No. 21-15641

IN THE

United States Court of Appeals

FOR THE

Ninth Circuit

SAN CARLOS APACHE TRIBE

Plaintiff-Appellant,

v.

XAVIER BECERRA, ET AL.,

Defendant-Appellee.

On Appeal from the United States District Court for the District of Arizona, Case No. 2:19-cv-05624-NVW
Before the Honorable Neil V. Wake

BRIEF *AMICI CURIAE* OF NATIVE AMERICAN TRIBES, TRIBAL ORGANIZATIONS, INDIAN HEALTH BOARDS AND THE NATIONAL CONGRESS OF AMERICAN INDIANS IN SUPPORT OF APPELLANT AND IN SUPPORT OF REVERSAL

CAROLINE P. MAYHEW
D.C. BAR NO. 1011766
HOBBS, STRAUS, DEAN
& WALKER, LLP
1899 L STREET NW,
SUITE 1200
WASHINGTON, D.C. 20036
(202) 822-8282

Counsel for Amici Curiae

GEOFFREY D. STROMMER*
OREGON BAR NO. 931106
STEPHEN D. OSBORNE
OREGON BAR NO. 034158
HOBBS, STRAUS, DEAN
& WALKER, LLP
215 SW WASHINGTON ST., STE. 200
PORTLAND, OR 97204
(503) 242-1745
**Counsel of Record*

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rules

Legislative Materials

Other Authorities

CORPORATE DISCLOSURE STATEMENT

The Alaska Native Health Board is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Alaska Native Tribal Health Consortium is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Arctic Slope Native Association is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Bristol Bay Area Health Corporation is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Chapa-De Indian Health is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Copper River Native Association is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Eastern Aleutian Tribes is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Indian Health Council is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Kodiak Area Native Association is an intertribal consortium that has no

parent corporation. No publicly held corporation owns 10% or more of its stock.

The National Congress of American Indians is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Navajo Health Foundation—Sage Memorial Hospital is a tribal organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Northwest Portland Area Indian Health Board is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The Norton Sound Health Corporation is a nonprofit organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Riverside-San Bernardino County Indian Health is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Southeast Alaska Regional Health Consortium is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

Tanana Chiefs Conference is an intertribal consortium that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

The United South and Eastern Tribes Sovereignty Protection Fund is a nonprofit, intertribal organization that has no parent corporation. No publicly held corporation owns 10% or more of its stock.

All other *Amici* are federally recognized Indian Tribes.

Date: September 27, 2021

/s/ *Geoffrey D. Strommer*
Geoffrey D. Strommer
Oregon Bar Number 931106
Stephen D. Osborne
Oregon Bar Number 034158
HOBBS, STRAUS, DEAN & WALKER, LLP
215 SW Washington Street, Suite 200
Portland, OR 97204
Phone: (503) 242-1745

Caroline P. Mayhew
D.C. Bar Number 1011766
HOBBS, STRAUS, DEAN & WALKER, LLP
1899 L Street NW, Suite 1200
Washington, D.C. 20036
Phone: (202) 822-8282

Counsel for Amici Curiae

INTEREST OF *AMICI*[1]

Amici are federally recognized Tribal Nations and tribal organizations that operate (or whose member Tribal Nations operate) health care programs for American Indian and Alaska Native beneficiaries pursuant to contracts with the Indian Health Service (IHS) under authorizations in Title I and Title V of the Indian Self-Determination and Education Assistance Act (ISDEAA). The federal health programs operated by the IHS and by *Amici* under contract are funded both through federal appropriations and through third-party collections made pursuant to statutory authorizations in the Indian Health Care Improvement Act (IHCIA) and other federal laws and required by law to be spent in furtherance of the contracted federal program. 25 U.S.C. § 5325. As ISDEAA tribal contractors, *Amici* or their member Tribal Nations are entitled under their contracts not only to this program funding, but also to contract support costs (CSC) for administrative and other expenses on the entire "Federal program" under contract. *Id*. § 5325(a)(3)(A).

[1] All parties have consented to the filing of this brief pursuant to Federal Rule of Appellate Procedure 29(a)(2). No party's counsel 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 counsel provided any monetary contribution to fund the preparation or submission of this brief.

The District Court below held that tribal contractors like *Amici* are not entitled to CSC on the portion of their contracted programs funded with third-party revenues, essentially because the statutory provisions requiring CSC do not reference those revenues by name or explicitly state that they are part of the "Federal program." But third-party revenues do not need special mention, because Congress has always viewed them as a necessary part of the "Federal program" carried out by the IHS and, therefore, by tribal contractors under the ISDEAA.

On appeal of the District Court's decision, *Amici* believe it is crucial for this Court to understand the integral role that Congress has given third-party revenues as one of multiple funding streams for these federal programs. The context and legislative history are clear on this point, but could not be fully discussed in the Appellant's opening brief. *Amici* thus submit this brief to aid the Court in understanding that context and how this case implicates Congress's dual goals in the ISDEAA and the IHCIA to uplift the health status of Indian people while also promoting tribal self-determination and self-governance.

INTRODUCTION AND SUMMARY

This case arises under two interrelated statutes enacted, in part, to implement the federal government's trust responsibilities to American Indians and Alaska Natives: the IHCIA and the ISDEAA. Together, they form the primary statutory framework for the modern Indian health system and reflect current federal policies

of tribal empowerment and self-determination. The IHCIA generally provides the programmatic authority and authorizations for appropriations for federal health care programs and services, while the ISDEAA authorizes tribes to assume responsibility, and associated funding, for programs and services that the federal government would otherwise be obligated to provide—like those in the IHCIA.

Congress has enacted, extended, and amended these laws over the years in response to persistent and disturbing deficiencies in the state of Indian health. The legislative history is replete with statistics and tragic personal stories of high mortality rates, low life expectancy, and a catalogue of diseases that disproportionately affect Indian communities. Just as consistently, these dismal health outcomes have been blamed on a chronic lack of funds for Indian programs. In particular, Congress has repeatedly acknowledged vast disparities in per capita spending on health care for Indians as compared with the general population.

Congress has incrementally increased direct appropriations to the IHS, the agency most directly responsible for the implementation of federal health programs for Indians, in partial response to these ongoing problems. But it has also sought to stabilize and grow Indian health program budgets through a variety of other available mechanisms, including the enactment of statutory provisions that authorize the IHS and tribes to recover third-party resources to help fund the federal programs and services they provide. These include authorizations to

collect reimbursements from other federal health programs like Medicare and Medicaid; special rights of recovery against private insurers, health maintenance organizations, and workers' compensation programs; codified payer of last resort status; and various measures intended to increase health insurance coverage among the IHS service population. In other words, Congress has sought to bring per capita spending on Indian health care up to par with per capita spending on the rest of the population, in part by granting Indian health programs greater access to the very same funding resources that rest of the population benefits from.

Along the way, Congress has made very clear that these resources are intended to increase Indian health program budgets and are to be "viewed as a much-needed supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian." H.R. Rep. No. 94-1026(III), at 21 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2782, 2796. These measures have in fact succeeded in increasing program funding, and third-party revenues have become an essential component (and large percentage) of both IHS and tribal health program budgets.[2] In short, there can be no doubt that the

[2] The IHS reports that it has collected over $1 billion annually in recent years through its *directly-operated facilities alone*. INDIAN HEALTH SERV., *IHS Profile* (Aug. 2020), https://www.ihs.gov/newsroom/factsheets/ihsprofile/. In FY 2020, IHS's $1.14 billion in collections from its federal facilities provided an approximately 20% increase to its $6 billion in appropriated funds. *Id*.

collection and expenditure of third-party revenues are an integral part of federal health programs for Indians today.

Tribal self-determination and self-governance have evolved significantly since enactment of the IHCIA in 1976, resulting in the transfer of responsibility for third-party billing and expenditures (along with many other federal activities) to tribal management and control. But that has not changed the essential character of the federal program or its funding. To the contrary—because third-party revenues and their expenditures are part and parcel of the federal program, the ISDEAA and the IHCIA mandate that tribal contractors must have the same ability as the IHS to utilize these funds for program expenses, rather than divert them for contract management and overhead. The very purpose of Congress's CSC mandate is to assure such parity in program funding between IHS and tribal contractors—and without it, the larger, interrelated goals of the IHCIA and the ISDEAA could not succeed. Because the District Court decision below fundamentally misunderstood what the IHCIA and ISDEAA require in this case, it should be overturned.

ARGUMENT

I. Congress has continuously expanded access to third-party resources as part of a comprehensive and coordinated effort to address chronic underfunding of Indian health programs, incrementally increase program budgets, and implement its federal trust responsibility to raise the health status of American Indian and Alaska Native people.

Congress has long acknowledged that "[f]ederal 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." 25 U.S.C. § 1601(1). Despite that federal responsibility and the many statutory duties enacted to carry it out, health care services for tribes and their citizens have long been stunted by woefully inadequate funding.

The failure of the federal government to provide funding for Indian health programs that even approaches the amounts spent on other federal health programs has been well documented. *See, e.g.*, U.S. COMM'N ON CIVIL RIGHTS, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans* at 66–68 (Dec. 2018) ("Broken Promises") (finding that in 2017, IHS health care expenditures per person were $3,332 compared to $9,207 for federal health care spending nationwide, and comparing per capita spending among federal health care programs in FY 2016 including Medicare ($12,744), Medicaid ($7,492), and the IHS ($2,834)). Not surprisingly, the disparities in funding have translated to real

disparities in health outcomes between Native Americans and the general United States population. *See, id.* at 65–66; INDIAN HEALTH SERV., *Disparities* (Oct. 2019), https://www.ihs.gov/newsroom/factsheets/disparities/.

These funding shortfalls and the resulting health outcomes have consistently served as the backdrop for federal legislation on Indian health and tribal self-determination. In seeking to redress these inequities, Congress has incrementally increased direct appropriations for the IHS over the years. *See, e.g.*, INDIAN HEALTH SERV., *IHS Profile* (Aug. 2020), https://www.ihs.gov/newsroom/factsheets/ihsprofile/ (showing IHS budget appropriations for FYs 2016–2020). Congress has also sought other ways to sustain and increase Indian health program budgets, including by tapping into the resources already set aside for some of the better-funded federal health programs. These measures have been generally successful, and over time the additional funding sources—sometimes referred to as "program income"—have become an essential component of IHS program funding. *Id*.

a. Medicare and Medicaid Reimbursement

When the IHCIA was first enacted in 1976, the House Committee on Interior and Insular Affairs surveyed the "deplorable status of Indian health" and lamented:

> The sad fact[s] are that the vast majority of Indians still live in an environment characterized by inadequate and understaffed health facilities; improper or nonexistent waste disposal and water supply systems; and continuing dangers of deadly or disabling diseases.

> These circumstances, in combination, cause Indians and Alaska Natives to suffer a health status far below that of the general population and plague Indian communities and Native villages with health concerns other American communities have forgotten as long as 25 years ago.

H.R. Rep. No. 94-1026(I), at 15 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2654. The Committee cited the disproportionately high rates of tuberculosis, respiratory illness, and infant mortality, as well as other afflictions among American Indian and Alaska Native people, concluding: "The health statistics relate a deplorable tale, a tale which has a tragic ending. While every other American can expect to live to the age of at least 70.8 years, the Indian and Alaska Native can expect to live only to age 65.1." *Id*. The Committee recognized that addressing these deficiencies would require, among other things, improved facilities and *more money*: "Per capita expenditures for Indian health purposes are 25 percent below per capita expenditures for health care in the average American community. The greater incidence of disease among Indians renders this deficiency all the more acute." *Id*. at 16, 1976 U.S.C.C.A.N. at 2655.

At the same time, Congress recognized another problem in delivering health care to Indian patients—a problem that also offered a potential solution. Many IHS beneficiaries were technically eligible for Medicare and Medicaid, but they were not accessing that coverage:

> [M]any of our national health programs, designed to assist the general population, are difficult or impossible to apply to Indians. Medicare,

> Medicaid, and social security programs afford little relief because, given the unique social situation of most Indians, very few know they are eligible for Medicare or have worked long enough for social security eligibility.

Id. Meanwhile, the IHS facilities where those patients were cared for were not yet authorized to bill Medicare or Medicaid, nor could most of those facilities meet the minimum qualifications for reimbursement. *See* H.R. Rep. No. 94-1026(III), at 20 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2782, 2795.

Thus, in 1976 Congress authorized IHS to bill Medicare and Medicaid for services provided by IHS and tribal facilities. Indian Health Care Improvement Act, Pub. L. No. 94-437, tit. IV, §§ 401 (Medicare), 402 (Medicaid), 90 Stat. 1400, 1408–1410 (1976), codified at 42 U.S.C. § 1396j and 42 U.S.C. § 1395qq. Congress emphasized that this measure was meant to increase the budget for underfunded tribal health programs, specifically confirming that Medicare and Medicaid funds received by the IHS should "be used to supplement—and not supplant—current IHS appropriations," and "that funds from Medicare and Medicaid will be used to expand and improve current IHS health care services and not to substitute for present expenditures." H.R. Rep. No. 94-1026(I), at 108 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2746; *see also*, H.R. Rep. No. 94-1026(III), at 21 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2782, 2796 (" . . . the receipt of Medicaid funds should not be considered justification for reductions in the IHS appropriations. These Medicaid payments are viewed as a much-needed

supplement to a health care program which has for too long been insufficient to provide quality health care to the American Indian.").

In crafting the IHCIA, Congress had considered whether a massive increase to IHS appropriations could effectively address the problems the agency faced. The bill of course included authorizations for additional appropriations, but both the House and Senate committees expressed concern that "mounting a 'crash' program . . . with its too sudden infusion of funds, inevitably proves to be uneconomical and unmanageable." H.R. Rep. No. 94-1026(I), at 18 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2657. Instead, Congress opted for an "incremental" approach, which it hoped would "serve to eliminate the documented excessive backlogs in health care requirements and establish a firm foundation upon which a continuous program capable of meeting the total health needs of the Indians and Alaska Native people could be maintained . . . ." *Id.* The Medicare and Medicaid reimbursement provisions included in the resulting legislation comprised one of six "inter-related titles," which the House and Senate reports described as "a sustained and coordinated Federal health effort . . . ." S. Rep. No. 94-133, at 13 (1975); H.R. Rep. No. 94-1026(I), at 18 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2657; *see also, id.* at 124, 1976 U.S.C.C.A.N. at 2762 (describing the bill as "a cohesive, phased approach to raising the health standards of American Indians to a level of parity with non-Indian citizens. Each title and

section of the bill is dependent upon and inter-related with the other provisions, resulting in a coordinated whole."). In short, Congress pursued a combination of funding mechanisms it believed would result in stronger, more sustainable federal health programs for Indians.

b. Private Insurance and Other Responsible Third Parties

In the years since 1976, Congress has continued its "sustained and coordinated effort" to increase overall IHS program budgets by incrementally increasing direct appropriations *and* expanding access to other sources of funding. This includes third-party collections not only from federally funded programs like Medicare and Medicaid, but also from private insurance coverage and other sources—all of which are considered "program income" under the ISDEAA. 25 U.S.C. §§ 5325(m), 5388(j).

In amending the IHCIA in 1988, Congress first adopted what is now Section 206, codified at 25 U.S.C. § 1621e, to empower the IHS to collect third-party reimbursements from private health insurance, accident insurance, and workers' compensation programs. Legislation was necessary because exclusionary clauses often contained in such policies denied payment for services to covered individuals who were not personally required to pay for the care they received (like IHS beneficiaries). *See* H.R. Rep. No. 100-222(II), at 19–20 (1987). The new

provision mandated that the IHS "shall have the right to recover the reasonable expenses incurred" in providing health services:

> to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive reimbursement or indemnification for such expenses if—(1) such services had been provided by a nongovernmental provider, and (2) such individual had been required to pay such expenses and did pay such expenses.

Indian Health Care Amendments of 1988, Pub. L. No. 100-713, tit. II, § 204, 102 Stat. 4784, 4811 (1988); 25 U.S.C. § 1621e(a). The provision expressly preempted any state law (or contract provision) to the contrary and provided a federal cause of action to enforce the recovery rights created therein. 25 U.S.C. § 1621e(c).

Congress later extended the same rights to tribes and tribal organizations as part of the 1992 amendments to the IHCIA, in response to reports that insurance companies were refusing to reimburse for services rendered by ISDEAA contractors (as opposed to the IHS itself). Indian Health Amendments of 1992, Pub. L. No. 102-573, tit. II, § 209, 106 Stat. 4526, 4551 (1992); *see* S. Rep. No. 102-392, at 20–21 (1992), *reprinted in* 1992 U.S.C.C.A.N. 3943, 3962–63. In so doing, Congress stated its intent that "tribal contractors [should] have the same right to recover against private insurance companies that IHS enjoys" and that "collections made by tribal health contractors shall remain with the contractor, in order to assure the availability of adequate funds to address unmet Indian health

care needs." S. Rep. No. 102-392, at 21 (1992), *reprinted in* 1992 U.S.C.C.A.N. 3943, 3962; H.R. Rep. No. 102-643(I), at 45–46 (1992).

When Congress passed the 1992 IHCIA amendments, the vast majority of third-party revenues were still collected, processed, and redistributed by the IHS—not by the tribally operated facilities whose services generated the collections. Congress noted that IHS management of third-party funds tended to disincentivize collection and reporting at the facility level, specifically because the IHS routinely decreased the allocation of appropriated funds to IHS and tribal programs that collected substantial third-party revenues. Further, the IHS frequently transferred revenues away from the facilities that generated them to other facilities that did not. S. Rep. No. 102-392, at 28–29 (1992), *reprinted in* 1992 U.S.C.C.A.N. 3943, 3970–71; H.R. Rep. No. 102-643(I) at 50–51 (1992). The 1992 amendments ended those practices through two measures: First, Congress provided that any payments received by an IHS or tribal facility "shall not be considered in determining appropriations for health care and services to Indians." Indian Health Amendments of 1992, Pub. L. No. 102-573, tit. IV, § 401, 106 Stat. 4526, 4565 (1992).[3] Second, Congress mandated that 80% of the Secretary's collections had to be returned to the facility where the services being billed were performed—up

[3] The ISDEAA currently provides that earning program income "shall not be a basis for reducing the amount of funds otherwise obligated to the contract." 25 U.S.C. § 5325(m).

from the previous requirement of 50%. *See* Indian Health Amendments of 1992, Pub. L. No. 102-573, tit. IV, § 401, 106 Stat. 4526, 4565 (1992).

Congress viewed both of these measures as ways to increase overall collections, hoping that the changes would "serve as an incentive to tribal health programs to become more aggressive in pursuing collections under Medicare and Medicaid programs[,]" S. Rep. No. 102–392, at 29 (1992), *reprinted in* 1992 U.S.C.C.A.N. 3943, 3971, and remove existing disincentives "for vigilant collections by Indian health facilities . . . ." H.R. Rep. No. 102–643(I), at 51 (1992). For the time being, those revenues would still be collected and distributed to tribal contractors by the IHS, just like appropriated funds, but in a manner that would more appropriately reflect congressional intent that third-party collections be used to *expand* program budgets rather than simply substitute for existing funds.

As in 1976, both the 1988 and the 1992 IHCIA amendments were motivated by Congress's concerns over the persistent and appalling health deficiencies among the IHS service population and the lack of adequate funding to effectively address them. While recognizing that "substantial progress" had been made since the enactment of the IHCIA in 1976, the House Committee on Interior and Insular Affairs in a 1987 report emphasized:

> [I]t is clear that Indians still lag far behind the rest of the Nation in many health areas and that there are still substantial unmet health care needs among the Indian tribes. This is no more evident than in a comparison of the per capita health expenditure by IHS for Indians with the per

> capita health expenditure for all other citizens. As shown in Table 8, *infra.*, using constant 1987 dollars, the per capita expenditure for Indians was $740.30 as compared to $1,554.40 for the Nation. When one considers that the IHS Indian service population is almost solely dependent upon IHS for health care, this disparity is of critical proportions.

H.R. Rep. No. 100–222(I), at 45 (1987).[4] Likewise, in 1992 the Senate Select Committee on Indian Affairs reiterated that although "the health status of the Indian people has improved since 1976, it remains inferior to that of the U.S. population as a whole," S. Rep. No. 102-392, at 3 (1992), *reprinted in* 1992 U.S.C.C.A.N. 3943, 3945, while also complaining that the President's budget request had failed to request sufficient funds to fully implement the IHCIA. *Id*. at 2–4. Again, then, Congress's steps to further increase third-party revenues must be viewed as one response to these program funding concerns.

c. IHCIA and ACA Reforms

Unfortunately, those concerns were still relevant when Congress again overhauled and modernized the IHCIA in 2010—this time as part of the Patient Protection and Affordable Care Act (ACA). Pub. L. No. 111-148, 124 Stat. 119 (2010). In introducing S. 1790, which would ultimately be enacted through

[4] The Committee also noted that, accounting for inflation, from 1977 to 1988 spending on Indian health programs "decreased by nearly 40 percent, while for the U.S. resident population, it increased by about 13 percent." *Id*. at 43.

incorporation by reference into Section 10221 of the ACA (with minimal amendments), Senator Byron Dorgan pleaded:

> We face a bona fide crisis in health care in our Native American communities, and this bill is a first step toward fulfilling our treaty obligations and trust responsibility to provide quality health care in Indian Country. . . . Native Americans suffer staggering health disparities due to an outdated, strained and underfunded health care system. *We have a federal health care system for Native Americans that is only funded at about half of its need.* Clinician vacancy rates within this system are high and misdiagnosis is rampant. Only those with "life or limb" emergencies seem to get care. Native Americans die of tuberculosis at a rate 600 percent higher than the general population, suicide rates are nearly double, alcoholism rates are 510 percent higher, and diabetes rates are 189 percent higher than the general population.
>
> These numbers are appalling and represent Third World conditions right here in the U.S.

155 Cong. Rec. S10493 (daily ed. Oct. 15, 2009) (statement of Sen. Dorgan) (emphasis added).

S. 1790 represented a comprehensive update to the IHCIA intended to remedy the crisis and bring the Indian health system into the 21st century. Among its many provisions was a significantly more robust Section 206 which, along with other changes, now provides that the IHS, an Indian tribe, or a tribal organization shall have the right to recover from an insurance company or health maintenance organization (or other responsible third payor) its reasonable billed charges "or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities . . . ." 25 U.S.C. § 1621e.

This change gives the IHS and tribal contractors a right to recover, *at a minimum*, its reasonable billed charges from any private insurance carrier—even in the absence of a provider contract as would normally be required for reimbursement—*or* to benefit from higher rates paid to nongovernmental providers.

The 2010 amendments to the IHCIA also made it easier for tribes to sponsor health insurance coverage for the beneficiaries they serve through the purchase of private insurance and creation of self-insured plans, *id.* § 1642, and provided that tribes carrying out ISDEAA contracts or compacts may purchase health insurance for their employees through the Federal Employees Health Benefits (FEHB) Program. *Id*. § 1647b. The 2010 amendments also authorized tribal health programs to direct bill for reimbursement from the Children's Health Insurance Program (CHIP), as well as from Medicare and Medicaid. *Id*. § 1641(d).

On top of the IHCIA amendments, Congress took steps in the ACA to incentivize American Indian and Alaska Native enrollment in new insurance Marketplaces that were part of the bill's broader health insurance market reforms.[5] The incentives include special monthly enrollment periods and cost-sharing exemptions for American Indians and Alaska Natives enrolling in Marketplace

[5] Additionally, Section 2902 of the ACA removed the "sunset" date for collection of reimbursements for Medicare Part B services, which had been authorized on a temporary basis by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No.108-173, 117 Stat. 2066 (2003). Pub. L. No. 111-148, tit. II, § 2902, 124 Stat. 119, 333 (2010).

plans. 42 U.S.C. § 18031(c)(6)(D); *id.* § 18071(d). As with the premium sponsorship and FEHB provisions noted above, these measures provide relatively little benefit to a majority of the individual American Indian and Alaska Native beneficiaries who gain coverage, since they are not required to pay for services provided at IHS and tribal health facilities in any event. Rather, they benefit the IHS and tribal health programs that serve those individuals by increasing the availability of third-party collections that become part of the overall program budgets.

Finally, to ensure that increased beneficiary enrollment under these various provisions would actually result in increased funding for the Indian health system, Congress codified longstanding administrative policy providing that the IHS and tribal health programs are the payers of last resort, notwithstanding any federal, state, or local law to the contrary. 25 U.S.C. § 1623(b). The preemptory power of this statutory provision significantly strengthens the rights of recovery exercised by the IHS and tribal contractors and embodies Congress's expectation that federal Indian health programs ought to benefit from virtually any and every available source of health care funding.

In September of 2019, the U.S. Government Accountability Office (GAO) responded to a request from Congress to review how the ACA had affected American Indian and Alaska Native access to health care. U.S. GOV'T

ACCOUNTABILITY OFF., GAO-19-612, *Indian Health Serv: Facilities Reported Expanding Servs. Following Increases in Health Ins. Coverage and Collections* 19 (2019). The GAO's findings confirm both that the ACA reforms resulted on average in a meaningful increase in third-party collections at both IHS and tribally operated facilities, especially for those located in states that took advantage of Medicaid Expansion, and that "increases in health insurance coverage and third-party collections helped [federally operated and tribally operated facilities] to continue their . . . operations and [] expand the services they offer . . . ." *Id*. The GAO reported:

> Officials we interviewed from all 17 selected federally operated and tribally operated facilities noted that they used increased third-party collections to fund their continued operations. Even as officials we interviewed from nearly all of the 11 selected federally operated IHS facilities reported that their facilities' third-party collections had grown from fiscal years 2013 to 2018, officials from most of these facilities also said they relied more heavily on these collections to support their continued operations. *Officials we interviewed from all of the IHS area offices told us that third-party collections provide a vital source of funding for federally operated IHS facilities in their area.* These collections allowed them to maintain a level of operations that would otherwise be challenging, for reasons such as increasing costs of payroll and of maintaining an aging infrastructure.

Id. (emphasis added). This result is certainly consistent with Congress's intent, as expressed over the years and embodied in legislation beginning with the 1976 IHCIA, that federal Indian health programs expand their budget (and, by extension, their program services) through a variety of means, including third-party revenues.

It also reflects the reality that those sources of funding are now an essential component of the "federal program."

d. Emergency Appropriations for Lost Third-Party Revenues

Since the 2010 reforms enacted through the ACA, program income has remained such an integral part of the federal program that its loss has occasionally spurred legislation to compensate with increased appropriations. In 2017 when certain IHS-operated hospitals in the Great Plains Area were in danger of losing accreditation (in part due to their failure to collect and manage program income), Congress responded by appropriating $29 million for "costs related to or resulting from accreditation emergencies" and allowing up to $4 million of that amount to be used as supplemental funding for the Purchased and Referred Care program, an IHS program particularly reliant on third-party revenues. Consol. Appropriations Act, Pub. L. No. 115-31, div. H, tit. II, 131 Stat. 135, 484 (2017); *see also Reexamining the Substandard Quality of Indian Health Care in the Great Plains Hearing Before the Comm. on Indian Affairs*, 114th Cong. (2016), at 14–18 (prepared statement of former Senator Dorgan), listing IHS policies and practices leading to severe deficiencies in the Great Plains region, including "significant backlogs in posting, billing and collecting claims from third party insurers" and repeated transfers of third-party payments between facilities); *id.* at 24–28 (prepared statement of Andy Slavitt, Acting Administrator, Centers for Medicare

and Medicaid Services (CMS), discussing IHS deficiencies threatening CMS accreditation).

Congress again stepped in when the IHS and tribal health facilities, like other hospitals and clinics around the country, suffered losses in third-party revenues as a result of the COVID-19 pandemic. This time, it appropriated to IHS nearly $2 billion to make up for program income shortfalls caused by cancelled or postponed elective procedures. *See* American Rescue Plan Act of 2021, Pub. L. No. 117-2, tit. XI, § 11001(a)(1)(A) (2021) (direct appropriation for "lost reimbursements"); *see also Evaluating the Response and Mitigation to the Covid-19 Pandemic in Native Comtys. and S.3650 Hearing Before the Comm. on Indian Affairs*, 116th Cong. (2020) at 44–60 (prepared statement of Lisa Elgin, Secretary, National Indian Health Board, citing losses in third-party reimbursements due to COVID-19).

Such interventions evidence that Congress continues to view third-party collections as part of the overall necessary funding for its federal health care programs for Indians—whether these programs are operated by the IHS directly or by a tribe or tribal organization under contract. Simply put, Congress does not fund IHS programs through IHS appropriations alone. It has combined those appropriations with various statutory authorizations, rights of recovery, and legal remedies intended to fill funding gaps and allow IHS and tribal programs to

maintain and grow their program budgets in a sustainable manner. While Congress will likely continue to incrementally increase IHS appropriations over time and may occasionally provide emergency increases, it otherwise allows and *expects* both the IHS and tribal contractors to fund their federal programs with third-party revenues as well as direct IHS appropriations.

II. Congress's goal of raising the status of Indian health goes hand in hand with its goal of promoting tribal self-determination and self-governance through tribal operation of federal programs on an equal footing with the IHS—including with respect to the collection and expenditure of third-party revenues.

Since Congress first enacted the IHCIA in 1976, the federal health programs it authorizes have evolved in tandem with the growth of tribal self-determination and self-governance under the ISDEAA. The two acts must be considered together, because they operate together to form a cohesive statutory basis for the modern Indian health system. Both are grounded in the trust responsibility to tribes and individual Indians. *See, e.g.*, 25 U.S.C. §§ 1602, 5301(a). Both are designed to ensure "maximum Indian participation" in the delivery of services pursuant to the federal responsibility. 25 U.S.C. § 1601(3); *id*. § 5302(a). Critically, both statutes require that the funding for tribal programs and facilities be no less than amounts for IHS's programs and facilities. 25 U.S.C. § 1602(7); *id*. § 5325(a)(1). Further, the two statutes often cross-reference each other. For example, the IHCIA authorizes "tribal health program[s]" to bill Medicare and

Medicaid, 25 U.S.C. § 1641(d)(1), and defines a "tribal health program" as a tribe or tribal organization operating a program under an ISDEAA agreement. *Id*. § 1603(25).

In short, both statutes promote tribal self-determination in health care and insist on parity of funding between IHS-run facilities and those operated by tribes. The ISDEAA and IHCIA are *in pari materia*, *Navajo Health Found.—Sage Mem'l Hosp., Inc. v. Burwell*, 263 F. Supp. 3d 1083, 1165 (D.N.M. 2016), *appeal dismissed*, No. 18-2043, 2018 WL 4520349 (10th Cir. July 11, 2018), and therefore and must "be taken together, as if they were one law." *United States v. Stewart*, 311 U.S. 60, 64 (1940) (internal quotation marks and citations omitted).

a. Transfer of Third-Party Billing Responsibilities from the IHS to Tribal Contractors

Tracking the development of tribal self-determination under the ISDEAA, the responsibility and authority for third-party billing for tribally run IHCIA programs has gradually transitioned from full IHS control to tribal control. Prior to 1988, IHS collected and distributed all third-party revenues from both IHS-run and tribally operated facilities. In fact, it distributed those revenues to tribal contractors *under their contract*, by "modify[ing] the Tribe's '638' contract to reflect" the amount of program income earned by the Tribe but billed and collected by IHS on the Tribe's behalf. S. Rep. No. 106–152, at 2 (1999).

IHS management of third-party collections created a number of problems, including those caused by IHS's reductions in appropriated funds for high-performing facilities and income redistribution practices that Congress set about to fix in its 1992 amendments to the IHCIA. But also, IHS was not particularly good at collections:

> The [tribal] contractors believe, with considerable justification, that third party collections would be greatly increased if they were permitted to handle them. For example, in some areas IHS has not placed all Medicaid-eligible patients in its billing system, and therefore no claims for these patients are being submitted at all. Also, the IHS Area Offices frequently do not follow up on rejected claims although many claims are improperly rejected. Some contractors estimate that collections at their service units would be tripled if the system were improved, and they are anxious to make the improvements.

H.R. Rep. No. 100–393, at 5–6 (1987).

The ISDEAA reflects the notion that federal programs are often run more effectively by tribes and therefore "Federal domination of programs for [Indians]" should give way to tribal self-determination. 25 U.S.C. § 5302(b).[6] Consistent with that goal, in its 1988 IHCIA amendments Congress took the first steps toward authorizing tribes to bill and collect program income directly rather than forcing them to rely on IHS. That year, Congress enacted a five-year "demonstration program" under which four tribes would be permitted to participate. Indian Health

[6] *See, e.g.*, INDIAN HEALTH SERV., *Tribal Self-Governance Fact Sheet* (July 2016), https://www.ihs.gov/newsroom/index.cfm/factsheets/tribalselfgovernance/.

Care Amendments of 1988, Pub. L. No. 100-713, tit. IV, § 402, 102 Stat. 4784, 4818–20 (1992) (adding Section 405 to the IHCIA). Tribes wishing to participate had to apply to the Secretary. 102 Stat. at 4819 (new Section 405(c)). The IHS retained substantial control over those tribes' collections even after approving their participation, and the collections remained "subject to all auditing requirements applicable to programs administered directly by the Service . . . ." *Id*. (new Section 405(b)(2)).

For the hundreds of tribes *not* admitted to the direct billing demonstration program, the IHS continued to collect Medicare and Medicaid reimbursements and to transfer those payments under each tribe's ISDEAA contract. It was not until 2000 that Congress made the direct billing demonstration project permanent, Alaska Native and Am. Indian Direct Reimbursement Act of 2000, Pub. L. No. 106-417, 114 Stat. 1812 (2000) (rewriting IHCIA Section 405),[7] and not until 2010 that Congress permitted all tribal contractors to elect "to directly bill for, and receive payment for, health care items and services" covered by third-party payers without prior approval from the IHS. 25 U.S.C. § 1641(d)(1).[8]

[7] Tribal billing remained subject to substantial IHS oversight, *see* 114 Stat. at 1814 (new Subsection 405(b)(3))), and in order to participate tribes still had to apply to the Secretary. *Id*. (new Subsection 405(c)(1)).

[8] The 2010 amendments to the IHCIA also confirmed that tribes must receive funding for programs and facilities that they operate "in amounts that are not less

It was 1994 when, on a parallel track, Congress amended the ISDEAA to expressly require that CSC shall include administrative and overhead costs of "the operation of the *Federal program* that is the subject of the contract[.]" *Id.* § 5325(a)(3)(A)(i) (emphasis added). At that time, it would have been assumed without question that "program income" was part of the "Federal program" Congress was referring to, since that program income had always been and was still being transferred to virtually all tribal contractors through their ISDEAA contracts. In other words, program income was distributed by the IHS to contractors in the same manner as appropriated funds to support the contracted federal program.

Today, IHS no longer distributes program income to ISDEAA tribal contractors in this manner—but only because the results of the direct billing demonstration program were successful and proved that tribes could perform the same third-party billing functions just as well as, if not better than, the IHS. Most, if not all, tribal contractors now exercise their rights under the IHCIA and the ISDEAA to perform third-party billing functions themselves as part of the contracted federal program.[9] But the fact that all contractors are now able exercise

---

than the amounts provided to programs and facilities operated directly by the [Indian Health] Service." *Id.* § 1602(7).

[9] ISDEAA tribal contractors can still elect to have IHS collect program income and distribute it through the contract, should they so choose. *See id.* § 1641(d)(1)

those rights does nothing to change the underlying assumption that "program income" is part of the "Federal program." Third-party billing and expenditures originated as federal activities carried out as part of a federal program, and they did not lose that character simply because they were transferred like so many other federal programs, functions, services, and activities to tribal control under the ISDEAA.

b. Parity Among IHS- and Tribally Operated Federal Programs

Given the role that Congress intended program income to play in the funding of federal Indian health programs, it would indeed be odd to conclude (as the District Court did here) that their expenditure by tribal contractors is *not* part of the federal program under contract. After all, earning and expending "program income" is one facet of the "Federal program" that both the IHS and its tribal contractors carry out.[10]

But there is a more fundamental reason to conclude that Congress intended for CSC to be paid on program income as well as appropriated funds. When Congress amended the ISDEAA in 1994 using the "Federal program" language, it

---

(tribes "may" elect to bill directly), 1641(c)(1) (describing IHS collection and use of funds for IHS facilities and tribal programs that do not elect to bill directly).

[10] There is no reason to suppose that Congress intended for the word "program" to have two different meanings in these contexts. *See Powerex Corp. v. Reliant Energy Svcs., Inc.*, 551 U.S. 224, 232 (2007) ("A standard principle of statutory construction provides that identical words and phrases within the same statute should normally be given the same meaning.").

plainly stated its intent that "program resources" should be used by tribal contractors (just like the IHS) for healthcare services and *not* for contract management or general overhead:

> In the event the Secretarial amount under section 106(a)(1) for a particular function proves to be insufficient in light of a contractor's needs for prudent management of the contract, *contract support costs* are to be available to supplement such sums. . . . Throughout this section the Committee's objective has been *to assure that there is no diminution in program resources* when programs, services, functions or activities are transferred to tribal operation. *In the absence of section 106(a)(2) as amended, a tribe would be compelled to divert program funds to prudently manage the contract, a result Congress has consistently sought to avoid*.

S. Rep. No. 103–374, at 9 (1994) (emphasis added).[11]

Underlying this statement is Congress's recognition that, for tribal self-determination and self-governance to flourish, there must be parity of resources as between IHS and tribally operated programs. To that end, CSC pays for administrative activities that the Secretary does not need to carry out because they are done by other federal agencies (for example, the Office of Personnel Management), or for costs like insurance that the IHS does not need to incur at all. 25 U.S.C. § 5325(a)(2). The IHS benefits from that extensive federal administrative support structure in *all* of its programs and services, regardless of

[11] That is why the new Section 106(a)(3) made CSC available for the entire "Federal program" and not just appropriated funds or the "secretarial amount." 25 U.S.C. § 5325(a)(3)(A)(i).

the funding source. It is thus able to take full advantage of the many third-party authorizations Congress has provided to expand its program base rather than pay for administrative support. To prevent the "diminution in program resources" or "diver[sion] of program funds" that Congress sought to avoid when programs are transferred from IHS to tribal control, tribes must *also* be able to recover CSC on *all* of the funding that supports the federal program, including third-party expenditures.

Parity between IHS and tribal programs is a baseline necessity for successfully achieving *both* of Congress's interrelated goals in the IHCIA and the ISDEAA—*i.e.*, meaningful improvement in the health status of Indian people nationwide, and tribal self-determination and self-governance of Indian programs. The reason is simple: if tribally operated programs do not have the same access to rights and resources as the IHS, they cannot provide the same quantity or caliber of services, and the health outcomes within their communities will suffer. Faced with such outcomes, tribes and tribal organizations may give up on self-determination and return (or "retrocede") Indian health programs back to direct IHS management, bringing a return to the "federal domination" of Indian programs ISDEAA was meant to dismantle. Avoiding precisely this outcome is at the heart of Congress's CSC mandate and of this case.

CONCLUSION

The District Court's decision below fails to account for the integral role Congress has given third-party collections in federal health programs for Indians, whether operated by the IHS or by an ISDEAA tribal contractor. As a result, it fundamentally undermines the congressional purposes underlying both the ISDEAA and the IHCIA, and it should be overturned.

Dated: September 27, 2021

/s/ *Geoffrey D. Strommer*

Geoffrey D. Strommer
Stephen D. Osborne
HOBBS, STRAUS, DEAN & WALKER, LLP
215 SW Washington Street, Suite 200
Portland, OR 97204
Phone: (503) 242-1745
Fax: (503) 242-1072
GStrommer@hobbsstraus.com
SOsborne@hobbsstraus.com

Caroline P. Mayhew
HOBBS, STRAUS, DEAN & WALKER, LLP
1899 L Street NW, Suite 1200
Washington, D.C. 20036
Phone: (202) 822-8282
Fax: (202) 296-8834
CMayhew@hobbsstraus.com

Counsel for Amici Curiae

Additional Counsel:

Robert R. Yoder
Yoder & Langford, P. C.
8175 East Evans Road, #13598
Scottsdale, Arizona 85267
Telephone: (602) 808-9578

robert@yoderlangford.com
Counsel for Gila River Indian Community of the Gila River Indian Reservation, Arizona

Esther A. Labrado
National Congress of American Indians
1516 P Street, NW
Washington, DC 20005
Counsel for National Congress of American Indians

Rob Lynch, Vice President
Legal Affairs and General Counsel
Alaska Native Tribal Health Consortium
4000 Ambassador Drive
Anchorage, AK 99508
(907) 729-1900
Counsel for the Alaska Native Tribal Health Consortium

Sara Hill, Attorney General
Cherokee Nation
17675 S. Muskogee Avenue
Tahlequah, OK 74464
(918) 453-5262
Counsel for the Cherokee Nation

Stephen Greetham, Senior Counsel
Chickasaw Nation
4001 N. Lincoln Blvd.
Oklahoma City, OK 73105
(580) 272-5236
Counsel for the Chickasaw Nation

Gregory Quinlan & George Wright
Citizen Potawatomi Nation
1601 S. Gordon Cooper Drive
Shawnee, OK 74801
(405) 878-4844
Counsel for the Citizen Potawatomi Nation

Brian Upton
Confederated Salish and Kootenai Tribes
P.O. Box 278
Pablo, Montana 59855
(406) 275-2806
Counsel for the Confederated Salish and Kootenai Tribes

Rebecca Liebing, Tribal Staff Attorney
Little River Band of Ottawa Indians
2608 Government Center Drive
Manistee, MI 49660
Counsel for the Little River Band of Ottawa Indians

Natasha Singh, General Counsel
Tanana Chiefs Conference
122 1st Avenue, Suite 600
Fairbanks, AK 99701
(907) 452-8251
Counsel for the Tanana Chiefs Conference

CERTIFICATE OF COMPLIANCE

This document complies with the type-volume limit of Fed. R. App. P. 32(a)(7)(B) and Fed. R. App. P. 29(a)(4)(G) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), this document contains 6,893 words.

This document complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) because this document has been prepared in a proportionally spaced typeface using Microsoft Word 2016 in font size 14 and Times New Roman font.

Date: September 27, 2021

/s/ *Geoffrey D. Strommer*

Geoffrey D. Strommer
Stephen D. Osborne
HOBBS, STRAUS, DEAN & WALKER, LLP
215 SW Washington Street, Suite 200
Portland, OR 97204

Caroline P. Mayhew
HOBBS, STRAUS, DEAN & WALKER, LLP
1899 L Street NW, Suite 1200
Washington, D.C. 20036

Counsel for Amici Curiae

STATEMENT OF THE PARTIES' CONSENT

In accordance with Fed. R. App. P. 29(a)(2) and 9th Cir. R. 29-2(a), Counsel reports that Counsel for Plaintiff-Appellant San Carlos Apache Tribe and for Defendants-Appellees Xavier Becerra, Michael Weahkee, and United States have given consent to the filing of this amicus brief.

Date: September 27, 2021

/s/ *Geoffrey D. Strommer*
Geoffrey D. Strommer
Stephen D. Osborne
HOBBS, STRAUS, DEAN & WALKER, LLP
215 SW Washington Street, Suite 200
Portland, OR 97204

Caroline P. Mayhew
HOBBS, STRAUS, DEAN & WALKER, LLP
1899 L Street NW, Suite 1200
Washington, D.C. 20036

Counsel for Amici Curiae

CERTIFICATE OF SERVICE

I hereby certify that on September 27, 2021, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

Participants in the case who are registered CM/ECF users will be served by the appellate CM/ECF system.

Date: September 27, 2021

/s/ *Geoffrey D. Strommer*

Geoffrey D. Strommer
Stephen D. Osborne
HOBBS, STRAUS, DEAN & WALKER, LLP
215 SW Washington Street, Suite 200
Portland, OR 97204

Caroline P. Mayhew
HOBBS, STRAUS, DEAN & WALKER, LLP
1899 L Street NW, Suite 1200
Washington, D.C. 20036

Counsel for Amici Curiae

ADDENDUM

Amici Federally Recognized Tribal Nations

Cherokee Nation
Chickasaw Nation
Chippewa Cree Indians of the Rocky Boy's Reservation, Montana
Citizen Potawatomi Nation
Confederated Salish and Kootenai Tribes
Coquille Indian Tribe
Cowlitz Indian Tribe
Eastern Band of Cherokee Indians
Gila River Indian Community of the Gila River Indian Reservation, Arizona
Jamestown S'Klallam Tribe
Ketchikan Indian Community
Little River Band of Ottawa Indians
Menominee Indian Tribe of Wisconsin
Metlakatla Indian Community, Annette Island Reserve
Native Village of Eyak
Pascua Yaqui Tribe of Arizona
Quileute Tribe of the Quileute Reservation
Saint Regis Mohawk Tribe
Salt River Pima-Maricopa Indian Community of the Salt River Reservation, Arizona
Shoalwater Bay Indian Tribe of the Shoalwater Bay Indian Reservation
Shoshone-Paiute Tribes of the Duck Valley Reservation, Nevada
Suquamish Indian Tribe of the Port Madison Reservation
Yakutat Tlingit Tribe
Zuni Tribe of the Zuni Reservation

Amici National Tribal Organizations

National Congress of American Indians

Amici Local and Regional Tribal Organizations

Alaska Native Health Board[12]

[12] Alaska Native Health Board has 28 member Tribes.

Alaska Native Tribal Health Consortium[13]

Arctic Slope Native Association[14]

Bristol Bay Area Health Corporation[15]

Chapa-De Indian Health[16]

Copper River Native Association[17]

Eastern Aleutian Tribes[18]

Indian Health Council[19]

Kodiak Area Native Association[20]

Navajo Health Foundation—Sage Memorial Hospital

Northwest Portland Area Indian Health Board[21]

Norton Sound Health Corporation[22]

Riverside-San Bernardino County Indian Health[23]

---

[13] Alaska Native Tribal Health Consortium has 229 member Tribes.

[14] Arctic Slope Native Association has eight member Tribes.

[15] Bristol Bay Area Health Corporation has 28 member Tribes.

[16] Chapa-De Indian Health has one member Tribe.

[17] Copper River Native Association has six member Tribes.

[18] Eastern Aleutian Tribes has seven member Tribes.

[19] Indian Health Council has nine member Tribes.

[20] Kodiak Area Native Association has ten member Tribes.

[21] Northwest Portland Area Indian Health Board has 43 member Tribes.

[22] Norton Sound Health Corporation has 16 member Tribes.

[23] Riverside-San Bernardino County Indian Health has nine member Tribes.

Southeast Alaska Regional Health Consortium[24]

Tanana Chiefs Conference[25]

United South and Eastern Tribes Sovereignty Protection Fund[26]

[24] Southeast Alaska Regional Health Consortium has fifteen member Tribes.

[25] Tanana Chiefs Conference has 42 member Tribes.

[26] United South and Eastern Tribes Sovereignty Protection Fund has 33 member Tribes.