UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TONYA HAMMITTE, *et al.*,

Plaintiffs,

v.

MICHAEL O. LEAVITT, *et al.*,

Defendants.
_____/

Civil No. 2:06cv11655

HON. AVERN COHN
MAG. JUDGE DONALD A. SCHEER

DEFENDANTS' MOTION TO DISMISS

Defendants, through their attorneys, Stephen J. Murphy, United States Attorney for the Eastern District of Michigan, and Peter A. Caplan, Assistant U.S. Attorney, move this court for an order dismissing this case pursuant to Fed.R.Civ.P. 12(b)(1) and (6). This motion, which is supported by the attached brief, is brought because the court lacks subject matter jurisdiction over this matter and because the complaint fails to state a claim upon which relief can be granted. Concurrence in the relief that is sought by this motion was requested on June 8, 2006, and was not obtained.

Respectfully yours,

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Dated: June 12, 2006

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BRIEF IN SUPPORT OF MOTION TO DISMISS

This complaint was brought by three American Indians who currently live in or near Detroit, Michigan, and American Indian Services, Inc. ("AIS"), a non-profit organization that provides social services to American Indians residing in the Detroit area. The individual plaintiffs allege that they represent a class of Indian people living in the Detroit metropolitan area who are eligible to receive health care services from the Indian Health Service ("IHS") and whose health care needs have not been adequately met. In addition to the IHS, the complaint names as defendants the United States Department of Health and Human Services ("HHS"), of which the IHS is a component, and Michael O. Leavitt, Secretary of Health and Human Services ("the Secretary").[1]

Plaintiffs plead two "claims" in their complaint. First, they allege that the IHS has breached a "fiduciary duty to appropriate resources in a calculated and non-arbitrary manner . . . in conjunction with the statutory mandates of the Snyder Act, 25 U.S.C. § 13 (1921) and the Indian

[1] For simplicity, defendants will be referred to, collectively, as "the IHS."

Health Care Improvement Act, 25 U.S.C. § 1601 (1992). . . ." Complt ¶ 72 ("statutory claim"). More specifically, plaintiffs allege that the IHS provides insufficient services to Indians residing in or near urban areas ("urban Indians"), allocating disproportionate resources to "American Indians living on or near rural reservations." Complt ¶ 4. In their second claim, plaintiffs allege that the manner in which the IHS allocates "resources" between urban Indians and Indians living on or near rural reservations violates their rights under the Due Process Clause of the Fifth Amendment to the United States Constitution. *Id.* ¶ 76 ("constitutional claim"). Plaintiffs purport to represent a class of similarly situated urban Indians.

Defendants have filed a motion to dismiss the complaint for failure to state a claim upon which relief may be granted and lack of subject matter jurisdiction. This is their brief in support of that motion.

STATUTORY BACKGROUND

The IHS's mission is "in partnership with the American Indian and Alaska Native people [to] raise their physical, mental, social, and spiritual health to the highest possible level." IHS FY 2006 Budget Justification, Overview at 3, found by accessing links at http://www.ihs.gov/AdminMngrResources/Budget/FY_2006_Budget_Justification.asp (last modified 2/17/05). To accomplish this mission the IHS focuses on providing preventive and primary health services to American Indians and Alaska Natives ("AI/ANs") and developing a community based public health system. *Id.*

The IHS delivers direct health care services to AI/ANs through three separate mechanisms: (1) It provides health care services to AI/ANs directly through its own facilities; (2) It funds contracts with tribal governments and tribal organizations for these entities to operate health care

delivery programs previously operated by the IHS; and (3) It funds contracts with urban Indian organizations for these entities to administer health care programs for urban Indians.

The Snyder Act and the Indian Health Care Improvement Act

Two statutes endow the IHS with authority to provide health care services to AI/ANs. The first, the Snyder Act of 1921, 25 U.S.C. § 13, constitutes a broad, general statutory mandate for the IHS to "expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians," for, among other things, the "relief of distress and conservation of health." 25 U.S.C. § 13.[2] The second of these statutes, the Indian Health Care Improvement Act of 1976, as amended ("IHCIA"), 25 U.S.C. § 1601, *et seq.*, established several programs to address particular Indian health needs, including alcohol and substance abuse treatment, diabetes education and treatment, and medical training. Relevant to this lawsuit, Title V of the IHCIA established programs to provide health care services to urban Indians. 25 U.S.C. §§ 1651-1660d.

The Indian Self Determination and Education Assistance Act

A third key statute, the Indian Self-Determination and Education Assistance Act of 1975, as amended, ("ISDEAA"), 25 U.S.C. § 450 et seq., authorized Indian tribes and tribal organizations ("tribes") to contract with the IHS to take over and operate, independent of the IHS, certain health care delivery programs established pursuant to the Snyder Act and the IHCIA. 25 U.S.C. §§ 450f, 458aaa-4.[3] Under the ISDEAA, the IHS funds the costs of health services

[2] By its terms, the Snyder Act of 1921 confers authority on the Bureau of Indian Affairs ("BIA"), an agency within the Department of the Interior. In 1954 Congress transferred the BIA's authorities and responsibilities concerning "the conservation of the health of Indians" to HHS. 42 U.S.C. § 2001(a).

[3] As a technical matter, the ISDEAA authorizes two types of contracts with tribes -- self-determination contracts under Title I of the ISDEAA, 25 U.S.C. §§ 450f-450n, and self-governance *compacts* under Title V of the ISDEAA (not to be confused with Title V of the IHCIA), 25 U.S.C.

provided by tribes to eligible Indians. 25 U.S.C. §§ 450j-1(a), 458aaa-7(c). The IHS pays tribes not only the amounts the IHS would have spent to operate the health care program contracted by the tribe, but also whatever additional administrative costs the contracting tribe incurs in the operation of the health care program. 25 U.S.C. §§ 450j-1(a)(2), 458aaa-7(c). The ISDEAA expressly forbids reduction of funding to a tribe in subsequent contract years except under limited, specified circumstances. 25 U.S.C. §§ 450j-1(b), 458aaa-7(d)(1)(C).

Title V of the IHCIA

Title V of the IHCIA authorizes the Secretary to "enter into contracts with . . . urban Indian organizations to assist such organizations in the establishment and administration . . . of programs" described in Title V. 25 U.S.C. § 1652. According to legislative history, "Title V clearly represents a Federal policy commitment to provide the essential authorities and financial resources to permit urban Indian organizations to develop needed health services and to strengthen relationships with existing community health and medicare programs." H.R. Rep. No. 94-1026, Part I, 94th Cong., 2d Sess., 117, *reprinted in* 1976 U.S.C.C.A.N. at 2755.

Under Title V, the IHS may enter into a contract with an urban Indian organization to provide "health care and referral services for urban Indians." 25 U.S.C. § 1653(a). In addition to requiring under such a contract that the urban Indian organization "where necessary, provide, or enter into contracts for the provision of, health care services for urban Indians," 25 U.S.C. § 1653(a)(12), the IHS must require such an urban Indian organization to estimate the current health status and needs of the urban Indians residing in the urban center, to "identify all public and private health services resources within such urban center which are or may be available to urban Indians,"

§§ 458aaa-458aaa-18. For simplicity, self-determination contracts and self-governance compacts under the ISDEAA will be referred to, collectively, as "contracts."

to "assist" such private "health resources" to provide services, to assist urban Indians to become familiar with and utilize available private health services resources within the urban center, to "provide basic health education," and to "identify gaps between unmet health needs of urban Indians and the resources available to meet such needs," among other things. 25 U.S.C. § 1653(a)(1)-(4), (6)-(8), (10). Under such contracts, the IHS also may require an urban Indian organization to "make recommendations . . . on methods of improving health service programs to meet the needs of urban Indians. . . ." 25 U.S.C. § 1653(a)(11). Title V of the IHCIA expressly limits the IHS's authority to enter into the contracts described above "to the extent, and in an amount, provided for in appropriation Acts." 25 U.S.C. § 1658.

Appropriations for Indian Health Services

IHS programs are funded through annual appropriations. Historically, Title V of the IHCIA included a separate authorization of appropriations, but the last of these expired at the end of federal fiscal year ("FY") 2000. 25 U.S.C. § 1660d. Since FY 2000, Congress has continued annually to appropriate funds for all IHS programs, whether under the IHCIA, the Snyder Act,[4] or the ISDEAA,[5] through two annual lump-sum appropriations, one for "Indian Health Services" and the other for "Indian Health Facilities." Pub. L. 106-113, 113 Stat. 1501 (FY 2000 Appropriations Act); Pub. L. 106-291, 114 Stat. 922 (F Y 2001 Appropriations Act); Pub. L. 107-63, 115 Stat. 414 (FY 2002 Appropriations Act); Pub. L. 108-7, 117 Stat. 11 (FY 2003 Appropriations Act); Pub. L. 108-108 (FY 2004 Appropriations Act); Pub. L. 108-447, 118 Stat 2809 (FY 2005 Appropriations Act); Pub.

[4] The Snyder Act generally authorizes the IHS to "direct, supervise, and expend such moneys as Congress may from time to time appropriate . . . [f]or relief of distress and conservation of health" of Indians. 25 U.S.C. § 13.

[5] The ISDEAA authorizes appropriations of "such sums as may be necessary to carry out" Title V of the ISDEAA relating to self-governance compacts. 25 U.S.C. § 458aaa-18.

L. 109-54, 119 Stat 499 (FY 2006 Appropriations Act). The lump-sum annual appropriation for Indian Health Services funds delivery of all health care services to AI/ANs. *Id.* The lump-sum annual appropriation for Indian Health Facilities funds construction and maintenance of primary care and sanitation facilities. *Id.* These appropriations are finite, for sums certain. *Id.* At least since 2000, Congress consistently has appropriated less funds annually for Indian Health Services than the IHS has requested in its annual budget submissions. *See* IHS Budget Home Page and links to budget documents, http://www.ihs.gov/AdminMngrResources/Budget/index.asp (last modified 2/9/06).

THE COMPLAINT

Factual Allegations

Plaintiffs allege that "[a]lthough defendant IHS is the single largest source of federal spending for American Indians, it constitutes only 0.5 percent of defendant HHS." Complt ¶ 30. They further contend that "[d]efendants' current funding levels are far below that necessary to maintain basic health services. . . .," *Id.* ¶ 33, and that "[t]he health care needs of urban American Indians are as great or greater as [sic] those of American Indians living on or near reservation lands and are among the most urgent and severe of any group in the United States." *Id.* ¶ 35. There is "only one IHS clinic providing health care for all urban American Indians in Michigan. . . .," according to the complaint. *Id.* ¶ 39. This clinic, American Indian Health & Family Services of South East Michigan ("American Indian Health Services"), is funded by the IHS under Title V of the IHCIA. *Id.*

Plaintiff Tonya Hammitte ("Hammitte"), a member of the Sault Ste. Marie Tribe of Chippewa, lives in Detroit. Complt ¶ 10. She had an abnormal Pap smear 12 years ago. *Id.* ¶ 43.

Because of the abnormal Pap smear, physicians recommended that Hammitte undergo a colposcopy twice yearly. *Id.* ¶ 44. American Indian Health Services, the IHS-funded clinic in Detroit, performed the Pap smear; however, it lacks the resources to provide colposcopies. *Id.* ¶¶ 40-48. Hammitte "has only been able to afford to undergo a colposcopy twice" in the past 12 years. *Id.* ¶ 47.

David Stone ("Stone"), a member of the White Earth Ojibwa Band of Minnesota, lives in Detroit. Complt ¶ 11. Stone was injured in 2002 "while working full time as a mechanic." *Id.* ¶ 52. He suffered from a severe hernia and was unable to obtain surgery free of charge either in Detroit through the IHS-funded American Indian Health Services clinic, or through his tribe. *Id.* ¶¶ 56-57.[6] Stone now owes $5000 for hernia surgery performed by a private physician. *Id.* ¶ 57. He currently is experiencing abdominal pain that "may be the consequence of a botched hernia surgery. . . ." *Id.* ¶ 58.[7]

Joseph Stewart ("Stewart"), a member of the Sault Ste. Marie Tribe of Chippewa, lives in Detroit. Complt ¶ 12. He has been diagnosed "as suffering from an unidentified liver disease." *Id.* ¶ 63. Stewart cannot afford the tests necessary for him to obtain an accurate diagnosis, or treatment, of his ailment. *Id.* ¶¶ 64-65.

Plaintiff AIS "provides social services and emergency support services to tribally enrolled American Indians living in and around Detroit, Michigan." Complt ¶ 13. These services include

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[6] The complaint is silent as to whether Stone was entitled to workers compensation benefits in connection with his on-the-job injury.

[7] The complaint is silent as to whether Stone has commenced an action for medical malpractice against the private physician who "botched" his hernia surgery. The complaint is also silent as to whether Stone has asserted the alleged malpractice as a basis for forgiveness, or reduction, of the $5000 debt.

"food, transportation, housing, and help with utility and water bills. . . ." *Id.* ¶ 70. AIS "attempts to satisfy the unmet medical needs of its constituents by directly paying for medical treatment when AIS funds are available." *Id.* ¶ 69. "[T]he cost of this assistance limits the funds [AIS] can use to provide assistance to other needy individuals." *Id.* ¶ 13.

Relief Requested

Plaintiffs seek declaratory and injunctive relief. They ask the court to declare that defendants have violated the Snyder Act, the IHCIA, and the Due Process Clause of the United States Constitution. Complt at 15-16. They seek to enjoin defendants "from failing or refusing to make immediately available to plaintiffs . . . the much needed health care services to which they are entitled under federal law." Complt at 16. They ask that defendants be ordered, among other things, "to regularly assess the unmet health care needs of urban American Indians," "to establish . . . a reasonable standard for the allocation of its health services and facilities budget that accurately reflects the unmet health care needs of the growing urban American Indian population," "to increase primary care and diagnostic services" to urban Indians, "to ensure that all urban American Indian health care facilities have in place a referral network for specialist care and provide payment for that specialist care," and "to provide the required relief in a manner that does not reduce the care, or adversely affect the level of care, available to those [AI/ANs] living on reservations. . . ." *Id.*

ARGUMENT

A. PLAINTIFFS' STATUTORY CLAIM UNDER THE APA SHOULD BE DISMISSED BECAUSE ALLOCATION OF FUNDS FROM THE IHS'S LUMP-SUM APPROPRIATION IS COMMITTED TO AGENCY DISCRETION BY LAW.

Plaintiffs allege that they are entitled to judicial review under the Administrative Procedures Act (" APA"), 5 U.S.C. § 702, as persons "aggrieved by agency action." Complt ¶ 8. However, the

APA exempts from judicial review "agency action . . . committed to agency discretion by law." 5 U.S.C. § 701(a)(2). In *Lincoln v. Vigil*, 508 U.S. 182 (1993), the Supreme Court held that where Congress has appropriated lump sums for health services to Indians, the IHS's allocation of those funds is committed to agency discretion by law and consequently is not subject to judicial review under the APA. Accordingly, the IHS's allocation of the lump-sum appropriation for Indian health services is not subject to judicial review, and this court lacks subject matter jurisdiction over plaintiffs' statutory claim.

Lincoln v. Vigil involved a challenge to the IHS's decision to discontinue a program for handicapped Indian children in the Albuquerque, Navajo, and Hopi reservation service areas. In the place of that program, the IHS proposed to create a nationwide program for handicapped Indian children which, necessarily, would no longer provide the comprehensive services that the plaintiffs had received under the local program. Handicapped Indian children eligible to receive services through the original, local program sued, alleging, much as have plaintiffs at bar, that the IHS "violated the federal trust responsibility to Indians, the Snyder Act, the [Indian Health Care] Improvement Act, the Administrative Procedure Act, . . . and the Fifth Amendment's Due Process Clause." 508 U.S. at 189. The Court held that the IHS's decision to discontinue the program for handicapped Indian children was "unreviewable under § 701(a)(2)." *Id.* at 193.

In reaching this conclusion, the Supreme Court observed that "both the Snyder Act and the [Indian Health Care] Improvement Act . . . speak about Indian health only in general terms." *Id.* at 193. As for the IHS's mission, the Snyder Act says no more than that it "shall direct, supervise, and expend such moneys as Congress may from time to time appropriate" for, among other purposes, the "conservation of health" of AI/ANs. 25 U.S.C. § 13. This broadly-worded statute contains no

further direction to the IHS regarding allocation of funds appropriated by Congress for Indian health, nor does it contain any language that would entitle AI/ANs to full funding of all health care needs.

Like the Snyder Act, the IHCIA, which establishes particular programs for "the conservation of health" of AI/ANs, including programs for urban Indians, contains no language that could be read as entitling plaintiffs to full federal funding of all their health care needs. Also like the Snyder Act, the IHCIA contains no direction to the IHS regarding allocation of appropriated funds among the Indian health programs authorized. 25 U.S.C. § 1601, §§ 1651-1660d. Moreover, the IHCIA expressly limits the IHS's authority "to enter into contracts" with urban Indian organizations under Title V "to the extent, and in an amount, provided for in appropriation Acts." 25 U.S.C. § 1658. As noted above, at all times relevant to this complaint Congress has appropriated funds for Indian health programs in two lump sums, one for health services and the other for facilities, without specifying any allocation among the health care programs the IHS administers. Congress has left to the IHS's discretion the allocation of appropriated funds among its service units that provide direct health care services to AI/ANs, tribally operated programs under the ISDEAA, and urban Indian programs. In the absence of congressional direction for allocation of appropriated funds, IHS's allocation of those funds cannot be found to violate either the Snyder Act or the IHCIA.[8]

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[8] Plaintiffs' characterization of their statutory claim as one for "Breach of Fiduciary Obligation," complt at 14 (subheading), does not change the legal analysis. The responsibility for articulating, giving content to, and implementing the "special relationship" between the United States and Indians lies with Congress, U.S. Const. Art. I, § 8, Cl. 3 (Indian Commerce Clause); *United States v. Kagama*, 118 U.S. 375, 383-84 (1886), and not with the courts. Congress has chosen to implement its view of the United States's obligations with respect to Indian health care by enacting the Snyder Act and the IHCIA, and related annual appropriations acts, conferring on the IHS broad discretion and flexibility to determine how best to provide services to Indians. In those statutes and appropriations, Congress declined to create vested rights in any particular programs or services provided under the auspices of the Snyder Act and the IHCIA, nor did it specify particular standards for the IHS to follow in allocating funds. *Cf.*, *Reuben Quick Bear v. Leupp*, 210 U.S. 50, (continued...)

Plaintiffs' contention that the Snyder Act and the IHCIA require the IHS to provide through the urban organizations it funds all necessary health care services to urban Indians finds no support in the language of either statute, or in any case law. To the contrary, to the extent that under the IHCIA the IHS may enter into urban contracts for the study of unmet health care needs, 25 U.S.C. § 1654, it is clear that in enacting this legislation Congress understood that not all urban Indian health care needs would be met by the programs authorized thereunder. This understanding also is evinced by the fact that under Title V of the IHCIA, urban Indian organizations that contract with the IHS must be required to use IHS funding to accomplish such tasks as "identify[ing] all public and private health services resources . . . which are or may be available to urban Indians," 25 U.S.C. § 1653(a)(4); "assist[ing] such health services resources in providing services to urban Indians," 25 U.S.C. § 1653(a)(6); "assist[ing] urban Indians in becoming familiar with and utilizing such health services resources," 25 U.S.C. § 1653(a)(7), and "identify[ing] gaps between unmet health needs of urban Indians and the resources available to meet such needs." 25 U.S.C. § 1653(a)(10).

Lincoln v. Vigil stands for the proposition that the IHS's allocation of funds appropriated by Congress for Indian Health Services, whether between urban programs and tribal programs, or among urban programs, is committed to agency discretion by law and is not subject to APA review. For these reasons, plaintiffs' statutory claim is without legal merit and the complaint fails to state a claim upon which relief may be granted, ant the complaint should be dismissed for lack of subject matter jurisdiction.

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[8](...continued)
80-81 (1908) (distinguishing between treaty funds, in which Indians have vested rights, and "the gratuitous appropriation of public moneys for the purpose of Indian education").

B. PLAINTIFFS' CONSTITUTIONAL CLAIM SHOULD BE DISMISSED BECAUSE THE IHS'S ALLOCATION OF SCARCE FUNDS AMONG VARIOUS PROGRAMS IS WITHIN ITS DISCRETION AND IS NOT UNREASONABLE.

In conclusory fashion, plaintiffs allege that defendants have distributed resources in "an irrational, arbitrary, and inequitable" manner to the detriment of those Indians who do not live on or near reservations. Complt ¶¶ 74-75. They claim that defendants have violated plaintiffs' right to equal protection under the Due Process Clause of the Fifth Amendment "by failing to provide plaintiffs and plaintiff class with health care equal to that provided to American Indians living on or near reservation lands." *Id.* ¶ 76. The factual allegations underlying this Fifth Amendment claim are that "[t]he overwhelming majority of defendants' funding for health care is provided to American Indians living on or near reservations . . .," and "[a]bout 46 percent of American Indians live in urban areas. . . ." *Id.* ¶¶ 36-37. Plaintiffs fail to state a legally cognizable constitutional claim.

As a threshold matter, the facts plaintiffs allege do not support their claim that urban Indians are not provided "health care equal to that provided to American Indians living on or near reservation lands." Hammitte does not say that if she lived on or near a reservation she would receive twice annual coloscopies, and Stewart does not allege that services are available on or near a reservation to diagnose and treat his liver ailment. Stone specifically alleges that he was not able to obtain the hernia operation he needed from the IHS facility on or near his reservation. In short, nothing in the plaintiffs' factual allegations supports their claim that Indians living on or near reservations receive health care superior to that available to them.

Even taking as true plaintiffs' conclusory allegation that the IHS provides health care for Indians living on or near reservations that is superior to that available to urban Indians, they state

no cognizable constitutional claim. It is well settled that the government has broad discretion to allocate funds for discretionary programs without violating equal protection rights. In *Dandridge v. Williams*, 397 U.S. 471 (1970), the Court explained:

> In the area of economics and social welfare, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some reasonable basis, it does not offend the Constitution simply because the classification is not made with mathematical nicety or because in practice it results in some inequality.

Id. at 485.[9] Supreme Court case law supports the constitutionality of this exercise of discretion in the realm of education and health services to Indians and even endorses programs that bestow special benefits on Indians living on or near reservations. In *Morton v. Ruiz*, 415 U.S. 199, 212, 214, 229, 230-31 (1974), the Court overturned on procedural grounds BIA's restriction of general assistance benefits authorized by the Snyder Act to Indians living on the reservation while, in dictum, expressly approved the restriction of such benefits to Indians residing on or near their reservation. The Court reasoned, "[h]aving found that the congressional appropriation was intended to cover welfare services at least to those Indians residing 'on or near' the reservation, it does not necessarily follow that the Secretary is without power to create reasonable classifications and eligibility requirements in order to allocate the limited funds available to him for this purpose." In *Morton v. Mancari*, 417 U.S. 535, 552 (1974), in the course of holding that federal employment preference for qualified Indians did not violate the Fifth Amendment, the Court similarly remarked, also in dictum, that "[literally] every piece of legislation dealing with Indian tribes and reservations . . . single out for special treatment a constituency of tribal Indians living on or near reservations."

[9] The Supreme Court has recognized that the Due Process clause of the Fifth Amendment embraces the principles of the Equal Protection Clause of the Fourteenth Amendment. *See, e.g., Weinberger v. Salfi*, 422 U.S. 749, 770 (1975).

See also Rice v. Cayetano, 528 U.S. 495, 519-20 (2000) (construing the foregoing language from *Mancari* and pointing out that the Court's rationale for finding the BIA's preference for Indian employees to be constitutional was based on the fact that "the BIA preference could be tied rationally to the fulfillment of Congress' unique obligation toward the Indians, and was reasonable and rationally designed to further Indian self-government") (quoting *Mancari*, 528 U.S. at 555; internal quotation marks omitted).

The ISDEAA is the prime example of Indian health legislation that singles out tribal Indians living on or near reservations. With the enactment of the ISDEAA, Congress declared its commitment to the self-determination of Indian tribes and "the development of strong and stable tribal governments capable of administering quality programs and developing the economies of their respective communities." 25 U.S.C. § 450a. In furtherance of this commitment, many of the earmarks in recent lump-sum appropriations for Indian Health Services have related to funds to support contracts with tribes to furnish health care services historically provided by the IHS under the Snyder Act and the IHCIA, even while none of these appropriations acts has made any specific mention of Title V of the IHCIA or urban Indian programs . *See generally* Pub. L. 106-113, 113 Stat. 1501 (FY 2000 Appropriations Act); Pub. L. 106-291, 114 Stat. 922 (FY 2001 Appropriations Act); Pub. L. 107-63, 115 Stat. 414 (FY 2002 Appropriations Act); Pub. L. 108-7, 117 Stat. 11 (FY 2003 Appropriations Act); Pub. L. 108-108 (FY 2004 Appropriations Act); Pub. L. 108-447, 118 Stat 2809 (FY 2005 Appropriations Act); Pub. L. 109-54, 119 Stat 499 (FY 2006 Appropriations Act). Moreover, Congress by statute has prohibited the IHS from reducing annual funding levels for tribal health programs. 25 U.S.C. §§ 450j-1(b), 458aaa-7(d)(1)(C).

To the extent that Congress's rational choice to fund self-determination contracts with tribes for Indian health care may have resulted in less availability of direct health care services for urban Indians than would be optimally desirable, the Fifth Amendment does not require anything different. In 1976, Congress enacted Title V in order to supplement the IHS system by extending health care services to an urban Indian population that previously was not receiving any direct care from the IHS. *See* H.R. Rep. No. 94-1026, Part I, 94th Cong., 2d Sess., 114, *reprinted in* 1976 U.S.C.C.A.N. at 2752. In designing the urban Indian health programs under Title V, Congress anticipated and addressed the likelihood that urban Indians would have to access for their health care services resources not funded by the IHS when it included among the functions of urban Indian organizations funded under Title V such activities as identifying other available resources, familiarizing urban Indians with such resources, and even assisting other resources to provide services to urban Indians. 25 U.S.C. § 1653(a). This is a rational approach to the allocation of scarce resources. Plaintiffs fail to state a cognizable claim under the Fifth Amendment.

C. THE COMPLAINT SHOULD BE DISMISSED FOR LACK OF SUBJECT MATTER JURISDICTION BECAUSE PLAINTIFFS LACK STANDING.

Just last month the Supreme Court reaffirmed the concept of "standing" as a core component of the case-or-controversy requirement of Article III of the Constitution. *DaimlerChrysler Corp. v. Cuno*, __ U.S. __, 126 S. Ct. 1854 (2006). The Court once again reiterated that "[t]he requisite elements of this 'core component derived directly from the Constitution,'" and that to meet this core component "[a] plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief." *Id.* at 1861 (internal quotation marks omitted). Not only must these three elements of standing be demonstrated by each plaintiff – (1) a personal injury, (2) fairly traceable to the defendant's allegedly unlawful conduct and (3)

likely to be redressed by the requested relief – but also each "plaintiff must demonstrate standing separately for each form of relief sought." *Id.* at 1867 (internal quotation marks omitted). Courts have referred to these three elements of Article III standing as "injury in fact," "causation," and "redressability." *See, e.g., Center for Biological Diversity v. Lueckel*, 417 F.3d 532, 536 (6th Cir. 2005). None of the plaintiffs at bar pleads a claim that meets the jurisdictional requirements of causation and redressability, and plaintiff AIS fails even to plead the requisite concrete injury for Article III standing. Accordingly, the complaint should be dismissed because plaintiffs lack standing.

DaimlerChrysler was brought by taxpayers in Toledo, Ohio, to challenge tax waivers accorded the DaimlerChrysler Corporation, on the ground that "tax breaks for DaimlerChrysler diminished the funds available to the city and State, imposing a 'disproportionate burden' on plaintiffs." 126 S. Ct. at 1859. The Court held that the plaintiffs lacked standing because the injury the taxpayers alleged was not "concrete and particularized." *Id.* at 1862. The Court explained:

> A taxpayer-plaintiff has no right to insist that the government dispose of any increased revenue it might experience as a result of his suit by decreasing his tax liability or bolstering programs that benefit him. To the contrary, the decision of how to allocate any such savings is the very epitome of a policy judgment committed to the "broad and legitimate discretion" of lawmakers, which "the courts cannot presume either to control or to predict."

Id. at 1863 (citations omitted). Thirty years earlier, in the seminal case of *Eastern Kentucky Welfare Rights Organization v. Simon*, 426 U.S. 26 (1976), the Supreme Court similarly held that the plaintiffs lacked standing to challenge under the APA a revenue ruling that provided favorable tax treatment to a nonprofit hospital that offered only emergency-room services, and not the full range of medical services, to indigents. *Id.* at 28. Individual plaintiffs who were indigents described

incidents in which they had been denied needed medical services by the hospital in question. *Id.* at 32-33. The organizational plaintiffs alleged that their mission of promoting access to health services by the poor was thwarted by the challenged revenue ruling. *Id.* at 39-40. The Court held that the organizational plaintiffs failed to allege any injury to themselves separate from those pleaded by the individual members and thus failed to meet the "injury-in-fact" requirement of Article III standing. *Id.* at 40. With respect to the individual plaintiffs, the *Simon* Court held that they failed to carry their burden of showing that their injuries were traceable to the challenged revenue ruling or that the relief requested – reinstatement of a prior revenue ruling – would result in their receiving the hospital services previously denied. *Id.* at 44-45. Accordingly, the Court directed that the complaint be dismissed for lack of subject matter jurisdiction.

Warth v. Seldin, 422 U.S. 490 (1975), another seminal Supreme Court standing case, also is instructive. In *Warth* the Court held that the low-income plaintiffs did not have standing to seek invalidation of a zoning ordinance. They alleged that the ordinance would prevent them from obtaining affordable housing, but the Court held that the plaintiffs failed to establish the causation for their alleged injury – that it was directly traceable to the zoning ordinance they opposed. In oft-quoted language, the Court explained that the plaintiffs relied "on little more than the remote possibility, unsubstantiated by allegations of fact, that their situation might have been better had [defendants] acted otherwise, and might improve were the court to afford relief." 422 U.S. at 507. Here, too, plaintiffs can only speculate that if the IHS allocated more of its Indian Health Services lump-sum appropriation to urban health care they would obtain all of the tests and procedures they allege are necessary.

Under the rationale of *DaimlerChrysler*, *Simon*, and *Warth*, AIS and the individual plaintiffs all lack standing because they fail to allege that they have suffered any concrete injury fairly traceable to the complained-of actions, or that such injury is is redressable by the relief requested.[10] AIS generally alleges that it provides emergency support services to urban Indians in the Detroit area and that "[d]ue to the shortage of funds, the cost of this assistance limits the funds they [sic] can use to provide assistance to other needy individuals." Complt ¶ 13. It also alleges that "AIS attempts to satisfy the unmet medical needs of its constituents by directly paying for medical treatment when AIS funds are available" and that "AIS has many constituents who depend on it to provide food, transportation, housing, and help with . . . bills, but because it must provide medical treatment and medicine that defendants are not, AIS is not able to spend money to provide other emergency services." *Id.* ¶¶ 69-70.

Even if AIS could allege a sufficiently concrete injury traceable to anything the IHS has or has not done, it still could not meet the redressability prong of Article III standing. AIS's allegations are essentially no different from those of the taxpayer plaintiffs in *DaimlerChrysler*, who alleged that reversing the tax breaks to DaimlerChrysler would increase revenues, which could be allocated to programs that benefitted the taxpayer plaintiffs. The Supreme Court concluded that these allegations were far too speculative to support standing, and it is equally speculative that were more IHS funds allocated to urban Indian organizations like AIS, it would be able to devote more of its funds to "other emergency services" for its constituents.

[10] AIS also lacks standing because its organization, which provides a variety of social services to urban Indians, is not "arguably within the zone of interests to be protected" by either the Snyder Act or the IHCIA. *See, e.g.*, *Simon*, 426 U.S. at 39 n.19 (discussing this nonconstitutional, prudential standing requirement).

Like the taxpayers in *DaimlerChrysler* and the indigents in *Simon* and *Warth*, the individual plaintiffs also fail to establish that any of the relief they request would redress their alleged injuries. These plaintiffs generally contend that certain medical services were unavailable to them because the IHS allocated insufficient funds to Detroit's urban program. These plaintiffs do not allege – nor could they – that were the IHS to allocate more funds to urban programs, the Detroit urban Indian organization would provide annual coloscopies to Hammitte or diagnose and treat Stewart's liver ailment. As for Stone, who already has obtained hernia surgery, none of the relief sought in the complaint would satisfy his $5,000 medical debt. Furthermore, it is only a matter of speculation that were the IHS to allocate more of its appropriations to its contract with American Indian Health Services, this Detroit urban Indian organization would be able to, or even choose to, provide treatment that would alleviate Stone's post-surgical pain. Nor could a court direct this non-party to furnish particular health care services to any of the plaintiffs.

Furthermore, because, as discussed above in Part A, how to allocate its lump sum appropriations is committed to the IHS's discretion by law, much of the relief that plaintiffs request is patently not within a court's power to grant. In fact, some of the relief plaintiffs request is impossible to grant as a practical matter. For example, plaintiffs ask for relief "that does not reduce the care, or adversely affect the level of care, available to those living on reservations." Complt at 16, ¶ (j). Yet they also ask the court to order the IHS, among other things, to "establish and adequately staff a sufficient number of health care facilities necessary to meet the medical needs of the urban American Indian population." Complt at 16, ¶ (g). Because a court cannot direct Congress to increase an appropriation, if such relief were to be granted the money to establish and staff

additional urban health care facilities would result in a concomitant reduction in the funding of other IHS health care programs, including those for Indians living on reservations.[11]

Plaintiffs fail to establish, as Article III of the Constitution demands they do, that they have suffered any injury fairly traceable to conduct of the defendants which is likely to be redressed by the relief they request. Accordingly, plaintiffs lack standing and the complaint should be dismissed for lack of subject matter jurisdiction.

CONCLUSION

For all of the foregoing reasons, the complaint should be dismissed for failure to state a claim upon which relief may be granted, and for lack of subject matter jurisdiction.

Respectfully yours,

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[11] In addition, many IHS health care programs for Indians living on or near reservations are funded in whole or in part under ISDEAA contracts. The ISDEAA's prohibition against reducing contract funding in subsequent years constitutes a significant statutory obstacle to shifting funds to health care programs for urban Indians. *See* 25 U.S.C. §§ 450j-1(b), 458aaa-7(d)(1)(C).

CERTIFICATION OF SERVICE

I hereby certify that on June 12, 2006, I electronically filed the foregoing paper with the Clerk of the Court using the ECF system which will send notification of such filing to the following:

None

I further certify that I have mailed by U.S. mail the paper to the following non-ECF participants:

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