THE INDIAN COUNTRY ABORTION SAFE HARBOR FALLACY

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Following the leaked draft of the United States Supreme Court decision in Dobbs v. Jackson Women's Health Organization, several conservative states have moved to restrict access to abortion. Oklahoma, for instance, has recently passed the nation's strictest abortion ban, exposing individuals to criminal and civil liability and defining life at "fertilization."

In response, commentators have raised the possibility of an abortion "safe harbor" on tribal lands. Similar musings followed the passage of Senate Bill 8 in Texas months earlier. In theory, this idea rests on a simple premise: state governments lack the power to regulate tribal lands, so tribal governments could open abortion clinics that serve as islands of access in conservative states. However, as we will argue in the following post, this proposal overlooks important legal, financial, political, and ethical considerations that, in our view, make the possibility of abortion safe harbors highly unlikely.

LEGAL CONCERNS

The idea that Native Nations possess tribal territorial self-governance to the exclusion of states finds its most prominent legal basis in Chief Justice John Marshall's characterization of tribes as "distinct political communities, having territorial boundaries, within which their authority is exclusive." In this view of tribal sovereignty, tribes exist wholly within the geographic boundaries of the United States, but the territorial boundaries of tribal lands mark the end of state power, and the beginning of tribal autonomy.

Justice Marshall's view comports with Justice Alito's preference that limitations upon reproductive health care be left to local legislators to determine reproductive rights for their own communities. Unfortunately, Justice Marshall's view of complete tribal territorial self-governance to the exclusion of states has been subsequently set aside, at least in part, by a series of damning U.S. Supreme Court cases since the 1970s, which are part of the on-going colonization of Indian country. Relevant to the proposal at hand, these cases have restricted tribal authority over matters of criminal and civil jurisdiction and health law.

CRIMINAL JURISDICTION

The United States prohibits tribes from exercising criminal jurisdiction over non-Indian United States citizens, except in very limited circumstances. A non-Indian who provided abortion care to a non-Indian patient would violate state criminal laws, subjecting both parties to state prosecution, even if the care was provided in Indian country.

Native abortion care providers and Native patients likely also fall under state criminal prohibitions if the particular tribal lands are subject to concurrent state criminal jurisdiction through enabling federal statutes such as Public Law (P.L.) 280, or comparable state-specific statutes like those in Kansas, Maine, and New York. With limited exceptions, P.L. 280 extends state criminal law to Native lands in Alaska, California, Minnesota, Nebraska, Oregon, and Wisconsin, as well as to certain reservations in Florida, Idaho and Washington.

For tribes not impacted by P.L. 280 or other tribal-specific restrictions on sovereignty, the local tribe will retain authority to criminalize or not criminalize conduct within their territory, subject to concurrent federal jurisdiction over some matters. These circumstances offer a small sovereign slice of relief from what may be oppressive state criminal prohibitions and an opportunity for tribal self-governance over both people and place.

CIVIL JURISDICTION

Most state abortion restrictions fall within a civil regulatory framework. These regulations heavily restrict abortion care, but ultimately permit some abortions in increasingly limited circumstances, such as in the case of rape or incest or during the first six or fifteen weeks of pregnancy. In some states, such as Texas and Oklahoma, civil relief is made available through private party lawsuits.

Determining what sovereign may exercise civil regulatory authority inside Indian reservations or on smaller parcels of tribal land is often fact-specific and unpredictable. As a result, challenges to both regulatory and adjudicatory jurisdiction are frequently brought in the courts of all three sovereigns: tribal, federal, and state.

To provide access to abortion care within Indian country, tribes must possess the regulatory authority to permit such care. While tribes are presumed to possess civil regulatory authority over tribal members within Indian country, federal judges have been reluctant to recognize tribal power over non-members "beyond what is necessary to protect tribal self-government or to control internal relations."

Tribes are rarely recognized by the United States to have power over people who are not citizens/members of that particular tribe. Under the *Montana* test, the tribal power only extends to other people when: (1) the outsider enters into a consensual relationship with the tribe or tribal members, such as through a contract; or (2) the outsiders' conduct threatens the political integrity, economic security, or the health or welfare of the tribe.

If the tribe is seeking to regulate a doctor who is not a citizen/member of the tribe where the abortion is performed, the regulation and provision of such healthcare *should* satisfy the second *Montana* prong—meaningful, self-determined reproductive healthcare is necessary for the health and welfare of the tribe, especially given the devastating historical deprivation of reproductive healthcare to Native women. However, courts have increasingly interpreted this standard narrowly, and it seems likely that a narrow interpretation would be used for patients who have no tribal citizenship.

Even so, the first *Montana* prong is likely sufficient to recognize tribal regulatory authority. A tribe seeking to ensure reproductive healthcare access can enter into a contract with the provider and/or patient, in which all parties acknowledge and consent to tribal jurisdiction for care provided within the tribe's boundaries, ensuring tribal civil regulatory jurisdiction.

Unfortunately, tribal authority and jurisdiction is rarely exclusive. Tribal power does not necessarily impact whether the state *also* possesses authority to regulate within Indian country. While states have consistently been held to lack regulatory powers over tribal members, states have been held to retain regulatory powers over non-Indians in Indian country in several cases. Under the *Bracker* test, state authority over non-Indians in Indian country can be preempted depending on the degree of federal regulation involved, and the respective governmental interests of the tribe and state. Like the progeny of *Montana*, the *Bracker* test has, at times, been applied to permit extensive state encroachment upon tribal sovereignty. Because Congress has yet to legislatively ensure abortion care, including specifically within Indian country, there is likely an insufficient federal regulatory scheme for preemption purposes. We have only crude analogies in case law, such the permissibility of tribal cannabis operations. Given the turmoil of this area of law, it is difficult to predict whether state abortion regulations would be found to be preempted.

HEALTH LAW

In addition to the jurisdictional issues outlined above, abortion regulation also triggers a slew of health law issues, tied to the unique federal Indian health care system. Due to treaty, trust, and statutory obligations, the federal government is required to provide healthcare to American Indians and Alaska Natives. The Indian health care systems consist of a complex network of providers including public and private facilities across

tribal, state, and the federal government. At the federal level, Indian Health Service (IHS) is an agency that provides direct services across over a hundred facilities; Tribal 638 facilities are tribally operated but federally-funded health facilities; and Urban Indian health programs are federally funded and operated by Urban Indian Organizations, nonprofit organizations designated by the federal government.

As part of a 638 contract or compact, tribes have the option to contract with the federal government to provide care through tribally-operated facilities, in what would otherwise have been a federal facility. Providers licensed in any state are exempt from the licensing requirements of the state in which the tribal health facility is located. However, this exemption only applies to the provision of health care operated within the scope of the 638 contract. Tribal health facilities operating outside of a 638 contract—to, for example, evade limitations of the Hyde Amendment detailed below—will be subject to Tribal law *and* face potential exposure to state jurisdiction under the *Bracker* preemption-balancing test. If a court determines the *Bracker* balancing test supports the extension of state licensing laws, this could, in effect, prevent any physicians from providing abortion care in practice. For example, Oklahoma's medical licensing laws define unprofessional conduct to include "[t]he commission of any act which is a violation of the criminal laws of any state when such act is connected with the physician's practice of medicine."

In addition to licensing exemptions, tribal 638 facilities operating within their 638 contract are covered under the Federal Tort Claims Act. However, should the provision of abortion care fall outside the construct of a 638 facility, tribal providers could be exposed to tort liability, which could, in addition to financial exposure, serve as an additional opening for the application of state law.

FINANCIAL RESOURCES

The structure of the Indian health care system also puts severe constraints on the financial resources that tribes could devote toward providing abortion care. The Hyde Amendment prohibits the use of federal funds for abortion care unless the pregnancy is a result of rape or incest or if the pregnancy endangers the life of the parent. The prohibition includes appropriations to IHS, thus limiting ability to provide abortion care at not only IHS direct facilities but also IHS-funded facilities like tribal 638s and urban Indian health programs. This lack of access to abortion care is compounded when the majority of funding for health services in Indian country comes from federal dollars. Given that tribes do not have the same tax base as other governments, tribes would likely need to rely heavily on other tribal funds, like successful business enterprises, to fund abortion care. Tribes could also rely on outside fundraising.

POLITICAL CONSIDERATIONS

Even if the legal and financial pieces fell into place, abortion is one of the most contentious political issues of our time, and tribal communities are not immune from this polarizing debate. While Native people overwhelmingly vote for Democrats, many have more complicated views on abortion, often based in generational traumas. For almost 100 years, the federal government forced Native children to attend assimilation boarding schools, denying parents the right to raise their own children. In the mid-20th century, IHS and other health care providers regularly sterilized Native women without their clear, informed consent.

These human rights violations have left tremendous voids in tribal communities, leaving even those who support abortion rights feeling melancholy about the bitter political debate. In addition, there are many Native people who oppose abortion due to socially-conservative religious beliefs about pregnancy, and some Tribal codes already prohibit abortion. While the abortion debate will look very different from tribe to tribe, attempts by outsiders to influence internal tribal debates will likely exacerbate existing tensions.

We have, in fact, seen this movie before. In 2006, in response to South Dakota's restrictive abortion legislation, then-president of the Oglala Sioux Tribe, Cecilia Fire Thunder, suggested opening an abortion clinic on the tribal reservation. She was ultimately impeached for her public stance on reproductive rights.

ETHICAL CONSIDERATIONS

The weeks after the release of the draft *Dobbs* opinion have, among much well-placed scrutiny and dismay, produced a troubling impulse to view tribes as a legal escape-hatch—a work-around to soften the blunt of harmful state abortion prohibitions. This response repeats an unfortunate history in which tribes have been ignored until (poof!) they might suddenly be useful to non-Indian interests. Such neglect has allowed devastating blows to tribal sovereignty to fester.

Intuitively, tribes *should* possess the territorial authority to regulate reproductive healthcare as they see fit. We allegedly live in the self-determination era of federal Indian law, increasingly reinforced by international law. But Native women know all-too-well these terms and promises are currently thin veneers atop a historical mountain of oppression. Native reproductive health has been under assault since contact. Native midwifery, healing, marital customs, kinship ties, and gender identity have all been targeted by assimilation policies.

Native reproductive health has been corralled into under-funded yet paternalistic clinics. Native bodies, too, have not been exempt. Denigrated. Fetishized. Targeted. The Missing and Murdered Indigenous Persons crisis articulates a centuries-long exposure to the highest rates of sexual and gender-based violence.

To turn to tribes now is galling. It reveals a disappointing ignorance of the legal battles tribes have been fighting, seemingly without end. But it also reveals a problematic disregard for the trauma and vulnerability that Native peoples face. No, tribes do not offer a safe-harbor from harmful state abortion prohibitions. It's time we step up to address why.

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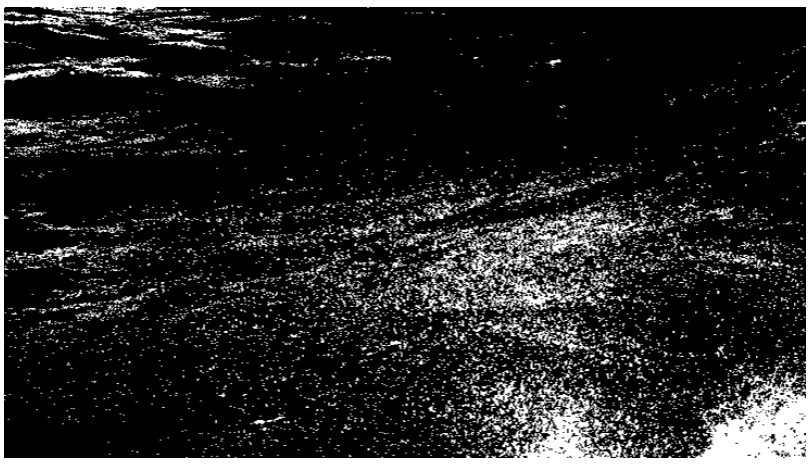

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