Nos. 23-250 and 23-253

IN THE

Supreme Court of the United States

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners,
v.

SAN CARLOS APACHE TRIBE,
Respondent.

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners,
v.

NORTHERN ARAPAHO TRIBE,
Respondent.

On Writs of Certiorari to the United States Courts of Appeals for the Ninth Circuit and Tenth Circuit

BRIEF OF *AMICI CURIAE* THE COALITION OF LARGE TRIBES, THE CONFEDERATED TRIBES OF THE WARM SPRINGS RESERVATION OF OREGON, THE TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS OF NORTH DAKOTA, PRAIRIE BAND POTAWATOMI NATION, SANTEE SIOUX NATION, YUHAAVIATAM OF SAN MANUEL NATION, GREENVILLE RANCHERIA AND THE ASSOCIATION ON AMERICAN INDIAN AFFAIRS IN SUPPORT OF RESPONDENTS

JOHN E. ECHOHAWK
MELODY L. MCCOY
KIM JEROME GOTTSCHALK
NATIVE AMERICAN RIGHTS FUND
250 Arapahoe Avenue
Boulder, CO 80302
(303) 447-8760
jechohwk@narf.org
mmccoy@narf.org
jeronimo@narf.org

JENNIFER H. WEDDLE
Counsel of Record
TROY A. EID
HARRIET MCCONNELL RETFORD
GREENBERG TRAURIG, LLP
1144 15th Street, Ste. 3300
Denver, CO 80202
(303) 572-6500
weddlej@gtlaw.com

Counsel for Amici Curiae
[Additional Counsel Listed On Inside Cover]

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D.C. 20002

MORGAN SAUNDERS
NATIVE AMERICAN RIGHTS FUND
950 F. Street, NW
Ste. 1050
Washington, DC 20004
saunders@narf.org

Counsel for Amicus Curiae the Turtle Mountain Band of Chippewa Indians of North Dakota

PATRICK R. BERGIN
PEEBLES KIDDER BERGIN & ROBINSON, LLP
2020 L Street
Ste. 250
Sacramento, CA 95811
(916) 441-2700
pbergin@ndnlaw.com

Counsel for Amicus Curiae Greenville Rancheria

JOSH NEWTON
HOWARD G. ARNETT
BEST BEST & KRIEGER LLP
360 SW Bond Street
Suite 400
Bend, Oregon 97702
josh.newton@bbklaw.com
howard.arnett@bblaw.com

Counsel for Amicus Curiae the Confederated Tribes of the Warm Springs Reservation of Oregon

BEN FENNER
PEEBLES KIDDER BERGIN & ROBINSON LLP
401 9th Street NW
Ste 700
Washington, DC 20004
(202) 405-4887
bfenner@ndnlaw.com

Counsel for Amicus Curiae Prairie Band Potawatomi Nation and Santee Sioux Nation

QUESTION PRESENTED

Whether the Indian Health Service must reimburse "contract support costs," defined as "any overhead expense incurred by the tribal contractor in connection with the operation of the Federal program, function, service, or activity pursuant to the contract," 25 U.S.C. § 5325(a)(3)(A)(ii), on those occasions when the tribal contractor, precisely as would the Indian Health Service, spends monies recovered from third-party insurers or government programs to support contracted Federal Indian healthcare programs.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	v
INTERESTS OF *AMICI CURIAE*	1
INTRODUCTION AND SUMMARY OF ARGUMENT	4
ARGUMENT	6
I. INDIAN HEALTHCARE IS A WELL-ESTABLISHED AND SIGNIFICANT FEDERAL RESPONSIBILITY	6
A. Congressional Confirmation of the Responsibility Began in 1832, Continues to the Present, and Evolved Gradually to Address Historical Failures and Present Needs	7
B. The Responsibility Also Is Firmly Rooted in the Federal-Tribal Relationship as Expressed in Treaties and Legislation	10
C. Successive Federal Agencies Continually have been Charged with Responsibility for Indian Healthcare	12
II. NOTWITHSTANDING THE FEDERAL RESPONSIBILITY TO PROVIDE INDIAN HEALTHCARE, HISTORIC AND PRESENT FAILURES TO DO SO ADEQUATELY ARE WELL-DOCUMENTED	13

TABLE OF CONTENTS—Continued

Page

III. THESE FAILURES ARE REFLECTED IN TODAY'S TROUBLING INDIAN COUNTRY HEALTH STATISTICS......... 20

IV. CONGRESSIONAL AUTHORIZATIONS FOR THIRD PARTY ASSISTANCE TO FEDERAL INDIAN HEALTHCARE HAVE BEEN BENEFICIAL, AND TRIBES MUST BE REIMBURSED FULLY WHEN USING THIS OPTION TO PROVIDE MORE FEDERAL PROGRAM SERVICES 24

CONCLUSION 27

TABLE OF AUTHORITIES

CASES Page(s)

Choctaw Nation v. Oklahoma,
397 U.S. 620 (1970) 6

Haaland v. Brackeen,
599 U.S. 255 (2023) 11

Michigan v. Bay Mills Indian Community,
572 U.S. 782 (2014) 11

STATUTES

25 U.S.C. § 13 8

25 U.S.C. § 71 11

25 U.S.C. §§ 1601–1683 6

§ 1601(a) 11

§ 1602 6

§ 1602(1) 11

25 U.S.C. §§ 5301 – 5332 8-9

25 U.S.C. § 5326 9

25 U.S.C. § 5342 24

42 U.S.C. § 2001 .... 8, 12

42 U.S.C. § 2001(b) 24

42 U.S.C. § 2002 .... 8, 24

42 U.S.C. § 2004a 8

Act of Feb. 15, 1929, 45 Stat. 1185 (1929) ... 24

Act of May 5, 1832, 4 Stat. 514 (1832) 7

TABLE OF AUTHORITIES—Continued

Page(s)

Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (1976)........ 6, 9, 11

Indian Health Facilities Act, Act of Aug. 5, 1954, ch. 658, § 2, 68 Stat. 674 (1954) 8

Indian Health Transfer Act, Act of Aug. 5, 1954, ch. 658, § 1, 68 Stat. 674 (1954) 8, 12, 24

Indian Sanitation Facilities Act, Act of July 31, 1959, Pub. L. No. 86-121, 73 Stat. 267 (1959).. 8

Indian Self-Determination and Education Assistance Act of 1975, Pub. L. No. 93-638, 88 Stat. 2203 (1975)........................ 8, 9, 13

Johnson O'Malley Act of 1934, Act of Apr. 16, 1934, 48 Stat. 596 (1934)................... 24

Pub. L. No. 93-580, S.J. Res. 133, 88 Stat. 1910 (1975).. 7

Pub. L. No. 111-148, 124 Stat. 119 (2010)... 9

Snyder Act, Act of Nov. 2, 1921, ch. 115, 42 Stat. 208 (1921)... 8, 9

TREATIES

Treaty with the Flatheads, 1855, art. 5, 12 Stat. 975 10

Treaty with the Klamath, 1864, art. 4, 16 Stat. 707 10

Treaty with the Tribes of Middle Oregon, June 25, 1855, 12 Stat. 963 1

Page(s)

Treaty with the Winnebago Tribe of Wisconsin, 7 Stat. 370 (1832) 10

Treaty with the Yakima, 1855, art. 5, 12 Stat. 951 10

Treaty with Umpquas and Calapoolas, 1854, art. 6, 10 Stat. 1125 (1854) 10

OTHER AUTHORITIES

1892 Ann. Rep. Comm'r Off. Indian Aff. Sec'y Interior (1892)................................ 10, 11

Charlene A. Wong, et al., *American Indian and Alaska Native Infant and Pediatric Mortality*, *United States, 1999-2009*, 104 Am. J. Pub. Health S320 (2014), https://ajph.aphapubliications.org/doi/full/10.2105/AJPH.2013.301598 22-23

The Confederated Tribes of the Warm Springs Reservation of Oregon & Indian Health Service, *Annual Health System Report for the Warm Springs Indian Reservation, December 31, 2016* (2016), *available at* https://warmsprings-nsn.gov/wp-content/uploads/2018 /11/2016-AHR-040318.pdf... 25

Cong. Rsch. Serv., *R41630, The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA* (Updated January 3, 2014)...................... 18

Cong. Rsch. Serv., *R43330, The Indian Health Service (IHS): An Overview* (2016).......... 10

Page(s)

Ctrs. for Disease Control and Prevention, Nat'l Ctr. for Health Stats *Provisional Life Expectancy Estimates for 2021* (2022), *available at* https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf 23

Data-Turtle Mountain, State Hist. Soc'y of N. Dakota, https://www.ndstudies.gov/curriculum/high-school/turtle-mountain/data-turtle-mountain (last visited Feb. 16, 2024) 2

Everett R. Rhoades & Dorothy A. Rhoades, *The Public Health Foundation of Health Services for American Indians and Alaska Natives*, 104 Am. J. Pub. Health S278 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035891/..... 7, 8, 10-13, 22

George St. J. Perrott & Margaret D. West, *Health Services for American Indians*, 72 Public Health Reports 565 (July 1957), https://www.jstor.org/stable/4589827........... 16, 17

Indian Health Serv., *About IHS*, https://www.ihs.gov/aboutihs/ (last visited Feb. 16, 2024) 12

Indian Health Serv., *Purchased/Referred Care: History*, https://www.ihs.gov/prc/history/ (last visited Feb. 16, 2024).......... 25

TABLE OF AUTHORITIES—Continued

Page(s)

J. David Hacker & Michael R. Daines, *American Indian Mortality in the Late Nineteenth Century: the Impact of Federal Assimilation Policies on a Vulnerable Population*, 110 Annales de Démographie Historique 17 (2005), https://www.cairn.info/revue-annales-de-demographie-historique-2005-2-pagge-17.htm#:~:text=Most%20estimates%20fall%20in%20the,in%20the%20last%20few%20decades 20, 21

Lewis Meriam, et al., *The Problem of Indian Administration* (1928), *available at* https://narf.org/nill/documents/meriam/k_meriam_chapter8_part1_health.pdf 15, 16, 21

National Tribal Budget Formulation Workgroup, *Reclaiming Tribal Health: A National Budget Plan to Rise Above Failed Policies and Fulfill Trust Obligations to Tribal Nations* (2020), *available at* https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf 23

Nell Jessup Newton, *et al*., Cohen's Handbook of Federal Indian Law (Lexus 2023) 10

Presidential Statement on Signing the Indian Health Care Improvement Act, 3 Pub. Papers 840 (Oct. 1, 1976), *available at* https://www.govinfo.gov/app/details/PPP-1976-book3 9

TABLE OF AUTHORITIES—Continued

Page(s)

Press Release, Senate Committee on Indian Affairs, *Indian Health Care Improvement Act Clears Senate Committee* (Dec. 3, 2009), https://www.indian.senate.gov/newsroom/press-release/democratic/indian-health-care-improvement-act-clears-senate-committee/ 9

Press Release, U.S. Dep't of Health and Human Servs., Ctrs. for Disease Control, *CDC data show disproportionate COVID-19 impact in American Indian Alaska Native populations* (Aug. 19, 2020) 23

Roy M. Nakamura, et al., *Excess Infant Mortality in an American Indian Population, 1940 to 1990*, 266 JAMA 2244 (1991) 22

S. Lyman Tyler, U.S. Dep't of the Interior, *A History of Indian Policy* (1973), https://eric.ed.gov/?id=ED092279 13-16

Task Force Six: Indian Health, *Report on Indian Health: Final Report to the American Indian Policy Review Commission* (1976) 7, 10-14, 16-18, 22, 24

Tina Norris, et al., *The American Indian and Alaska Native Population: 2010: 2010 Census Briefs* (Issued January 2012), *available at* https://www.census.gov/history/pdf/c2010br-10.pdf 2

Page(s)

U.S. Census Bureau, *Turtle Mountain Reservation and Off-Reservation Trust Land, ND—MT—SD* (2022), https://data.census.gov/profile/Turtle_Mountain_Reservation_and_Off-Reservation_Trust_Land,_ND--MT--SD?g=2500000US4345#health 2

U.S. Census Bureau, *U.S. Census Bureau History: American Indians and Alaska Natives*, census.gov (Nov. 2021), https://www.census.gov/history/www/homepage_archive/2021/november_2021.html#:~:text=The%201900%20Census%20enumerated%20Indians,American%20Indian%20population%20totaled%20237%2C196 20-21

U.S. Cong. Off. of Tech. Assessment, *OTA-H-290, Indian Health Care* (1986), *available at* https://ota.fas.org/reports/8609.pdf........ 6, 9, 11, 14

U.S. Dep't of Health and Human Servs., *FY 2024 Indian Health Service Justification of Estimates for Appropriations Committees* (2024), *available at* https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ32223.pdf........ 23

TABLE OF AUTHORITIES—Continued

Page(s)

U.S. Dep't of Health and Human Servs., Assistant Secretary for Planning and Evaluation, Off. of Health Policy, *HP-2022-21, How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives* (2022), https://aspe.hhs.gov/reports/funding-ihs 20

U.S. Dep't of Health and Human Servs., Off. of Inspector Gen., *OIE-6-16-00390, Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals* (2019), https://oig.hhs.gov/oei/reports/oei-06-16-00390.asp 19

U.S. Dep't of Health, Educ., and Welfare, Pub. Health Serv., Off. of the Surgeon Gen. Div. of Pub. Health Methods, *Health Services for American Indians* (1957), https://www.google.com/books/edition/_/dFVh_mNdbGIC?hl=en&gbpv=1 .... 16, 21

U.S. Dep't of the Interior, *Rep. of the Comm'r on Indian Affs. to the Sec'y of Interior* (1916) 21

U.S. Gov't Accountability Off., *GAO-05-789, Health Care Services Are Not Always Available to Native Americans* (2005), *available at* https://www.gao.gov/products/gao-05-789 .... 18, 22

Page(s)

U.S. Gov't Accountability Off., *GAO-16-333, Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times* (2016), *available at* https://www.gao.gov/products/gao-16-333 18

U.S. Gov't Accountability Off., *GAO-17-317, Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others* (2017), *available at* https://www.gao.gov/assets/gao-17-317.pdf................................ 19

U.S. Gov't Accountability Off., *GAO-19-74R, Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs* (2018), *available at* https://www.gao.gov/products/gao-19-74r 19-20

U.S. Gov't Accountability Off., *GAO-19-612, Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections* (2019), *available at* https://www.gao.gov/ products/gao-19-612 ... 25, 26

U.S. Gov't Accountability Off., *GAO-22-104742, Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services* (2022), *available at* https://www.gao.gov/products/gao-22-104742.................. 26

TABLE OF AUTHORITIES—Continued

Page(s)

U.S. Gov't Accountability Off., *GAO-24-105723, Indian Health Service: Many Federal Facilities are in Fair or Poor Condition and Better Data are Needed on Medical Equipment* (Nov. 2023), *available at* https://www.gao.gov/ products/gao-24-105723 19

The White House Historical Association, "Self Determination Without Termination;" President Richard M. Nixon's Approach to Native American Policy Reform, *available at* https://www.whitehousehistory.org/self-determination-without-termination.. 8

William Howard Taft, "Diseases Among the Indians: Message from the President of the United States in Relation to the Present Conditions of Health on Indian Reservations and Schools," S. Doc. No. 907 (1912).. 14, 15

INTERESTS OF THE *AMICI CURIAE*[1]

Amicus Curiae, the Coalition of Large Tribes ("COLT"), was established in 2011 to provide a unified advocacy base for sovereign, federally recognized Indian tribes governing large trust land bases. COLT represents the interests of the more than 50 tribes with reservations encompassing 100,000 acres or more, some the size of States like Delaware and West Virginia, including the Crow Tribe, Blackfeet Tribe, Shoshone-Bannock Tribes, Oglala Sioux Tribe, Mandan, Hidatsa and Arikara Nation, Rosebud Sioux Tribe, Sisseton Wahpeton Sioux Tribe, Cheyenne River Sioux Tribe, Fort Belknap Indian Community, Shoshone-Paiute Tribes of the Duck Valley Reservation and others. The federal Indian healthcare services that COLT tribes and their reservations receive, pursuant to their Treaties with the United States and federal statutes, are greatly impacted by the third party revenue contract support costs at issue here.

Amicus Curiae, the Confederated Tribes of the Warm Springs Reservation of Oregon ("Confederated Tribes of Warm Springs"), is a sovereign, federally recognized Indian tribe and is the legal successor-in-interest of the Treaty of June 25, 1855, with the Tribes of Middle Oregon (12 Stat. 963). The Confederated Tribes of Warm Springs occupy a reservation of approximately 640,000 acres located in what is today the State of Oregon. Today, the reservation's health delivery system, which includes ambulatory care, community health services, community counseling services, and

---

[1] Pursuant to this Court's Rule 37.6, counsel for *amici curiae* certify that no part of this brief was authored by counsel for any party, and no such counsel or party made a monetary contribution to the preparation or submission of the brief. Respondent the Northern Arapaho Tribe is a member of COLT and this Rule 37.6 certification applies equally to it.

emergency medical transport is operated in part by the Confederated Tribes of Warm Springs, and in part by the Indian Health Service ("IHS"). Third party revenue contract support costs are typically utilized to purchase private sector services, most of which are not offered by the tribal or IHS health delivery system, for eligible Indians. As is true for members of other tribes, the health outcomes for the Confederated Tribes Warm Springs' members fall short of the general population of the United States.

Amicus Curiae, the Turtle Mountain Band of Chippewa Indians of North Dakota, is a sovereign, federally recognized Indian tribe with a reservation established in 1882, where federal Indian health services began in 1906. *Data-Turtle Mountain*, State Hist. Soc'y of N. Dakota, https://www.ndstudies.gov/curriculum/high-school/turtle-mountain/data-turtle-mountain. In 2010, the Tribe was among the 20 most populous Indian tribes in the United States. Tina Norris, et al., *The American Indian and Alaska Native Population: 2010: 2010 Census Briefs*, https://www.census.gov/history/pdf/c2010br-10.pdf. In 2020 about 30% of the Tribe members lacked healthcare coverage. U.S. Census Bureau, *Turtle Mountain Reservation and Off-Reservation Trust Land, ND—MT—SD* (2022), https://data.census.gov/profile/Turtle_Mountain_Reservation_and_Off-Reservation_Trust_Land,_ND--MT--SD?g=2500000US4345#health. Like the other *amici* tribes, third party revenue contract support costs help address the Tribe's health needs.

Amicus Curiae Prairie Band Potawatomi Nation has been able to expand available services and improve access as a result of self-determination and the third-party revenue contract support costs at issue here. In 2002 (before compacting) the "Holton Service

Unit" had 1841 active patients accounting for 13,733 ambulatory visits. In 2022 (after compacting) the Nation's Health Center had 3321 active patients accounting for 61,099 ambulatory visits. Available services have also increased because of self-determination. The "Holton service unit" in 2003 was a small primary care clinic that provided very limited pharmacy and lab services. Since compacting, the Prairie Band Potawatomi Health Center has expanded to include on-site services such as Radiology, ultrasound, MRI, a full medical Lab, a full-service pharmacy, a Behavioral Health program, community health and home health programs, a diabetes prevention program, and a dental clinic.

Amicus Curiae the Santee Sioux Nation is a tribal government that, like Respondents, has contracted or compacted with IHS to provide a federal program of health care services to Indians that formerly were provided by the United States.

Amicus Curiae Yuhaaviatam of San Manuel Nation, also known as San Manuel Band of Mission Indians does not provide contracted health services directly, but the Tribe is a member of a consortium of nine tribes governing the Riverside San Bernardino County Indian Health, Inc., which receives federal funding to serve Southern California's Riverside and San Bernardino Counties. In that capacity, the Tribe has an interest in ensuring that contractors receive all support cost funding to which they are entitled.

Amicus Curiae, the Greenville Rancheria is a federally recognized Indian tribe located outside of Greenville, California, an unincorporated community nestled in the Sierra Nevada Mountains of California. Greenville Rancheria operates two medical and dental clinics at two rural locations and employs more than thirty-five physicians. The Tribe's clinics provide a range of

services aimed at creating a seamless system of access to cost-effective primary and preventive healthcare for both tribal and non-tribal members. Like many rural and tribal communities, facilities like Greenville Rancheria's clinic often serve as critical access points for healthcare due to limited alternatives.

Amicus curiae, the Association on American Indian Affairs, is the oldest non-profit serving Indian Country, protecting sovereignty, preserving culture, educating youth and building capacity. The Association was formed in 1922 to change the destructive path of federal policy from assimilation, termination, and allotment, to sovereignty, self-determination and self-sufficiency. Throughout its more than 100-year history, the Association has provided national advocacy on watershed issues that support sovereignty and culture, while working at a grassroots level with Indian tribes to support the implementation of programs that affect real lives on the ground. The Association has advocated for changes to federal law and policy to promote constitutionally and treaty-protected rights of Indian tribes and their members to healthcare.

INTRODUCTION AND SUMMARY OF ARGUMENT

Since the United States' founding, the federal government has acknowledged and assumed, through treaties, legislation, and executive action, substantial responsibility to provide Indian healthcare. The federal government's discharge of that solemn responsibility, however, has been uneven, leading to health outcomes that fall well-below the rest of the nation and that result in persistent and avoidable human suffering and death.

In Section 1 of this brief, *amici curiae* show through historical analysis that Indian healthcare is a well-established and significant federal responsibility. The brief sets forth the origins of this responsibility and its evolution over time to the modern scheme, relying on multiple sources of law, including treaties and almost two centuries of federal legislation, including the most recent laws wherein Congress expressly acknowledges the federal responsibility for Indian healthcare and the federal-tribal trust relationship as among the bases for the responsibility. The section concludes with an overview of the successive federal agencies that have been charged with the responsibility to oversee the federal government's delivery of Indian healthcare.

Section 2 explains that notwithstanding the long-standing responsibility to provide Indian healthcare, the historical and present record documents the federal government's failure to consistently deliver adequate Indian healthcare.

Section 3 focuses on how the federal government's failure to deliver adequate healthcare is reflected in historical and current statistics showing that Indian health outcomes fall below those of the rest of the nation.

The brief concludes with Section 4, which centers on how Congress, in accordance with its constitutional role, has continued to take legislative action intended to fulfill the federal government's responsibility to provide Indian healthcare. For the past half century, Congress has done so in concert with legislation aimed at promoting Indian self-determination, which allows Indian tribes to contract federal Indian health programs, functions, services, or activities. Adequate funding is essential to the success of tribes that choose to enter into such contracts. Congress understands this, which is why it has required the Indian Health

Service to reimburse "contract support costs" incurred by tribal contractors when the tribe spends monies recovered from third party insurers or other government programs to support the tribe's contracted programs, functions, services, or activities.

ARGUMENT

I. INDIAN HEALTHCARE IS A WELL-ESTABLISHED AND SIGNIFICANT FEDERAL RESPONSIBILITY.

At the heart of this case is the federal government's duty to provide Indian healthcare, an obligation acknowledged from "the very beginning of the United States as an independent nation." U.S. Cong. Off. of Tech. Assessment, *OTA-H-290, Indian Health Care* 8 (1986), https://ota.fas.org/reports/8609.pdf. The landmark Indian Health Care Improvement Act ("IHCIA"), Pub. L. No. 94-437, 90 Stat. 1400 (1976), codified as amended at 25 U.S.C. §§ 1601–1683, is "[a]n Act to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs." *See also Choctaw Nation v. Oklahoma*, 397 U.S. 620 n.6 (1970) (citation omitted) (explaining that it is "the responsibility of the Federal Government to act as trustee for Indian lands, rights, and resources . . . and to provide certain services such as education and health"). After almost 250 years, the federal government's "special trust responsibilit[y]" for Indian healthcare remains firmly established. 25 U.S.C. § 1602.

A. Congressional Confirmation of the Responsibility Began in 1832, Continues to the Present, and Evolved Gradually to Address Historical Failures and Present Needs.

"[D]evastating epidemics of infectious diseases provided the initial impetus" for federal involvement in Indian healthcare. Everett R. Rhoades & Dorothy A. Rhoades, *The Public Health Foundation of Health Services for American Indians and Alaska Natives*, 104 Am. J. Pub. Health S.278, S.278-79 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035891/. The first dedicated congressional appropriation was in 1832: $12,000.00 for smallpox vaccinations. Act of May 5, 1832, 4 Stat. 514 (1832). Similar modest *ad hoc* appropriations, primarily for vaccines and medicines for chronic illnesses, but also the occasional physician, occurred intermittently for another century, principally to protect federal military posts, other federal enclaves, and the federal Indian boarding school system. Task Force Six: Indian Health, *Report on Indian Health: Final Report to the American Indian Policy Review Commission* 29 (1976) ("*AIPRC Health Report*") ("Under [the Interior] department, agency physicians . . . gave little attention to the Indians and acted more in the capacity of doctors for the government employees, or in connection with Indian schools[.]").[2]

Growing "public outrage" over Indian health conditions, and multiple government-sponsored studies confirming abundant problems eventually led to broader legislation. *AIPRC Health Report*, *supra*, at 29. "A

---

[2] The American Indian Policy Review Commission began on January 2, 1975, when President Gerald R. Ford signed Pub. L. No. 93-580, S.J. Res. 133, 88 Stat. 1910 (1975).

cardinal event was the 1911 congressional appropriation of $40,000 specifically for [Indian] health care." Rhoades & Rhoades, *supra*, at S.280. A decade later the Snyder Act, Act of Nov. 2, 1921, ch. 115, 42 Stat. 208 (1921), codified as amended at 25 U.S.C. § 13, generally authorized appropriations and expenditures for, *inter alia*, "relief of distress and conservation of [Indian] health . . . [and] the employment of . . . physicians."

The 1950s brought the Indian Health Transfer Act, Act of Aug. 5, 1954, 68 Stat. 674 (1954) codified as amended at 42 U.S.C. § 2001 (transferring federal responsibility for Indian healthcare from the Interior Department to the Department of Health, Education, and Welfare), the Indian Health Facilities Act, Act of Aug. 5, 1954, 68 Stat. 674 (1954), codified as amended at 42 U.S.C. § 2002 (addressing hospital construction costs), and the Indian Sanitation Facilities Act, Act of July 31, 1959, Pub. L. No. 86-121, 73 Stat. 267 (1959), codified as amended at 42 U.S.C. § 2004a (authorizing needed sanitation facilities including domestic and community water supplies and facilities, drainage facilities, and waste-disposal facilities for Indian homes, communities and lands).

With the Indian Self-Determination Era, came one of the two most significant modern legislative developments governing the federal responsibility for Indian healthcare.[3] The Indian Self-Determination and Education Assistance Act ("ISDA") of 1975, Pub. L. No. 93-638, 88

---

[3] The Indian Self-Determination Era began in the 1970s following President Nixon's efforts to rearticulate federal policy on Indian Affairs. The White House Historical Association, "Self Determination Without Termination;" President Richard M. Nixon's Approach to Native American Policy Reform, *available at* https://www.whitehousehistory.org/self-determination-without-termination.

Stat. 2203 (1975), codified as amended at 25 U.S.C. §§ 5301-32, authorizes and encourages tribes to contract for the administration and operation of federal Indian programs, including federal Indian healthcare programs. *Id*. at § 5326.

The other seminal contemporary enactment came immediately after ISDA: the IHCIA. As President Ford stated, Congress passed the IHCIA specifically to address critical "well-documented needs for improvement in [federal] Indian health manpower, services and facilities[.]" Presidential Statement on Signing the Indian Health Care Improvement Act, 3 Pub. Papers 840 (Oct. 1, 1976), available at https://www.govinfo.gov/app/details/PPP-1976-book3. The IHCIA leaves intact, but strengthens, the Snyder Act by authorizing additional funding and consolidating existing and adding new Indian health services and programs. The IHCIA "clearly reflect[s] Congress' view of the Federal responsibilities" for Indian healthcare. *OTA-H-290, Indian Health Care, supra*, at 45.

With bi-partisan support, *see* Press Release, Senate Committee on Indian Affairs, *Indian Health Care Improvement Act Clears Senate Committee* (Dec. 3, 2009), https://www.indian.senate.gov/newsroom/press-release/democratic/indian-health-care-improvement-act-clears-senate-committee/ 2010, legislation further solidified the Nation's commitment to still-needed improvements in federal Indian healthcare by making the IHCIA permanent, *i.e.*, not subject to future reauthorization. Pub. L. No. 111-148, 124 Stat. 119 (2010). Today, the ISDA and the IHCIA exemplify Congress' commitment to the federal-tribal relationship, discussed next, in the form of both the modern federal policy of tribal self-determination and the historic federal responsibility for Indian healthcare.

B. The Responsibility Also Is Firmly Rooted in the Federal-Tribal Relationship as Expressed in Treaties and Legislation.

The bases for "the special federal responsibility for health services to Indians" include "certain treaties, in which Indians were promised health and other services in return for the Indian land, water, and other resources that were being taken from them." *AIPRC Health Report*, *supra*, at 33. The first Treaty between the United States and an Indian tribe to include health services expressly in exchange for land was the United States' Treaty with the Winnebago Tribe of Wisconsin in 1832, 7 Stat. 370 (1832), cited in Cong. Rsch. Serv., *R43330, The Indian Health Service (IHS): An Overview* 25 (2016).[4] Although treaty obligations "extended federal responsibility beyond . . . [vaccines,] . . . health services were minimal, [] spottily distributed, and usually consisted of a single physician with heavy responsibilities but very limited resources."[5] Rhoades

---

[4] Examples of Treaties with specific healthcare provisions can be found in Nell Jessup Newton, *et al*., Cohen's Handbook of Federal Indian Law § 22.01[1] n.8 (Lexus 2023) (citing Treaty with the Yakima, 1855, art. 5, 12 Stat. 951 (federal government to maintain hospital, medicines, and physicians); Treaty with Umpquas and Calapoolas, 1854, art. 6, 10 Stat. 1125 (1854) (federal government to provide hospital and physician); *accord* § 22.04[1] n.9 (citing, *inter alia*, "Treaty with the Klamath, 1864, art. 4, 16 Stat. 707 (hospitals); Treaty with the Flatheads, 1855, art. 5, 12 Stat. 975 (hospital and physician).

[5] For example, by 1892, the federal government employed a physician at the Warm Springs Agency who provided medical services to the Indians residing there. 1892 Ann. Rep. Comm'r Off. Indian Aff. Sec'y Interior I (1892), 424. In his June 30, 1892, report to the Commissioner of Indian Affairs, the agency physician advised that "[a]bout 90 per cent of all Indians on this reservation apply to me for treatment during their illness." *Id.* He also reported that his ability to treat the Indians was limited and

& Rhoades, *supra*, at S.280. "In most cases, the insubstantial obligations of these treaties were never actually met." *AIPRC Health Report*, *supra*, at 28. In any event, notwithstanding that future Treaty making with Tribes ended in 1871, existing treaty provisions remain in force unless expressly abrogated by Congress. 25 U.S.C. § 71; *see also Haaland v. Brackeen*, 599 U.S. 255, 369-70 (2023) (Thomas, J., dissenting).

"Having a treaty that specified some form of health care was, however, not a prerequisite for a tribe to receive health services." *OTA-H-290, Indian Health Care, supra,* at 43. Federal Indian healthcare also is anchored in the "fundamental relationship between Indian tribes and the U.S. Government." *Id*. at 8. Decisions of this Court have defined aspects of the federal-tribal relationship now for "[t]wo centuries…." *Michigan v. Bay Mills Indian Community,* 572 U.S. 782, 806 (2014) (Sotomayor, J., concurring). The IHCIA expressly codifies the relationship as a basis for the federal responsibility for Indian healthcare. *See* 25 U.S.C. § 1601(a) (Congress finding "Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people"); *accord* § 1602(1) (declaring national Indian health policy is based on "this Nation['s] fulfillment of its special trust responsibilities and legal obligations to Indians").

---

advised the Commissioner of the need for a hospital to better serve the needs of his Indian patients. *Id.*

C. Successive Federal Agencies Continually have been Charged with Responsibility for Indian Healthcare.

From 1803 to 1849, with federal management of Indian affairs generally under the War Department, Indian healthcare, which consisted primarily of vaccines, was provided "by members of the army medical staff." *AIPRC Health Report*, *supra*, at 28. In 1849, Congress transferred the responsibility from military to civilian control by relocating the Bureau of Indian Affairs (BIA) from the War Department to the newly created Department of the Interior, where Indian health services expanded marginally beyond vaccines to other treatments. *Id*. 29.

After a century of extremely poor results by the BIA, *see generally* Rhoades & Rhoades, *supra*, at S.279-82, in 1954, President Eisenhower approved legislation transferring Indian healthcare responsibilities to the newly created Division of Indian Health within the U.S. Public Health Service, at that time within the also newly created U.S. Department of Health, Education and Welfare, now the Department of Health and Human Services. Act of Aug. 5, 1954, 68 Stat. 674 (1954) codified as amended at 42 U.S.C. § 2001. Officially renamed the Indian Health Service (IHS) in 1968, today, IHS "provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized tribes in 37 states." Indian Health Serv., *About IHS*, https://www.ihs.gov/aboutihs/.

II. NOTWITHSTANDING THE FEDERAL RESPONSIBILITY TO PROVIDE INDIAN HEALTHCARE, HISTORIC AND PRESENT FAILURES TO DO SO ADEQUATELY ARE WELL-DOCUMENTED.

Congress enacted the ISDA in significant part because, for as long as the federal government has had the responsibility to provide Indian healthcare, provision of that care has been deficient. The failures are consistent and systemic: misguided policies, ineffective administration, inadequate staffing and facilities, and underfunding, all of which have led directly to low levels and quality of care. These failures have been tracked and reported extensively from the 1800s to today. Regardless of date, the findings remain the same—the overall federal provision of Indian healthcare remains substandard.

For the first half of the nineteenth century when Indian healthcare was under the War Department and consisted of smallpox vaccines, "its activity was minimal and its appropriations small." *AIPRC Health Report*, *supra*, at 28. It was "neither systematic nor organized." Rhoades & Rhoades, *supra*, at S.279. "[V]accines often did not arrive and there was a shortage of doctors to administer them." *AIPRC Health Report*, *supra*, at 28.

Little changed with the 1849 transfer to the Interior Department, where Indian healthcare was "unsupervised and . . . inactive." S. Lyman Tyler, U.S. Dep't of the Interior, *A History of Indian Policy* 107 (1973), https://eric.ed.gov/?id=ED092279 ("*A History of Indian Policy*"). Interior continued to use military physicians under contract, Rhoades & Rhoades, *supra*, at S.280, and not until 1878 were "physicians on Indian reservations

required to be graduates of medical colleges." *AIPRC Health Report*, *supra*, at 29.

By 1900, only "five hospitals had been constructed to serve Indians." *OTA-H-290, Indian Health Care, supra,* at 44. "The healthcare which Indians actually received in the first 100 years was delivered in a piecemeal, inconsistent fashion, and the few appropriations made were never large enough to meet the overwhelming need." *AIPRC Health Report*, *supra*, at 27. "Preventive or general health care was not possible under these circumstances . . . [it] was solely of the crisis type." *Id.*

In one of the first twentieth century presidential messages dealing with Indians, President Taft described a "truly shameful situation" that "startled the country." *A History of Indian Policy*, *supra*, at 107.

> In many parts of the Indian country infant mortality, tuberculosis and disastrous diseases generally prevail to an extent exceeded only in some of the most insanitary of our white rural districts and in the worst slums of our large cities. The death rate of the Indian country is 35 per thousand as compares with 15 per thousand–the average death rate of the United States as a whole . . . Last year, of 42,000 Indians examined for disease, over 16 percent of them had trachoma, a contagious disease of the eye, frequently resulting in blindness, and so easily spread that it threatens both the Indian communities and all their white neighbors . . . Of the 40,000 Indians examined, 6,000 had tuberculosis. Few Indian homes anywhere have proper sanitary conditions, and in most instances the bad conditions of their domestic surroundings is almost beyond belief.

> As guardians of the welfare of the Indians, it is our immediate duty to give the race a fair chance for an unmaimed birth, healthy childhood, and a physically efficient maturity. The most vigorous campaign ever waged against diseases among the Indians is now under way. It began in 1909. Prior to that time little attention had been given to the hygiene and health of the Indians. In some reservations, equal in area to a State, there were not more than two physicians, frequently only one. In 1909 tens of thousands of Indians were substantially without any chance to reach a doctor.

William Howard Taft, "Diseases Among the Indians: Message from the President of the United States in Relation to the Present Conditions of Health on Indian Reservations and Schools," S. Doc. No. 907, at 1-3 (1912), excerpted in *A History of Indian Policy*, *supra*, at 108.

In 1928, a comprehensive study performed by what later became the Brookings Institute, in cooperation with the Secretary of the Interior, found that "Although in the medical work of the Indian Service the variation between the best and the worst is wide, taken as a whole practically every activity undertaken by the national government for the promotion of the health of the Indians is below a reasonable standard of efficiency." Lewis Meriam, et al., *The Problem of Indian Administration* 189 (1928), https://narf.org/nill/documents/meriam/k_meriam_chapter8_part1_health.pdf. "The health work of the Indian Service falls markedly below the standards maintained by the Public Health Service, the Veterans' Bureau, and the Army and the Navy, and those prescribed for the states . . . under the Maternity and Infancy Act." *Id.* "The Indian Service hospitals, sanatoria, and sanatorium schools are, with few

exceptions, below minimum standards for effective work in the three essentials of plant, equipment, and personnel" and "low salaries have resulted in a high turnover[.]" *Id.* at 190, 189 respectively. In sum, "[l]ack of appropriations and, possibly until the recent reorganization of the medical service under the present administration, lack of vision and real understanding have precluded the establishment in the Indian Service of a real program of preventive medicine." *Id.* at 190. Yet into the 1930s and beyond, the Interior Department's Indian healthcare "continued to operate inefficiently with inadequate funds." *AIPRC Health Report*, *supra*, at 30. By 1955, there still were fewer than 60 hospitals or medical facilities for Indians nationwide. *A History of Indian Policy*, *supra*, at 181-182.

Not long after the 1955 transfer of federal Indian healthcare to the Department of Health, Education and Welfare, the Public Health Service, at the direction of the U.S. House of Representatives Committee on Appropriations, undertook a comprehensive study of Indian health problems. Findings from the Committee's report echoed those in the Meriam Report. "Health services for Indians have been provided by the Federal Government for over a hundred years; but in spite of this fact . . . health facilities are either non-existent in some areas, or, for the most part, obsolescent and in need of repair; personnel housing is lacking or inadequate." U.S. Dep't of Health, Educ., and Welfare, Pub. Health Serv., Off. of the Surgeon Gen. Div. of Pub. Health Methods, *Health Services for American Indians* vii (1957), https://www.google.com/books/edition/_/dFVh_mNdbGIC?hl=en&gbpv=1. "This all points to a gross lack of resources equal to the present load of sickness and accumulated neglect." *Id.; see also* George St. J. Perrott & Margaret D. West, *Health Services for American Indians*, 72 Public Health Reports 565,565

(July 1957), https://www.jstor.org/stable/4589827 ("Under [the Interior Department], the Indian health program had never had enough qualified staff, well-equipped facilities, or funds to extend services to all Indians needing them. This applied particularly to preventive services."). Immediately after the transfer from Interior, "[t]he total number of persons employed . . . increased . . . but recruitment continue[d] to be a problem" and "[i]n few areas ha[d] the Indian health program been able to provide adequate field health services for families living far from existing health facilities." *Id.* at 568, 567 respectively.

Two decades after the transfer, "while the level of Indian health ha[d] improved . . . [it was] still significantly below the level of the general United States population." *AIPRC Health Report*, *supra*, at 12. The AIPRC Indian Health Task Force's summary identified the following key deficiencies: (1) "Inadequate policy to solve the problems of Indian Health;" (2) "Inadequate appropriations;" (3) "Lack of adequate mechanisms for delivery of services;" (4) "Lack of responsiveness on the part of state and local agencies toward Indians;" and (5) "Lack of oversight and accountability at all levels of Indian Health Service." *Id.* at 12-13. Numerous recommendations followed, including ensuring adequate funding and a clear policy to implement IHS' programs and responsibilities. *See id.* at 50 ("The Indian Health Service must be immediately funded to a level permitting elimination of the backlog of unmet needs."); *id.* at 12 (noting a lack of IHS "clear overall direction or policy [and as] a result operat[ing] primarily as an emergency and crisis oriented service"). The Task Force also recommended greater Indian involvement and self-determination in healthcare, "the principle of self-determination requires that each tribe possess the option of exercising as

much authority and control over the Federal programs now serving them as they desire." *Id.* at 22.

Federal failures have persisted in this century. A 2005 U.S. Government Accountability Office (GAO) report found that Indian access to primary care services "was not always assured because of factors such as the amount of waiting time between the call to make an appointment and the delivery of a service, travel distances to facilities, or a lack of transportation." U.S. Gov't Accountability Off., *GAO-05-789, Health Care Services Are Not Always Available to Native Americans* 4 (2005), https://www.gao.gov/products/gao-05-789. For example, "waiting times at 4 IHS-funded facilities ranged from 2 to 6 months for certain types of appointments, and 3 IHS-funded facilities reported that some Native Americans were required to travel over 90 miles one way to obtain care." *Id.*

A decade later the GAO reported that IHS "continue[s] to experience obstacles to ensuring patient access due to extensive staff vacancies and aging infrastructure and equipment." U.S. Gov't Accountability Off., *GAO-16-333, Indian Health Service: Actions Needed to Improve Oversight of Patient Wait Times* 21 (2016), https://www.gao.gov/products/gao-16-333. Insufficient staffing remained a significant barrier to adequate healthcare services. *See* Cong. Rsch. Serv., *R41630, The Indian Health Care Improvement Act Reauthorization and Extension as Enacted by the ACA* 5-6 (Updated January 3, 2014) ("IHS had high vacancy rates in many of its health professions —25% for physicians, 15% for dentists, and 16% for nurses . . . as of January 2010. These vacancy rates are higher than those of federally funded health centers in rural areas, facilities that also have a difficult time recruiting providers.") (footnote omitted).

By 2017, the GAO had added improving federal management of programs that serve Indian tribes and their members to its "High Risk List," in part because inadequate oversight hindered IHS's ability to ensure that Indians have timely access to quality healthcare. *See* U.S. Gov't Accountability Off., *GAO-17-317, Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others* (2017) https://www.gao.gov/assets/gao-17-317.pdf. Two years later, core underlying organizational issues were identified that hinder IHS from improving its hospital management, including lack of formal structure, lack of policies and roles, and lack of a clear view of hospital performance and problems. U.S. Dep't of Health and Human Services, Off. of Inspector Gen., *OIE-6-16-00390, Organizational Challenges to Improving Quality of Care in Indian Health Service Hospitals* 11-15 (2019), https://oig.hhs.gov/oei/reports/oei-06-16-00390.asp. Most recently, the GAO reported that over 60% of IHS medical facility buildings are in "fair" or "poor" condition, compared to the goal of having 90 percent in good or excellent condition. U.S. Gov't Accountability Off., *GAO-24-105723, Indian Health Service: Many Federal Facilities are in Fair or Poor Condition and Better Data are Needed on Medical Equipment* 18 (Nov. 2023), https://www.gao.gov/products/gao-24-105723. Additionally, "the "data were not complete or reliable for determining the state of IHS medical equipment in its federally operated facilities." *Id.* 29.

Disparate underfunding also remains an issue. In 2017, IHS per capita spending was $4,078, whereas Medicaid was $8,109, Veterans Health Administration was $10,692, [and] Medicare $13,185. U.S. Gov't Accountability Off., *GAO-19-74R, Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs* 5 (2018), https://

www.gao.gov/products/gao-19-74r. "Funding for the [IHS] addresses only an estimated 48.6% of the health care needs for AI/ANs and has historically been subject to year-by-year discretionary allocations from Congress, which creates substantial long-term uncertainty in funding levels and makes it challenging to maintain and modernize needed health care infrastructure." U.S. Dep't of Health and Human Servs., Assistant Secretary for Planning and Evaluation, Off. of Health Policy, *HP-2022-21, How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives* 1 (2022), *available at* https://aspe.hhs.gov/reports/funding-ihs.

III. THESE FAILURES ARE REFLECTED IN TODAY'S TROUBLING INDIAN COUNTRY HEALTH STATISTICS.

"There are long standing and persistent health and health care disparities among American Indians and Alaska Natives (AI/ANs), which are the result of centuries" of compounding failures. *HP-2022-21, How Increased Funding Can Advance the Mission of the Indian Health Service* 1. During the nineteenth century, the nationwide Indian population declined from about 600,000, *see* J. David Hacker & Michael R. Daines, *American Indian Mortality in the Late Nineteenth Century: the Impact of Federal Assimilation Policies on a Vulnerable Population*, 110 Annales de Démographie Historique 17, 1 (2005) https://www.cairn.info/revue-annales-de-demographie-historique-2005-2-page-17.htm#:~:text=Most%20estimates%20fall%20in%20the,in%20the%20last%20few%20decades, to only 237,000. U.S. Census Bureau, *U.S. Census Bureau History: American Indians and Alaska Natives*, census.gov (Nov. 2021), https://www.census.gov/history/www/homepage_archive/2021/november_2021.html#:~:text=Th

e%201900%20Census%20enumerated%20Indians,American%20Indian%20population%20totaled%20237%2C196. The over 50% decline has been attributed in significant part to disease and lack of healthcare. Hacker & Daines, *supra,* at 19.

Few improvements were reported throughout the twentieth century. "The greatest problems confronting us are tuberculosis, trachoma, and a high infant mortality. . . . [A]pproximately three-fifths of the Indian infants die before the age of 5 years." U.S. Dep't of the Interior, *Rep. of the Comm'r on Indian Affs. to the Sec'y of Interior* 4-5 (1916). "Indian Office records show for the Indian population a high birth rate and a high death rate, with excessively high infant mortality and a large portion of deaths from tuberculosis." Meriam Report at 196.

The seminal 1957 Public Health Service report noted that, "Indians of the United States today have health problems resembling in many respects those of the general population of the Nation a generation ago." U.S. Dep't of Health, Educ., and Welfare, Pub. Health Serv., Off. of the Surgeon Gen. Div. of Pub. Health Methods, *Health Services for American Indians* 1. "Poor health is reflected in . . . high death rates [and] [r]ates of hospitalization[.]" *Id.* at 2. "The difference in rates [wa]s particularly striking for children." *Id.* For example, in 1953, "[f]or Indian children, the death rate was more than double the national average. *Id.* Further, "almost 40 percent of the patient[s] . . . in the Indian hospitals . . . were children under 15." *Id.* Among the major causes identified were tuberculosis, influenza, pneumonia, gastroenteritis, dysentery, and various communicable diseases. *Id.*

Into the second half of the twentieth century, the data was similar. As reported in 1976, "since Indian

Health Service assumed the responsibility in 1955, Indian health is still significantly below the level of the general United States population. This disparity is not only manifest in terms of incidence of illness and disease, but also in terms of the severity of the diseases." *AIPRC Health Report*, *supra*, at 12. Further, "there is 'a shorter life expectancy of 65.1 years for Indians compared with 70.8 years in the general population,'" and Indian infant mortality rates still exceed those of the other populations. *Id.* at 176. In another specific example, in 1991, the Journal of the American Medical Association published a paper studying infant mortality from 1940 to 1990 on the reservation for *amicus* Confederated Tribes of Warm Springs. *See* Roy M. Nakamura, et al., *Excess Infant Mortality in an American Indian Population, 1940 to 1990*, 266 JAMA 2244 (1991). The study concluded that the infant mortality rate on the Warm Springs Reservation was still "2.6 times the national (all races) rate in the 1980s." *Id.* at 2244.

Nor has much progress been documented in the twenty-first century. "Despite [some] successes, "overall mortality rates for AI/AN populations during recent decades have not continued to fall." Rhoades & Rhoades, *supra*, at S.284. "Native Americans living in IHS areas have lower life expectancies than the U.S. population as a whole and face considerably higher mortality rates [i.e., more than double] for some conditions." U.S. Gov't Accountability Off., *GAO-05-789, Indian Health Service: Health Care Services Are Not Always Available to Native Americans* 6 (2005), https://www.gao.gov/products/gao-05-789. Less than a decade ago it was reported that mortality rates for American Indian and Alaska Native infants and children continue to exceed those of the general United States population. Charlene A. Wong, et al., *American Indian and Alaska*

Native Infant and Pediatric Mortality, *United States, 1999-2009* 104 Am. J. Pub. Health S320, S321 (2014), https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2013.301598.

The COVID-19 pandemic worsened these statistics. *See, e.g*., Press Release, U.S. Dep't of Health and Human Servs., Ctrs for Disease Control, *CDC data show disproportionate COVID-19 impact in American Indian Alaska Native populations* (Aug. 19, 2020). "AI/AN life expectancy dropped from an estimated 71.8 years in 2019 to 65.2 years in 2021 – the same life expectancy as the general United States population in 1944." U.S. Dep't of Health and Human Servs., *FY 2024 Indian Health Service Justification of Estimates for Appropriations Committees* CJ-3 (2024), https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2024-IHS-CJ32223.pdf. The AI/AN life expectancy in 2021 was almost 11 years less than the average life expectancy for all races and origins. *See* Ctrs. for Disease Control and Prevention, Nat'l Ctr. for Health Stats *Provisional Life Expectancy Estimates for 2021*, at 3 (2022), https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf. That statistic is even more stark in certain states. *See* National Tribal Budget Formulation Workgroup, *Reclaiming Tribal Health: A National Budget Plan to Rise Above Failed Policies and Fulfill Trust Obligations to Tribal Nations* 2 (2020), https://www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf ("[I]n South Dakota in 2014, median age at death for Whites was 81, compared to 58 for American Indians.").

IV. CONGRESSIONAL AUTHORIZATIONS FOR THIRD PARTY ASSISTANCE TO FEDERAL INDIAN HEALTHCARE HAVE BEEN BENEFICIAL, AND TRIBES MUST BE REIMBURSED FULLY WHEN USING THIS OPTION TO PROVIDE MORE FEDERAL PROGRAM SERVICES.

"[O]utside help" historically has been used to address the evident unmet needs of Indian health and supplement the federal responsibility for Indian healthcare. *AIPRC Health Report*, *supra*, at 30. When Indian healthcare was under the Interior Department in the first half of the nineteenth century, "[w]henever possible, it made use of state and local agencies, and even a few tribal facilities, who were reimbursed for the care they provided to Indians." *Id.*

In the twentieth century, that tradition continued as the Secretary of the Interior was ordered to allow state employees and agents to enter upon Indian lands "for the purpose of making inspection of health and education conditions and enforcing sanitation and quarantine regulations." Act of Feb. 15, 1929, 45 Stat. 1185 (1929). The Johnson O'Malley Act of 1934, Act of Apr. 16, 1934, 48 Stat. 596 (1934) (codified as amended at 25 U.S.C. § 5342), authorizes the federal government to contract with agencies, including state agencies, to provide services including medical services to Indians. And the 1954 Indian Health Transfer Act authorizes IHS to contract out Indian hospitals to states, local governments, and non-profit institutions. 42 U.S.C. § 2001(b). The 1957 Indian Health Facilities Act authorizes IHS to contribute to the construction costs of non-Indian hospitals which might serve Indians. 42 U.S.C. § 2002.

In addition to providing direct care, the federal agencies providing Indian healthcare long have used contract care, presently known as Purchased/Referred Care, for health services to Indians at IHS's expense. According to IHS, "[t]he term contract health services originated under BIA when medical health care services were contracted out to health care providers. . . .In January 2014, the Consolidated Appropriation Act of 2014 renamed the Contract Health Services program to the Purchased/Referred Care (PRC) program." Indian Health Service, *Purchased/Referred Care: History*, https://www.ihs.gov/prc/history/.

Since first authorized by Congress in 1976, reimbursements provided by third parties for the cost of Indian healthcare, such as from Medicare, Medicaid, and private insurers, have increased significantly and with positive impacts. *See* U.S. Gov't Accountability Off., *GAO-19-612, Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections* 15 (2019), https://www.gao.gov/products/gao-19-612 ("Third-party collections across all federally operated IHS facilities increased 51 percent from fiscal year 2013 through fiscal year 2018, according to our analysis of IHS data.").[6]

Increased funding from third-party coverage helps address persistent problems, including staffing. "In one example, officials from a federally operated IHS

---

[6] The Annual Health System Report for *amicus* Confederated of Warm Springs provides another example showing how Indian tribes are using monies collected from third parties to support their contracted healthcare programs. *See, e.g.,* The Confederated Tribes of the Warm Springs Reservation of Oregon & Indian Health Service, *Annual Health System Report for the Warm Springs Indian Reservation, December 31, 2016* (2016) https://warmsprings-nsn.gov/wp-content/uploads/2018/11/2016-AHR-040318.pdf.

hospital said they added about 30 additional nurses from 2013 to 2018 as a result of increased third-party collections." *Id.* at 21; *see also id.* at 22 ("Officials from a national tribal organization noted that the use of third-party collections to enhance provider salaries at one facility led to a decrease in provider turnover from about 40 percent prior to 2014 to 14 percent in 2018."). "IHS increasingly relies on funding from third-party collections for its operations, including to procure medical supplies, pharmaceuticals, and health care services." U.S. Gov't Accountability Off., *GAO-22-104742, Indian Health Service: Information on Third-Party Collections and Processes to Procure Supplies and Services* 2 (2022), https://www.gao.gov/products/gao-22-104742 (footnote omitted). "Third-party collections represent a significant portion of IHS facilities' healthcare delivery budgets. For example, IHS's fiscal year 2021 budget justification noted that some IHS health care facilities reported that 60 percent or more of their annual budgets rely on revenue collected from third-party payers." *Id.*

Congressional authorizations for third party assistance to supplement the federal responsibility for Indian healthcare are longstanding. These authorizations include almost 50 years of allowing and encouraging tribal contracting of federal healthcare programs and services and the collection of third party revenues to support those federal programs. To advance the important goals of tribal self-determination and improvement of Indian healthcare outcomes, Congress has required federal reimbursement of specified contract support costs associated with both tribal contracting and the collection of third-party revenue. Congress understands that the required reimbursement must include costs incurred by tribes when they spend monies recovered from third-party insurers or other government programs and use

those monies to support the tribe's contracted federal programs, services, functions or activities.

CONCLUSION

The decisions of the U.S. Courts of Appeals for the Ninth and Tenth Circuits should be affirmed.

Respectfully submitted,

JOHN E. ECHOHAWK
MELODY L. MCCOY
KIM JEROME GOTTSCHALK
NATIVE AMERICAN RIGHTS FUND
250 Arapahoe Avenue
Boulder, CO 80302
(303) 447-8760
jechohwk@narf.org
mmccoy@narf.org
jeronimo@narf.org

MORGAN SAUNDERS
NATIVE AMERICAN RIGHTS FUND
950 F. Street, NW
Ste. 1050
Washington, DC 20004
saunders@narf.org

Counsel for Amicus Curiae the Turtle Mountain Band of Chippewa Indians of North Dakota

JENNIFER H. WEDDLE
Counsel of Record
TROY A. EID
HARRIET MCCONNELL RETFORD
GREENBERG TRAURIG, LLP
1144 15th Street, Ste. 3300
Denver, CO 80202
(303) 572-6500
weddlej@gtlaw.com

Counsel for Amici Curiae

JOSH NEWTON
HOWARD G. ARNETT
BEST BEST & KRIEGER LLP
360 SW Bond Street
Suite 400
Bend, Oregon 97702
josh.newton@bbklaw.com
howard.arnett@bblaw.com

Counsel for Amicus Curiae the Confederated Tribes of the Warm Springs Reservation of Oregon

PATRICK R. BERGIN
PEEBLES KIDDER BERGIN
& ROBINSON, LLP
2020 L Street
Ste. 250
Sacramento, CA 95811
(916) 441-2700
pbergin@ndnlaw.com
Counsel for Amicus Curiae Greenville Rancheria

BEN FENNER
PEEBLES KIDDER BERGIN
& ROBINSON LLP
401 9th Street NW
Ste 700
Washington, DC 20004
(202) 405-4887
bfenner@ndnlaw.com
Counsel for Amicus Curiae Prairie Band Potawatomi Nation and Santee Sioux Nation

February 20, 2024