Nos. 19-840, 19-1019

IN THE

Supreme Court of the United States

CALIFORNIA, *et al.*, *Petitioners*,

v.

TEXAS, *et al.*, *Respondents*.

TEXAS, *et al.*, *Petitioners*,

v.

CALIFORNIA, *et al.*, *Respondents*.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF OF TRIBES AND TRIBAL ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS STATE OF CALIFORNIA, *ET AL.*

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STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

Amici are federally recognized Tribal Nations, local and regional tribal organizations, and national tribal organizations as listed in Appendix A to this brief.[2] Individually or collectively, *amici* all either operate health care facilities and provide direct health care services to their citizens and other beneficiaries, or they advocate on health issues affecting American Indian and Alaska Native people, or both. For the reasons stated below, they will be directly and uniquely affected by the disposition of this case.

When Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA" or "Act"), it enacted along with it several provisions relating specifically to the Indian health system. In particular, Section 10221 amended and modernized the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. §§ 1601–1680v, a stand-alone law first enacted in 1976 that provides the statutory framework for health care programs and services to American Indian and Alaska Native beneficiaries. Congress also enacted other Indian-specific provisions in the ACA to carry out the federal trust responsibility and further improve the status of Indian health through,

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[1] No counsel for any party to this case 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. This brief is filed with the consent of all parties. Written consent from counsel of record for Petitioners State of California, *et al.*, is on file with the authors of this brief. All other parties have granted blanket consent to the filing of *amicus* briefs, as reflected on the docket.

[2] In total, 471 Tribal Nations are represented by *amici curiae*, either directly or indirectly through membership in an *amici* tribal organization.

inter alia, increasing access to federal funding and other resources to support the Indian health system.[3]

These Indian provisions of the ACA have nothing to do with health insurance or the individual mandate deemed unconstitutional by the District Court. Nevertheless, because the District Court held the individual mandate inseverable from the entire Act, its sweeping decision extended to them. The Fifth Circuit vacated the District Court's severability ruling, but agreed that the individual mandate is unconstitutional. If this Court likewise agrees, the *amici* have a vital and urgent interest in ensuring that a proper severability analysis is applied to sustain the separate and severable Indian-specific provisions.

Amici and the tribal health care programs they operate depend on a legal architecture that includes the IHCIA as a critical cornerstone. Many *amici*, for example, have entered into agreements with the Secretary of Health and Human Services, acting through the Indian Health Service (IHS) under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §§ 5301–5399, to provide health care services directly to Indian people in their geographic areas. In carrying out their ISDEAA agreements, *amici* directly implement various provisions of the IHCIA and rely on others (as well as other Indian-specific provisions of the ACA) for crucial legal rights and protections. Over the past decade, these provisions have allowed *amici* and the Indian health system as a whole to modernize in important ways and

[3] As used in this brief, the term "Indian" or "Indians" includes American Indians and Alaska Natives, and the term "Indian health system" refers collectively to Indian Health Service (IHS), tribally operated, and urban Indian health programs serving eligible American Indian and Alaska Native beneficiaries.

to ensure that health care services are delivered to Indian people in the most effective possible manner. Striking them down would be misguided and enormously disruptive—especially now, as Indian Country and the rest of the United States grapple with the deadly coronavirus pandemic.

SUMMARY OF THE ARGUMENT

Should this Court find that the ACA's individual mandate is unconstitutional, it should sever that provision from the remainder of the Act, in particular Section 10221 (the IHCIA amendments) and other Indian-specific provisions enacted by Congress to carry out the federal trust responsibility. These Indian-specific provisions of the ACA have a separate genesis and purpose from the remainder of the Act, and are neither related to nor dependent on the individual mandate specifically or health insurance reform more generally.

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, 1490, 1482 (2018) (internal citations omitted). Applying this standard, Section 10221 and other Indian-specific provisions of the ACA must be preserved. Section 10221 represents only a single page of the ACA, but it incorporates by reference S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009, 111th Cong. (2009), a 274-page bill that amended and updated the IHCIA. The IHCIA was first enacted as a standalone law in 1976, and although the 2010 amendments were ultimately enacted by way of the ACA, they have

a separate legislative history from the remainder of the Act.

More importantly, along with other Indian-specific provisions of the ACA, the IHCIA serves an entirely separate legislative purpose: It provides the foundation for an independent, freestanding Indian health care system that does not depend, in any measure, on operation of the ACA's individual mandate. These provisions include important programmatic authorities for the IHS and Tribal Nations carrying out health care programs and services under the ISDEAA, and expand access to resources to remedy historical underfunding and neglect of the system.

If a provision of a federal statute is unconstitutional but potentially severable, the "touchstone for any decision about remedy is legislative intent[.]" *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 586 (2012) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006)). In enacting S. 1790 by way of the ACA, Congress expressly affirmed a longstanding federal Indian health care policy "in fulfillment of [the federal government's] special trust responsibilities and legal obligations to Indians[.]" S. 1790, 111th Cong. § 103 (2009), as enacted by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221(a), 124 Stat. 935 (2010). Congress has continued to pursue that policy in subsequent legislation that builds on the IHCIA's programmatic provisions, including in its recent emergency response to the coronavirus pandemic.

Striking down the IHCIA amendments and other Indian-specific provisions on the ground that a wholly unrelated private insurance coverage mandate is constitutionally invalid would disregard the trust responsibilities espoused by Congress and subvert

federal Indian health care policy, without any indication that Congress had anticipated—let alone intended—such a result. Because the federal courts "cannot 'use [their] remedial powers to circumvent the intent of the legislature[,]'" the IHCIA amendments and other Indian-specific provisions of the ACA must be preserved. *Ayotte*, 546 U.S. at 330 (2006) (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979) (Powell, J., concurring in part and dissenting in part)).

ARGUMENT

Once a portion of a statute is found unconstitutional, the purpose of the severability rule is to separate and save other portions of the legislation that are practically and legally independent and therefore valid. In *Free Enterprise Fund v. Public Company Accounting Oversight Board*, this Court stated: "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. 477, 508 (2010) (internal citations omitted); *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," *Immigration & Naturalization Serv. 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 587 ("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.").

I. The IHCIA Amendments and other Indian-specific provisions of the ACA are fully operative, independent provisions of law that are not related to or dependent on the individual mandate.

A. The Indian Health Care Improvement Act

The IHCIA is a primary and critical component of the 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 key 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 health services to American Indians and Alaska Natives.[4]

The Indian health care system is unique and exists largely apart from the mainstream health care delivery system in the United States. Services to eligible beneficiaries are provided directly at IHS and tribal hospitals and clinics and urban Indian clinics,

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[4] *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 Apr. 23, 2020).

supplemented by the purchase of health services from other providers where necessary. Funding to support those services is provided through annual appropriations from Congress. While the IHS and tribal 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 prerequisite for receiving direct services through Indian health care providers. Eligibility for IHCIA-authorized programs is defined in federal regulations, 42 C.F.R. § 136.12, and eligible American Indian and Alaska Native patients receive care at no cost to them even when they lack any form of health insurance coverage.[5]

The legislative history of the IHCIA, like its substantive purpose, is distinct from the remainder of the ACA. As originally enacted in 1976, the appropriations authority in 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. Indian Health Amendments of 1992, Pub. L. No. 102-573, 106 Stat. 4526. In 1999, a new effort to reauthorize the expired provisions and make much needed improvements to the IHCIA began. In that year and throughout the ensuing decade, Congress continued to appropriate funds for IHCIA programs through annual appropriations under other authority, while considering legislation to update the law's

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[5] *See* 25 U.S.C. § 1680r(b). In the past, Congress has expressly prohibited the IHS from charging for services, *e.g.*, Pub. L. No. 104-134, 110 Stat. 1321 (1996), and that is still IHS policy today. Although tribal health programs are permitted to charge beneficiaries for services, 25 U.S.C. § 1680r(a), they almost never do.

provisions and make the expired appropriations authority permanent.[6]

On October 15, 2009, Senator Byron Dorgan and 15 co-sponsors introduced S. 1790, an independent bill to amend and reauthorize the IHCIA. 155 Cong. Rec. 24,957 (2009).[7] S. 1790 contained over 270 pages of amendments that modernized the IHCIA and made all of its provisions permanent federal law without an expiration date. The amendments further 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 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, among other changes. Following its introduction, S. 1790 was referred to the Senate Committee on Indian Affairs, the panel with

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[6] *See* Cong. Research Serv., R.41630, *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.

[7] *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 Apr. 23, 2020).

primary jurisdiction over Indian health. It was then reported favorably out of that Committee.[8]

In the meantime, H.R. 3590—which would become the Senate's health care reform legislation and, eventually, the ACA—evolved as the product of the Majority Leader's reconciliation of health care reform measures considered and approved by the Senate Finance Committee and the Health, Education, Labor and Pensions (HELP) Committee. S. 1790 was added to H.R. 3590 later, as part of a Manager's package of amendments adopted by the Senate on December 22, 2009—two days before H.R. 3590 passed the Senate.[9] The relevant amendment added a new Part III to Title X of the ACA, titled "Indian Health Care Improvement." That Part consisted solely of Section 10221, a single page of legislation incorporating by reference and enacting into law S. 1790, and making four alterations to the text of that measure. *See* Appendix B.

When the President signed H.R. 3590 into law on March 23, 2010, S. 1790 (the IHCIA amendments) became law along with it. However, as the Fifth Circuit majority recognized, "[t]he ACA's framework of economic regulations and incentives spans over 900 pages of legislative text and is divided into ten titles. Most of the provisions directly regulating health insurance, including the one challenged in this case, are found in Titles I and II," and "the other titles

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[8] *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).

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

generally address" other topics, including "improv[ing] health care for Native Americans (Title X)." (footnotes omitted). *Texas v. United States,* 945 F.3d 355, 396 (5th Cir. 2019). Judge King's dissenting opinion similarly noted that "the ACA contains countless other provisions that are unrelated to the private insurance market—and many that are only tangentially related to health insurance at all[,]" including "Title III of Part X [sic], which reauthorizes and amends the Indian Health Care Improvement Act, a decades-old statute creating and maintaining the infrastructure for tribal healthcare services." *Id*. at 418 (King, J., dissenting). Thus, although S. 1790 was included in Title X of the massive and sprawling ACA, like many other discrete provisions of the law it is not tied to the individual mandate or other insurance market reform measures concentrated in Titles I and II of that Act.

B. Other Indian-specific Provisions of the ACA

The ACA contains several other beneficial Indian provisions that, like the IHCIA amendments, were added to the Senate's health care reform bill as a matter of legislative convenience and efficiency—not because they were part of or related to the insurance market reforms that include the individual mandate. Instead, like the IHCIA amendments, 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 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 invite 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 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." 155 Cong. Rec. 24,957 (2009) (statement of Sen. Dorgan). 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." *Id.* Even now, funding for the Indian health system remains "inequitable and unequal," as the United States Commission on Civil Rights detailed in a recent report.[10]

Although no provision of the IHCIA or the ACA directly appropriates funding for the Indian health system,[11] 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 affirms that the Indian health system is the payer of last resort, which means that all other forms of payment, including Medicare, Medicaid, the Department of Veterans Affairs,

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[10] 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.

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

and private insurance must pay before the IHS will pay for a service to an eligible beneficiary.[12]

- 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.[13]
- 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 charge, in order to improve access to catastrophic coverage.[14]
- Section 9021 amends the Internal Revenue Code to exclude from an individual tribal

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[12] 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).

[13] 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.

[14] 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. It 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.

> 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.[15]

As with the IHCIA itself, none of these other Indian-specific provisions is related to or dependent upon the individual mandate. They are fully operative as stand-alone law, and therefore they must be preserved unless it is "evident" that Congress would not have enacted them without the individual mandate. *Chadha*, 462 U.S. at 934; *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 586–87.

II. Congress enacted the Indian-specific provisions of the ACA to fulfill its unique trust obligations to Indians, and the Indian-specific provisions continue to serve that goal.

The IHCIA was crafted in response to the deplorable health status of Indian people and the shameful condition of health and sanitation facilities on and around Indian reservations. *See* H.R. Rep. No. 94-1026, pt. 1, at 1–17 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652–57. It is one of many distinct and specialized federal laws designed by Congress to address the unique needs of tribal communities. These laws carry out treaty obligations assumed by the United States in

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[15] This 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. It 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.

exchange for vast cessions of land and resources by Tribal Nations, and implement the federal trust responsibility to Indians that evolved from those and other historical dealings.[16]

In enacting the IHCIA in 1976, Congress expressed a firm commitment to carry out the trust responsibility 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.

Indian Health Care Improvement Act, Pub. L. No. 94-437, Sec. 3, 90 Stat. 1401 (1976). Congress repeated this language and took it a step further in the text of the 2010 amendments to the IHCIA, declaring 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

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[16] *See generally* COHEN'S HANDBOOK OF FEDERAL INDIAN LAW § 22.01[3], at 1384 (Nell Jessup Newton ed., 2012) ("Obligation to Provide Services"). Articulated in treaties, judicial decisions, laws, regulations and policies over more than two centuries, the federal trust responsibility 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); ISDEAA, 25 U.S.C. §§ 5301, 5302, 5381, 5384(a), 5385(a), 5387(g); Exec. Order No. 13,175, 65 Fed. Reg. 67,249 (2000); Memorandum on Tribal Consultation, 2009 Daily Comp. Pres. Doc. 1 (Nov. 5, 2009); Dep't of Health and Human Services, *Tribal Consultation Policy* 1–2 (2010), https://www.hhs.gov/sites/default/files/iea/tribal/tribalconsultation/hhs-consultation-policy.pdf.

health status for Indians and urban Indians and to provide all resources necessary to effect that policy[.]" Pub. L. No. 111-148, § 10221(a), 124 Stat. 935 (2010) (codified at 25 U.S.C. § 1602).[17]

A severability analysis requires the courts to "seek to determine what Congress would have intended in light of the Court's constitutional holding." *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 586 (quoting *United States v. Booker*, 543 U.S. 220, 246 (2005)). It would be wrong to conclude that Congress—without ever saying so—intended the fulfillment of its "special trust responsibilities and legal obligations to Indians" to be contingent on otherwise unrelated private insurance market reforms. It is self-evident from Congress's declaration of purpose in enacting the IHCIA amendments that the 111th Congress, sitting in 2010, would have intended to preserve those and other Indian-specific provisions regardless of the individual mandate. Nothing in the text or the legislative history of the ACA suggests otherwise.

Nor is there anything in the text or legislative history of the Tax Cuts and Jobs Act of 2017, Pub. L. 115-97, 131 Stat. 2054 (TCJA), to indicate that the 115th Congress intended to abandon its federal trust commitments to Indians when it voted to eliminate the individual mandate tax penalty without altering any other provision of the Act. The Conference Report accompanying the TCJA correctly notes that Indians, among other groups, were never subject to the

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[17] When introducing S. 1790 in 2009, 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." 155 Cong. Rec. 24,957 (2009) (statement of Sen. Dorgan).

individual mandate tax penalty to begin with. H.R. Rep. No. 115-466, at 324 (2017); 26 U.S.C. § 5000A(e)(3) (exempting members of Indian tribes). Congress's decision to reduce the amount of that penalty to $0, therefore, would have had no effect on them or on the operation of the distinct, Indian-specific provisions of the ACA. There is no other evidence in the legislative record that Congress in 2017 even *considered* the possibility that eliminating the individual mandate tax penalty could have any impact on the IHCIA amendments or other Indian-specific provisions, let alone that Congress *intended* to unravel them.

Although the individual mandate is now effectively gone, Congress has consistently demonstrated its intent to keep the Indian health system and the legal architecture that supports it fully intact. That intent is reflected in continued annual appropriations for IHCIA and related Indian health programs, *see, e.g.*, Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, 133 Stat. 2534, 2730–34 (2019), and in other legislation addressing public health. For example, less than a year after passing the TCJA, the very same Congress passed measures to increase access to supplemental funding for Tribal Nations and tribal health programs to respond to the national opioid epidemic in American Indian and Alaska Native communities.[18] Likewise, in the Coronavirus Aid,

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[18] *See* Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, § 7073, 132 Stat. 3894, 4031 (2018) (amending 42 U.S.C. § 294i to qualify tribes and tribal health programs, as defined in section 4 of the IHCIA, for grant funding for the education and training of health care professionals in pain care); *id.* § 7181(a), 132 Stat. 3894, 4068–69 (codified at 42 U.S.C. § 290ee-3, note) (amending the 21st Century Cures Act to

Relief, and Economic Security (CARES) Act enacted this past March 27, Pub. L. No. 116-136, tit. VII, 134 Stat. 281, 550–51 (2020), the current Congress authorized an appropriation of over $1 billion in additional resources to "prevent, prepare for, and respond to" coronavirus through the IHS and tribal health programs. Notably, the CARES Act appropriation specifically identifies several IHCIA-authorized programs that are to be included in the utilization of the emergency funds.[19]

Both the opioid crisis and the coronavirus pandemic have disproportionately ravaged American Indian and Alaska Native populations, which suffer high rates of pre-existing conditions and, in some cases, lack reliable access to basic necessities like clean water and

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establish a 5 percent set-aside for grants made available to Indian tribes to address the opioid crisis).

[19] The statutory language states, in relevant part:

> For an additional amount for "Indian Health Services", $1,032,000,000, to remain available until September 30, 2021, to prevent, prepare for, and respond to coronavirus, domestically or internationally, including for public health support, electronic health record modernization, telehealth and other information technology upgrades, Purchased/Referred Care, Catastrophic Health Emergency Fund, Urban Indian Organizations, Tribal Epidemiology Centers, Community Health Representatives, and other activities to protect the safety of patients and staff [.]

Pub. L. No. 116-136, tit. VII, 134 Stat. 281, 550–51 (2020). It also states that "of amounts provided under this heading in this Act, not less than $450,000,000 shall be distributed through IHS directly operated programs and to tribes and tribal organizations under the Indian Self-Determination and Education Assistance Act and through contracts or grants with urban Indian organizations under title V of the Indian Health Care Improvement Act[.]" *Id.*

adequate shelter.[20] The IHCIA and related Indian health provisions, including those enacted as part of the ACA, are intended precisely to increase the capacity of the Indian health system to respond to and address these problems—whether in the context of ordinary primary and preventive care or in the case of public health emergencies.

Given that the "touchstone for any decision about remedy is legislative intent," *Nat'l Fed'n of Indep. Bus.*, 567 U.S. at 586 (quoting *Ayotte*, 546 U.S. at 330), those provisions that can continue to carry out Congress's goal of implementing the federal trust responsibility to Indians should be left to do so, regardless of the impact of the constitutional ruling on *separate* legislative goals that may be reflected in other provisions of the ACA. The Indian-specific provisions still "function in a *manner* consistent with the intent of Congress[,]" *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987), and they are needed now more than ever. It would be extraordinarily disruptive to the Indian health system, and thus to important congressional policy objectives, to upend those provisions simply because they were enacted alongside the ACA's individual mandate.

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[20] *See, e.g.*, Simon Romero, *Checkpoints, Curfews, Airlifts: Virus Rips Through Navajo Nation*, N.Y. TIMES (Apr. 9, 2020), www.nytimes.com/2020/04/09/us/coronavirus-navajo-nation.html; *Opioids in Indian Country: Beyond the Crisis to Healing the Community: Hearing Before the Senate Comm. On Indian Affairs*, 115th Cong. 3 (2018), https://www.indian.senate.gov/sites/default/files/upload/HHS%20IHS%20testimony%20Opioids%20Indian%20Country%20SCIA%203-14-18%20revised.pdf.

CONCLUSION

If this Court deems the ACA's individual mandate unconstitutional, it should sever that provision from, at a minimum, Section 10221 and other Indian-specific provisions enacted by Congress to carry out the federal trust responsibility to Indians. These Indian-specific provisions are not related to or dependent on the individual mandate specifically or health insurance reform more generally, and they implement a separate and distinct legislative purpose. A proper severability analysis thus compels that they remain intact.

Respectfully submitted,

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May 13, 2020

APPENDIX

APPENDIX A

LIST OF *AMICI CURIAE*

Amici Federally Recognized Tribal Nations

Absentee Shawnee Tribe of Indians of Oklahoma
Cabazon Band of Mission Indians
Chemehuevi Indian Tribe of the
Chemehuevi Reservation
Cherokee Nation
Cheyenne and Arapaho Tribes
Chickaloon Native Village
Chippewa Cree Tribe
Choctaw Nation of Oklahoma
Citizen Potawatomi Nation
Confederated Salish and Kootenai Tribes
Confederated Tribes of the Colville Reservation
Confederated Tribes of the
Warm Springs Reservation of Oregon
Coquille Indian Tribe
Eastern Band of Cherokee Indians
Federated Indians of Graton Rancheria
Forest County Potawatomi Community
Fort Belknap Indian Community
Gila River Indian Community
Jamestown S'Klallam Tribe
The Klamath Tribes
Little River Band of Ottawa Indians
Lytton Rancheria of California
Mashantucket Pequot Indian Tribe
Menominee Indian Tribe of Wisconsin
Mille Lacs Band of Ojibwe
Mississippi Band of Choctaw Indians
Mohegan Tribe of Indians of Connecticut
Navajo Nation

Nisqually Indian Tribe
Northern Arapaho Tribe
Oglala Sioux Tribe
Oneida Nation
Pala Band of Mission Indians
Pascua Yaqui Tribe
Passamaquoddy Tribe at Indian Township
Pechanga Band of Luiseño Indians
Ponca Tribe of Nebraska
Puyallup Tribe of Indians
Quinault Indian Nation
Red Lake Band of Chippewa Indians
Saint Regis Mohawk Tribe
Salt River Pima-Maricopa Indian Community
Seminole Tribe of Florida
Seneca Nation
Shoalwater Bay Indian Tribe
Suquamish Tribe
Swinomish Indian Tribal Community
The Viejas Band of Kumeyaay Indians
Wampanoag Tribe of Gay Head (Aquinnah)
Wichita and Affiliated Tribes of Oklahoma
Yurok Tribe

Amici National Tribal Organizations

National Indian Health Board
National Council of Urban Indian Health
National Congress of American Indians

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
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

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[1] Tribal Nations listed with an asterisk are not on the Bureau of Indian Affairs list of federally recognized tribal entities. *Indian Entities Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs*, 85 Fed. Reg. 5462 (January 30, 2020).

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 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 Nanwalek (English Bay)
Native Village of Port Graham
Qutekcak Native Tribe (Seward)*
Native Village of Tatitlek

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

Council of Athabascan Tribal Governments, whose members include:

Arctic Village
Beaver Village
Native Village of Fort Yukon
Canyon Village*
Native Village of Stevens
Chalkyitsik Village
Birch Creek Tribe
Native Village of Venetie Tribal Government
Circle Native Community

Eastern Aleutian Tribes, whose members include:

Agdaagux Tribal Council (from King Cove)
Akutan Tribal Council
False Pass Tribal Council
Nelson Lagoon Tribal Council
Qagan Tayagungin Tribal Council (From Sand Point)
Unga Tribal Council (From Sand Point)
Pauloff Harbor Tribal Council (From Sand Point)

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

Kodiak Area Native Association, whose members include:

Alutiiq Tribe of Old Harbor
Native Village of Afognak
Native Village of Akhiok
Native Village of Larsen Bay

Native Village of Ouzinkie
Native Village of Port Lions
Sun'aq Tribe of Kodiak
Kaguyak Village
Tangirnaq Native Village (aka Woody Island)

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

Mount Sanford Tribal Consortium, whose members include:

Cheesh-Na Tribe
Mentasta Traditional Council

Northern Valley Indian Health, whose members include:

Grindstone Indian Rancheria of Wintun-Wailaki 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 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-Bernardino 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

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
Douglas Indian Association
Hoonah Indian Association
Hydaburg Cooperative Association

Juneau Tlingit & Haida Community Council*
Klawock Cooperative Association
Organized Village of Kake
Organized Village of Kasaan
Petersburg Indian Association
Sitka Tribe of Alaska
Skagway Traditional Council
Wrangell Cooperative Association

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

United South and Eastern Tribes, Inc., whose members include:

Alabama-Coushatta Tribe of Texas
Aroostook Band of Micmacs
Catawba Indian Nation (Catawba Tribe of South Carolina)
Cayuga Nation
Chickahominy Indian Tribe
Chickahominy Indian Tribe – Eastern Division
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 of Florida
Mississippi Band of Choctaw Indians
Mohegan Tribe of Connecticut

Narragansett Indian Tribe
Oneida Indian Nation
Pamunkey Indian Tribe
Passamaquoddy Tribe
Penobscot Nation
Poarch Band of Creeks
Rappahannock Tribe, Inc.
Saint Regis Mohawk Tribe
Seminole Tribe of Florida
Seneca Nation of Indians
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

APPENDIX B

PART III-INDIAN HEALTH CARE IMPROVEMENT

Sec. 10221. Indian Health Care Improvement.

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

(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.

(b) AMENDMENTS.—

(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—
25 USC 1616*l*.

(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 mid-level 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.