Nos. 11-393 & 11-400

IN THE
SUPREME COURT OF THE UNITED STATES

NATIONAL FEDERATION OF INDEPENDENT BUSINESS, ET AL.

Petitioners,

v.

KATHLEEN SEBELIUS, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

Respondents.

STATES OF FLORIDA, ET AL., PETITIONERS HHS, NO. 11-400

FLORIDA, ET AL,

Petitioners,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.

Respondents.

On Writs of Certiorari
to the United States Courts of Appeals
for the Eleventh Circuit

BRIEF OF AMICI CURIAE OF THE NATIONAL INDIAN HEALTH BOARD; AFFILIATED TRIBES OF NORTHWEST INDIANS; BRISTOL BAY AREA HEALTH CORPORATION; CONSOLIDATED TRIBAL HEALTH PROJECT, INC.; COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS; JAMESTOWN S'KLALLAM TRIBE OF

WASHINGTON; KOOTENAI TRIBE OF IDAHO; LUMMI NATION; MANIILAQ ASSOCIATION; MENOMINEE INDIAN TRIBE OF WISCONSIN, METLAKATLA INDIAN COMMUNITY; MISSISSIPPI BAND OF CHOCTAW INDIANS; NATIONAL CONGRESS OF AMERICAN INDIANS; NORTHERN VALLEY INDIAN HEALTH, INC.; NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD; NORTON SOUND HEALTH CORPORATION; SEMINOLE TRIBE OF FLORIDA; SUQUAMISH INDIAN TRIBE; SUSANVILLE INDIAN RANCHERIA; SWINOMISH INDIANS OF THE SWINOMISH RESERVATION; AND THE UNITED SOUTH AND EASTERN TRIBES, INC., IN SUPPORT OF RESPONDENT UNITED STATES

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January __, 2012

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GLOSSARY OF ACRONYMS

ACA	Patient Protection and Affordable Care Act
AFA	Annual Funding Agreement
DHHS	Department of Health and Human Services
IHS	Indian Health Service, an Agency of the DHHS
ISDEAA	Indian Self-Determination & Education Assistance Act

ATTACHMENT A

LIST OF MEMBER TRIBES OF *AMICI* TRIBAL ORGANIZATIONS

Affiliated Tribes of Northwest Indians (AK, WA, OR, ID, CA, MT, NV)

Organized Village of Kasaan

Central Council of the Tlingit & Haida Indian Tribes

Hoopa Valley Tribe, California

Karuk Tribe

Blackfeet Tribe of the Blackfeet Indian Reservation of Montana

Chippewa-Cree Indians of the Rocky Boy's Reservation, Montana

Confederated Salish & Kootenai Tribes of the Flathead Reservation, Montana

Shoshone-Paiute Tribes of the Duck Valley Reservation, Nevada

Summit Lake Paiute Tribe of the Duck Valley Reservation, Nevada

Chinook Tribe

Duwamish Tribe

Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon

Confederated Tribes of the Chehalis Reservation, Washington

Coeur D'Alene Tribe of the Coeur D'Alene Reservation, Idaho

Confederated Tribes of the Colville Reservation, Washington

Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon

Coquille Tribe of Oregon

Cow Creek Band of Umpqua Indians of Oregon

Cowlitz Indian Tribe, Washington

Confederated Tribes of the Grand Ronde Community of Oregon

Hoh Indian Tribe of the Hoh Indian Reservation, Washington

Jamestown S'Klallam Tribe of Washington

Kalispel Indian Community of the Kalispel Reservation, Washington

Klamath Tribes, Oregon

Kootenai Tribe of Idaho

Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington

Lummi Tribe of the Lummi Reservation, Washington

Makah Indian Tribe of the Makah Indian Reservation, Washington

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington

Nez Perce Tribe, Idaho

Nisqually Indian Tribe of the Nisqually Reservation, Washington

Nooksack Indian Tribe of Washington

Northwestern Band of Shoshoni Nation of Utah (Washakie)

Port Gamble Indian Community of the Port Gamble Reservation, Washington

Puyallup Tribe of the Puyallup Reservation, Washington

Quileute Tribe of the Quileute Reservation, Washington

Quinault Tribe of the Quinault Reservation, Washington

Samish Indian Tribe, Washington

Sauk-Suiattle Indian Tribe of Washington

Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation, Washington

Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho

Confederated Tribes of Siletz Indians of Oregon (previously listed as the Confederated Tribes of the Siletz Reservation)

Skokomish Indian Tribe of the Skokomish Reservation, Washington

Snoqualmie Tribe, Washington

Snohomish Tribe

Spokane Tribe of the Spokane Reservation, Washington

Squaxin Island Tribe of the Squaxin Island Reservation, Washington

Steilacoom Tribe

Stillaguamish Tribe of Washington

Suquamish Indian Tribe of the Port Madison Reservation, Washington

Swinomish Indians of the Swinomish Reservation, Washington

Tulalip Tribes of the Tulalip Reservation, Washington

Confederated Tribes of the Umatilla Reservation, Oregon

Upper Skagit Indian Tribe of Washington

Confederated Tribes of the Warm Springs Reservation of Oregon

Confederated Tribes and Bands of the Yakama Nation, Washington

Bristol Bay Area Health Corporation (AK)

Portage Creek Village (aka Ohgsenakale)

Ekwok Village

New Stuyahok Village

New Koliganek Village Council

Dillingham (Curyung Tribal Council)

Native Village of Aleknagik

Village of Clarks Point

Native Village of Ekuk

Knugank Tribal Council

Chignik Bay Tribal Council

Native Village of Chignik Lagoon

Chignik Lake Village

Native Village of Perryville

Ivanof Bay Village

Manokotak Village

Twin Hills Village

Traditional Village of Togiak

Native Village of Goodnews Bay

Platinum Traditional Village

Ugashik Village

Native Village of Pilot Point

Egegik Village

Naknek Native Village

South Naknek Village

Levelock Village

King Salmon Tribe

Native Village of Port Heiden

Native Village of Kanatak

Nondalton Village

Village of Iliamna

Pedro Bay Village

Kokhanok Village

NewhalenVillage

Igiugig Village

Consolidated Tribal Health Project, Inc. (CA)

Cahto Indian Tribe of the Laytonville Rancheria, California

Coyote Valley Band of Pomo Indians of California

Guidiville Rancheria of California

Hopland Band of Pomo Indians of the Hopland Rancheria, California

Pinoleville Pomo Nation, California

Potter Valley Tribe, California

Redwood Valley Rancheria of Pomo Indians of California

Sherwood Valley Rancheria of Pomo Indians of California

Council of Athabascan Tribal Governments (AK)

Arctic Village (Native Village of Venetie Tribal Government)

Beaver Village

Birch Creek Tribe

Canyon Village

Chalkyitsik Village

Circle Native Community

Native Village of Fort Yukon

Rampart Village

Native Village of Stevens

Village of Venetie (Native Village of Venetie Tribal Government)

Maniilaq Association (AK)

Native Village of Kotzebue

Native Village of Ambler

Native Village of Buckland

Native Village of Kiana

Native Village of Kivalina

Native Village of Kobuk

Native Village of Noatak

Noorvik Native Community

Native Village of Point Hope

Native Village of Selawik

Native Village of Shungnak

Northwest Portland Area Indian Health Board (WA, OR, ID, UT)

Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon

Confederated Tribes of the Chehalis Reservation, Washington

Coeur D'Alene Tribe of the Coeur D'Alene Reservation, Idaho

Confederated Tribes of the Colville Reservation, Washington

Confederated Tribes of the Coos, Lower Umpqua and Siuslaw Indians of Oregon

Coquille Tribe of Oregon

Cow Creek Band of Umpqua Indians of Oregon

Cowlitz Indian Tribe, Washington

Confederated Tribes of the Grand Ronde Community of Oregon

Hoh Indian Tribe of the Hoh Indian Reservation, Washington

Jamestown S'Klallam Tribe of Washington

Kalispel Indian Community of the Kalispel Reservation, Washington

Klamath Tribes, Oregon

Kootenai Tribe of Idaho

Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington

Lummi Tribe of the Lummi Reservation, Washington

Makah Indian Tribe of the Makah Indian Reservation, Washington

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington

Nez Perce Tribe, Idaho

Nisqually Indian Tribe of the Nisqually Reservation, Washington

Nooksack Indian Tribe of Washington

Northwestern Band of Shoshoni Nation of Utah (Washakie)

Port Gamble Indian Community of the Port Gamble Reservation, Washington

Puyallup Tribe of the Puyallup Reservation, Washington

Quileute Tribe of the Quileute Reservation, Washington

Quinault Tribe of the Quinault Reservation, Washington

Samish Indian Tribe, Washington

Sauk-Suiattle Indian Tribe of Washington

Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation, Washington

Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho

Confederated Tribes of the Siletz Indians of Oregon

Skokomish Indian Tribe of the Skokomish Reservation, Washington

Snoqualmie Tribe, Washington

Spokane Tribe of the Spokane Reservation, Washington

Squaxin Island Tribe of the Squaxin Island Reservation, Washington

Stillaguamish Tribe of Washington

Suquamish Indian Tribe of the Port Madison Reservation, Washington

Swinomish Indians of the Swinomish Reservation, Washington

Tulalip Tribes of the Tulalip Reservation, Washington

Confederated Tribes of the Umatilla Reservation, Oregon

Upper Skagit Indian Tribe of Washington

Confederated Tribes of the Warm Springs Reservation of Oregon

Confederated Tribes and Bands of the Yakama Nation, Washington

Norton Sound Health Corporation (AK)

Native Village of Brevig Mission

Native Village of Council

Native Village of Diomede

Native Village of Elim

Native Village of Gambell

Chinik Eskimo Community (Golovin)

King Island Community

Native Village of Koyuk

Mary's Igloo

Nome Eskimo Community

Native Village of St. Michael

Native Village of Savoonga

Native Village of Shaktoolik

Native Village of Shishmaref

Village of Solomon

Stebbins Community Association

Native Village of Teller

Native Village of Unalakleet

Native Village of Wales

Native Village of White Mountain

United South and Eastern Tribes, Inc. (ME, NY, MA, MS, NC, NY, FL, SC, LA, AL, RI, CT, TX)

Eastern Band of Cherokee Indians of North Carolina

Miccosukee Tribe of Indians of Florida

Mississippi Band of Choctaw Indians, Mississippi

Seminole Tribe of Florida

Chitimacha Tribe of Louisiana

Seneca Nation of New York

Coushatta Tribe of Louisiana

Saint Regis Mohawk Tribe, New York

Penobscot Tribe of Maine

Passamaquoddy Tribe of Maine

Houlton Band of Maliseet Indians of Maine

Tunica-Biloxi Tribe of Louisiana

Poarch Band of Creek Indians of Alabama

Narragansett Indian Tribe of Rhode Island

Mashantucket Pequot Tribe of Connecticut

Wampanoag Tribe of Gay Head (Aquinnah) of Massachusetts

Alabama-Coushatta Tribes of Texas

Oneida Nation of New York

Aroostook Band of Micmac Indians of Maine

Catawba Indian Nation

Jena Band of Choctaw Indians, Louisiana

Mohegan Indian Tribe of Connecticut

Cayuga Nation of New York

Mashpee Wampanoag Tribe, Massachusetts

Shinnecock Indian Tribe

INTEREST OF *AMICI*[1]

The [insert number] tribes across the nation who are *amici* or members of *amici* tribal organizations represented on this brief are direct beneficiaries of several Indian-specific provisions included in the Patient Protection and Affordable Care Act (―Act" or "ACA")[2] that have a separate purpose and genesis from the minimum coverage provision that the Eleventh Circuit Court of Appeals declared unconstitutional but severable from remaining provisions of the Act.[3] The Indian-specific provisions of the ACA are legally separable from the remainder of the Act, are related solely to the Federal responsibility to provide health care to Indian tribes and their members, and are of critical importance to the delivery of health care services to Indian tribes and their members throughout the country.

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[1] No counsel for a party authored this brief in whole or part, and no person other than *amici* made a monetary contribution to the preparation or submission of this brief.

[2] The Patient Protection and Affordable Care Act, Pub.L. No. 111–148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010 (―HCERA"), Pub.L. No. 111–152, 124 Stat. 1029 (2010).

[3] The Eleventh Circuit Court of Appeals decision is reported at *Florida v. United States Department of Health and Human Services*, 648 F.3d 1235 (11th Cir. 2011). The district court decision is reported at *Florida v. United States Department of Health and Human Services*, 780 F. Supp. 2d 1256 (N.D. Fla. 2011) *order clarified*, 780 F. Supp. 2d 1307 (N.D. Fla. 2011), *aff'd in part, rev'd in part sub nom. Florida v. HHS.*

Amici include federally-recognized tribes and tribal organizations from across the nation, many of which are located in the Petitioner states.[4]

The National Indian Health Board (NIHB) represents tribal governments—both those that operate their own health care delivery systems through contracting and compacting under the ISDEAA, and those receiving health care directly from the Indian Health Service. Its Board of Directors is made up of tribal member representatives from twelve Area Health Boards which are organized to correspond to the twelve IHS service areas. NIHB provides a variety of services to tribes, 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.

Amici Jamestown S'Klallam Tribe of Washington; Kootenai Tribe of Idaho; Lummi Nation; Menominee Indian Tribe of Wisconsin, Metlakatla Indian Community; Mississippi Band of Choctaw Indians; Seminole Tribe of Florida; Suquamish Indian Tribe; Susanville Indian Rancheria; and the Swinomish Indians of the Swinomish Reservation are federally-recognized tribes.

Amici National Indian Health Board; Affiliated Tribes of Northwest Indians; Bristol Bay Area Health Corporation; Consolidated Tribal Health Project, Inc.;

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[4] One or more of *amici* tribes or tribes who are members of *amici* tribal organizations are located within 23 of the 26 Petitioner states. No federally-recognized tribes are located in Georgia, Ohio or Pennsylvania.

Council of Athabascan Tribal Governments; Maniilaq Association; National Congress of American Indians; Northern Valley Indian Health, Inc.; Northwest Portland Area Indian Health Board; Norton Sound Health Corporation; and United South and Eastern Tribes, Inc. are tribal organizations[5] representing consortiums of federally-recognized tribes.

Amici tribes and tribal organizations have extensive knowledge of Indian health care policy and the implementation of federal laws related to Indian health care. *Amici* also have considerable experience with the history and operation of current health care laws, including the IHCIA and the legislative history of the reauthorization and amendment of the IHCIA enacted in Section 10221 of the ACA and other related Indian-specific provisions in the ACA.

Many of the *amici* tribes and tribal organizations have entered into agreements with the Secretary of Health and Human Services, acting through the Indian Health Service (―IHS”), pursuant to authority of the Indian Self-Determination and Education Assistance Act (―ISDEAA”), 25 U.S.C. § 450 et seq., through which they provide health care services directly to Indian people in their geographic areas.

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[5] A list of the member tribes of each of the tribal organizations listed in this paragraph is attached as Attachment A.

Amici submit this brief with the consent of all parties. If this Court reaches the question of severability, the *amici* believe the brief will help the Court understand the severability question in a broader context framed by the unique history of the IHCIA and other Indian-specific provisions of the ACA.

ARGUMENT

The IHCIA amendments and several other beneficial Indian provisions of the ACA have a separate genesis from the minimum coverage provision, are not connected to or dependent on the application of minimum coverage, and involve legally independent rights and obligations related solely to Indian tribes, Indian people and Indian health providers. The IHCIA amendments were developed over a period of ten years in a separate legislative process from the ACA. The Indian-specific provisions were put into the Senate's health care reform bill that became the ACA because it was a moving legislative vehicle, not because they were part of or related to the minimum coverage component or integral pieces of the general health care reform fabric.

Amici agree with the Court of Appeals' conclusion that the district court's ―wholesale" invalidation of the ACA was improper. Based on a detailed review of the Act's provisions, the court concluded that the ―lion's share" of the provisions of

the ACA are ―wholly unrelated” to minimum coverage and should remain intact. 648 F.3d at 1322-23.[6]

The independent, stand-alone Indian-specific provisions are among the ―lion's share” of provisions of the ACA that are ―wholly unrelated” to minimum coverage. As a practical matter, many of the Indian-specific provisions have been effectively implemented already by IHS and the tribes, well ahead of the minimum coverage requirement, which does not take effect until 2014. And, as demonstrated below, the Indian-specific provisions can and do function independently ―in a *manner* consistent with the intent of Congress.” *Alaska Airlines, Inc. v. Brock,* 480 U.S. 678, 685 (1987).[7]

We begin with a discussion of the history of Congress's involvement in Indian health care policy and describe the separate purposes and genesis of ACA Section 10221 incorporating the IHCIA amendments, as well as the other Indian-specific provisions in the ACA. We then show that, consistent with governing severability rules, the Indian-specific provisions of the ACA are independent, freestanding laws

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[6] It is clear that the ACA is a package of many diverse provisions. Even a casual reading of the ACA demonstrates that Congress did not seek to achieve only one purpose in this massive law. The Court of Appeals' exhaustive review and catalog of the Act's provisions is summarized in Appendix I to the opinion. *See* 648 F.3d at 1365-71.

[7] We note that the Attorney General for the State of Washington has acknowledged that IHCIA is severable from rest of the ACA. The States' Court of Appeals brief at page 65 n. 8. This is not mentioned in the States' cert petition. [Need to check if this is in Petitioner States' Brief on merits.]

that should remain intact even if this Court determines that the minimum coverage provision is unconstitutional.

I. Section 10221, reauthorizing and amending the IHCIA, is fully operative as law and is not related to and does not depend on the minimum coverage provision.

Originally enacted in 1976, the Indian Health Care Improvement Act is one of many distinct and specialized federal laws designed by Congress to address the unique needs of tribal communities and to carry out the Federal government's trust responsibility to Indians.[8] Since 1976, the IHCIA has functioned as the stand-alone statutory framework for the delivery of health care services to Indian people, independent of any requirement that individual Indians obtain minimum coverage health insurance. For over ten years, *amici* tribes and tribal organizations worked with Congress to urge enactment of much needed improvements to the IHCIA. This effort resulted in the drafting of S. 1790, a separate and independent bill favorably reported by the Senate Committee on Indian Affairs. The IHCIA amendments thus

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[8] The IHCIA and other provisions reflect the Federal government's trust responsibility and legal obligation to provide health care services to Indian tribes and Indian people. 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.*, President's Memorandum on Tribal Consultation, 74 Fed. Reg. 57881 (Nov. 9, 2009), and Executive Order 13175 on Consultation and Coordination with Tribes, as guided by the trust relationship, 65 Fed. Reg. 67249 (Nov. 6, 2000).

had a separate legislative genesis from the process that produced the bulk of the ACA.

S. 1790, the IHCIA amendments legislation, was added as Section 10221 to H.R. 3590, the Senate's health care reform legislation, just two days before that bill which became the ACA was passed by the Senate. On December 22, 2009, the Senate adopted a Manager's package of amendments, one of which was a new Part III to Title X titled ―Indian Health Care Improvement.”[9] Part III consisted solely of Section 10221, a single page of legislation incorporating by reference over 260 pages of amendments to the IHCIA that originated as S. 1790, with four alterations to the text of that measure. H.R. 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. 111-148.

S. 1790, titled the ―Indian Health Care Improvement Reauthorization and Extension Act of 2009”, came out of a different committee than the remainder of the ACA, and has an entirely distinct legislative history. S. 1790 was introduced on October 15, 2009, by Senator Byron Dorgan and 15 co-sponsors; it was referred to the Senate Committee on Indian Affairs, the panel with primary jurisdiction over Indian health. By contrast, H.R. 3590 was the product of the Majority Leader's

[9] S. Amdt. 3276: Roll Vote No. 387, 111th Cong., 155 Cong. Rec. S13716 (daily ed. Dec. 22, 2009) and 155 Cong. Rec. S13504 (daily ed. Dec. 19, 2009) [text of Amdt. 3276].

reconciliation of health care reform measures considered and approved by two other Senate committees – Finance and Health, Education, Labor and Pensions (HELP) – which have jurisdiction over all other health legislation. Amending the IHCIA was not a part of nor related to the efforts of those panels to craft health care reform bills.

The separate genesis of the IHCIA reforms is consistent with Congress's separate and distinct treatment of Indian health care and the delivery of health care services to Indian people. IHCIA was enacted in 1976 in response to the deplorable health status of Indian people, the shameful condition of the Indian hospitals and clinics, and inadequate or non-existent sanitation facilities.[10] After reciting a catalog of the conditions which imperil Indian health, the new 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."[11]

The IHCIA has been reauthorized and amended a number of times since 1976, with extensive substantive amendments enacted in 1992 to strengthen its

[10] The 94th Congress enacted the IHCIA to bring order and direction to the unsatisfactory manner in which Indian health care was then delivered by the Federal government. *See* H.R. Rep. No. 94-1026-Part I, at 1-17 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652-2657.

[11] Indian Health Care Improvement Act, Pub. L. No. 94-437, Sec. 3, *reprinted in* 1976 U.S.C.C.A.N. (90 Stat. 1401).

programmatic provisions. In 1999, a new effort to reauthorize and update 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 – the first time this occurred in more than 15 years.[12] But none of these bills was enacted.

Meanwhile, the health care crisis in Indian country continued. As Senator Byron Dorgan observed in 2009 when introducing the seventh IHCIA Senate bill, ―[w]e 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."[13] Despite improvement in some health status measures over prior decades, Indian health disparities continued to suggest comparisons with third world countries. Senator Dorgan cited to but a few of these: ―Native Americans die of tuberculosis at a rate 600 percent higher 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."[14]

Attacking these health status deficiencies requires a sufficient level of resources, which the Indian health system chronically lacks. When Congress

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[12] Indian Health Care Improvement Act Amendments of 2007, S. 1200: Roll Vote No. 32, 110th Cong., 154 Cong. Rec. S1155 (daily ed. Feb. 26, 2008).

[13] 155 Cong. Rec. S10493 (daily ed. Oct. 15, 2009).

[14] *Id*.

enacted the IHCIA in 1976, it reported that per capita expenditures for Indian health were then “25 percent below per capita expenditures for health care in the average American community.”[15] The problem of inadequate funding has not been cured in the years since 1976. The U.S. Commission on Civil Rights reported that for 2003, the IHS spending for Indian medical care was 62 percent lower than the U.S. per capita amount.[16] It also reported that the per capita amount spent on IHS medical care ($1,194) was only *half* the per capita amount spent on health care for Federal prisoners ($3,808), and at the bottom of the list of all federal health programs.[17] When introducing S. 1790 in the fall of 2009, Senator Dorgan observed that the health care system for Native Americans is “only funded at about half of its need.”[18]

The IHCIA revisions to the Indian health system address these long-standing concerns and are extremely important to Indian tribes. The amendments enacted by the ACA made the IHCIA a permanent Federal law without expiration date; enhanced authorities to recruit/retain health care professionals to overcome high

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[15] H.R. Rep. No. 94-1026-Part I, at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2655.

[16] U.S. Comm’n on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System,* 98 (Sept. 2004), http://www.usccr.gov/pubs/nahealth/nabroken.pdf.

[17] *Id*. The other federal programs in the comparison were: Medicare ($5,915); Veterans Affairs users ($5,213); U.S. per capita ($5,065); Medicaid acute care ($3,879); and the Federal Employees Health Benefit program benchmark ($3,725). *Id.*

[18] 155 Cong. Rec. S10493 (daily ed. Oct. 15, 2009) (statement of Sen. Dorgan).

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 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 but not previously authorized for the Indian health system.

These critical amendments to the IHCIA are not related to and do not depend on the minimum coverage provision, nor has their constitutionality been questioned in any ACA litigation. They should remain intact.

II. Other ACA provisions intended to benefit Indian health and Indian people are not related to and do not depend on the minimum coverage provision.

Several other beneficial Indian provisions were also put into the Senate's health care reform bill:

- In Section 2901[19] Congress grouped into one section three unrelated subsections that benefit individual Indians or the Indian health system administered by tribes: (a) a cross-reference to the cost-sharing exemption for Indians enrolled in a qualified health plan offered through a state Exchange; (b) codification of payer of last resort status for the components of the Indian health provider system; and (c) designation of the IHS, tribes and tribal organizations that operate health programs, and urban Indian organizations as "express lane agencies" which, at the election of the state in which the program is located, are authorized to make Medicaid and CHIP eligibility determinations to facilitate enrollment of eligible individuals in those programs.

- Section 2902[20] amends Sec. 1880 of the Social Security Act, the statutory provision which authorizes IHS and tribally-operated hospitals and clinics to receive reimbursements from Medicare. Sec. 2902 removed the "sunset" date for collection of reimbursements for Medicare Part B services authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173).

[19] These provisions were included in the health care reform bill reported by the Finance Committee and included in H.R. 3590 approved by the Senate. S. Rep. No. 111-89, at 105 (2009).

[20] This provision was included in the Finance Committee's health care reform bill reported to the Senate and was retained in H.R. 3590 as approved by the Senate. *Id.* at 260.

- Sec. 3314[21] 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 Sec. 3314 amendment removed this barrier by directing that effective Jan. 1, 2011, the cost of drugs borne or paid by an Indian pharmacy are to be considered out-of-pocket costs of the patient.

- Section 9021[22] 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 an Indian tribe or tribal organization to its members. The provision overrides the determination by the Internal Revenue Service that the value of health benefits purchased by an Indian tribe for its members constituted taxable income to the member even when a tribe stepped in to provide such coverage to compensate for insufficient funding from the IHS.

These Indian-specific provisions are not related to the minimum coverage provision and their constitutionality has not been challenged. Thus, like the IHCIA component of the ACA, they should remain in full force and effect.

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

III. The Indian–specific provisions of the ACA are among the "lion's share" of the Act's provisions "wholly unrelated" to minimum coverage and should remain intact.

The ACA's Indian-specific provisions make vital improvements to the Indian health care delivery system. None of the Indian-specific provisions described above is related to or dependent upon the efficacy or validity of the minimum coverage provision. In fact, members of Indian tribes are exempt from the penalty for failure to acquire minimum coverage. *See* 26 U.S.C. § 5000A(e)(3). This exemption reflects acknowledgement of the Federal government's trust responsibility for Indian health and is consistent with the Congressional practice of enacting Indian-specific health care laws to carry out that responsibility.

The Indian health care delivery system is distinct from the mainstream health care system. It was established by the Federal government to carry out a Federal responsibility to the indigenous people who, without the IHS system, would not have meaningful access to health services. IHS health care facilities are located in Indian communities. IHS programs are tailored to address the needs of those communities. IHS personnel are responsible for directly providing care unless a tribe elects to take over operation of health programs under the ISDEAA and the IHCIA, as many have done.

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[22] 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.

Unlike the mainstream health delivery system for which the minimum coverage and guaranteed-issue insurance reforms were created, the Indian health system is not insurance-based. Rather, it is designed specifically to perform the Federal trust responsibility for Indian health, and the IHCIA directs how this Federal responsibility is to be carried out. Services to Indian people are provided directly at IHS and tribal hospitals and clinics, supplemented by the purchase of contract health services when such hospitals and clinics are unable to provide them. While these Indian 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 IHS care. Eligibility for IHCIA-authorized programs is defined in Federal regulations based on Indian status and is not dependent on obtaining health insurance.

These laws were enacted to carry out treaty and other land-cession obligations assumed by the United States. They have evolved as programs designed to implement the federal trust responsibility to provide health care to Indians and enhance tribal self-determination and self-governance, while providing tools for tribes to increase the quality and quantity of governmental services, including health

care services, to Indian people. *See generally Cohen's Handbook of Federal Indian Law* §§ 22.01[1] - 22.01[3] (“Obligation to Provide Services”) (2005 ed.).[23]

Neither the district court nor the Eleventh Circuit Court of Appeals analyzed the Indian-specific ACA provisions, and therefore did not make any factual findings that distinguish them from the minimum coverage requirement and related insurance industry reforms. If such analyses were performed, however, application of the Supreme Court's severability rules would demonstrate that the Indian-specific provisions are among the “lion's share” of ACA provisions that are “wholly unrelated” to minimum coverage. *See* 648 F.3d at 1322-23.

As this Court recently 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." *Free Enterprise Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161 (2010) (citations and internal quotation marks omitted). A court should “strive to salvage” as much as

[23] Adopted initially in 1976, the IHCIA, 25 U.S.C. § 1601 et seq., has been amended several times as described above. Congress has repeatedly enacted broad legislation to facilitate tribal control of Federal programs for Indians, including the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450 et seq. (authorizing tribes to contract and control federal programs); Tribally Controlled Schools Act, 25 U.S.C. § 2501 et seq. (education); Native American Housing Assistance and Self-Determination Act, 25 U.S.C. § 4101 et seq. (housing); Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. § 3401 et seq. (employment and work training); Indian Child Welfare Act, 25 U.S.C. § 1901 et seq. (adoption and child welfare). The Supreme Court has long recognized the

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)). ―Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law.” *See Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999) (applying severability principles to executive order) (quoting *Champlin Refining Co. v. Corporation Comm'n of Okla.*, 286 U.S. 210, 234 (1932)).[24]

After careful review of the entire ACA, the 11th Circuit Court of Appeals reversed the district court's ―wholesale” invalidation of the Act. The court concluded that ―[i]n light of the stand-alone nature of hundreds of the Act's provisions and their manifest lack of connection” to minimum coverage, the district court ―erred in its wholesale invalidation of the Act.” 648 F.3d at 1323.[25]

―distinctive obligation of trust incumbent upon the government” in its dealings with tribes. *See Seminole Nation v. United States*, 316 U.S. 286, 296 (1942).

[24] Since respect for Congress's purpose and intent requires careful analysis to determine whether a particular provision of a statute is unconstitutional, it stands to reason that the remaining portions of the statute, presumed valid, should also be scrutinized carefully to determine if they are independent provisions of law and therefore remain valid. ―[A]n Act of Congress ought not to be construed to violate the Constitution if any other possible construction remains available.” *NLRB v. Catholic Bishop of Chicago*, 440 U.S. 490, 500, 99 S.Ct. 1313 (1979).

As summarized by the Court of Appeals, this Court has eschewed wholesale invalidation of statutes. “In the overwhelming majority of cases, the Supreme Court has opted to sever the constitutionally defective provision from the remainder of the statute.” 648 F.3d at 1321, *citing*, *inter alia*, *Free Enterprise Fund*, 130 S.Ct. at 3161–62.[26]

If this Court declares the minimum coverage provision unconstitutional, there may be a legitimate question whether it is integral to implementation of certain other provisions included in the ACA.[27] But there can be no question about the fact that

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[25] The Court of Appeals also ruled that lack of a severability clause in the ACA did not require invalidation of the statute in its entirety, even though a severability clause was included in an earlier version of the legislation but dropped from the version of the bill enacted into law. The presence or absence of a severability clause may inform review, but it is still necessary to analyze whether Congress would have enacted each provision of the statute even when a clause is included in the statute. *See Alaska Airlines, Inc. v. Brock,* 480 U.S. 678, 686 (1987).

[26] In no recent case has the Court questioned the validity of a statute in its entirety without engaging in or requiring an analysis of the relationship between an unconstitutional provision and the remainder of the statute's provisions. *See Randall v. Sorrell*, 548 U.S. 230, 262 (2006), where the Court did strike the entire law, but only after reviewing the entire law and concluding that saving it would have required the Court to, among other things, “write words into the statute.” *See also Ayotte*, 546 U.S. at 329-30 (holding that invalidating the New Hampshire Parental Notification Prior to Abortion Act in its entirely may not be justified and remanding to lower courts to determine if narrower relief was possible).

[27] For example, the courts have divided on the question whether insurance industry reforms such as guaranteed issue and pre-existing conditions must be severed along with the minimum coverage provision. The Court of Appeals in this case reviewed those provisions and allowed them to stand. *See* 648 F.3d at 1323-1328. In *Goudy-Bachman v. United States Department of Health and Human Services*, __ F.Supp.2d __, 2011 WL 4072875 (M.D. Pa. 2011), the court severed those same two market

the Indian-specific provisions are separate and distinct from the controversial minimum coverage provision and related insurance industry reforms included in the ACA.

Simply put, the Indian-specific provisions can and do function independently ~~–in~~ a *manner* consistent with the intent of Congress," *Alaska Airlines,* 480 U.S. at 685 (emphasis in original), and those provisions should remain intact even if the minimum coverage provision is held unconstitutional and severed.

CONCLUSION

If this Court affirms the ruling by the 11th Circuit Court of Appeals that the minimum coverage provision is unconstitutional, we respectfully request that the Court also uphold the Circuit Court's ruling that the remaining provisions of the Act are severable and remain valid, at least with respect to the Indian-specific provisions, which are clearly separable and fully operative as law, and are intended to carry out the well-established special obligations of the United States to Indians.

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reform provisions. The United States argues that the Act's guaranteed-issue and community-rating insurance industry reforms must be severed if the minimum coverage provision is stricken. *See* Respondent United States Brief at__.

Respectfully submitted this ___th day of January, 2012.

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