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No. 11-11021 & 11-11067

UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

STATE OF FLORIDA, by and through
Attorney General Pam Bondi, et al.,
Plaintiffs-Appellees,
v.
UNITED STATES DEPARTMENT OF
HEALTH AND HUMAN SERVICES, et al.,
Defendants-Appellants.

On Appeal from the United States District Court for the
Northern District of Florida, 3:10-cv-00091-RV-EMT

BRIEF *AMICI CURIAE* OF THE NATIONAL INDIAN HEALTH BOARD; AFFILIATED TRIBES OF NORTHWEST INDIANS; ALL INDIAN PUEBLO COUNCIL; BRISTOL BAY AREA HEALTH CORPORATION; CHICKASAW NATION; CONFEDERATED TRIBES OF THE COLVILLE RESERVATION; CONSOLIDATED TRIBAL HEALTH PROJECT, INC.; COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS; GREAT PLAINS TRIBAL CHAIRMAN'S ASSOCIATION; KICKAPOO TRADITIONAL TRIBE OF TEXAS; KOOTENAI TRIBE OF IDAHO; LYTTON RANCHERIA OF CALIFORNIA; MANIILAQ ASSOCIATION; METLAKATLA INDIAN COMMUNITY;MISSISSIPPI BAND OF CHOCTAW INDIANS; NATIONAL CONGRESS OF AMERICAN INDIANS; NEZ PERCE TRIBE; NORTHERN VALLEY INDIAN HEALTH, INC.; NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD; NORTON SOUND HEALTH CORPORATION; PALA BAND OF LUISENO MISSION INDIANS; SEMINOLE TRIBE OF FLORIDA; SHOALWATER BAY INDIAN TRIBE; SUQUAMISH INDIAN TRIBE; SUSANVILLE INDIAN RANCHERIA; UNITED SOUTH AND EASTERN TRIBES, INC.; AND YERINGTON PAIUTE TRIBE; IN SUPPORT OF APPELLANTS AND FOR REVERSAL OF THE DECISION BELOW

GEOFFREY D. STROMMER*
CAROL L. BARBERO
ELLIOTT A. MILHOLLIN
VERNON L. PETERSON
JESSICA M. WILES
Hobbs, Straus, Dean & Walker, LLP

Counsel for *Amici Curiae*
* Counsel of Record

CERTIFICATE OF INTERESTED PERSONS AND CORPORATE DISCLOSURE STATEMENT

Pursuant to 11th Cir. R. 26.1-1, undersigned counsel for *Amici Curiae* certifies that, to the best of his knowledge, the following is a list of additional persons or entities that have or may have an interest in the outcome of this case and were not contained in the Appellants' opening brief. The *amici* tribal corporations and tribal consortiums listed below (identified with an asterisk) have no parent corporations and, as they have no stock, no publicly held company owns 10 percent or more of their stock.[1]

Affiliated Tribes of Northwest Indians*

All Indian Pueblo Council*

Bristol Bay Area Health Corporation*

Chickasaw Nation

Confederated Tribes of the Colville Reservation

Consolidated Tribal Health Project, Inc.*

Council of Athabascan Tribal Governments*

Great Plains Tribal Chairman's Association*

Kickapoo Traditional Tribe of Texas

---

[1] Member tribes of each these tribal organizations are listed on Attachment A hereto.

Kootenai Tribe of Idaho

Lytton Rancheria of California

Maniilaq Association*

Metlakatla Indian Community

Mississippi Band of Choctaw Indians

National Congress of American Indians*

National Indian Health Board*

Nez Perce Tribe

Northern Valley Indian Health, Inc.*

Northwest Portland Area Indian Health Board*

Norton Sound Health Corporation*

Pala Band of Luiseno Mission Indians

Seminole Tribe of Florida

Shoalwater Bay Indian Tribe

Suquamish Indian Tribe

Susanville Indian Rancheria

United South and Eastern Tribes, Inc.*

Yerington Paiute Tribe

/s/_________________________
Geoffrey D. Strommer
Counsel for *Amici Curiae*
April 7, 2011

ATTACHMENT A

LIST OF MEMBER TRIBES OF *AMICI* TRIBAL ORGANIZATIONS

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

Organized Village of Kasaan

Central Council of the Tlingit & Haida Indian Tribes

Hoopa Valley Tribe, California

Karuk Tribe

Blackfeet Tribe of the Blackfeet Indian Reservation of Montana

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

Confederated Salish & Kootenai Tribes of the Flathead Reservation, Montana

Shoshone-Paiute Tribes of the Duck Valley Reservation, Nevada

Summit Lake Paiute Tribe of the Duck Valley Reservation, Nevada

Chinook Tribe

Duwamish Tribe

Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon

Confederated Tribes of the Chehalis Reservation, Washington

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

Confederated Tribes of the Colville Reservation, Washington

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

Coquille Tribe of Oregon

Cow Creek Band of Umpqua Indians of Oregon

Cowlitz Indian Tribe, Washington

Confederated Tribes of the Grand Ronde Community of Oregon

Hoh Indian Tribe of the Hoh Indian Reservation, Washington

Jamestown S'Klallam Tribe of Washington

Kalispel Indian Community of the Kalispel Reservation, Washington

Klamath Tribes, Oregon

Kootenai Tribe of Idaho

Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington

Lummi Tribe of the Lummi Reservation, Washington

Makah Indian Tribe of the Makah Indian Reservation, Washington

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington

Nez Perce Tribe, Idaho

Nisqually Indian Tribe of the Nisqually Reservation, Washington

Nooksack Indian Tribe of Washington

Northwestern Band of Shoshoni Nation of Utah (Washakie)

Port Gamble Indian Community of the Port Gamble Reservation, Washington

Puyallup Tribe of the Puyallup Reservation, Washington

Quileute Tribe of the Quileute Reservation, Washington

Quinault Tribe of the Quinault Reservation, Washington

Samish Indian Tribe, Washington

Sauk-Suiattle Indian Tribe of Washington

Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation, Washington

Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho

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

Skokomish Indian Tribe of the Skokomish Reservation, Washington

Snoqualmie Tribe, Washington

Snohomish Tribe

Spokane Tribe of the Spokane Reservation, Washington

Squaxin Island Tribe of the Squaxin Island Reservation, Washington

Steilacoom Tribe

Stillaguamish Tribe of Washington

Suquamish Indian Tribe of the Port Madison Reservation, Washington

Swinomish Indians of the Swinomish Reservation, Washington

Tulalip Tribes of the Tulalip Reservation, Washington

Confederated Tribes of the Umatilla Reservation, Oregon

Upper Skagit Indian Tribe of Washington

Confederated Tribes of the Warm Springs Reservation of Oregon

Confederated Tribes and Bands of the Yakama Nation, Washington

All Indian Pueblo Council (NM, TX)

Pueblo of Acoma, New Mexico

Pueblo of Cochiti, New Mexico

Pueblo of Isleta, New Mexico

Pueblo of Jemez, New Mexico

Kewa, New Mexico

Pueblo of Laguna, New Mexico

Pueblo of Nambe, New Mexico

Ohkay Owingeh, New Mexico

Pueblo of Picuris, New Mexico

Pueblo of Pojoaque, New Mexico

Pueblo of Sandia, New Mexico

Pueblo of Santa Ana, New Mexico

Pueblo of Santa Clara, New Mexico

Pueblo of San Felipe, New Mexico

Pueblo of San Ildefonso, New Mexico

Pueblo of Taos, New Mexico

Pueblo of Tesuque, New Mexico

Ysleta Del Sur Pueblo of Texas

Pueblo of Zia, New Mexico

Zuni Tribe of the Zuni Reservation, New Mexico

Bristol Bay Area Health Corporation (AK)

Portage Creek Village (aka Ohgsenakale)

Ekwok Village

New Stuyahok Village

New Koliganek Village Council

Dillingham (Curyung Tribal Council)

Native Village of Aleknagik

Village of Clarks Point

Native Village of Ekuk

Knugank Tribal Council

Chignik Bay Tribal Council

Native Village of Chignik Lagoon

Chignik Lake Village

Native Village of Perryville

Ivanof Bay Village

Manokotak Village

Twin Hills Village

Traditional Village of Togiak

Native Village of Goodnews Bay

Platinum Traditional Village

Ugashik Village

Native Village of Pilot Point

Egegik Village

Naknek Native Village

South Naknek Village

Levelock Village

King Salmon Tribe

Native Village of Port Heiden

Native Village of Kanatak

Nondalton Village

Village of Iliamna

Pedro Bay Village

Kokhanok Village

NewhalenVillage

Igiugig Village

Consolidated Tribal Health Project, Inc. (CA)

Cahto Indian Tribe of the Laytonville Rancheria, California

Coyote Valley Band of Pomo Indians of California

Guidiville Rancheria of California

Hopland Band of Pomo Indians of the Hopland Rancheria, California

Pinoleville Pomo Nation, California

Potter Valley Tribe, California

Redwood Valley Rancheria of Pomo Indians of California

Sherwood Valley Rancheria of Pomo Indians of California

Council of Athabascan Tribal Governments (AK)

Arctic Village (Native Village of Venetie Tribal Government)

Beaver Village

Birch Creek Tribe

Canyon Village

Chalkyitsik Village

Circle Native Community

Native Village of Fort Yukon

Rampart Village

Native Village of Stevens

Village of Venetie (Native Village of Venetie Tribal Government)

Great Plains Tribal Chairman's Association (ND, SD, NB)

Cheyenne River Sioux Tribe of the Cheyenne River Reservation,

South Dakota

Rosebud Sioux Tribe of the Rosebud Indian Reservation,

South Dakota

Crow Creek Sioux Tribe of the Crow Creek Reservation,

South Dakota

Yankton Sioux Tribe of South Dakota

Lower Brule Sioux Tribe of the Lower Brule Reservation,

South Dakota

Sisseton-Wahpeton Oyate of the Lake Traverse Reservation,

South Dakota

Oglala Sioux Tribe of the Pine Ridge Reservation,

South Dakota

Flandreau Santee Sioux Tribe of South Dakota

Three Affiliated Tribes of the Fort Berthold Reservation,

North Dakota

Standing Rock Sioux Tribe of North & South Dakota

Turtle Mountain Band of Chippewa Indians of North Dakota

Spirit Lake Tribe, North Dakota

Omaha Tribe of Nebraska

Ponca Tribe of Nebraska

Santee Sioux Nation, Nebraska

Winnebago Tribe of Nebraska

Maniilaq Association (AK)

Native Village of Kotzebue

Native Village of Ambler

Native Village of Buckland

Native Village of Kiana

Native Village of Kivalina

Native Village of Kobuk

Native Village of Noatak

Noorvik Native Community

Native Village of Point Hope

Native Village of Selawik

Native Village of Shungnak

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

Burns Paiute Tribe of the Burns Paiute Indian Colony of Oregon

Confederated Tribes of the Chehalis Reservation, Washington

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

Confederated Tribes of the Colville Reservation, Washington

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

Coquille Tribe of Oregon

Cow Creek Band of Umpqua Indians of Oregon

Cowlitz Indian Tribe, Washington

Confederated Tribes of the Grand Ronde Community of Oregon

Hoh Indian Tribe of the Hoh Indian Reservation, Washington

Jamestown S'Klallam Tribe of Washington

Kalispel Indian Community of the Kalispel Reservation, Washington

Klamath Tribes, Oregon

Kootenai Tribe of Idaho

Lower Elwha Tribal Community of the Lower Elwha Reservation, Washington

Lummi Tribe of the Lummi Reservation, Washington

Makah Indian Tribe of the Makah Indian Reservation, Washington

Muckleshoot Indian Tribe of the Muckleshoot Reservation, Washington

Nez Perce Tribe, Idaho

Nisqually Indian Tribe of the Nisqually Reservation, Washington

Nooksack Indian Tribe of Washington

Northwestern Band of Shoshoni Nation of Utah (Washakie)

Port Gamble Indian Community of the Port Gamble Reservation, Washington

Puyallup Tribe of the Puyallup Reservation, Washington

Quileute Tribe of the Quileute Reservation, Washington

Quinault Tribe of the Quinault Reservation, Washington

Samish Indian Tribe, Washington

Sauk-Suiattle Indian Tribe of Washington

Shoalwater Bay Tribe of the Shoalwater Bay Indian Reservation,
Washington

Shoshone-Bannock Tribes of the Fort Hall Reservation of Idaho

Confederated Tribes of the Siletz Indians of Oregon

Skokomish Indian Tribe of the Skokomish Reservation, Washington

Snoqualmie Tribe, Washington

Spokane Tribe of the Spokane Reservation, Washington

Squaxin Island Tribe of the Squaxin Island Reservation, Washington

Stillaguamish Tribe of Washington

Suquamish Indian Tribe of the Port Madison Reservation, Washington

Swinomish Indians of the Swinomish Reservation, Washington

Tulalip Tribes of the Tulalip Reservation, Washington

Confederated Tribes of the Umatilla Reservation, Oregon

Upper Skagit Indian Tribe of Washington

Confederated Tribes of the Warm Springs Reservation of Oregon

Confederated Tribes and Bands of the Yakama Nation, Washington

Norton Sound Health Corporation (AK)

Native Village of Brevig Mission

Native Village of Council

Native Village of Diomede

Native Village of Elim

Native Village of Gambell

Chinik Eskimo Community (Golovin)

King Island Community

Native Village of Koyuk

Mary's Igloo

Nome Eskimo Community

Native Village of St. Michael

Native Village of Savoonga

Native Village of Shaktoolik

Native Village of Shishmaref

Village of Solomon

Stebbins Community Association

Native Village of Teller

Native Village of Unalakleet

Native Village of Wales

Native Village of White Mountain

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

Eastern Band of Cherokee Indians of North Carolina

Miccosukee Tribe of Indians of Florida

Mississippi Band of Choctaw Indians, Mississippi

Seminole Tribe of Florida

Chitimacha Tribe of Louisiana

Seneca Nation of New York

Coushatta Tribe of Louisiana

Saint Regis Mohawk Tribe, New York

Penobscot Tribe of Maine

Passamaquoddy Tribe of Maine

Houlton Band of Maliseet Indians of Maine

Tunica-Biloxi Tribe of Louisiana

Poarch Band of Creek Indians of Alabama

Narragansett Indian Tribe of Rhode Island

Mashantucket Pequot Tribe of Connecticut

Wampanoag Tribe of Gay Head (Aquinnah) of Massachusetts

Alabama-Coushatta Tribes of Texas

Oneida Nation of New York

Aroostook Band of Micmac Indians of Maine

Catawba Indian Nation

Jena Band of Choctaw Indians, Louisiana

Mohegan Indian Tribe of Connecticut

Cayuga Nation of New York

Mashpee Wampanoag Tribe, Massachusetts

Shinnecock Indian Tribe

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II. Section 10221 of the ACA, reauthorizing and amending the IHCIA, and other Indian-specific provisions in the ACA, are all separable from the individual mandate provision held unconstitutional by the district court. 20

A. Assuming the district court correctly ruled the individual mandate unconstitutional, proper application of the Supreme Court's severability test would have resulted in a determination that the Indian-specific provisions of the ACA remained intact as valid law. 20

B. By invalidating the ACA in its entirety, the district court improperly frustrated the will of Congress. 23

C. The court erred by concluding that the entire ACA is connected to the individual mandate rather than viewing the ACA as a collection of diverse laws. 25

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U.S. Comm'n on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System,* 98 (Sept. 2004) 14

STATEMENT OF *AMICI CURIAE* INTEREST[1]

The close to 350 tribes across the nation who are *amici* or members of *amici* tribal organizations represented on this brief are directly affected by the district court's decision to invalidate the Patient Protection and Affordable Care Act ("Act" or "ACA") in its entirety, including several Indian-specific provisions that have a separate purpose and genesis from the individual mandate declared unconstitutional by the court. These Indian-specific provisions are legally separable from the remainder of the Act, are related solely to the Federal responsibility to provide health care to Indian tribes and their members, and are of critical importance to the delivery of health care services to Indian tribes and their members throughout the country. If this Court reaches the question of severability, the *amici* have a strong interest in ensuring that the analysis includes a thoughtful consideration of the severability rules as applied to these separate and separable Indian-specific provisions of the Act.

Amici include federally-recognized tribes and tribal organizations from across the nation, many of which are located in the Plaintiff states.[2]

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[1] Pursuant to FRAP 29(c)(5), *amici curiae* state that no counsel to any party to this dispute authored this brief in whole or in part and no person or entity, other than *amici* and their counsel, made a monetary contribution to the preparation or submission of this brief.

The National Indian Health Board (NIHB) represents tribal governments—both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service. Its Board of Directors is made up of tribal member representatives from twelve Area Health Boards which are organized to correspond to the twelve IHS service areas. NIHB provides a variety of services to tribes, the Area Health Boards, tribal organizations, federal agencies, and private foundations, including advocacy, policy development, research and training on Indian health issues, and tracking legislation and regulations.

The National Congress of American Indians (NCAI), founded in 1944, is the oldest, largest and most representative American Indian and Alaska Native organization serving the broad interests of tribal governments and communities. NCAI is comprised of more than 200 American Indian tribes and Alaska Native villages and other associated organizations. NCAI's mission is to inform the public and all branches of the federal government about tribal self-government, treaty rights, and a broad range of federal policy issues affecting tribal governments.

---

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

Amici Lytton Rancheria of California; Pala Band of Luiseno Mission Indians of the Pala Reservation, California; Seminole Tribe of Florida; Suquamish Indian Tribe of the Port Madison Reservation, Washington; Susanville Indian Rancheria, California; Yerington Paiute Tribe of the Yerington Colony and Campbell Ranch, Nevada; Mississippi Band of Choctaw Indians, Mississippi; Metlakatla Indian Community, Annette Island Reserve; Nez Perce Tribe, Idaho; Kickapoo Traditional Tribe of Texas; Shoalwater Bay Indian Tribe; Confederated Tribes of the Colville Reservation; Chickasaw Nation; and Kootenai Tribe of Idaho are federally-recognized tribes.

Amici Consolidated Tribal Health Project, Inc.; Northern Valley Indian Health, Inc.; United South and Eastern Tribes, Inc.; Bristol Bay Area Health Corporation; Council of Athabascan Tribal Governments; Northwest Portland Area Indian Health Board; Affiliated Tribes of Northwest Indians; Maniilaq Association; Great Plains Tribal Chairman's Association; Norton Sound Health Corporation; and All Indian Pueblo Council are tribal organizations[3] representing consortiums of federally-recognized tribes.

Many of the *amici* tribes and tribal organizations have entered into agreements with the Secretary of Health and Human Services, acting through the

[3] A list of the member tribes of each of the tribal organizations listed in this paragraph is attached as Attachment A to the Certificate of Interested Persons and Corporate Disclosure Statement.

Indian Health Service ("IHS"), pursuant to authority of the Indian Self-Determination and Education Assistance Act ("ISDEAA"), 25 U.S.C. § 450 et seq., in which they provide health care services directly to Indian people in their geographic areas.[4] For example, the Seminole Tribe of Florida ("Seminole Tribe") has a Compact and Funding Agreement that implements provisions of the Indian Health Care Improvement Act ("IHCIA"), 25 U.S.C. § 1601 et seq., including amendments to that law enacted as part of the ACA. Pursuant to its Compact and Funding Agreement, the Seminole Tribe has the responsibility to provide a broad range of health care programs and services authorized by the IHCIA amendments.

The Seminole Tribe serves tribal members and other eligible individuals within a specific geographic area in the state of Florida, operating several clinics and offering a variety of Indian health care programs. In providing these services, the Seminole Tribe relies on the IHCIA provisions in the ACA that have been incorporated into the Seminole Tribe's ISDEAA Compact and Funding Agreement.

Individually or collectively, *amici* tribes and tribal organizations either operate health care facilities and provide health care services to member Indians

[4] The Self-Governance Compact and Funding Agreement are governed by Title V of the ISDEAA, 25 U.S.C. § 458aa et seq.

and other beneficiaries pursuant to agreements with the IHS or they advocate on health issues affecting Indian people.

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

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

STATEMENT OF ISSUES

This brief of *amici* addresses the following issue:

Assuming the district court was correct in finding a discrete provision of the ACA unconstitutional, did the court err by applying the severability rule improperly, resulting in an order invalidating the ACA in its entirety, including the Indian-specific provisions of the ACA?

SUMMARY OF THE ARGUMENT

The district court held unconstitutional the "individual mandate" provision of the ACA[5] and declared the Act invalid in its entirety, including Section 10221, which reauthorized and amended the IHCIA, as well as other Indian-specific health care provisions incorporated in the ACA.

This case raises an important question: Whether the court below correctly applied the Supreme Court's severability rules when it invalidated the ACA in its entirety, including the Indian-specific provisions that are of critical importance to Indian tribes and tribal organizations throughout the country. The Indian-specific provisions have a separate genesis from the individual mandate provision, involve legally independent rights and obligations related solely to Indian tribes, Indian people and Indian health providers and should remain valid if the individual mandate is severed from the Act.

When a court finds a portion of a statute unconstitutional, the remainder is presumed valid. If a remaining provision is independent and "fully operative as a law," the court must leave it intact unless it is evident that Congress would not have enacted it separately. *See Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999) (quoting *Champlin Refining Co. v. Corporation*

[5] *See* § 1501 of the ACA, *codified in* 26 U.S.C. § 5000A. The so-called "individual mandate" provision is termed "minimum essential coverage" in § 1501.

Comm'n of Okla., 286 U.S. 210, 234 (1932)). "[T]he normal rule is that partial, rather than facial, invalidation is the required course." *Free Enterprise Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161 (2010) (citation and internal quotation marks omitted).

Section 10221 and the other Indian-specific provisions in the Act fall well within the "normal rule." They support an independent, freestanding Indian health care system, and are "fully operative" as separate laws. There is no evidence that the district court recognized or considered the terms and separate genesis of the Indian-specific provisions. Having failed to follow the "required course" of analysis,[6] the district court's severability ruling is overbroad, and should be reversed, at a minimum with respect to Section 10221 and other Indian-specific provisions of the Act.

ARGUMENT AND CITATIONS OF AUTHORITY

The Indian Health Care Improvement Act is one of many distinct and specialized federal laws designed by Congress to address the unique needs of tribal communities. These laws were enacted to carry out treaty and other land-cession

[6] There was an alternative course the district court could have followed. For example, the district court in *Virginia v. Sebelius*, 728 F.Supp.2d 768, 789 (E. D. Va. 2010), recognized that the ACA encompassed "a wide variety of topics related and unrelated to health care." In that case the court acted circumspectly and severed only the individual mandate and "directly-dependent provisions" which specifically refer to the individual mandate, leaving the remainder of the ACA intact. *Id.* at 790.

obligations assumed by the United States. They have evolved as programs designed to implement the federal trust responsibility to provide health care to Indians and enhance tribal self-determination and self-governance, while providing tools for tribes to increase the quality and quantity of governmental services, including health care services, to Indian people. *See generally Cohen's Handbook of Federal Indian Law* §§ 22.01[1] - 22.01[3] ("Obligation to Provide Services") (2005 ed.).[7]

Since 1976, the IHCIA has functioned as a stand-alone statutory framework for the delivery of health care services to Indian people, independent of any type of an individual mandate to obtain health insurance. The IHCIA is critically important legislation that helps address the chronic health disparities in Indian country. For over ten years, *amici* tribes and tribal organizations worked to enact much needed improvements to the IHCIA through a legislative process that was

[7] Adopted initially in 1976, the IHCIA, 25 U.S.C. § 1601 et seq., has been amended several times as described below. Congress has enacted broad legislation to facilitate tribal control of programs, including the Indian Self-Determination and Education Assistance Act, 25 U.S.C. § 450 et seq. (authorizing tribes to contract and control federal programs); Tribally Controlled Schools Act, 25 U.S.C. § 2501 et seq. (education); Native American Housing Assistance and Self-Determination Act, 25 U.S.C. § 4101 et seq. (housing); Indian Employment, Training, and Related Services Demonstration Act, 25 U.S.C. § 3401 et seq. (employment and work training); Indian Child Welfare Act, 25 U.S.C. § 1901 et seq. (adoption and child welfare). The Supreme Court has long recognized the "distinctive obligation of trust incumbent upon the government" in its dealings with tribes. *See Seminole Nation v. United States*, 316 U.S. 286, 296 (1942).

separate and independent from the ACA. These amendments were added at the last minute to the bill that became the ACA because it was highly likely to be enacted.

The IHCIA amendments legislation, S. 1790, was a separate bill with a separate legislative genesis from the process that produced the ACA. Rather than enact S. 1790 on its own, Congress incorporated it by reference in a single paragraph of text in Section 10221 of the ACA. S. 1790 itself contains over 260 pages of legislative text amending and permanently reauthorizing the IHCIA. S. 1790 was added as Section 10221 to H.R. 3590 only two days before that bill which became the ACA was passed by the Senate.[8] Section 10221 and other the Indian-specific health care provisions of the Act operate independently of the individual mandate provision declared unconstitutional by the district court.

The reauthorization of and amendments to the IHCIA, along with other Indian provisions included in the ACA, provide critically important improvements to the delivery of health care to Indian people in the United States. By failing to even examine whether provisions like Section 10221 and other Indian-specific provisions of the ACA could remain intact absent the individual mandate, the district court committed error.

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[8] H.R. 3590 as passed by the Senate on December 24, 2009, was adopted by the House of Representatives on March 21, 2010, and signed into law by the President on March 23, 2010 as Pub. L. 111-148.

We begin with a discussion of the history of Congress's treatment of Indian health care and the separate purposes and genesis of Section 10221 and other Indian-specific provisions in the ACA. Then we show that consistent with governing severability rules the Indian-specific provisions of ACA are independent, freestanding laws that should remain even if this Court upholds the district court's determination that the individual mandate is unconstitutional.

I. The history of Congress's Indian health care legislation demonstrates that the IHCIA and other Indian-specific provisions of the ACA are entirely separate from the individual mandate provision of the ACA.

A. The reauthorization and amendment of the IHCIA.

The IHCIA amendments enacted by Section 10221 of the ACA became part of H.R. 3590 – the Senate's health care reform legislation that eventually became law – only two days before that legislation was passed by the Senate. On December 22, 2009, the Senate adopted a Manager's package of amendments, one of which was a new Part III to Title X titled "Indian Health Care Improvement."[9] Part III consisted solely of Section 10221, a single page of legislation incorporating by reference amendments to the IHCIA that originated as a separate piece of legislation – S. 1790 – with the addition of four alterations to the text of that measure.

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

S. 1790, titled the "Indian Health Care Improvement Reauthorization and Extension Act of 2009", came out of a different committee than the remainder of the ACA, and has an entirely separate legislative history. S. 1790 was introduced on October 15, 2009, by Senator Byron Dorgan and 15 co-sponsors and was referred to the Senate Committee on Indian Affairs, the panel with primary jurisdiction over Indian health. By contrast, H.R. 3590 was the product of the Majority Leader's reconciliation of health care reform measures considered and approved by two other Senate committees – Finance and Health, Education, Labor and Pensions (HELP) – which have jurisdiction over all other health legislation. Amending the IHCIA was not a part of nor related to the efforts of those panels to craft health care reform bills.

The legislative effort to reauthorize and amend the IHCIA had begun ten years earlier. Stand-alone IHCIA reauthorization bills were introduced and considered in the 106th Congress and each successive Congress until one eventually passed when incorporated by reference in the ACA.

The IHCIA was initially enacted in 1976. It reflects the Federal government's trust responsibility and legal obligation to provide health care services to Indian tribes and Indian people. Articulated in treaties, judicial decisions, laws, regulations and policies over more than two centuries, the Federal

trust responsibility to Indians is robustly recognized by all branches of the Federal government.[10]

In 1976, in response to the deplorable health status of Indian people, the shameful condition of the Indian hospitals and clinics, and inadequate or non-existent sanitation facilities, the 94th Congress enacted the IHCIA to bring order and direction to the unsatisfactory manner in which Indian health care was then delivered.[11] After reciting a catalog of the conditions which imperil Indian health, the new law made a firm commitment to Indian people in its Declaration of Policy:

> "The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy."[12]

The IHCIA has been reauthorized and amended a number of times since 1976, with extensive substantive amendments enacted in 1992 to strengthen its programmatic provisions. In 1999, a new effort to reauthorize and update the IHCIA began. In that year and throughout the ensuing decade, IHCIA bills were

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[10] *See, e.g.*, President's Memorandum on Tribal Consultation, 74 Fed. Reg. 57881 (Nov. 9, 2009), and Executive Order 13175 on Consultation and Coordination with Tribes, as guided by the trust relationship, 65 Fed. Reg. 67249 (Nov. 6, 2000). *See also* n. 8, *supra*.

[11] *See* H.R. Rep. No. 94-1026-Part I, at 1-17 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652-2657.

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

introduced in every Congress. Some achieved congressional committee approval and one bill was debated on the Senate floor – the first time this occurred in more than 15 years.[13] But the political and legislative stars did not align to achieve enactment.

Meanwhile, there was a continuing health care crisis in Indian country. As Senator Byron Dorgan observed when introducing the seventh IHCIA Senate bill in 2009, "[w]e face a bona fide crisis in health care in our Native American communities, and this bill is a first step toward fulfilling our treaty obligations and trust responsibility to provide quality health care in Indian Country."[14] Despite improvement in some health status measures over prior decades, Indian health disparities continued to read like those of third world countries. Senator Dorgan cited to but a few of these: "Native Americans die of tuberculosis at a rate 600 percent higher than the general population, suicide rates are nearly double, alcoholism rates are 510 percent higher, and diabetes rate are 189 percent higher than the general population."[15]

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

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

[14] 155 Cong. Rec. S10493 (daily ed. Oct. 15, 2009).

[15] *Id.*

enacted the IHCIA in 1976, it reported that per capita expenditures for Indian health were then "25 percent below per capita expenditures for health care in the average American community."[16]

The problem of inadequate funding has not been cured in the ensuing decades. The U.S. Commission on Civil Rights reported that for 2003, the IHS spending for Indian medical care was 62 percent lower than the U.S. per capita amount.[17] It also reported that the per capita amount spent on IHS medical care ($1,194) was only *half* the per capita amount spent on health care for Federal prisoners ($3,808), and at the bottom of the list of all federal health programs.[18] When introducing S. 1790 in the fall of 2009, Senator Dorgan observed that the health care system for Native Americans is "only funded at about half of its need."[19]

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

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

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

[19] 155 Cong. Rec. S10493 (daily ed. Oct. 15, 2009) (statement of Sen. Dorgan).

It is impossible to overstate the importance of the IHCIA revisions to the Indian health system. The amendments enacted by the ACA made the IHCIA a permanent Federal law without expiration date; enhanced authorities to recruit/retain health care professionals to overcome high vacancy rates; expanded programs to address diseases such as diabetes that are at alarmingly high levels in Indian country; augmented the ability of tribal epidemiology centers to devise strategies to address local health needs; provided more equitable and innovative procedures for construction of health care and sanitation facilities; expanded opportunities for third party collections in order to maximize all revenue sources; established comprehensive behavioral health initiatives, with a particular focus on the Indian youth suicide crisis; and expressly authorized operation of modern methods of health care delivery such as long-term care and home- and community-based care, staples of the mainstream health system but not previously authorized for the Indian health system.

B. Other ACA provisions intended to benefit Indian health and Indian people are unrelated and do not depend on the individual mandate.

The ACA contains several other beneficial Indian provisions that, like the IHCIA component, were put into the Senate's health care reform bill because it was a moving legislative vehicle, not because they were part of or related to the individual mandate component or integral pieces of the health care reform fabric.

The constitutionality of these Indian-specific provisions has not been challenged. Thus, like the IHCIA component, all should remain in full force and effect.

A description of each provision follows.

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

These provisions were included in the health care reform bill reported by the Finance Committee as all topics are under Finance Committee jurisdiction. [20] The provision was included in H.R. 3590 approved by the Senate.

[20] S. Rep. No. 111-89, at 105 (2009).

- **Sec. 2091. Elimination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics**. This provision amends Sec. 1880 of the Social Security Act, the statutory provision which authorizes IHS and tribally-operated hospitals and clinics to receive reimbursements from Medicare. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108-173) expanded the Medicare Part B services for which such reimbursements were authorized for the five-year period Jan. 1, 2005 through Dec. 31, 2009. Sec. 2091 removed the "sunset" date and authorized these entities to continue to collect reimbursements for all Medicare Part B services without interruption.

This provision was included in the Finance Committee's health care reform bill reported to the Senate[21] and was retained in H.R. 3590 as approved by the Senate.

- **Sec. 3314. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under Part D**. This provision corrects a problem encountered by IHS, tribal and urban Indian organization pharmacies that provide Medicare Part D prescription drugs to their Indian patients without cost. Since the value of such drugs was not counted as out-of-pocket costs of the patient,

[21] *Id*. at 260.

the patient was not able to qualify for the catastrophic coverage level under Part D. The Sec. 3314 amendment removed this barrier by directing that effective Jan. 1, 2011, the cost of drugs borne or paid by an Indian pharmacy are to be considered out-of-pocket costs of the patient.

This provision was added to the Finance Committee bill during mark-up,[22] and was retained in the reconciled bill, H.R. 3590, approved by the Senate.

- **Sec. 9021. Exclusion of health benefits provided by Indian tribal governments**. This section amends the Internal Revenue Code to exclude from an individual tribal member's gross income the value of health benefits, care or coverage provided by the IHS or by an Indian tribe or tribal organization to its members. The provision overrides the determination by the Internal Revenue Service that the value of health benefits purchased by an Indian tribe for its members constituted taxable income to the member – even when a tribe stepped in to provided such coverage to make up for insufficient funding from the IHS.

This provision was added to the Finance Committee's health care reform bill that was reported to the Senate[23] and was retained in the reconciled bill, H.R. 3590, approved by the Senate.

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[22] *Id*. at 260.

[23] *Id*. at 356.

C. The Indian health care system is separate and distinct from the insurance-based system, and thus Section 10221 and the other Indian-specific ACA provisions are separable from the individual mandate and should remain valid.

None of the Indian-specific provisions described above is related to or dependent upon the efficacy or validity of the individual mandate. In fact, members of Indian tribes are exempt from the individual mandate penalty, *see* 26 U.S.C. § 5000A(e)(3), in recognition of the trust responsibility for Indian health and consistent with the Congressional practice of enacting Indian-specific health care laws.

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

Unlike the mainstream health delivery system for which the individual mandate and guaranteed-issue insurance reforms were created, the Indian health system is not insurance-based. Rather, it is designed specifically to perform the trust responsibility, and the IHCIA directs how this Federal responsibility for

Indian health is to be carried out. Services to Indian people are provided directly at IHS and tribal hospitals and clinics, supplemented by the purchase of contract health services. While these Indian programs are authorized to collect reimbursements from Medicare, Medicaid and private insurance when they serve Indian patients with such coverage, enrollment in an insurance plan is not a pre-requisite for receiving IHS care. Eligibility for IHCIA-authorized programs is defined in federal regulations based on Indian status and is not dependent on obtaining health insurance.

The district court did not review any Indian-specific ACA provisions, and therefore did not make the factual findings that would have distinguished them from the individual mandate reforms. Proper application of the Supreme Court's severability rules demonstrates that the Indian-specific provisions of the ACA are separable and remain valid even if the individual mandate is severed.

II. Section 10221 of the ACA, reauthorizing and amending the IHCIA, and other Indian-specific provisions in the ACA, are all separable from the individual mandate provision held unconstitutional by the district court.

A. Assuming the district court correctly ruled the individual mandate unconstitutional, proper application of the Supreme Court's severability test would have resulted in a determination that the Indian-specific provisions of the ACA remained intact as valid law.

Once a portion of a statute is found unconstitutional, the purpose of the court's severability rule is to separate and save those other portions of the legislation that are practically and legally independent and therefore valid.

As the Supreme Court stated most recently:

> "Generally speaking, when confronting a constitutional flaw in a statute, *we try to limit the solution to the problem, severing any problematic portions while leaving the remainder intact*. Because the unconstitutionality of a part of an Act does not necessarily defeat or affect the validity of its remaining provisions, *the normal rule is that partial, rather than facial, invalidation is the required course.*"

Free Enterprise Fund, 130 S.Ct. at 3161 (emphasis added) (citations and internal quotation marks omitted); *see also*, *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006) (the court should "strive to salvage" the remainder of the statute).

Severing the problematic provision to leave "the remainder intact" involves application of a two-part test. First, upon finding a provision unconstitutional, the court must determine whether other provisions function independently and remain "fully operative as a law"; if so, the invalid provision is "presumed severable." *I.N.S. v. Chadha,* 462 U.S. 919, 934 (1983). Second, the court must "sustain" the remaining provisions unless it is "evident" that Congress would have preferred the rest of the statute (or particular sections) to be invalidated along with the unconstitutional provision. *See Free Enterprise Fund,* 130 S.Ct. at 3161-62 (citations omitted). Essentially, this means respecting Congress's intent regarding the remaining provisions. "Unless it is evident that the legislature would not have enacted those provisions which are within its power, independently of that which is not, the invalid part may be dropped if what is left is fully operative as a law."

Minnesota v. Mille Lacs Band of Chippewa Indians, 526 U.S. at 191 (applying severability principles to executive order) (quoting *Champlin Refining Co.*, 286 U.S. at 234); *see also, Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984) (court should refrain from invalidating more of statute than necessary).

The Indian-specific provisions of the ACA function as stand-alone, "fully operative" laws that implement a unique health care delivery system in Indian country. This system is operated by the IHS or by tribes, such as many of the *amici* tribes, who take over health program operations through agreements with the IHS. Nothing in the district court's analysis of the individual mandate even hints at a finding that Congress intended or would have preferred that the provisions applicable only to the Indian health system be invalidated along with the individual mandate. In fact, in its January 31, 2011 Order, the district court acknowledged that "some (perhaps even most) of the remaining provisions [of ACA] can most likely function independently of the individual mandate." Record Excerpts ("RE") 2066. This accurate observation make inexplicable the court's subsequent conclusion that "there is nothing to indicate that [the remaining provisions] can [function] in the manner intended by Congress." RE 2067.

This conclusion is wrong on two counts. First, it is contrary to the "normal rule," which requires that other sections remain operative *unless* there is evidence that Congress *would not* have enacted them independently. *Free Enterprise Fund,*

130 S.Ct. at 3161. Second, this conclusion is factually wrong regarding the Indian-specific provisions, which have no connection to and are not dependent upon the individual mandate, and thus can "function in a *manner* consistent with the intent of Congress." *Alaska Airlines, Inc.* v. *Brock,* 480 U.S. 678, 685 (1987) (emphasis in original). Nothing in any of the ACA's Indian-specific provisions, in either their text or historical context, provides any evidence that Congress would not have enacted them without the individual mandate. *Free Enterprise Fund,* 130 S.Ct. at 3161.

B. By invalidating the ACA in its entirety, the district court improperly frustrated the will of Congress.

After declaring the individual mandate unconstitutional, the district court was clearly daunted by the prospect of reviewing a statute 2,700 pages long with several hundred sections. RE 2066. However, the "normal" rule of presumed validity requires that the court take some objective measure of the remaining provisions. In reviewing the constitutionality of a statute the court "should act cautiously" because "[a] ruling of unconstitutionality frustrates the intent of the elected representatives of the people. Therefore, a court should refrain from invalidating more of the statute than is necessary." *Regan,* 468 U.S. at 652. "[W]henever an act of Congress contains unobjectionable provisions separable from those found to be unconstitutional, it is the duty of [the] court to so declare, and to maintain the act in so far as it is valid." *Id.*, at 652-53 (quoting *El Paso &*

Northeastern R. Co. v. Gutierrez, 215 U.S. 87, 96 (1909)). Whether an unconstitutional provision is severable "is largely a question of legislative intent, but the presumption is in favor of severability." *Id.* at 653. Thus, a court should "strive to salvage" as much as possible of a statute, so that the court does not "use its remedial powers to circumvent the intent of the legislature." *Ayotte,* 546 U.S. at 330 (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979)). If careful analysis is required to determine that a particular provision of a statute is unconstitutional,[24] it stands to reason that the remaining portions of the statute, presumed valid, should also be scrutinized carefully before determining if they are independent "fully operative" provisions of law and therefore remain valid, or if they bear such close connection to the unconstitutional provision that they too must be invalidated.[25]

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[24] "[A]n Act of Congress ought not to be construed to violate the Constitution if any other possible construction remains available." *NLRB v. Catholic Bishop of Chicago*, 440 U.S. 490, 500, 99 S.Ct. 1313 (1979).

[25] In the five severability cases cited by the district court the Supreme Court, after careful analysis, opted for severing the unconstitutional provision and leaving the remainder intact. *See Free Enterprise Fund v. Pub. Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3161–62 (2010) (Sarbanes-Oxley Act); *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 328–31 (2006) (New Hampshire Parental Notification Prior to Abortion Act); *New York v. U.S.*, 505 U.S. 144, 186–87 (1992) (Low-Level Radioactive Waste Act); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684–87 (1987) (Airline Deregulation Act); *INS v. Chadha*, 462 U.S. 919, 934–35 (1983) (Immigration and Nationality Act). By contrast, in a recent case where the Court did strike the entire law, it did so after concluding that saving it would have required the Court to, among other things, "write words into the statute." *Randall v. Sorrell*, 548 U.S. 230, 262 (2006) (Vermont Campaign Finance Reform Act).

In this case the district court devoted sixty plus pages to the analysis of the constitutionality of the individual mandate, but only eleven pages to the determination that the Act was invalid in its entirety. The court did not evaluate the history or genesis of the Indian-specific provisions in any way. In fact the court specifically disclaimed any intent to review the entire Act, noting that it would "take considerable time and extensive briefing" to go through "the 2,700-page Act line-by-line, invalidating dozens (or hundreds) of some sections while retaining dozens (or hundreds) of others." RE 2073. Without such analysis, however, the court was not able to "limit the solution" to the perceived problem with the individual mandate. *See Free Enterprise Fund*, 130 S.Ct. at 3161. By invalidating the Indian-specific provisions along with the rest of the Act, the court nullified much more than was necessary to excise the effect of the individual mandate. If this Court reaches the severance issue and applies the severability rule consistent with Supreme Court doctrine, the validity of the Indian provisions will be apparent and should be upheld.

C. The court erred by concluding that the entire ACA is connected to the individual mandate rather than viewing the ACA as a collection of diverse laws.

The ACA is a package of many diverse provisions. As even the district court recognized, some of the provisions in the ACA "have only a remote and tangential connection to health care." RE 2066. The district court in *Virginia v.*

Sebelius noted that the final version of the 2,700 page bill encompassed "a wide variety of topics related and unrelated to health care." 728 F.Supp.2d at 789. Even a casual reading of the ACA demonstrates that Congress did not seek to achieve only one purpose in this massive law. Nonetheless, the district court concluded that the individual mandate "was, in fact, the keystone or lynchpin of the entire health reform effort." RE 2068. The court inaccurately characterized the entire ACA as "a carefully-balanced and clockwork-like statutory arrangement comprised of pieces that all work toward one primary legislative goal," and on that basis reached the unsupportable conclusion that, having found one provision unconstitutional, "severability is not appropriate." RE 2066. There is debate about how interconnected the individual mandate is with some provisions in the ACA.[26] But there can be no argument about the fact that the individual mandate bears no relation at all to the Indian-specific provisions of the ACA.

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[26] The United States argues that the individual mandate stands or falls with the Act's guaranteed-issue and community-rating insurance industry reforms, but no more. *See* Brief for Appellants at 59. The district court in *Virginia v. Sebelius*, severed only the individual mandate (Section 1501) and "directly-dependent provisions which make specific reference to Section 1501." 728 F.Supp.2d at 789. The court in *Virginia v. Sebelius* was more circumspect in recognizing that the Act encompassed "a wide variety of topics related and unrelated to health care," and that it would require "extensive expert testimony and significant supplementation of the record" for the Court to "determine what, if any, portion of the bill *would not* be able to survive independently." *Id.* at 786 (emphasis added).

To conclude, as the district court did, that the individual mandate is "essential" to the entire ACA paints the ACA with one very broad brush, when a closer reading shows varied brushstrokes and at least one set of discrete canvases – the Indian-specific provisions that are "fully operative" as independent laws. The district court recognized that when "Congress intended a given statute to be viewed as a bundle of separate legislative enactment or a series of short laws, which for purposes of convenience and efficiency were arranged together in a single legislative scheme, it is presumed that any provision declared unconstitutional can be struck and severed without affecting the remainder of the statute." RE 2065-66. The district court inexplicably failed to recognize that the ACA is just such an act – a "bundle" of separate laws, including the Indian-specific provisions. In so doing, the district court improperly invalidated the entire Act contrary to the Supreme Court's severability rules.

D. The court erred by according too much significance to the lack of a severability clause in the statute.

The district court accorded too much significance to the fact that the ACA does not contain a "severability clause," and that although one had been included in an earlier version of the legislation, none appears in the bill that finally became law. RE 2068-69. However, the absence of such a clause, in and of itself, "does not raise a presumption against severability." *Alaska Airlines,* 480 U.S. at 686. In fact, the presence of a severability clause merely creates the presumption of

severability. It is still necessary to engage in the severability inquiry, even where such a clause is included in the statute. *See id.* (where a severability clause is included in the statute, only "strong evidence" can overcome it).[27]

Thus, the presence or absence of a severability clause may inform review, but it is still necessary to analyze whether Congress would have enacted each provision of the statute in any event.[28] The district court reached too far in concluding that Congress's failure to include a severability clause in the ACA "can be viewed as strong evidence that Congress recognized the Act could not operate *as intended* without the individual mandate." RE 2069 (emphasis in original). That conclusion misses the mark because once again it incorrectly assumes that the individual mandate applies to all aspects of the ACA. In weighing the absence of a severability clause, the court failed to give any consideration to the terms and genesis of Section 10221 and other Indian-specific provisions because of its

[27] The district court supports its view by quoting *Russello v. United States*, 464 U.S. 16, 23-24 (1983) ("Where Congress includes [particular] language in an earlier version of a bill but deletes it prior to enactment, it may be presumed that the [omitted provision] was not intended.") However, *Russello* is not relevant. It involved a rule of interpretation that the substantive meaning of a provision alters when limiting language in the text of the provision is struck from a later version, and thus has no relevance to the presence or absence of a severability clause, which is governed by the rules discussed above.

[28] Notably, Senate and House drafting manuals provide that a severability clause is unnecessary *unless* Congress intends to make portions of a statute unseverable. *See Interpreting by the Book: Legislative Drafting Manuals and Statutory Interpretation*, 120 Yale L.J. 185, 190 (2010).

intense focus on the individual mandate provision. The Indian-specific provisions are clearly separable and should not be invalidated.

CONCLUSION

If this Court affirms the district court's ruling that the individual mandate is unconstitutional, the district court's invalidation of the ACA in its entirety should nonetheless be reversed, at least with respect to the Indian-specific provisions, which are separable and should be upheld.

Respectfully submitted this 7th day of April, 2011.

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CERTIFICATE OF SERVICE

I hereby certify that on this 7th day of April, 2011, I have filed an original and six copies of the foregoing brief by overnight mail for filing with the Clerk of the U.S. Court of Appeals for the Eleventh Circuit. I also certify that, on this same day, I have served a copy of the foregoing brief upon the following counsel by placing a copy in the United States mail, first class postage prepaid and addressed as follows:

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