ability of the Service, an Indian tribe, or a tribal organization to participate in any program or to provide any service authorized by any other Federal law.".

25 USC 1616r.

(2) The Indian Health Care Improvement Act (as amended by section 134(b) of the bill referred to in subsection (a)) is amended by striking section 125 (relating to treatment of scholarships for certain purposes).

(3) Section 806 of the Indian Health Care Improvement Act (25 U.S.C. 1676) is amended—

(A) by striking "Any limitation" and inserting the following:

"(a) HHS APPROPRIATIONS.—Any limitation"; and

(B) by adding at the end the following:

Applicability.
Abortions.

"(b) LIMITATIONS PURSUANT TO OTHER FEDERAL LAW.—Any limitation pursuant to other Federal laws on the use of Federal funds appropriated to the Service shall apply with respect to the performance or coverage of abortions.".

42 USC 1395*l*, 1395qq.

(4) The bill referred to in subsection (a) is amended by striking section 201.

## Subtitle C—Provisions Relating to Title III

### SEC. 10301. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR AMBULATORY SURGICAL CENTERS.

(a) IN GENERAL.—Section 3006 is amended by adding at the end the following new subsection:

"(f) AMBULATORY SURGICAL CENTERS.—

"(1) IN GENERAL.—The Secretary shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social