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MEMORANDUM

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TO: NATIONAL INDIAN HEALTH BOARD

FROM: HOBBS, STRAUS, DEAN & WALKER, LLP Geoff Strommer BY:NAM

RE: ***Health Care Litigation Update***

This memorandum provides an update on recent litigation implicating the Affordable Care Act (ACA) and other health care related topics of particular interest to tribes and tribal health programs.

Litigation continues over the ACA, and recent and pending lawsuits have challenged the contraceptive coverage mandate and transgender protections on religious freedom grounds; put into question the ability of the Administration to make direct payments to health insurance issuers to offset required cost-sharing reductions; attacked the implementation and validity of the ACA "employer mandate"; challenged the Administration's decision to delay enforcement of the ACA's minimum standards for insurance coverage; and questioned the validity of the ACA and certain of its provisions on constitutional grounds. And while a lawsuit brought by legislators in Alaska challenging Medicaid Expansion in the state was abandoned this past year, a similar lawsuit in Arizona remains pending.

In addition, pending litigation arising under the Indian Self-Determination and Education Assistance Act (ISDEAA) addresses issues relating to mandatory lease funding; recurring base funding; the Secretary's duty to approve successor funding agreements; and contract support costs. Finally, a number of recent and pending cases raise other critical Indian health care issues including reimbursement under the Catastrophic Health Emergency Fund; reimbursement from the Department of Veterans Affairs for services to eligible veterans; and issues arising under third-party contracts.

I. Affordable Care Act Challenges

Litigation in opposition to the ACA has not entirely dissipated since the Supreme Court's landmark decisions in *National Federation of Independent Businesses v. Sebelius*, 132 S. Ct. 2566 (2012) [hereinafter *NFIB v. Sebelius*] and *King v. Burwell*, 135 S. Ct. 2480 (2015). In *NFIB v. Sebelius*, the Supreme Court upheld the ACA's individual mandate, which requires individuals to have health insurance that meets certain minimum standards or pay a "shared responsibility payment," as within Congress's valid taxing

authority. And, in *King v. Burwell*, the Court held that premium tax credits—which serve to ensure that low-income individuals can afford to comply with the individual mandate—are available on federally facilitated health insurance exchanges as well as state-based exchanges. Either case could have essentially upended the ACA, had the Court ruled the other way. But despite these rulings largely affirming the statutory scheme, additional challenges to discrete aspects of the law have continued in the lower courts, and in the case of religious exercise challenges to the ACA's requirement to provide contraceptive coverage, up to the Supreme Court yet again.

Religious Challenges to Contraceptive Coverage and Transgender Discrimination Protections

In the past two years the Supreme Court has issued two decisions in response to religious freedom challenges to contraceptive coverage requirements under the ACA. Specifically, the ACA requires applicable large employers to offer insurance coverage that includes preventive care and screening for women at no cost. 42 U.S.C. § 300gg-13(a)(4). The Department of Health and Human Services (HHS) has interpreted this requirement to include contraceptive coverage without any cost sharing requirements. *See* Coverage of Preventive Services Under the [ACA], 77 Fed. Reg. 8725 (Feb. 15, 2012). However, the HHS regulations provided a religious accommodation under which non-profit religious organizations could certify their objection and avoid having to pay for such coverage for their employees.[1] In *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014), the Supreme Court held that the regulatory requirement to provide free access to contraception violated the Religious Freedom Restoration Act (RFRA) when applied to closely held corporations whose owners had religious objections to providing such coverage. The Court found that the government had a less restrictive alternative to ensure employee access to contraceptive coverage with no cost sharing, as evidenced by the opt-out provision for non-profit religious organizations, and so was not justified in burdening the religious exercise of the families who own Hobby Lobby and similar closely held corporations.

Since *Hobby Lobby*, challenges to the contraceptive mandate have continued. In fact, there have been over 100 lawsuits challenging the mandate since the ACA's passage.[2] In several of these cases, employers allege that the requirement to fill out a form certifying their objection to providing contraceptive coverage is itself a substantial burden on their religious freedom under the RFRA. With the exception of the Eighth Circuit in *Sharpe Holdings, Inc. v. U.S. Dep't of Health & Human Servs.*, 801 F.3d 927 (8th Cir. 2015), the United States Courts of Appeals have held in these cases that the notice requirement is not a substantial burden on religious exercise in violation of the

[1] The regulations provide that when such an employer objects to contraceptive coverage, the insurance company rather than the employer must pay the cost of the coverage.

[2] National Women's Law Center, *Status of the Lawsuits Challenging the Affordable Care Act's Birth Control Coverage Benefit* (Oct. 27, 2015), https://nwlc.org/wp-content/uploads/2015/11/RR_RP_Status_of_Lawsuits_Challenging_Contraception.pdf.

RFRA. On September 6, 2015, the Supreme Court granted certiorari in seven of these cases and consolidated the cases for briefing and argument. *See Zubik v. Burwell*, 136 S. Ct. 444 (2015).[3]

The Supreme Court heard oral arguments in the cases on March 23, 2016. In an unusual move, following arguments the Court asked the parties to submit supplemental briefs "that address whether and how contraceptive coverage may be obtained by petitioners' employees through petitioners' insurance companies, but in a way that does not require any involvement of petitioners beyond their own decision to provide health insurance without contraceptive coverage to their employees." Docket Entry, *Zubik v. Burwell*, 136 S. Ct. 1557 (Mar. 29, 2016) (No. 14-1418). On May 16, 2016, the Court issued a per curiam opinion vacating the judgments of the Courts of Appeals and remanding for further proceedings in light of the parties' briefs, which the Court said confirm that such an option is possible and would not, in the Petitioners' view, infringe their religious exercise. The Court was clear that its opinion "expresses no view on the merits of the cases" and stated:

> Given the gravity of the dispute and the substantial clarification and refinement in the positions of the parties, the parties on remand should be afforded an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans "receive full and equal health coverage, including contraceptive coverage." ... We anticipate that the Courts of Appeals will allow the parties sufficient time to resolve any outstanding issues between them.

Zubik v. Burwell, 136 S. Ct. 1557, 1560 (2016). In total, more than a dozen cases including *Sharpe Holdings, Inc.* were sent back to the courts of appeals with these unusual instructions.[4]

Even more recently, on August 23, 2016, five States (Texas, Wisconsin, Nebraska, Kentucky, and Kansas) joined with several health care providers in bringing suit against the Secretary of Health and Human Services, challenging a recent regulation providing that discrimination on the basis of sex as prohibited under section 1557 of the

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[3] The remaining six cases consolidated with Zubik were: *Priests for Life v. Dep't of Health and Human Servs.*, 772 F.3d 229 (D.C. Cir. 2014); *Roman Catholic Archbishop of Washington v. Sebelius*, 19 F. Supp. 3d 48 (D.C. Cir. 2013); *East Tex. Baptist Univ. v. Burwell*, 793 F.3d 449 (5th Cir. 2015); *Little Sisters of the Poor v. Burwell*, 794 F.3d 1151 (10th Cir. 2015); *Southern Nazarene University v. Burwell*, 2013 WL 6804265 (W.D. Okla. 2013) (consolidated with *Little Sisters of the Poor*, 749 F. 3d 1151, *supra*); and *Geneva College v. Sec'y of Health and Human Servs.*, 778 F.3d 422 (3rd Cir. 2015).

[4] In addition to *Sharpe Holdings, Inc.* and the seven cases consolidated in *Zubik*, the Court separately granted pending petitions for certiorari and remanded in light of *Zubik* the following cases: *Dordt College v. Burwell*, 801 F.3d 946 (8th Cir. 2015); *Univ. of Notre Dame v. Burwell*, 786 F.3d 606 (7th Cir. 2015); *Grace Schools and Diocese of Fort Wayne-South Bend v. Burwell*, 801 F.3d 788 (7th Cir. 2015); and *East Tex. Baptist Univ. v. Burwell*, 793 F.3d 449 (6th Cir. 2015).

ACA includes discrimination on the basis of gender identity. *See* Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016). The complaint alleges that the regulations are inconsistent with the ACA and other federal laws governing anti-discrimination and the provision of health care services, and that the regulations violate the First, Fifth, and Tenth Amendments as well as the RFRA. The case is *Franciscan Alliance, Inc. v. Burwell*, No. 7:16-cv-00108-O (N.D. Tex. filed Aug. 23, 2016).

House v. Burwell

A federal district court recently issued its decision in another high-profile challenge to the Administration's implementation of the ACA from the United States House of Representatives. *United States House of Representatives v. Burwell*, No. 14-1967, 2016 WL 2750934 (D.D.C. May 12, 2016) [hereinafter *House v. Burwell*]. The House of Representatives advanced two arguments in the case: First, the House argued that the Administration spent billions of dollars that Congress had not appropriated, in violation of Article I, § 9, cl. 7 of the U.S. Constitution,[5] in order to make direct payments to health insurance issuers to offset the expense of the cost-sharing reductions in the ACA. Second, the House argued that the Administration had effectively amended the ACA by delaying the implementation of the employer mandate and by issuing regulations that only impose penalties when large employers fail to offer coverage to a certain percentage of employees and their dependents, even though the ACA requires that *all* employees and their dependents be offered coverage.

On September 9, 2015, the court dismissed the House of Representatives' claims regarding implementation of the employer mandate but ruled that it had standing to pursue its appropriations-related claims. *United States House of Representatives v. Burwell*, 130 F. Supp. 3d 53 (D.D.C. 2015). Then, on May 12, 2016, the court ruled in favor of the House of Representatives on the appropriations question, finding that Congress has not appropriated funding for the cost-sharing reduction reimbursements and that the Administration had no authority to use funds from an existing permanent appropriation to make the payments. *House v. Burwell*, 2016 WL 2750934. The court granted an injunction prohibiting the Administration from utilizing the permanent appropriation to make the reimbursement payments, but stayed the injunction pending appeal. The Administration filed a notice of appeal on July 6, 2016 as to both of the district court's rulings, and the appeal is now pending before the United States Court of Appeals for the District of Columbia Circuit.

The district court decision in *House v. Burwell* does not mean that insurance issuers can stop granting cost-sharing reductions to qualified individuals. However, if the decision stands it will introduce a great deal of uncertainty as to whether and how

[5] Article I, § 9, cl. 7 provides, in relevant part: "No money shall be drawn from the treasury, but in consequence of appropriations made by law[.]"

insurance issuers will be reimbursed for the costs of those reductions. As the Administration pointed out in its briefs, this could lead to an increase in premiums (and thus federal spending on premium subsidies) or litigation against the Treasury by issuers seeking to recover losses resulting from compliance with the cost-sharing reduction requirements.

Employer Mandate Litigation

House v. Burwell is not the only ACA litigation with a focus the "employer mandate," which requires "applicable large employers" with 50 or more full-time employees to offer those employees and their dependents health coverage that meets certain minimum requirements. 26 U.S.C. § 4980H. Employers are assessed a penalty if they fail to provide such coverage and an employee or dependent then qualifies for a premium tax credit by purchasing insurance through an exchange. While the House of Representatives in *House v. Burwell* attacked the Administration's delayed and partial implementation of the employer mandate as contrary to the statute, other cases filed prior to the Supreme Court's decision in *King v. Burwell* raised claims that the statutory mandate itself is flawed.

Before the Supreme Court in *King v. Burwell* upheld the availability of premium tax credits on federally facilitated health insurance exchanges, the Oklahoma Attorney General as well as the State of Indiana and 29 Indiana school districts initiated lawsuits asserting that, because their states utilized federal facilitated health exchanges, tax credits were not available and therefore the employer mandate tax penalty could never be validly triggered by an employee qualifying for a premium tax credit in that state. The district court ruled in favor of the State of Oklahoma in *Oklahoma ex rel. Pruitt v. Burwell*, 51 F. Supp. 3d 1080 (E.D. Okla. 2014) but following the outcome of *King* the parties agreed that the district court judgment should be reversed, and on July 28, 2015, the Tenth Circuit issued an order reversing the district court's decision. Procedural Termination, *Oklahoma ex rel. Pruitt v. Burwell*, No. 14-7080 (10th Cir. July 28, 2015). In *Indiana v. IRS*, the plaintiffs have conceded that *King* disposed of their challenge to the IRS regulations allowing premium tax credits on federally facilitated exchanges. However, they continue to press their separate claims that the ACA violates the Tenth Amendment to the extent that it applies the employer mandate to states and their political subdivisions, because (they argue) the mandate amounts to a federal tax on the State. Joint Notice Regarding Further Proceedings, *Indiana v. IRS*, No. 1:13-cv-1612 (S.D. Ind. July 21, 2015). The case is now pending before a magistrate judge in the Southern District of Indiana.

Another pending employer mandate case relates specifically to tribal governments, and again targets the Administration's implementation. In 2014, the Northern Arapaho Tribe filed suit in federal district court in the District of Wyoming, challenging IRS regulations extending the employer mandate to tribal governmental employers. *Northern Arapaho Tribe v. Burwell*, No. 14-cv-247 (D. Wyo. filed Dec. 8,

2014). Although the ACA does not specifically apply the employer mandate to tribal governments, the IRS regulations define governmental entities for purposes of the mandate to include tribal governmental employers. 26 C.F.R. §§ 54.4980H-1(a)(23), 301.6056-1(b)(7). The Northern Arapaho Tribe argued that the regulations were invalid because they contravene the language of the statute. The Tribe also argued that Congress never intended the employer mandate to apply to tribal governmental employers, as evidenced by the fact that Congress exempted individual Indians from the individual mandate. The Tribe further asserted that the employer mandate would make insurance more expensive for tribal member employees because an offer of insurance from an employer would make them ineligible for the tax credits and cost-sharing benefits that they would otherwise be entitled to when purchasing insurance through an exchange.

On July 2, 2015, the district court dismissed the Northern Arapaho Tribe's case. *Northern Arapaho Tribe v. Burwell*, 118 F. Supp. 3d 1264 (D. Wyo. 2015). Among other bases for dismissal, the court found that the Anti-Injunction Act barred the lawsuit—a holding also reached by the Fifth Circuit in a different case alleging that the employer mandate violated the Origination Clause (discussed below) and constitutes a taking in violation of the Fifth Amendment to the U.S. Constitution.[6] *Hotze v. Burwell*, 784 F.3d 984 (5th Cir. 2015).[7] The court in *Northern Arapaho Tribe* also found, however, that in any event the ACA unambiguously expressed Congress's intent that the employer mandate apply to tribes. The court reasoned that if Congress wished to exempt tribes from the employer mandate, it needed to have done so explicitly. The Tribe appealed to the Tenth Circuit Court of Appeals on August 28, 2015, and briefing is now underway in that court.

Challenges to Implementation Delays

Nor is *House v. Burwell* the only case to challenge the Administration's delay of controversial ACA provisions. The D.C. Circuit recently affirmed dismissal of another case, *Virginia ex rel. Morrisey v. Department of Health & Human Services*, in which the State of West Virginia challenged the Administration's decision to delay enforcement of the ACA's minimum standards for insurance coverage. *W. Virginia ex rel. Morrisey v. United States Dep't of Health & Human Servs.*, No. 15-5309, 2016 WL 3568089 (D.C. Cir. July 1, 2016). The decision prevented the cancellation of existing insurance plans, allowing individuals to keep their current plans so long as states did not take action to bar the renewal of those plans. The State of West Virginia argued that in addition to violating the ACA, this "administrative fix" was an unlawful delegation of federal power to the states in violation of articles I and II of the Constitution and violated the Tenth Amendment by making states responsible for determining whether federal law should be enforced. On October 30, 2015, the district court dismissed the case, finding that the

[6] The Anti-Injunction Act prohibits suits to restrain the assessment or collection of a tax. 26 U.S.C. § 7421.

[7] In February of 2016, the Supreme Court declined to review the Fifth Circuit's decision in *Hotze*. *Hotze v. Burwell*, 136 S. Ct. 1165 (2016).

State of West Virginia had not suffered the kind of concrete injury normally required to confer standing in federal court. *State of W. Virginia v. United States Dep't of Health & Human Servs.*, 145 F. Supp. 3d 94 (D.D.C. 2015). The D.C. Circuit affirmed the district court's decision on July 1, 2016. 2016 WL 3568089.

Origination Clause Challenges

In early 2016, the Supreme Court denied certiorari in two cases challenging the ACA based on the Constitution's Origination Clause. *See Sissel v. Dep't of Health & Human Servs.*, 136 S. Ct. 925 (2016); *Hotze v. Burwell*, 136 S. Ct. 1165 (2016). The Origination Clause requires that bills for raising revenue originate in the House of Representatives, but the ACA originated in the Senate. The Court of Appeals for the District of Columbia rejected an origination challenge in *Sissel v. Department of Health and Human Services*, 760 F.3d 1 (D.C. Cir. 2014), on the grounds that the ACA was not a "bill for raising revenue" within the meaning of the clause. The Fifth Circuit did the same in *Hotze v. Burwell*, 784 F.3d 984 (5th Cir. 2015), on jurisdictional grounds. Those decisions stand as a result of the Supreme Court's refusal to hear the two cases.

States' Challenge to the Health Insurance Providers Fee

Another recent case, filed in 2015 by the State of Texas along with Indiana, Kansas, Louisiana, Nebraska, and Wisconsin in the U.S. District Court for the Northern District of Texas, challenges the Administration's implementation of the ACA's Health Insurance Providers Fee. *Texas v. United States of America*, No. 7:15-cv-00151 (N.D. Tex. filed Oct. 22, 2015). The Health Insurance Providers Fee, created under Section 1910 of the ACA, is an annual fee imposed on health insurance providers that was intended to generate revenue to help fund federal premium subsidies for low-income individuals. Though the fee is imposed on health insurance providers, the States allege that regulations implementing the fee shift the burden of the fee to the States in some instances, in violation of the ACA and the Tenth Amendment. The States, all of which provide Medicaid and CHIP services through contracts with managed care organizations (MCOs), point to regulations governing Medicaid and CHIP and requiring that capitation rates paid to MCOs be "actuarially sound," which, also by regulation, requires certification from an actuary employing standards established by the American Academy of Actuaries. In turn, standards adopted by the American Academy of Actuaries in 2015 require capitation rates to include recovery of the amount of taxes MCOs are required to pay. Thus, the States argue, the federal government has essentially required that the States reimburse MCOs for the fees if the States wish to continue receiving Medicaid and CHIP funding.

The States raise a number of constitutional and statutory claims, including that the fee is an impermissibly coercive exercise of Congressional authority and that it amounts to a tax on the States in violation of the Tenth Amendment. On August 4, 2016, the district court issued an order in response to the Administration's motion to dismiss the

case. Memorandum Opinion and Order, *Texas v. United States of America*, No. 7:15-cv-00151 (N.D. Tex. Aug. 4, 2016). The court dismissed the States' claims seeking a refund of the fees already paid on standing grounds, noting that it was the MCOs and not the States that actually paid the fees. However, the court declined to dismiss the States' claims for declaratory relief that would effectively bar collection of the fee from MCOs, as well as the States' Tenth Amendment claims, among others.

II. Challenges to Medicaid Expansion

The Alaska Legislative Council voted in June of 2016 to drop its lawsuit challenging Governor Walker's decision to expand Medicaid after losing in the state Superior Court. The suit, filed in state court in 2015, was *Alaska Legislative Council v. Walker*, No. 3AN-15-09208 (Alaska Super. Ct. filed Aug. 24, 2015). The Legislative Council had argued in the case that it alone, and not the Governor, had the authority to authorize additional groups of people to be eligible for Medicaid. The Governor, on the other hand, relied on language in the Alaska Medicaid statute extending eligibility to all state residents "for whom the Social Security Act requires Medicaid coverage," and argued that even though the penalty for noncompliance with Medicaid Expansion was struck down in *NFIB v. Sebelius*, the Social Security Act as amended by the ACA still textually requires expanded coverage. On March 1, 2016, the Superior Court ruled in favor of the Governor and dismissed the case. *Alaska Legislative Council v. Walker*, No. 3AN-15-09208 (Alaska Super. Ct., March 1, 2016). While the House initially attempted to pursue the appeal on its own, its motion for substitution of a party was denied on June 24, 2016. Shortly thereafter, the Alaska Legislative Council voted not to pursue the appeal.

In Arizona, lawmakers have also attempted to challenge their State's plan for funding Medicaid expansion. *Biggs v. Brewer*, No. CV 2013-011699 (Ariz. Super. Ct. (Maricopa) filed Sept. 12, 2013). The thirty-six legislators and three citizens who filed suit argued that passage of a "hospital assessment" that would fund Arizona's share of Medicaid Expansion was a tax and therefore required a two-thirds vote under state law rather than the simple majority with which it was passed. On August 26, 2015, the trial court granted the defendants' motions for summary judgment. Under Advisement Ruling, *Biggs v. Brewer*, No. CV 2013-011699 (Ariz. Super. Ct. (Maricopa), Aug. 26, 2015). The plaintiff legislators appealed, and the case is now pending before the Arizona Court of Appeals. *Biggs v. Betlach*, No. 15-0743 (Ariz. Ct. App. Div. 1).

III. Indian Self-Determination Act Litigation

ISDEAA Leasing Authority

On March 22, 2016, a federal district court judge for the United States District Court for the District of Columbia issued a ruling in *Maniilaq Association v. Burwell*, ordering the Indian Health Service (IHS) to negotiate full lease compensation under

Section 105(*l*) of the ISDEAA and implementing regulations for a proposed lease of Maniilaq Association's clinic facility in Kivalina, Alaska. *Maniilaq Ass'n v. Burwell*, No. 1:15-cv-00152, 2016 WL 1118256 (D.D.C. Mar. 22, 2016) (*Maniilaq II*). Section 105(*l*) provides that the Secretaries of Health and Human Services and the Department of the Interior "shall enter into a lease with the Indian tribe or tribal organization that holds title to, a leasehold interest in, or a trust interest in, a facility used by the Indian tribe or tribal organization for the administration and delivery of services" under the ISDEAA, at the request of the tribe or tribal organization. 25 U.S.C. § 450j(*l*)(a). Section 105(*l*) also states that the Secretary "shall compensate" the tribe or tribal organization for any lease under that section, but is not clear on its face regarding the required level of compensation. 25 U.S.C. § 450j(*l*)(b).

Maniilaq II is a follow-up to prior litigation regarding IHS' obligation to enter into and fully fund a Section 105(*l*) lease for Maniilaq's clinic facility in Ambler, Alaska. *Maniilaq Association v. Burwell*, 72 F. Supp. 3d 227 (D.D.C. 2014) (*Maniilaq I*). In that case, the IHS failed to respond to Maniilaq's Ambler lease request within 45 days, as required by statute, and eventually responded by rejecting the proposal on multiple grounds, including: (1) a lease under section 105(*l*) cannot be incorporated into an ISDEAA funding agreement; (2) Maniilaq must apply for a lease through the IHS Lease Priority System, which gives the IHS discretion to prioritize lease requests; and (3) IHS is not required to provide monetary compensation for Section 105(*l*) leases, and may offer "non-monetary compensation" only. Maniilaq challenged the rejection in federal district court. The district court held that a Section 105(*l*) lease may be incorporated into an ISDEAA funding agreement, and that Maniilaq's lease proposal was deemed accepted by operation of law when IHS failed to respond within the 45 days required by statute.

The court in *Maniilaq I* did not reach the question of lease compensation, however, since it ruled that the IHS was legally bound to enter into the lease as proposed. When Maniilaq later submitted a lease request for its Kivalina clinic facility, the IHS denied the proposed lease on the grounds that it was not required to pay lease compensation above the program amount that Maniilaq already received for the clinic in its ISDEAA funding agreement under a discretionary "Village Built Clinic" leasing program. Maniilaq's requested compensation amount, which was based on specific regulatory criteria options set out in implementing regulations at 25 C.F.R. Part 900, Subpart H, was significantly more, but the IHS argued that the regulations were discretionary. In its March 22, 2016 order, the court rejected the IHS's legal arguments and ordered the IHS to negotiate full lease compensation under the regulatory criteria. Following those negotiations, on July 27, 2016, the court ordered the IHS to enter into the lease and to pay the negotiated compensation amount—roughly an 825% increase over the amount that Maniilaq had received under the Village Built Clinic leasing program—pending any appeal of the underlying decision. Order, *Maniilaq Association v. Burwell*, No. 1:15-cv-00152 (D.D.C. July 27, 2016). The IHS has until September 26, 2016 to seek an appeal.

Recurring Base and Successor AFA Disputes

Another ongoing case involving contract funding under the ISDEAA was brought by the Seneca Nation of Indians against HHS in August 2014. *Seneca Nation of Indians v. Dep't of Health & Human Servs*, No. 1:14-cv-01493 (D.D.C. filed Aug. 29, 2014). The case essentially concerns whether the IHS must treat a court award of contract funding as part of a tribe's recurring base funding in subsequent years, but the case has a complicated procedural history. In previous litigation, the Tribe successfully established that a proposal to amend its FY 2010 and FY 2011 funding agreement to correct a user population count error and increase base funding by $3,774,392 was deemed approved by operation of law because the IHS did not issue a response within 90 days, as required by the ISDEAA. *Seneca Nation of Indians v. Dep't of Health and Human Servs.*, 945 F. Supp. 2d 135 (D.D.C. 2013). While that case was pending, however, the Tribe requested the same increase for FY 2012, and the IHS timely declined. The Tribe filed a claim with the Interior Board of Indian Appeals (IBIA) over the FY 2012 amount. *See Seneca Nation of Indians v. Nashville Area Chief Contracting Officer, Indian Health Service* (Docket No. IBIA 12-041).

After the original litigation concerning FY 2010 and FY 2011 was resolved by the district court in the Tribe's favor, and while the FY 2012 claim was still pending in the IBIA, IHS again rejected funding agreements for FY 2013, FY 2014, and FY 2015 that included the additional $3,774,392. In August 2014, the Tribe filed suit in federal district court in the District of Columbia challenging the 2013–2015 denials on the grounds that, under the ISDEAA and IHS regulations, the IHS may not reduce the Tribe's annual funding level except as provided by statute, nor reject a successor annual funding agreement that is substantially the same as the prior funding agreement. The IBIA stayed its proceeding on the FY 2012 claims pending resolution of the Tribe's district court suit over the 2013–2015 claims. However, HHS moved to dismiss the district court case in June 2015, arguing that it could not be resolved prior to resolution of the stayed IBIA case because the Tribe's arguments regarding non-reduction of funding and successor funding agreements hinged on the contents of its FY 2012 funding agreement. The district court agreed, but stayed the case pending resolution of the FY 2012 claim by the IBIA rather than dismiss the case. *Seneca Nation of Indians v. U.S. Dep't of Health & Human Servs.*, 144 F. Supp. 3d 115 (D.D.C. 2015).

The IBIA assigned the case to an Administrative Law Judge (ALJ), who issued a recommended decision in favor of the Tribe. The IHS appealed to the Health and Human Services Departmental Appeals Board (DAB), which issued a decision upholding the ALJ's recommendation on June 30, 2016. *Seneca Nation of Indians*, DAB No. 2715 (H.H.S. June 30, 2016). The DAB held that the funding increase became part of the Tribe's ISDEAA "base funding" when the Tribe's amendment proposal was deemed accepted by operation of law—or at the least, when the district court ordered the funding agreement amended—and that none of the statutory criteria for reduction of base funding applied. The DAB also upheld the ALJ's finding that the IHS was required to approve

the Tribe's FY 2012 funding agreement because it was substantially the same as the final FY 2011 funding agreement. The Tribe's FY 2013-2015 claims are now active again in the district court, and the Tribe has filed a motion for summary judgment on the basis of the DAB ruling.

In another case with an equally complicated history, the Sage Memorial Hospital brought suit in 2014 against the Indian Health Service after the Navajo Area Indian Health Service (NAIHS) declined to renew its 2010 ISDEAA contract, set to expire on September 30, 2013, and to enter into funding agreements under the renewed contract for FYs 2014 and 2015. On April 9, 2014, the district court entered a preliminary injunction requiring the IHS to continue funding the Sage Memorial Hospital according to the terms of the Hospital's 2010 contract and 2013 Funding Agreement until the case could be resolved on the merits. *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, 100 F. Supp. 3d 1122 (D.N.M. 2015). In granting the preliminary injunction, the district court found that, for purposes of preliminary relief, Sage Memorial Hospital had shown that the proposed contract and funding agreement were likely substantially the same as their predecessors, and thus the IHS was likely prohibited by regulation from rejecting them. The district court rejected arguments by the IHS that the proposals should be considered different from the previous contracts in light of a performance evaluation and audit report that the IHS had received suggesting misuse of federal funds—information unknown to it when it approved the predecessor agreements. The district court held that the IHS could only look to the contents of the contract documents themselves to determine whether they were substantially the same as their predecessors, and that the IHS may not use the contract proposal rejection criteria in place of the reassumption procedures where outside information suggests a problem with contract performance.

On August 31, 2015, the district court issued a decision on the merits of Sage Memorial Hospital's request for injunctive and mandamus relief ordering the IHS to enter into and fund its contract proposal. *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, No. CIV 14-0958, 2015 WL 9777785 (D.N.M. Oct. 26, 2015). The district court ruled in favor of the Hospital, again finding that the proposed contracts and the proposed FY 2014 funding agreement were substantially the same as their predecessors and that the IHS was therefore prohibited by regulation from declining the proposals. Though the district court found that the FY 2015 funding agreement was not substantially similar to its predecessor due to a significant increase in the funding amount proposed, the district court found that the IHS did not properly apply the statutory declination criteria to the Hospital's proposal and it was therefore deemed approved. As a result, the court ordered the IHS to enter into and fully fund the proposed contract and funding agreements. The court also agreed to schedule a hearing on damages claimed by the Hospital as a result of the IHS's actions.

In the meantime, the IHS also declined to enter into Sage Memorial Hospital's proposed FY 2016 funding agreement. The Sage Memorial Hospital again supplemented its complaint and filed a motion for summary judgment on the declination of the FY 2016

funding agreement, arguing that it is substantially the same as the Hospital's FY 2015 funding agreement, which has now been deemed accepted by the district court. The IHS has countered that the court's deemed approval of the FY 2015 funding agreement does not qualify as a "prior annual funding agreement" under the regulations requiring the Secretary to approve a successor annual funding agreement if it is "substantially the same as a prior annual funding agreement" because it was deemed accepted by the district court rather than negotiated and agreed to by the parties. That question is now pending before the district court.

Contract Support Cost Litigation

The Sage Memorial Hospital case also includes contract support cost-related claims, which have been addressed in two separate opinions by the district court and are still pending. First, the Sage Memorial Hospital alleged that the IHS violated the Contract Disputes Act (CDA) in responding to its claims for unpaid contract support costs for fiscal years 2009 through 2013 by responding with a form letter that was not responsive to the Hospital's specific claims and by identifying an unreasonable deadline for a final decision (roughly fourteen months from the date of submission) that was also contingent on the Hospital's "cooperation." On June 17, 2015, the district court ruled that by making the date of decision contingent on the Hospital's "cooperation," the IHS failed to identify a date certain by which a decision would be rendered, as required by the CDA, and therefore the claims were deemed denied. *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, 110 F. Supp. 3d 1140 (D.N.M. 2015). The court also found that the fourteen month time frame for issuing a decision was unreasonable under the Contract Disputes Act, which requires an agency to issue a decision within a reasonable amount of time.

Thereafter, the Sage Memorial Hospital amended its complaint, adding claims challenging the deemed denial of its contract support cost claims and seeking as damages the full amount of the claims. The IHS responded by issuing a "contracting officer's decision" and filing a counterclaim alleging that the Hospital in fact owed the IHS for indirect contract support cost funding that the IHS paid but that the Hospital did not spend on eligible activities. The Hospital filed a motion to dismiss the counterclaim, arguing that the "contracting officer's decision" (which provides jurisdiction for the counterclaim) was not valid because the agency lost the authority to issue an administrative decision on the claims once the claims became part of the litigation. The Hospital also argued that the decision was not valid because it provided several alternate bases for liability, but only one aggregate damages figure. On December 14, 2015, the district court rejected the Hospital's motion to dismiss the counterclaim, finding that litigation of the Hospital's contract support cost claims did not divest the contracting officer of authority to issue a decision on the *IHS's* claims to recover allegedly misspent funds, and that the contracting officer's decision provided the Hospital with sufficient notice of those claims. *Navajo Health Found.-Sage Mem'l Hosp., Inc. v. Burwell*, 157 F.

Supp. 3d 1119 (D.N.M. 2015). However, the parties later stipulated to dismissal of the IHS counterclaim.

Following dismissal of the counterclaim, on August 1, 2016 Sage Memorial Hospital filed three separate motions for partial summary judgment. The first motion asks the court to hold unlawful the IHS's "allocation" of contract support costs between the portion of program activities funded by IHS appropriations and the portion funded by third-party revenues. This practice results in a reduction of contract support costs awarded because the IHS claims only to be liable for that portion of overhead costs allocated to program activities paid for with appropriated funds. The second motion asks the court to declare that the IHS's interpretation of 25 U.S.C. § 450j-1(a)(3)(A)—which states that contract support cost funding shall not duplicate any funding provided in the 106(a)(1) Secretarial amount—is overbroad and contrary to law. The IHS has taken the position that the duplication provision prohibits the IHS from awarding as contract support costs any additional payments for a *type* or *category* of costs that was included in the Secretarial amount, regardless of the actual amount that was included and regardless of whether or not that amount is sufficient to cover reasonable costs necessarily incurred by a tribe in that category. Finally, the third motion addressed various affirmative defenses raised by the IHS. Briefing is underway on these motions and the court has set a motions hearing for September 16, 2016.

IV. Other Indian Health Care Litigation

Catastrophic Health Emergency Fund & Purchased/Referred Care Eligibility

The IHS has recently taken the position in federal district court litigation that tribal self-insured plans are alternate resources for purposes of the Catastrophic Health Emergency Fund (CHEF), and for the underlying Purchased/Referred Care (PRC) program of which the CHEF is one component. The case, *Redding Rancheria v. Burwell,* Civ. No. 14-2035 (D.D.C. filed Dec. 2, 2014), was filed by the Redding Rancheria (Redding) after the IHS rejected a contract proposal by Redding intended to clarify interaction of the CHEF with Redding's tribal self-insurance plan. Redding uses its tribal self-insurance plan to supplement its PRC program, which it operates under a self-governance compact with the IHS under the ISDEAA. In order to maximize efficiency, Redding coordinates coverage under its self-insurance program with coverage under its PRC program, using PRC funds to access Medicare-Like Rates (MLR) where possible and tribal self-insurance to access network rates where MLR is not available through the PRC program. Redding's tribal self-insurance program thus includes language limiting its ability to cover care otherwise entitled to MLR, and also excluding services eligible for coverage under the CHEF.

The IHS denied several CHEF claims submitted by Redding, in part on the grounds that Redding's self-insurance plan was an "alternate resource" that should have paid for the care. The IHS then rejected a compact amendment proposed by Redding to

clarify that Redding had a right to coordinate care between its PRC and tribal self-insurance programs without impacting its eligibility for CHEF coverage. Redding exercised its right under the ISDEAA to appeal the IHS's rejection of its proposed amendment, and alleged that the IHS's actions violated its compact and the ISDEAA, as well as the IHS's own policy on tribal self-insurance plans.

In the case, IHS admits that its existing policy makes an exception to treating tribal self-insurance as an alternate resource, but argues that this policy was invalidated by the payer of last resort rule that was enacted as Section 2901(b) of the Affordable Care Act in 2010. Section 2901(b) provides that: "Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations ... shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary." 25 U.S.C. § 1623(b). The IHS argues in the Redding case to limit the payer of last resort rule in Section 2901(b) to IHS contracted or compacted Purchased/Referred Care (PRC) programs and thus tribal self-insurance must pay before IHS.

Cross-motions for summary judgment are pending with the court and oral argument has been requested in the *Redding* case.

Department of Veterans' Affairs Reimbursement

A recent case brought by the Gila River Indian Community in March, 2016 against the U.S. Department of Veterans Affairs (VA) challenges the reimbursement policies adopted by the VA under Section 10221(a) of the ACA, codified at 25 U.S.C. § 1645(c). *Gila River Indian Community v. Dept. of Veterans Affairs, et al.*, No. 2:16-cv-00772 (D. Ariz. filed Mar. 22, 2016). Section 1645(c) provides that:

> The [Indian Health] Service, Indian tribe, or tribal organization shall be reimbursed by the Department of Veterans Affairs or the Department of Defense (as the case may be) where services are provided through the Service, an Indian tribe, or a tribal organization to beneficiaries eligible for services from either such Department, notwithstanding any other provision of law.

The VA did not immediately implement this provision after its enactment in 2010. Instead, the VA entered into lengthy negotiates with the IHS, which ultimately resulted in an Inter-Agency Agreement and a template reimbursement agreement, released in 2012, designed to govern VA reimbursement to tribal health programs. Under the template agreement, reimbursement is prospective only, not retroactive to the ACA's effective date; is limited to direct care services and does not extend to PRC services; and does not extend to non-Native veterans receiving care at tribal facilities.

In an amended complaint filed on July 11, 2016, the Gila River Indian Community alleges that it was entitled to VA reimbursements beginning on the date of enactment of Section 1645(c) (March 23, 2010) as a matter of federal law, regardless of any agreement. The Community also alleges that the reimbursement limitations in the Inter-Agency Agreement and the template agreement violate Section 1645(c) and the ACA payor of last resort provision at 25 U.S.C. § 1623(b).[8] The Community asks the court to declare that the VA is in violation of these provisions of law and to compel the VA to comply with its statutory reimbursement duties. The VA has responded with a motion to dismiss, arguing that the Community's claims must be heard in the Court of Appeals for Veterans Claims under the Veterans' Judicial Review Act, and that the Community has failed to challenge a "final agency action" as required for judicial review. The VA also contests the Community's interpretation of Sections 1645 and 1623(b).

Third-Party Contract Dispute Cases

In April 2014, the Grand Traverse Band of Ottawa and Chippewa Indians sued Blue Cross and Blue Shield of Michigan (BCBSM) for violations of the Employee Retirement Income Security Act (ERISA) and breach of a contract under which BCBSM administers the Tribe's self-insured employee benefits plan. *Grand Traverse Band of Ottawa & Chippewa Indians v. Blue Cross & Blue Shield of Mich.*, No. 5:14-cv-11349 (E.D. Mich. filed April 1, 2014). The Tribe alleged that BCBSM has been paying more than it should have under the contract for Contract Health Services (CHS) and under federal regulations capping the payments at the Medicare-like Rates. The Tribe also alleged that BCBSM was collecting an administrative fee from the money it used to pay claims in violation of the contract. The parties settled the issue of administrative fees while continuing to litigate the applicability of Medicare-like Rates. On July 17, 2015, BCBSM filed a third party complaint against Munson Medical Center, arguing that it breached its contract with BCBSM by failing to provide necessary information or charge rates. BCBSM argues that Munson Medical Center is responsible to the extent that BCBSM is found liable to the Tribe.

In two orders issued on May 19 and June 27, 2016, the district court dismissed the Tribe's federal ERISA claims without prejudice, but elected to retain jurisdiction over the remaining state law breach of contract claims. *See* Opinion and Order, *Grand Traverse Band*, No. 5:14-cv-11349 (E.D. Mich. May 19, 2016); Order Granting in Part Motion for Reconsideration, *Grand Traverse Band*, No. 5:14-cv-11349 (E.D. Mich. June 27, 2016). The Tribe has filed a motion for leave to file an amended complaint to clarify its federal

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[8] Section 1623(b) provides:

> Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 1603 of this title) shall be the payer of last resort for services provided by such Service, tribes, or organizations to individuals eligible for services through such programs, notwithstanding any Federal, State, or local law to the contrary.

ERISA claims, which allege breach of fiduciary duty on the part of BCBSM due to its failure to take advantage of Medicare-like Rates. The Tribe's request to file the amended complaint is now pending before the district court.

The Alaska Native Tribal Health Consortium (ANTHC) sued Premera Blue Cross (Premera) in 2012 for failure to pay the higher of ANTHC's reasonable billed charges or the highest amount Premera would pay to a non-governmental entity as required under section 206 of the Indian Health Care Improvement Act, 25 U.S.C. § 1621e. *Alaska Native Tribal Health Consortium v. Premera Blue Cross*, No. 3:12-cv-00065 (D. Alaska filed Mar. 27, 2012). In September 2014, ANTHC moved for summary judgment, arguing that its billed charges should be deemed reasonable. Premera filed a cross motion for summary judgment, arguing that ANTHC's billed charges were not reasonable or, in the alternative, that Premera had paid ANTHC in accordance with the Alaska Usual and Customary Rate which is usually higher than ANTHC's billed charges. In July 2015, the court denied the motions for summary judgment, finding that questions remained over whether Premera had paid substantially less than ANTHC's billed charges. *Alaska Native Tribal Health Consortium v. Premera Blue Cross*, No. 3:12-cv-0065, 2015 WL 12159388 (D. Alaska July 2, 2015). Following additional discovery, ANTHC again filed a motion for partial summary judgment, arguing that Premera's allowed amounts were reasonable and that ANTHC has a right to recover, at a *minimum*, the difference between those allowed amounts and what Premera actually paid. Premera's brief in response is due by September 16, 2016, and a jury trial has been set for March 20, 2017.

V. Conclusion

There is a great deal of activity in the federal courts still as implementation of the ACA and the IHCIA reauthorization continues, and as tribes and tribal organizations continue to grow their health care programs under their sovereign tribal authority and that of the IHCIA and ISDEAA. We intend to keep tracking and reporting on these developments as they unfold.

If you have any questions about the cases discussed above, please contact Geoff Strommer at gstrommer@hobbsstraus.com or (503) 242-1745 or Caroline Mayhew at cmayhew@hobbsstraus.com or (202) 822-8282.