Issues of Contemporary Health Policy and Law for Two-Spirit, Indigiqueer, Transgender and Gender-Diverse Communities in Indian Country

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Key Foundational Principles of Federal Indian Law

Tribal nations possess the sovereign power to regulate activities within "Indian lands," a legal term of art that generally encompasses lands owned by the federal government or tribal nations that benefit Indians or Indian tribes.[1] Tribal nations possess criminal jurisdiction over "Indian country,"[2] a legal term of art that generally encompasses lands set aside by the federal government for the benefit of tribal nations and/or individual American Indigenous persons.[3] Tribal powers arise from the inherent political and legal sovereignty of tribal nations, acknowledged by the United States government in its Constitution, its Acts of Congress, agency pronouncements, Indian treaties, and judicial decisions.[4]

The scope of tribal powers often results from a negotiation of sorts with the federal government through the duty of protection, another legal term of art usually referred to as the federal trust responsibility.[5] The relationship between tribal nations and the United States arose from the federal government's various promises of protection – among them being health care – for tribal nations and individual Indigenous persons during what is often known within U.S. history as the treaty-making era.[6] Virtually every governmental function performed by tribal, federal,

[1] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 11.
[2] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 3.
[3] 18 U.S.C. § 1151.
[4] *See generally* Maggie Blackhawk, *Legislative Constitutionalism and Federal Indian Law*, 132 YALE L.J. 2205 (2023); Elizabeth A. Reese, *The Other American Law*, 73 STAN. L. REV. 555 (2021).
[5] *See generally* Matthew L.M. Fletcher, *The Dark Matter of Federal Indian Law: The Duty of Protection*, 75 Me. L. Rev. 305 (2023).
[6] *Id.*

state, and local governments for the benefit of persons within Indian country is governed by tribal inherent powers and the federal government's duty of protection.

Indian Country Health Care

In the context of health care, the United States long ago assumed a general duty to ensure the health and welfare of Indigenous persons who are citizens of federally acknowledged tribal nations.[7] Some early 19th century treaties between the United States and various tribal nations established a federal obligation to provide relief from smallpox and other communicable diseases, for example.[8] In the Snyder Act of 1921, Congress authorized the federal government to expend federal funds on health care in Indian country in order to fulfill its broad obligations under the duty of protection.[9] It is under this authority that the Indian Health Service[10] variously administers Congressional appropriations to federally acknowledged tribes on an annual basis. Sadly, Congress has never adequately funded those programs, leading to oft-tragic health outcomes in Indian country that persist to this day.[11]

By the 1880s and in later decades, the federal government asserted the authority to provide a much wider range of governmental services under its duty of protection, such as housing, education, and public safety. Sadly, enabled by a series of United States Supreme Court decisions in the 1880s and early 1900s,[12] the federal government used its powers to dominate and control the lives of Indigenous persons throughout most of the 20th century.[13] Federal control over Indian country dramatically undermined tribal governments and tribal cultures. Federal bureaucrats

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[7] Federal acknowledged or recognized tribal nations are Indian tribes to which the United States acknowledges a legal duty of protection. Currently, there are 574 federally acknowledged tribal nations. *See* Indian Entities Recognized by and Eligible To Receive Services From the United States Bureau of Indian Affairs, 89 Fed. Reg. 944 (Jan. 8, 2024).

[8] Gina Kruse, Victor A. Lopez-Carmen, Anpotowin Jensen, Lakotah Hardie, and Thomas D.Sequist, *The Indian Health Service and American Indian/Alaska Native Health Outcomes*, 43 ANN. REV. PUB. HEALTH 559, 561-62 (2022).

[9] 25 U.S.C. § 13.

[10] The Indian Health Service is a subagency within the United States Department of Health and Human Services and oversees the health care of approximately 2.8 million of the estimated 3.8 million American Indian and Alaska Native persons in the United States (https://www.ihs.gov/newsroom/factsheets/quicklook/).

[11] *See generally* U.S. Commission on Civil Rights, A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country (July 2003); U.S. Commission on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans (2018); U.S. Government Accountability Office, Actions Needed to Improve Information on Federal Funds That Benefit Native Americans (May 2022).

[12] United States v. Kagama, 118 U.S. 375 (1886); Cherokee Nation v. Hitchcock, 187 U.S. 294 (1902); Lone Wolf v. Hitchcock, 187 U.S. 553 (1903).

[13] *E.g.*, Felix S. Cohen, *The Erosion of Indian Rights, 1950-1953*, 62 YALE L.J. 348 (1953) (surveying federal bureaucratic control over reservation residents in the 1950s).

used Congressional funds set aside for each Indian reservation as a means of control over Indian lives. After World War II through the 1960s, for example, the federal government pursued conflicting policies of asserting complete control over reservation lives while simultaneously pursuing the unilateral termination of the tribal-federal relationship.[14] Notably, in the late 1940s and early 1950s, Congress authorized several states to assume jurisdiction over Indian country crimes.[15]

However, in the 1970s, Congress turned its national Indian affairs policy toward tribal self-determination. In 1975, Congress enacted the first major self-determination statute, the Indian Self-Determination and Education Assistance Act, often known as Public Law 638.[16] The theory and policy of Public Law 638 was the devolution, or delegation, of federal control over Indian country to tribal nations. Under Public Law 638, tribal nations could enter into contracts with the federal government, including the Bureau of Indian Affairs and Bureau of Indian Education within the Department of the Interior, the Indian Health Service within the Department of Health and Human Services, and the Department of Housing and Urban Development, to provide governmental services to tribal citizens. Federal bureaucratic resistance and limited tribal governmental capacity severely undercut the policy of Public Law 638 well into the 1990s, but eventually tribal nations and the federal government began to work somewhat cooperatively. Currently, tribal governments acting as federal contractors under Public Law 638 provide most federally funded governmental services in Indian country.[17]

Now, the United States and tribal nations share the obligation to provide health care services to reservation residents (including many non-Indians[18]) and citizens of federally acknowledged tribal nations residing off-reservation.[19] The

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[14] *See generally* Charles F. Wilkinson & Eric R. Biggs, *The Evolution of the Termination Policy*, 5 AM. INDIAN L. REV. 139 (1977).

[15] *See generally* Robert A. Anderson, *Negotiating Jurisdiction: Retroceding State Authority over Indian Country Granted by Public Law 280*, 87 WASH. L. REV. 915 (2012); John J. Francis, Stacy L. Leeds, Aliza Organick, and Jelani Jefferson Exum, *Reassessing Concurrent Tribal-State-Federal Criminal Jurisdiction in Kansas*, 59 U. KAN. L. REV. 949 (2010); Robert B. Porter, *The Jurisdictional Relationship between the Iroquois and New York State: An Analysis of 25 U.S.C. 232, 233*, 27 HARV. J. ON LEGIS. 497 (1990).

[16] 25 U.S.C. § 5301 et seq.

[17] Geoffrey D. Strommer & Stephen D. Osborne, *The History, Status, and Future of Tribal Self-Governance under the Indian Self-Determination and Education Assistance Act*, 39 AM. INDIAN L. REV. 1 (2014-2015).

[18] Non-Indians eligible for IHS services include an eligible Indian's children/minor dependents and/or spouse (including if "same-sex"); a non-Indian person pregnant with an eligible Indian's child for the duration of pregnancy and post-partum periods; an eligible Indian's household members for various public health matters; and non-Indian employees and veterans in limited circumstances (Indian Health Manual, Section 2-1.2B, https://www.ihs.gov/ihm/pc/part-2/chapter-1-eligibility-for-services/#2-1.2B).

[19] State governments and privately-owned providers also provide health care to tribal citizens and reservation residents, but that work is outside the scope of this article.

Indian Health Service (IHS) is the default administrator, but tribal nations and urban Indian health care programs may contract with IHS to directly provide services instead of the federal government. The Indian Health Care Improvement Act of 1976 and its various amendments serve as the source of this authority.[20]

As explained above, under federal law, tribal nations have the option to step into the IHS's role and provide reservation health care with federal funds.[21] Federal law requires tribal nations expending federal funds to meet certain requirements related to funds management and the eligibility of health care recipients but, as a general matter, tribal nations exercise their sovereign prerogatives in the provision of health care. For example, during the COVID-19 pandemic, tribal health clinics had broad discretion to distribute vaccines to tribal citizen elders first, then children, and then the general population without federal authorization or oversight.[22] Also, once tribal citizens had all been vaccinated, many tribal clinics expanded services to nonmembers both on- and off-reservation. In general, tribal health facilities largely have free reign to expend (and expand) federal funds on culturally appropriate preventative and routine medical care.[23] This includes the integration of traditional Indian medicine into the structure of colonial (allopathic) healthcare.[24]

The United States' duty of protection to tribal citizens and other Indians extends beyond Indian lands. The federal government does provide some health care services through the Office of Urban Indian Health Care Programs through the IHS.[25] Tribally controlled health care is Medicare- and Medicaid-eligible as well. Some tribes have resources to cover Medicare premiums owed for tribal citizens and offer contract health services programs that allow tribal citizens, descendants, and employees to access healthcare at non-IHS and non-tribal health facilities.[26] Eligible Indians who are active duty military servicemembers or veterans may receive healthcare services through associated entitlement programs. Tribal citizens who are

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[20] Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, 90 Stat. 1400 (1976). *See also* Vanessa Anne Racehorse, *Tribal Health Self-Determination: The Role of Tribal Health Systems in Actualizing the Highest Attainable Standard of Health for American Indians and Alaska Natives*, 56 COLUM. HUM. RTS. L. REV. 183, 200-05 (2024) (summarizing the statutory authority for the administration of federal Indian country health programs).
[21] 25 U.S.C. § 5321.
[22] Emily E. Haroz, Christopher G. Kemp, Victoria M. O'Keefe, Katherine Pocock, David R. Wilson, Loretta Christensen, Melissa Walls, Allison Barlow, and Laura Hammitt, *Nurturing Innovation at the Roots: The Success of COVID-19 Vaccination in American Indian and Alaska Native Communities*, 112(3) AM. J. PUB. HEALTH 383 (2023).
[23] Racehorse, *supra*, at 204-05.
[24] Rhoades ER. The Indian health service and traditional Indian medicine. *Virtual Mentor*. 2009;11(10):793-798. Published 2009 Oct 1. doi:10.1001/virtualmentor.2009.11.10.mhst1-0910
[25] *See* 25 U.S.C. §§ 1601, 1651-58.
[26] *E.g.*, Saginaw Chippewa Indian Tribe of Michigan v. Blue Cross Blue Shield of Mich., 32 F.4th 548, 554-55 (6th Cir. 2022) (describing a tribe's contract health services program).

incarcerated in either tribal or federal systems also fall under the federal government's duty of protection, but are perhaps the most marginalized within the "doughnut holes," or coverage gaps, of federal health policy and law.[27]

Tribal Two-Spirit/LGBTQ+ Health Care Laws

Few tribal nations have enacted health care laws specifically relating to Two-Spirit/LGBTQ+ persons[28], though various (supportive) resolutions have been passed by tribal entities in recent years.[29,30,31,32] As sovereigns separate from both U.S. federal and state governments, tribal nations may enact their own laws within their own legal and political jurisdictions. The only limitations on those laws come from federal law, most notably the Indian Civil Rights Act, which requires tribal nations to guarantee certain individual rights protections to any persons under tribal jurisdiction.[33] "Tribal jurisdiction" includes both territorial-based and consent-based jurisdiction, meaning authority over individuals on tribally owned and controlled lands as well as individuals who consent in writing to come under tribal authority.[34] Recent scholarship on tribal same-sex marriage laws, for example, indicate that no more than a couple dozen tribes have enacted any law on same-sex marriage, whether enfranchising or disenfranchising this social right to tribal citizens or on tribal lands.[35]

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[27] Camplain C, Camplain R. The Unmet Health Care Needs of Indigenous People Incarcerated in Tribal Jails. *JAMA.* 2024;332(4):279–280. doi:10.1001/jama.2024.7392
[28] Two-Spirit is a cultural term that may be used by Indigenous individuals who identify as sexually or gender-queer.
[29] Resolution #21-03-11: Support for Trans and Gender-Affirming Care in IHS, Tribal, and Urban Indian Health Facilities – 2021 Strategic Vision and Action Plan. Northwest Portland Area Indian Health Board. Quarterly Board Meeting. April 2021. Archived on 27 Nov 2024. Available at https://web.archive.org/web/20241127200925/https://www.paths remembered.org/npaihb-resolution-gac-strategic-plan-itu/.
[30] Resolution #2021-20: Support for Trans and Gender-Affirming Care in IHS, Tribal, and Urban Indian Health Facilities – 2021 Strategic Vision and Action Plan. Affiliated Tribes of Northwest Indians. Virtual Winter Convention. May 2021. Available at https://atnitribes.org/wp-content/uploads/2021/06/Res-2021-20.pdf.
[31] AK-21-014: Support for Trans and Gender-Affirming Care in IHS, Tribal, and Urban Indian Health Facilities – 2021 Strategic Vision and Action Plan. National Congress of American Indians. Mid Year Conference. June 2021. Available at https://ncai.assetbank-server.com/assetbank-ncai/action/viewAsset?id=210&index=2&total=1000&view=viewSearchItem.
[32] Resolution 25-03: Standing in Support of Our Two Spirit Relatives. National Indian Health Board. March 2025. Available at https://www.nihb.org/wp-content/uploads/2025/03/25-03-NIHB-Resolution-Support-for-Two-Spirit-Relatives.pdf.
[33] *See* 25 U.S.C. § 1302(a).
[34] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS §§ 11 (territorial jurisdiction), 13(a) (territorial and consent-based jurisdiction).
[35] *See* Ann E. Tweedy, *Tribal Laws & Same-Sex Marriage: Theory, Process, and Content*, 46 Colum. Human Rights L. Rev. 105, 106-07 (2015).

Tribal nations are also governments charged with guaranteeing civil rights protections to persons under tribal jurisdiction. Though few tribal nations have legislated in this space, silence in tribal law does not mean that tribal governments either support or disfavor laws allowing health care for Two-Spirit, Indigiqueer, and transgender and gender-diverse (2S/IQ/TGD) persons (hereafter termed gender-affirming medical care, or GAMC). The lack of civil rights protections in Indian country, generally, is evidence of a lack of serious civil rights violations by tribal nations. In general, as two federal appellate courts have concluded, tribal nations offer better civil rights protections than one would receive under federal or state law.[36]

In recent years, state (2021-present) and now federal (2025-present) governmental actors have restricted healthcare services for Two-Spirit/LGBTQ+ populations across the United States, particularly TGD minors.[37][38] During the Trump-Pence and Biden-Harris administrations, GAMC access expanded for 2S/IG/TGD persons within IHS and tribal health facilities. For example, estrogen and testosterone medications were added to the IHS national drug formulary in 2022.[39] Further, the IHS incorporated provisions within its far overdue revised referral care policy, which addressed several provisions that did not align with current evidence-based standards of practice in the United States; this included the authorization (as opposed to previously explicit denial[40]) of funding for various gender-related medical care for eligible 2S/IQ/TGD Indians through the Purchased/Referred Care (i.e., Contract Health Services) Program in 2024.[41] Under the Trump-Vance administration, such advances in GAMC access within Indian

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[36] *E.g.*, Norton v. Ute Indian Tribe of the Uintah and Ouray Reservation, 862 F.3d 1236, 1250 (10th Cir. 2017) ("[T]ribal courts often provide litigants with due process that 'exceed[s] the protections offered by state and federal courts.'") (quoting Matthew L.M. Fletcher, American Indian Tribal Law 325 (2011)); FMC Corp. v. Shoshone-Bannock Tribes, 942 F.3d 916, 944 (9th Cir. 2019) (same).

[37] Dawson L, Kates J. Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions. KFF. 18 Jun 2025. Accessed on 1 Jul 2025. https://www.kff.org/other/dashboard/gender-affirming-care-policy-tracker/?utm_campaign=KFF-Global-Health-Policy.

[38] Exec. Order No. 14187, 90 Fed. Reg. 8771 (January 28, 2025).

[39] Indian Health Service National Pharmacy and Therapeutics Committee Formulary Brief: Gender-Affirming Medications, February 2022. Archived on 22 Dec 2024. Accessed on 1 Jul 2025. https://web.archive.org/web/20241228192138/https://www.ihs.gov/sites/nptc/themes/responsive2017/display_objects/documents/guidance/NPTC-Formulary-Brief-Gender-Affirming-Medications.pdf.

[40] Manual Exhibit 2-3-B, Indian Health Service Medical Priority Levels. Indian Health Manual. Accessed on 1 Jul 2025. https://www.ihs.gov/sites/ihm/themes/responsive2017/display_objects/documents/pc/58619-1_Manual_Exhibit_2-3-B_IHS_MedicalPrioritiesRolesAndResponsibilities.pdf.

[41] Indian Health Service Medical Priority Levels. 1 Jan 2024. Indian Health Service, Purchased/Referred Care. Archived on 22 Dec 2024. Accessed on 1 Jul 2025. https://web.archive.org/web/20241222182931/https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/PRC_Medical_Priorities.pdf.

Country have either been rolled back[42] or shrouded in the uncertainty of ill-defined, unwritten, or otherwise non-public policy and procedure within the IHS[43][44] and tribal health systems.

The complexities of state and federal GAMC restrictions in the United States are amplified within the comparably complex jurisdictional landscape of Indian health care policy and law.

The Hypothetical

This policy brief asks a hypothetical question in a political environment in which the U.S. federal government and many states disfavor the delivery of GAMC to 2S/IQ/TGD persons, even to the point of criminalizing such care. It further assumes that a tribal nation is willing and capable of delivering GAMC.

Imagine that A is a 12-year-old Indigiqueer tribal member who is eligible for Indian Health Service benefits and lives in a state in which GAMC, including puberty blockers, is restricted. This tribal member and their family are seeking medication from an on-reservation tribal health clinic to temporarily suspend puberty as the tribal member accesses support from their family and healthcare team regarding future plans to proceed with a puberty that aligns with their desired secondary sex characteristics and gender.

Specific Legal Principles at Play

The answer to the hypothetical question depends on many factors, including (1) whether the state law is authorized by an Act of Congress such as Public Law 280, (2) whether the state law is a criminal law or a civil-regulatory law, and (3) whether the patient or health care professional is a tribal citizen, a nonmember Indian person, or a non-Indian person. The answer here also assumes that the relevant state

[42] Indian Health Service Medical Priority Levels. 2025. Indian Health Service, Purchased/Referred Care. Archived on 22 Dec 2024. Accessed on 1 Jul 2025. https://www.ihs.gov/sites/prc/themes/responsive2017/display_objects/documents/PRC_Medical_Priorities.pdf.

[43] Indian Health Service National Core Formulary. Accessed on 1 Jul 2025. https://www.ihs.gov/NPTC/formularysearch/.

[44]https://www.ihs.gov/default/sites/nptc/themes/responsive2017/display_objects/documents/guidance/NPTC-Formulary-Brief-Gender-Affirming-Medications.pdf/NPTC-Formulary-Brief-Gender-Affirming-Medications.pdf

law does affirmatively criminalize the provision of GAMC and, further, that federal law prohibits the use of federal money by tribal nations to provide GAMC.

This section details the key legal principles that allow us to advise on the question:

Indian Country, Tribal/Indian Lands, Off-Reservation

Territorial jurisdiction is critically important to understanding the power of tribal nations to authorize GAMC. Land ownership and status tends to determine jurisdiction.

First, lands set aside by the federal government for Indian or tribal purposes and that remain under federal superintendency are lands classified as "Indian country."[45] Lands held by the federal government in trust for the benefit of Indians or tribes and lands within the exterior boundaries of Indian reservations are considered "Indian country."[46] "Indian country" is critical to determining federal, state, and tribal *criminal* jurisdiction.

Second, Indian or tribally-owned lands within Indian country are typically called "Indian lands" or "tribal lands."[47] Land ownership status is critically important to determining tribal *civil* jurisdiction over nonmember Indian persons or non-Indian persons.

Third, off-reservation lands are lands that are neither Indian country nor Indian or tribal lands. Tribal jurisdiction on off-reservation lands is very narrow, usually confined to tribal citizens and those who explicitly consent to tribal jurisdiction, typically through a written commercial contract, lease, or employment contract. States generally have jurisdiction over off-reservation activity of both Indians and tribal nations (subject to tribal sovereign immunity).[48]

Federal Indian Law Preemption

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[45] 18 U.S.C. § 1151.

[46] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 68.

[47] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS §§ 11 (Indian lands), 12 (nonmember lands).

[48] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 25 (sovereign immunity), 31(b) (off-reservation state authority).

A core principle of federal Indian law is that state law has no force in Indian country absent the express consent of Congress.[49] Long ago, for example, the Supreme Court held that federal law preempted state criminal jurisdiction over Indian country.[50] This principle extends to state taxation[51] and state and local police powers (the general power to regulate individuals, whether tribal citizens, nonmember Indian persons, or non-Indian persons, under tribal jurisdiction).[52] Courts will find that a state law designed to regulate either a tribe or a tribal citizen in Indian country is preempted by federal constitutional principles. Similarly, state efforts to assert "concurrent" regulatory powers with tribes or the federal government typically fail.[53]

Federal preemption is tied to the Constitution's Supremacy Clause, which provides that a state law that conflicts with a federal law is preempted.[54] The leading case on preemption is *Bracker v. White Mountain Apache Tribe*.[55] There, the Supreme Court held that states cannot tax on-reservation economic activity (even by nonmembers) where the federal government had considerable control over the activity and the activity derived from reservation natural resources (timber, in that case). In other words, where federal and tribal interests are sufficient to outweigh a state's interests, the state law is preempted.

Outcomes in preemption cases are impossible to predict. A federal Indian law preemption case requires the court to balance the interests of federal, state, and tribal governments. The *Bracker* preemption analysis is, at bottom, an invitation to the judiciary to play politics. This analysis allows the Court to "weigh" competing state, federal, and tribal "interests," which too often leads the Court to assess which governmental policies were, in its view, superior. The Burger, Rehnquist, and Roberts Courts were or are all federalism/states' rights courts, meaning the majority of Justices on the Court possess political commitments to state interests over federal and tribal interests. Unfortunately for Indians and tribes, the Supreme Court has muddied the waters of federal Indian policy considerably by elevating states rights in Indian affairs cases. The Court usually denigrates tribal interests as immaterial unless they involve resources or markets that are indigenous (no pun intended) to

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[49] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 71.
[50] *E.g.*, Worcester v. Georgia, 31 U.S. 515, 561 (1832) (holding that states cannot enforce their criminal laws in Indian country absent federal consent).
[51] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 32.
[52] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 31.
[53] *E.g.*, New Mexico v. Mescalero Apache Tribe, 462 U.S. 324 (1983) (wildlife conservation laws).
[54] *See* CONST. art. VI, cl. 2.
[55] 448 U.S. 136 (1980).

tribal lands.[56] For example, the Supreme Court recently appeared to depart from the understanding that state criminal laws have no force in Indian country in a case involving state criminal jurisdiction over non-Indian crime in Indian country.[57] That decision assumed as a matter of law that state jurisdiction over non-Indians does not end at the reservation boundary unless Congress forbids state jurisdiction.[58] So, in the case of tribal interests regarding the provision of GAMC within their jurisdiction, there is no supportive precedent.

Public Law 280-Type States

State governments authorized by Congress may exercise criminal jurisdiction, and do so, over some 70 percent of Indian reservations. A series of federal laws enacted in the 1940s and 1950s, most notably Public Law 280,[59] granted criminal jurisdiction to a discreet set of state governments.[60] These state governments can enforce state criminal law in reservations located in Alaska, California, Florida, Idaho, Minnesota, Montana, Nebraska, Nevada, New York, Oregon, Washington, and Wisconsin (with a few reservations excepted). Because the reservations in these states tend to be less populous, state criminal jurisdiction only extends to a minority of tribal citizens in Indian country. In Public Law 280-type states, federal criminal jurisdiction is generally replaced with state authority. Even so, partly because Congress never appropriated funds to states to exercise that jurisdiction, state criminal jurisdiction is often spotty and inefficient.[61] It is also frequently politicized.

Public Law 280 authorizes and directs states to assume criminal jurisdiction over all persons in Indian country, but does not allow states regulatory or taxation authority over Indians and tribes within Indian country.[62] Given overlapping and occasionally conflicting state and tribal policies, what constitutes a criminal law as opposed to a civil or regulatory law in Indian country is often unclear. The courts have adopted a somewhat subjective test referred to as the civil-regulatory versus

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[56] *E.g.*, *Bracker*, 448 U.S. at 150 (finding preemption of state taxation of timber-related economic activity on tribal lands); *Cabazon Band*, 480 U.S. at 218-19 (same, but with state regulation of tribal bingo).
[57] *See* Oklahoma v. Castro-Huerta, 597 U.S. 629 (2023).
[58] *See id*. at 637 (quoting Nevada v. Hicks, 533 U.S. 353, 361 (2001)).
[59] 18 U.S.C. § 1152.
[60] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 72.
[61] *See generally* DUANE CHAMPAGNE & CAROLE GOLDBERG, CAPTURED JUSTICE: NATIVE NATIONS AND PUBLIC LAW 280 (2d ed. 2020).
[62] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 34.

criminal-prohibitory legal test.[63] Under this analytic framework, a state law regulating or restricting a given activity is considered a "civil-regulatory" law, even if violations of the law could lead to criminal penalties.[64] The leading case is *California v. Cabazon Band of Mission Indians*.[65] There, the Supreme Court held that California and its political subdivisions could not regulate the tribal bingo hall because state and local law allowed limited forms of bingo. Public Law 280-type laws only authorize states to assume criminal jurisdiction in Indian country, not taxation authority or the power to enforce civil offenses.

Assessing the Hypothetical

Even a relatively simple hypothetical involving Indian country jurisdiction and overlapping sovereignties contains many factors that complicate any answer to our hypothetical regarding GAMC. We look to whether the tribal service provider was working on or off the reservation, whether the parties (both provider and patient) are tribal citizens or not, and whether the state in which the tribe is located is authorized to exercise criminal jurisdiction in Indian country.

Non-Public Law 280 States: Tribal Citizens on Indian Lands

A state law restricting GAMC provided by a tribal health clinic to *tribal members* on Indian lands is definitively unenforceable.

However, one state court recently held that states can prosecute Indians for Indian country-based conduct.[66] This one case may be an outlier, but the Supreme Court's inconsistency in its preemption cases gives fuel to activist judges harboring political commitments favoring states' rights or against LGBTQ+ rights. State interests in restricting GAMC are highly politicized and perhaps open to attack on the merits. Tribal health clinics operating with federal oversight and federal appropriations, designed to fulfill federal policy obligations to tribal nations, should be exempt from state restrictions, but that does not mean they will be in court, especially if the federal government intervenes in favor of state interests.

Non-Public Law 280 States: Nonmembers on Indian Lands

[63] *See id*. cmt. *b*.
[64] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 34, cmt. *b*.
[65] 480 U.S. 202 (1987).
[66] *See* City of Tulsa v. O'Brien, 2024 OK CR 31 (2024).

A state law restricting gender-affirming medical care provided by a tribal health clinic to *nonmembers* on Indian lands is likely unenforceable. There is a slight possibility the courts could conclude that tribal actions involving nonmembers have consequences for off-reservation actors, giving rise to state interests that theoretically could breach the tribal sovereignty barrier. There have been no decisions holding in any context that on-reservation activities by tribal nations justified state authority, however.

A nonmember (whether a nonmember Indian person or non-Indian person) who receives GAMC from a tribal facility could possibly be prosecuted by a state upon physically leaving Indian country, though there could be non-federal Indian law-related jurisdictional defenses available in such cases. Equally so if the nonmember is the provider of said GAMC to a tribal citizen or nonmember at the tribal facility. Ultimately, it comes down to prosecutorial discretion, which is inherently a political function.

Urban Indians

Tribal or IHS facilities providing GAMC to tribal citizens off-reservation likely would not be subject to state restrictions. Normally, states have jurisdiction over off-reservation Indian and tribal activities, but when federal and tribal resources are expended to fulfill a federal or tribal purpose, state law tends to be preempted. It is more likely that federal Indian law preemption principles would prevent state jurisdiction over the tribal citizens receiving services in this context.

Public Law 280-Type States: Tribal Citizens on Indian Lands

Whether a Public Law 280-type state could restrict tribal GAMC services delivered to tribal citizens depends on whether the state law fully criminalizes GAMC. Whether a specific state law would constitute a criminal-prohibitory law is often a difficult question, but this brief assumes that the state law is criminal.

The Supreme Court long ago determined that a state cannot prosecute on-reservation tribal citizen activities as a violation of state criminal law.[67] Again, the relevant legal framework is federal Indian law preemption. In general, state interests in on-reservation conduct by tribal nations and tribal citizens are weak. Tribal health clinics, especially those that expend purely tribal funds on GAMC, are more likely to be exempt from state laws because state interests in how a tribal nation governs

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[67] *Cf.* Worcester v. Georgia, 31 U.S. 515 (1831) (concluding that state criminal jurisdiction does not extend into Indian country absent Congressional authorization).

are at their weakest. Scholars addressing whether a state law abortion ban could be enforced against tribal nations have reached the same conclusion.[68]

Public Law 280-Type States: Nonmembers on Indian Lands

The delivery of GAMC by tribal health care services to nonmembers is more likely to be subject to state prosecution or regulation. The Supreme Court has settled on the premise that state laws apply to on-reservation nonmember activities unless preempted by federal law or the state law infringes on tribal self-governance.[69]

State laws might still be preempted if they run afoul of federal interests, though that seems unlikely in the current political environment. The best argument in favor of preemption is to elevate the federal interests at issue in the establishment and funding of Indian country health care regimes. Federal interests may waver in this political environment, though the Indian country health care system is the strongest embodiment of a federal interest. From the earliest treaties and federal laws until today, the United States acknowledges an obligation to guarantee health care. For example, vaccinations of Indians for smallpox, polio, COVID-19, and other infectious diseases that could spread in and out of Indian country constitute a core federal obligation. While courts usually hold that state power to regulate nonmembers on tribal lands interferes with federal policies and/or tribal self-governance,[70] we are not aware of cases analogous to the context of health care generally, or to healthcare or other issues involving 2S/LGBTQ+ persons specifically.

A state might attempt to assume jurisdiction over nonmembers who provide or receive GAMC on Indian lands, but only after they depart from Indian lands. State laws presumably would apply to these nonmembers after they depart from Indian lands,[71] but federal and tribal law could potentially preempt state interests. Treaty-guaranteed hunting and fishing rights are a classic example of state law being preempted by federal law, even on off-reservation lands,[72] but again, preemption analysis is fraught.

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[68] *See* Lauren van Schilfgaarde, Aila Hoss, Ann E. Tweedy, Sarah Deer, and Stacy Leeds, *Tribal Nations and Abortion Access: A Path Forward*, 46 HARV. J. GENDER & L. 1, 47-48 (2023).

[69] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 29.

[70] *See* RESTATEMENT OF THE LAW OF AMERICAN INDIANS § 29(b), (c).

[71] *E.g.*, Wagnon v. Prairie Band Potawatomi Nation, 546 U.S. 95 (2005) (state tax imposed on off-reservation wholesaler).

[72] *See generally* RESTATEMENT OF THE LAW OF AMERICAN INDIANS §§ 85, comment *c*.

Concluding Remarks

As in many areas of extant law and policy on Turtle Island and within the colonially-known United States, clarity on our hypothetical will require litigation – within both U.S. and tribal courts – as to the legality and jurisdictional implications of GAMC restrictions in Indian country. In the interim, 2S/IQ/TGD persons will likely face disparate healthcare access in both Indian and non-Indian health facilities under existing precedent now set by the Supreme Court.[73]

[73]United States v. Skrmetti, 605 U.S. ___ (2025).