IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

REDDING RANCHERIA, a federally-recognized Indian Tribe, Plaintiff, v. SYLVIA MATTHEWS BURWELL, Secretary, United States Department of Health and Human Services, *et al*., Defendants.	)	Civ. No. 14-2035 (RMC)

BRIEF OF ALASKA NATIVE HEALTH BOARD, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD, UNITED SOUTH AND EASTERN TRIBES, INC., JAMESTOWN S'KLALLAM TRIBE, SEMINOLE TRIBE OF FLORIDA, MOHEGAN TRIBE OF CONNECTICUT, AND SUQUAMISH TRIBE AS *AMICI CURIAE* IN OPPOSITION TO DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND IN SUPPORT OF PLAINTIFF'S CROSS-MOTION FOR SUMMARY JUDGMENT

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INTEREST OF *AMICI*[1]

Amici are federally recognized Indian tribes and inter-tribal organizations that operate a variety of health care programs under the Indian Self-Determination and Education Assistance Act (ISDEAA), the Indian Health Care Improvement Act (IHCIA), and their inherent tribal governmental authority.[2] These health programs include, among others, both Contract Health Services (CHS)[3] and tribal self-insurance plans that supplement those CHS programs, similar in many ways to the CHS and self-insurance programs operated by the Redding Rancheria at issue in this case. The CHS program is chronically underfunded.[4] *Amici* and their member tribes, like other tribes across the country, seek to extend and enhance their CHS programs in various ways, including the use of supplemental tribal funding and through access to the Catastrophic Health Emergency Fund (CHEF) program operated by Defendant Indian Health Service (IHS).

Amici and their member tribes have a strong interest in this litigation because the IHS has taken the position in its briefs that Section 2901(b) of the Affordable Care Act (ACA), 25 U.S.C. § 1623(b), overrides the IHS's longstanding policy exempting tribal self-insurance plans from its

[1] No counsel for any party authored this brief in whole or in part, no party or party's counsel contributed money intended to fund preparation or submission of this brief, and no other person or entity other than *amici*, their members and their counsel provided any monetary contribution to fund the preparation or submission of this brief.

[2] Together, *amici* tribes and tribal organizations represent nearly 300 federally recognized tribes across the country. A listing of those tribes is appended hereto as Appendix A.

[3] The Consolidated Appropriation Act of 2014, Pub. L. No. 113-76, changed the name of the Contract Health Service ("CHS") program to the Purchased/Referred Care ("PRC") program. However, to remain consistent with the Parties' briefs and to avoid confusion, *amici* will refer to these programs as "CHS" throughout this brief.

[4] *See, e.g.*, Nat'l Cong. of Am. Indians, *Fiscal Year 2017 Indian Country Budget Request* 57 (Jan. 2016), http://www.ncai.org/resources/ncai-publications/NCAI-2017-BudgetReport-Layout-FINAL.pdf.

"payer of last resort" rule for purposes of CHS and CHEF. This is the first time the IHS has taken such a position in the six years since that provision was enacted by Congress.[5]

Neither *amici* nor other tribes across the country were provided prior notice of the IHS's novel interpretation or the law, nor were they given the opportunity to comment. The IHS has not consulted with tribes on its new interpretation as required by the Indian Health Care Improvement Act,[6] the IHS's own consultation policy,[7] or Executive Order 13175.[8]

The IHS has, simultaneously with this litigation, released a Notice of Proposed Rulemaking that would adopt CHEF regulations treating tribal self-insurance plans as alternate resources for purposes of CHEF eligibility. Catastrophic Health Emergency Fund, 81 Fed. Reg. 4239 (Jan. 26, 2016) (proposed rule). The comment period for that rulemaking was extended until May 10, 2016, and *amici* submitted public comments. 81 Fed. Reg. 12,851 (Mar. 11, 2016) (extending comment period). However, the IHS's legal position in this litigation renders those

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[5] Prior to this litigation, the IHS had not taken the position, at least publically, that it believed that Section 2901(b) rendered tribal self-insured plans an alternate resource, nor was that generally understood to be the case. For example, in 2013 when the GAO issued its report recommending that Medicare-Like Rate authority be extended to non-hospital services, it cited Section 2901(b) and noted that "certain tribally funded insurance plans are not considered alternate resources and the CHS program must pay for care before billing the tribally funded insurance plan." U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-272, INDIAN HEALTH SERVICE: CAPPING PAYMENT RATES FOR NONHOSPITAL SERVICES COULD SAVE MILLIONS OF DOLLARS FOR CONTRACT HEALTH SERVICES 11 n.27. In its response, the HHS did not take exception to this statement. *Id*. at 47.

[6] 25 U.S.C. § 1602(5).

[7] The IHS consultation policy is available at https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_circ_main&circ=ihm_circ_0601 and requires the IHS to consult with tribes on policies that have tribal implications and substantial direct effects on tribes and their relationship to the United States and access to federal programs.

[8] Exec. Order No. 13175, 65 Fed. Reg. 67,249 (Nov. 6, 2000) *reprinted in* 2000 U.S.C.C.A.N. at B77; The White House, *Memorandum for Heads of Executive Departments and Agencies re: Tribal Consultation* (Nov. 5, 2009), https://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president.

comments moot, as it reveals that the IHS has already made a definitive decision to treat tribal supplemental programs as alternate resources despite the early stage of the rulemaking process.

The IHS's unannounced policy decision will have a significant impact on *amici*'s tribal health programs. Federal CHS and CHEF dollars are woefully insufficient to meet the existing demand for health care services to tribal members and their families. In FY 2015, for example, the CHS program denied an estimated $644,953,000 for an estimated 132,000 needed CHS referrals.[9] The underfunding of the CHS program leads to the widespread rationing of care, with CHS funds often available only for priority "level I" care necessary to preserve "life or limb." The CHEF program is similarly underfunded.[10]

Rather than ration care to address only life or limb emergencies, or let tribal members and their families go without care for the portion of the fiscal year after federal CHS and CHEF funding has run out, many tribes have chosen to divert some of their own resources to fill in the gaps. While some tribes have done so on an as-needed basis, others have done so through tribally funded self-insurance programs for their members in various ways, depending on their particular needs and circumstances, consistent with the underlying federal policies of tribal self-determination as reflected in the ISDEAA and IHCIA. The IHS's new policy position will significantly impact *amici*'s and other tribes' ability to do so by treating supplemental tribal funds as "alternate resources" that may preclude that tribe's access to federal CHS funding.

Amici thus have a strong interest in this litigation, and submit this brief to register their opposition to the sudden policy change announced by the IHS in this case. Moreover, *amici* believe this brief will aid the Court in resolving this case by presenting relevant legal arguments

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[9] DEP'T OF HEALTH & HUMAN SERVS., INDIAN HEALTH SERV., JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, FISCAL YEAR 2017 CJ-106 (Jan. 11, 2016).

[10] *Id.*

that have not been fully addressed by the Parties, and by providing a broader policy perspective than can be provided by a single tribal Plaintiff.[11]

SUMMARY OF ARGUMENT

In its Motion for Summary Judgment, the IHS argues that Redding Rancheria's proposal to exempt its self-insurance plan as an alternate resource for purposes of CHS eligibility would violate the "payer of last resort" provision in Section 2901(b) of the ACA, 25 U.S.C. § 1623(b), which (according to Defendants) requires the IHS to modify its longstanding policy exempting tribal self-insurance plans from its payer of last resort rule. Defs.' Mem. Law Supp. Mot. Summ. J. 33, ECF No. 31-1. This argument violates Section 202(d)(5) of the IHCIA, 25 U.S.C. § 1621a(d)(5), which establishes a payer of last resort provision that is specific to the CHEF. It also misinterprets Section 2901(b) and runs counter to everything Congress hoped to achieve in enacting the ACA and permanently reauthorizing the IHCIA in 2010.

Through this brief, *amici* seek to aid the Court in resolving this case by exposing the error of the IHS's position in light of the specific and relevant statutory language as well as the broader statutory and policy context. First, the common legislative purpose behind each of the statutory schemes at issue in this case—the ISDEAA, the IHCIA, and the American Indian and Alaska Native provisions of the ACA—is to acknowledge, define, and implement the federal trust responsibility to provide health care to American Indians and Alaska Natives while maximizing tribal involvement and self-determination in the implementation of federal health care programs.

Second, § 1621a(d)(5), which was permanently reauthorized in the ACA, does not permit the IHS to treat tribal self-insured plans as alternate resources for purposes of CHEF. Section

[11] *Amici* do not object to allowing the IHS an opportunity to respond to these new arguments, if it would like to do so.

1621a(d)(5) authorizes the Secretary to promulgate regulations to deny CHEF payments to any provider "eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement[.]" Tribal sources of reimbursement are absent from this list, yet the IHS's new position essentially adds them as a matter of agency policy. Such action is neither within the Secretary's statutory authority to administer the CHEF program under § 1621a, nor is it authorized by Section 2901(b), which does not override § 1621a(d)(5) or otherwise require any change to longstanding IHS policy.

Finally, the position taken by the IHS in this litigation would penalize those tribes that choose to supplement insufficient federal funding for CHS and CHEF by defining tribal self-insurance as an alternate resource. Through this new policy the IHS would shift the *full* responsibility to fund contract health care to any tribe that chooses to supplement inadequate federal funding, and essentially disclaim *any* responsibility to provide such care as a part of its federal health care responsibilities to Indians, even to the extent that federal funding remains available. This new agency position makes little sense in light of provisions in the IHCIA and ACA designed to increase tribal access to, and ability to leverage, federal resources, and would saddle tribes with a terrible choice: either operate their tribal health programs exclusively with underfunded CHS program dollars and ration care in order to access CHEF, or supplement those dollars to meet the needs of tribal members but risk losing access to CHEF.

Because the IHS's position in this litigation is neither supported nor permitted by the agency's statutory authority, Defendants' Motion for Summary Judgment should be denied.

ARGUMENT

I. The IHS is responsible for carrying out the federal trust responsibility to provide health care to Indians, as directed by Congress.

The United States has a unique and historic trust responsibility to provide health care to American Indians and Alaska Natives. *See* 25 U.S.C. § 1601(1). Initially reflected in promises made in treaties between the United States and the various Indian tribes in exchange for land and cessation of hostilities, the trust responsibility since has been expressed in a number of laws enacted by Congress that authorize, direct, and fund the provision of health care services to Indian people.[12]

Over the course of the 20th Century, funding and access to health care for American Indians and Alaska Natives remained significantly lower than for the general population, leading to widespread and endemic health disparities. *See* U.S. COMM'N ON CIVIL RIGHTS, A QUIET CRISIS: FEDERAL FUNDING AND UNMET NEEDS IN INDIAN COUNTRY 42-43 (2003). In 1975 and 1976, Congress enacted a series of laws intended to address these disparities and increase tribal access to other federal healthcare resources. In 1975, Congress enacted the Indian Self-Determination and Education Assistance Act, Pub. L. No. 93-638, 25 U.S.C. 450 *et seq.*, which enabled tribal governments and tribal organizations like the *amici* to take control of IHS programs and reallocate programs and funding to meet the needs of the beneficiaries they serve.

[12] *See, e.g.,* Snyder Act, 25 U.S.C. § 13; Johnson-O'Malley Act, 25 U.S.C. § 452; Transfer Act, 42 U.S.C. § 2001, *et seq.* (transferring responsibility for Indian health to Public Health Service); and annual appropriations to the Indian Health Service included in the Interior and Related Agencies Appropriations Acts or omnibus appropriations, *e.g.*, Fiscal Year 2016 Consolidated Appropriations Act, Pub. L. No. 114-113 (Dec. 18, 2015).

In 1976, Congress enacted the IHCIA.[13] The IHCIA, Pub. L. No. 94-437, 25 U.S.C. § 1601*, et seq*., was comprehensive IHS reform legislation intended to address: inadequate and under-staffed health facilities; improper or non-existent sanitation facilities; prevalence of disease; poor health status; inadequate funding;[14] low enrollment of Indians in Medicare, Medicaid, and Social Security; and the need for health care for Indian people who had moved from reservations to urban areas, among other things. Recognizing the inadequacy of IHS funding, Congress also enacted amendments to the Social Security Act in 1976 to allow IHS and tribal health programs to bill Medicare and Medicaid. 42 U.S.C. § 1395qq (eligibility of IHS/tribal facilities for Medicare payments); 42 U.S.C. § 1396j (eligibility of IHS/tribal facilities for Medicaid payments).

In 2010, Congress amended and permanently authorized the IHCIA as part of the Affordable Care Act. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 10221 (Mar. 23, 2010). In doing so, Congress found, among other things, that "[a] major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2). Congress further declared that:

> "[I]t is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians –

[13] The IHCIA was amended and permanently reauthorized by Section 10221 of the Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010).

[14] The House Interior and Insular Affairs Committee noted that per capita spending on Indian health in 1976 was 25 percent less than the average American per capita amount. H.R. Rep. No. 94-1026, pt. I, at 16 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2655. According to the U.S. Commission on Civil Rights, IHS per capita spending for Indian medical care in 2003 was 62 percent lower than the U.S. per capita amount. U.S. COMM'N ON CIVIL RIGHTS, BROKEN PROMISES: EVALUATING THE NATIVE AMERICAN HEALTH CARE SYSTEM 98 (2004).

> (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy;
> [. . .]
> (3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities;
> [. . .]
> (5) to require that all actions under this chapter shall be carried out with active and meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination; [and]
> [. . .]
> (7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

25 U.S.C. § 1602. Consistent with these goals, Congress enacted a number of provisions designed to increase tribes' access to and ability to leverage federal resources. For example, Congress provided that tribal health care programs could use federal health care dollars to purchase health coverage for the beneficiaries they served, either through private forms of insurance, or through self-insured plans. 25 U.S.C. § 1642. At the same time, Congress expanded the authority of IHS and tribal health care programs to bill third party resources, but specifically exempted tribal self-insured plans from the IHS's right of recovery unless the Tribe authorized the IHS to do so in writing. 25 U.S.C. § 1621e(f).

Congress also enacted Section 2901(b) of the ACA, now codified at 25 U.S.C. § 1623, in order to increase access to third party alternate resources. Section 2901(b) was added to the ACA at the urging of tribes and tribal organizations like the *amici* in order to codify the IHS's existing payer of last resort regulations at 42 C.F.R. § 136.61. Tribal interest in doing so was primarily motivated by state Medicaid programs, some of which had taken the position over the years that Medicaid's payer of last resort statute, 42 U.S.C. § 1395y(b), trumped the IHS payer of last resort regulations, particularly when tribes supplemented their programs through self-

insured plans. Though some tribes had been successful in convincing the Centers for Medicare and Medicaid Services that tribal self-insured plans for their members were not "alternate," i.e., non-tribal resources,[15] it was believed that codifying the existing IHS regulation in statute would protect tribal health programs from being treated as alternate resources for Medicaid purposes in the future.

Each of these statutory provisions reflects Congress' understanding that the provision of health care services to Indian people is a *federal* trust responsibility, even as tribes are entitled to the maximum possible involvement in federal decision-making and are empowered to exercise self-determination with respect to the provision of services to their members. It is the IHS's primary responsibility to carry out these federal trust duties and specific statutory directives relating to Indian health care.[16]

II. Congress enacted a payer of last resort provision specific to the CHEF in Section 202 of the IHCIA, and nothing in Section 2901 overrides that provision or the consistent and longstanding policy exempting tribal self-insurance plans.

In support of its Motion for Summary Judgment, the IHS argues that Redding Rancheria's proposal to exempt its self-insurance plan as an alternate resource for purposes of CHS eligibility would violate the payer of last resort provision in Section 2901(b). Defs.' Mem. Law Supp. Mot. Summ. J. 33, ECF No. 31-1. The IHS further argues that the enactment of 2901(b) in 2010 invalidated its longstanding rule that tribally-funded self-insured plans are *not* considered alternate resources for purposes of both CHEF and the underlying CHS program. *Id*.

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[15] *See* Exhibit A, Letter from Gerald Walters, Director, Financial Services Group, Centers for Medicare and Medicaid Services, to Mitchell Cypress, Chairman of the Tribal Council, Seminole Tribe of Florida (Jan. 13, 2010).

[16] *See Agency Overview*, INDIAN HEALTH SERVICE, https://www.ihs.gov/aboutihs/overview/ (last visited May 9, 2016).

at 7, 37-38. The IHS's interpretation cannot be squared with the statutory text or purpose of the ACA and the IHCIA.

First, though the IHS relies on Section 2901 of the ACA to support its argument that tribal self-insurance plans are alternate resources for purposes of the CHEF, the CHEF in fact has its own alternate resource rule, codified at Section 202(d)(5) of the IHCIA, 25 U.S.C. § 1621a(d)(5). Section 1621a establishes the CHEF and was added to the IHCIA by the Indian Health Care Amendments of 1988, Pub. L. No. 100-713, § 202, 102 Stat. 4784, 4803 (Nov. 23, 1988). Subsection 1621a(d)(5) has thus been in effect for almost 28 years and provides:

> (d) REGULATIONS.—The Secretary shall promulgate regulations consistent with the provision of this section to—
> [. . .]
> (5) establish a procedure that will ensure that no payment shall be made from CHEF to any provider of treatment to the extent that such provider is eligible to receive payment for the treatment from any other Federal, State, local, or private source of reimbursement for which the patient is eligible.

The list of alternate resources to CHEF in § 1621a(d)(5) does not include tribal self-insured health plans or any other tribal resources. Rather, it is limited to "any other Federal, State, local, or private source of reimbursement for which the patient is eligible." As described in the IHS's own briefs, the IHS has historically interpreted and implemented its payer of last resort regulations at 42 C.F.R. § 136.61 consistently with § 1621a(d)(5) in its CHEF guidelines by excluding tribal self-insurance plans so long as they have an exclusionary clause. *See* Defs.' Mem. Law Supp. Mot. Summ. J. 6, ECF No. 31-1; Defs.' Reply Supp. Mot. Summ. J. 9 n.5, ECF No. 35.

The Secretary has waited until this year to propose the regulations required by § 1621a(d). The proposed rule was published in the Federal Register on January 26, 2016—*after* the commencement of this lawsuit—and would define alternate resources for CHEF as "any

Federal, State, *Tribal*, local or private source of coverage for which the patient is eligible." 81 Fed. Reg. 4239 (Jan. 26, 2016) (emphasis added). IHS added the word "tribal" to the list of alternate resources otherwise listed in 25 U.S.C. § 1621a(d)(5) without explanation, and that addition is beyond the Secretary's rulemaking authority. *Amici* have submitted comments to that effect as part of the ongoing rulemaking process; however, the Secretary is attempting to preempt that process and to achieve the same result through this litigation.

The Secretary cannot expand her statutory authority to implement agency policies simply by pursuing a litigation strategy rather than notice and comment rulemaking.[17] In *Pharmaceutical Research and Manufacturers of America v. Department of Health and Human Services*, 43 F. Supp. 3d 28 (D.D.C. 2014) ("*Pharma*"), this court found that the Secretary's rulemaking authority for the 340B drug discount program was restricted to three distinct matters that did not include adopting a regulation governing 340B discounts for orphan drugs. *Id.* at 39-40. As the court noted in the *Pharma* case, other general rulemaking authority cannot be relied on when the regulation concerns a specific program for which Congress provided specific authority to issue regulations. *Id.* at 40-41. That is the case here, as § 1621a specifically governs the CHEF program. Regardless of the method by which the Secretary adopts and implements her policy—i.e., through rulemaking or litigation—Section 1621a(d) only authorizes the Secretary to deny CHEF funding on the basis of alternate resources to a provider who can obtain reimbursement "from any other Federal, State, local, or private source of reimbursement for

[17] "Agencies are empowered to make policy only insofar as Congress expressly or impliedly delegates that power." *W. Minn. Mun. Power Agency v. Fed. Energy Regulatory Comm'n*, 806 F.3d 588, 593 (D.C. Cir. 2015). *See also*, *Detroit Int'l Bridge Co. v. Gov't of Canada*, 53 F. Supp. 3d 1, 14 (D.D.C. 2014), *judgment entered*, 53 F. Supp. 3d 28 (D.D.C. 2015) ("First, an agency's power is no greater than that delegated to it by Congress. Second, agency actions beyond delegated authority are *ultra vires* and should be invalidated. Third, courts look to an agency's enabling statute and subsequent legislation to determine whether the agency has acted within the bounds of its authority.") (internal quotations and citations omitted).

which the patient is eligible." 25 U.S.C. § 1621a(d)(5). Because this list does not include "tribal" sources of payment, the Secretary lacks authority to treat tribal self-insurance plans as alternate resources for CHEF.

Second, the separate payer of last resort provision in Section 2901(b) of the ACA does not overcome § 1621a(d)(5) with respect to the CHEF program, nor does it compel any change in IHS's longstanding policy with respect to the treatment of tribal self-insurance plans for purposes of CHS. Section 2901(b) simply codifies the payer of last resort status of the IHS *and* of tribes, providing:

> Health programs operated by the Indian Health Service, Indian Tribes, tribal organizations, and Urban Indian organizations (*as those terms are defined in* [*section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603)*]) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

25 U.S.C. § 1623(b) (emphasis added).

The IHS argues in this case that the emphasized parenthetical language in Section 2901(b) restricts payer of last resort status to IHS contracted or compacted CHS programs by referencing the definitions of "Indian health programs" and "tribal health programs" in 25 U.S.C. § 1603(12) and (25) respectively. *See* Defs.' Mem. L. Supp. Mot. Summ. J. 7-8, 7 n.8, ECF No. 31-1. That interpretation of Section 2901(b) is not supported by the plain language of the statute. The definitions in § 1603 to which the parenthetical language refers are the definitions of the "Indian Health Service," "Indian tribes, tribal organizations," and "Urban Indian organizations" in § 1603 paragraphs (18), (14), (26) and (29) respectively – not the term "health program." Section 1603 does not define the term "health program." Though Section 1603 *does* define the terms "Indian health program" and "tribal health program," Section 2901 does not use those terms. Rather, it uses the phrase "health programs operated by. . . Indian tribes." That language

is broader in scope than only IHS programs operated by tribes under ISDEAA agreements, and so the IHS is wrong in asserting that Section 2901(b) compels the policy result it seeks to advance.

Section 2901(b) was enacted by the ACA in 2010, the same legislation that permanently reauthorized § 1621a(d)(5), and there is no reason to interpret them as conflicting or to read Section 2901(b) as superseding § 1621a(d)(5). *Morton v. Mancari*, 417 U.S. 535, 550-51 (1974) ("Where there is no clear intention otherwise, a specific statute will not be controlled or nullified by a general one, regardless of the priority of enactment"); *id*. at 551 ("The courts are not at liberty to pick and choose among congressional enactments, and when two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective."); *accord Halverson v. Slater*, 129 F.3d 180, 185-86 (D.C. Cir. 1997); *see also*, *id*. at 185 (courts "must read the statutes to give effect to each if we can do so while preserving their sense and purpose."). Moreover, any ambiguity in Section 2901(b) must be resolved in favor of the tribal plaintiff under Indian canons of statutory construction. *Cobell v. Norton*, 240 F. 3d 1081, 1101 (D.C. Cir. 2001) (agency interpretation of ambiguous statute not entitled to *Chevron* deference where Indian canon of interpretation applies, requiring statutes to be "construed liberally in favor of Indians, with ambiguous provisions interpreted to their benefit"); *Muscogee (Creek) Nation v. Hodel*, 851 F.2d 1439, 1444-45 (D.C. Cir. 1988).

III. IHS's new policy position is entirely at odds with the purpose of the IHCIA reauthorization and the American Indian/Alaska Native provisions of the ACA, and attempts to force tribes to subsidize a federal responsibility recognized by Congress in those Acts.

The IHS's interpretation is not only contrary to the statutory text and mandatory rules of statutory interpretation, it is also fundamentally inconsistent with Congress' intent to expand

tribal health programs' access to federal health care resources and programs in permanently authorizing the IHCIA, both as a general policy matter and in terms of specific statutory provisions. For example, Congress specifically authorized tribes to provide health coverage to their members using federal funds, including CHS funds, through self-insured plans. 25 U.S.C. § 1642. Under the IHS's interpretation of Section 2901(b), an individual covered under self-insurance funded by CHS dollars could not qualify for the CHS program. Congress surely did not intend to allow tribes to leverage federal program dollars in this manner, only to disqualify them from the benefit of other programs designed to extend and preserve those resources.

Fundamentally, the IHS's interpretation could mean that any tribe that supplemented its CHS program in any way—be it through a self-insured plan, by tribal council resolution approving a member's specific request for assistance, or otherwise—would be ineligible for the CHS program, and by extension, the CHEF program. It would force Tribes into a Hobson's choice: either operate their tribal health programs exclusively with underfunded IHS CHS program dollars and ration care in order to access CHEF, or supplement those dollars to meet the needs of their members and forgo access to CHEF.

The IHS argues that its interpretation preserves scarce CHEF resources, whereas Redding Rancheria's proposed contract amendment would impermissibly burden them. Defs.' Reply Supp. Mot. Summ. J. 14 & 19, ECF No. 35. But there is no indication that Congress intended to preserve federal resources by barring access to the CHEF program simply because a tribe chooses to supplement its inadequately funded CHS program. On the contrary, Congress expressly recognized the ongoing *federal* responsibility for Indian health care in the IHCIA: one of Congress' overarching goals in the IHCIA was "to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts

provided to programs and facilities operated directly by the Service." 25 U.S.C. § 1602(7). The IHS's interpretation stands in direct conflict with this goal, and it is absurd to think that Congress would agree with an interpretation of the law that would require tribes to subsidize and pay for care they are entitled to under federal programs like CHEF simply because they supplement that care with their own funds.

The IHS's interpretation is also penny-wise and pound foolish. Tribes supplement their CHS programs in order to be able to refer their patients out for specialty care their clinics cannot provide when the CHS program lacks sufficient funds to do so alone. In 2014, for example, only 66% of IHS-operated CHS programs were able to approve *any* referrals in priority categories other than Medical Priority I, meaning that preventive care services and any other services not deemed necessary to preserve "life or limb" were frequently deferred.[18] Of course, treating health conditions *before* they develop into emergent conditions is considerably more efficient (and, of course, humane) than rationing care until there is no choice but to treat the patient in a high-cost emergency treatment facility.

While the IHS may presume that all tribes with self-insured plans have the financial capacity to pay for care that would otherwise be covered by CHEF, that is not the case. Certain tribes may have sufficient resources to do so, but the majority do not. For them, having to choose between supplementing their CHS programs with tribal funds but losing access to CHEF, or rationing care in order to be eligible for CHEF, would result in higher costs to their programs and lower access to care for the beneficiaries they serve. And at bottom, the IHS's newly adopted position flies in the face of its federal trust responsibility to ensure that *all* tribes and

[18] DEP'T OF HEALTH & HUMAN SERVS., INDIAN HEALTH SERV., JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, FISCAL YEAR 2017 CJ-106 (Jan. 11, 2016).

their members have access to federal health care resources to the extent Congress has made them available.

The IHS does not seem to have taken any of these implications into account, having announced its novel interpretation of Section 2901(b) for the first time in the context of this litigation. Over six years have passed since the enactment of Section 2901(b), and the IHS's attempt to overturn decades of policy is inconsistent with its obligation to consult with tribes under the IHCIA, its own tribal consultation policy, and Presidential Executive Orders. The policy implications for the IHS's new position are significant. If upheld, it would effectively bar access to CHS and the CHEF program for services provided to any IHS beneficiary whose coverage was supplemented by their Tribe. There is nothing in Section 2901(b) that compels such a radical result, and this Court should decline the agency's attempt to achieve this fundamental change in how it operates its programs by means of this litigation.

CONCLUSION

The Defendants' Motion for Summary Judgment should be denied.

Respectfully Submitted,

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APPENDIX

APPENDIX A

LIST OF *AMICI* TRIBES

Jamestown S'Klallam Tribe

Seminole Tribe of Florida

Mohegan Tribe of Connecticut

Suquamish Tribe

LIST OF *AMICI* TRIBAL ORGANIZATIONS AND MEMBER-TRIBES

Amici Alaska Native Health Board, Northwest Portland Area Indian Health Board, and United South and Eastern Tribes, Inc. count the following federally recognized tribes as member-tribes:

Alaska Native Health Board (representing all 229 federally-recognized Native Villages in Alaska)

Agdaagux Tribe of King Cove

Akiachak Native Community

Akiak Native Community

Alatna Village

Algaaciq Native Village (St. Mary's)

Allakaket Village

Alutiiq Tribe of Old Harbor

Angoon Community Association

Anvik Village

Arctic Village (See Native Village of Venetie Tribal Government)

Asa'carsarmiut Tribe

Atqasuk Village (Atkasook)

Beaver Village

Birch Creek Tribe

Central Council of the Tlingit & Haida Indian Tribes

Chalkyitsik Village

Cheesh-Na Tribe (previously listed as the Native Village of Chistochina)

Chevak Native Village

Chickaloon Native Village

Chignik Bay Tribal Council (previously listed as the Native Village of Chignik)

Chignik Lake Village

Chilkat Indian Village (Klukwan)

Chilkoot Indian Association (Haines)

Chinik Eskimo Community (Golovin)

Chuloonawick Native Village

Circle Native Community

Craig Tribal Association

Curyung Tribal Council

Douglas Indian Association

Egegik Village

Eklutna Native Village

Emmonak Village

Evansville Village

Galena Village

Gulkana Village

Healy Lake Village

Holy Cross Village

Hoonah Indian Association

Hughes Village

Huslia Village

Hydaburg Cooperative Association

Igiugig Village

Inupiat Community of the Arctic Slope

Iqurmuit Traditional Council

Ivanoff Bay Tribe

Kaguyak Village

Kaktovik Village (aka Barter Island)

Kasigluk Traditional Elders Council

Kenaitze Indian Tribe

Ketchikan Indian Corporation

King Island Native Community

King Salmon Tribe

Klawock Cooperative Association

Knik Tribe

Kokhanok Village

Koyukuk Native Village

Levelock Village

Lime Village

Manley Hot Springs Village

Manokotak Village

McGrath Native Village

Mentasta Traditional Council

Metlakatla Indian Community, Annette Island Reserve

Naknek Native Village

Native Village of Afognak

Native Village of Akhiok

Native Village of Akutan

Native Village of Aleknagik

Native Village of Ambler

Native Village of Atka

Native Village of Barrow Inupiat Traditional Government

Native Village of Belkofski

Native Village of Brevig Mission

Native Village of Buckland

Native Village of Cantwell

Native Village of Chenega (aka Chanega)

Native Village of Chignik Lagoon

Native Village of Chitina

Native Village of Chuathbaluk (Russian Mission, Kuskokwim)

Native Village of Council

Native Village of Deering

Native Village of Diomede (aka lnalik)

Native Village of Eagle

Native Village of Eek

Native Village of Ekuk

Native Village of Ekwok

Native Village of Elim

Native Village of Eyak (Cordova)

Native Village of False Pass

Native Village of Fort Yukon

Native Village of Gakona

Native Village of Gambell

Native Village of Georgetown

Native Village of Goodnews Bay

Native Village of Hamilton

Native Village of Hooper Bay

Native Village of Kanatak

Native Village of Karluk

Native Village of Kiana

Native Village of Kipnuk

Native Village of Kivalina

Native Village of Kluti Kaah (aka Copper Center)

Native Village of Kobuk

Native Village of Kongiganak

Native Village of Kotzebue

Native Village of Koyuk

Native Village of Kwigillingok

Native Village of Kwinhagak (aka Quinhagak)

Native Village of Larsen Bay

Native Village of Marshall (aka Fortuna Ledge)

Native Village of Mary's Igloo

Native Village of Mekoryuk

Native Village of Minto

Native Village of Nanwalek (aka English Bay)

Native Village of Napaimute

Native Village of Napakiak

Native Village of Napaskiak

Native Village of Nelson Lagoon

Native Village of Nightmute

Native Village of Nikolski

Native Village of Noatak

Native Village of Nuiqsut (aka Nooiksut)

Native Village of Nunam Iqua

Native Village of Nunapitchuk

Native Village of Ouzinkie

Native Village of Paimiut

Native Village of Perryville

Native Village of Pilot Point

Native Village of Pitka's Point

Native Village of Point Hope

Native Village of Point Lay

Native Village of Port Graham

Native Village of Port Heiden

Native Village of Port Lions

Native Village of Ruby

Native Village of Saint Michael

Native Village of Savoonga

Native Village of Scammon Bay

Native Village of Selawik

Native Village of Shaktoolik

Native Village of Shishmaref

Native Village of Shungnak

Native Village of Stevens

Native Village of Tanacross

Native Village of Tanana

Native Village of Tatitlek

Native Village of Tazlina

Native Village of Teller

Native Village of Tetlin

Native Village of Tuntutuliak

Native Village of Tununak

Native Village of Tyonek

Native Village of Unalakleet

Native Village of Unga

Native Village of Venetie Tribal Government (Arctic Village and Village of Venetie)

Native Village of Wales

Native Village of White Mountain

Nenana Native Association

New Koliganek Village Council

New Stuyahok Village

Newhalen Village

Newtok Village

Nikolai Village

Ninilchik Village

Nome Eskimo Community

Nondalton Village

Noorvik Native Community

Northway Village

Nulato Village

Nunakauyarmiut Tribe

Organized Village of Grayling (aka Holikachuk)

Organized Village of Kake

Organized Village of Kasaan

Organized Village of Kwethluk

Organized Village of Saxman

Orutsararmiut Traditional Native Council (aka Bethel)

Oscarville Traditional Village

Pauloff Harbor Village

Pedro Bay Village

Petersburg Indian Association

Pilot Station Traditional Village

Platinum Traditional Village

Portage Creek Village (aka Ohgsenakale)

Pribilof Islands Aleut Communities of St. Paul & St. George Islands

Qagan Tayagungin Tribe of Sand Point Village

Qawalangin Tribe of Unalaska

Rampart Village

Saint George Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)

Saint Paul Island (See Pribilof Islands Aleut Communities of St. Paul & St. George Islands)

Seldovia Village Tribe

Shageluk Native Village

Sitka Tribe of Alaska

Skagway Village

South Naknek Village

Stebbins Community Association

Sun'aq Tribe of Kodiak

Takotna Village

Tangimaq Native Village (formerly Lesnoi Village (aka Woody Island))

Telida Village

Traditional Village of Togiak

Tuluksak Native Community

Twin Hills Village

Ugashik Village

Umkumiut Native Village

Village of Alakanuk

Village of Anaktuvuk Pass

Village of Aniak

Village of Atmautluak

Village of Bill Moore's Slough

Village of Chefornak

Village of Clarks Point

Village of Crooked Creek

Village of Dot Lake

Village of Iliamna

Village of Kalskag

Village of Kaltag

Village of Kotlik

Village of Lower Kalskag

Village of Ohogamiut

Village of Red Devil

Village of Salamatoff

Village of Sleetmute

Village of Solomon

Village of Stony River

Village of Venetie (See Native Village of Venetie Tribal Government)

Village of Wainwright

Wrangell Cooperative Association

Yakutat Tlingit Tribe

Yupiit of Andreafski

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 Shoshone 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 Indian Tribal Community, 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

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

Eastern Band of Cherokee Indians, North Carolina

Miccosukee Tribe of Indians of Florida

Mississippi Band of Choctaw Indians

Seminole Tribe of Florida

Chitimacha Tribe of Louisiana

Seneca Nation of Indians, New York

Coushatta Tribe of Louisiana

Saint Regis Mohawk Tribe, New York

Penobscot Indian Nation, Maine

Passamaquoddy Tribe—Pleasant Point, Maine

Passamaquoddy Tribe—Indian Township, Maine

Houlton Band of Maliseet Indians, Maine

Tunica-Biloxi Tribe of Louisiana

Poarch Band of Creek Indians, Alabama

Narragansett Indian Tribe, Rhode Island

Mashantucket Pequot Tribal Nation, Connecticut

Wampanoag Tribe of Gay Head (Aquinnah), Massachusetts

Alabama-Coushatta Tribe of Texas

Oneida Indian Nation, New York

Aroostook Band of Micmacs, Maine

Catawba Indian Nation, South Carolina

Jena Band of Choctaw Indians, Louisiana

The Mohegan Tribe, Connecticut

Cayuga Nation, New York

Mashpee Wampanoag Tribe, Massachusetts

Shinnecock Indian Nation, New York