UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TONYA HAMMITTE, et al.

Plaintiffs,

-vs-

MICHAEL O. LEAVITT, in his official capacity as Secretary of the Department of Health and Human Services, et al.,

Defendants.
_____/

CIVIL NO. 2:06-cv-11655

HON. AVERN COHN
MAG. JUDGE SCHEER

DEFENDANTS' REPLY BRIEF IN SUPPORT OF THEIR MOTION TO DISMISS

The issue before this Court is not whether the health care services furnished by the Indian Health Service (IHS) to American Indians and Alaska Natives (AI/ANs) are adequate to meet all health care needs; unhappily, given Congressional funding levels, they are not. *See* 25 U.S.C. § 1601(c), (d) (Congressional findings in IHCIA that despite services that "have resulted in a reduction in the prevalence and incidence of preventable illnesses among...Indians," "the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States"). Rather, the issue is whether the allegations of fact in the complaint state a claim under any treaty or statute, or the Constitution, of the United States. Since they do not, the complaint must be dismissed. Moreover, plaintiffs' inability to establish that the judicial relief they request is likely to redress the injuries they allege deprives them of standing and this Court of subject matter jurisdiction.

I. PLAINTIFFS' BREACH OF TRUST CLAIM, STANDING ALONE, CANNOT SUPPORT THE RELIEF THEY SEEK.

Plaintiffs do not rely exclusively on any statute for their claim that urban Indians' health care needs are not being adequately funded by the IHS. (Response Brief, fn.6) Rather, the essence of their non-constitutional claim is based on what they call the government's trust obligation to provide urban Indian people "adequate and accessible health care." (Resp. Br. at 9) As direct support for this theory, plaintiffs cite two district court decisions, *White v. Califano*, 437 F. Supp. 543 (D.S.D.), *aff'd* per curiam, 581 F.2d 697 (8th Cir. 1978), and *McNabb v. Heckler*, 628 F. Supp. 544 (D. Mont.), *aff'd*, 829 F.2d 787 (9th Cir. 1987). However, neither of these cases stands for the proposition that a trust doctrine by itself imposes financial obligations on the federal government; both recognize that only Congressional action imposes such obligations. Where these cases do refer to a trust doctrine, and the appellate decision in *White* does not discuss the trust theory at all, it is simply one of several factors to consider when construing statutes that were designed to favor Indians.

White v. Califano involved a mentally ill Indian, living on a reservation, who was in need of involuntary commitment for immediate psychiatric treatment. She was not able to obtain such care, however, because the State of South Dakota and the federal government each argued that the other was primarily responsible for payment for such treatment. The appeals court decision focused on the fact that the state could not execute a commitment order because the individual resided on a reservation – sovereign land on which the state was unable to exercise its power. Because the state could not act, the court of appeals held that the federal government had to act, basing its conclusion on the fact that "federal policy as reflected by legislative and administrative action places responsibility for providing the necessary care upon the United

States." 581 F.2d at 698 (emphasis added). Although the appellate court cited the federal government's "unique relationship" with American Indians, it did not explore the implications of that relationship beyond the United States's obligation to act in that single case. Moreover, the appellate court was very careful not to adopt wholesale the district court's very broad view of this "unique relationship" but rather limited its adoption of the district court opinion to the "statement of facts and ...reasoning as applied to the conclusions quoted" in the appellate decision.[1] In fact, the word "trust" does not appear anywhere in the Eighth Circuit's opinion in *White*. Significantly, the portions of the district court opinion that plaintiffs rely upon for their breach of trust claim are those that were *not* adopted by the court of appeals.

The circumstances giving rise to *McNabb v. Bowen*, 829 F.2d 787 (9th Cir. 1987), were much the same as those in *White*, and the case is distinguishable for the same reasons. Again, neither the federal government nor state authorities were willing to pay for an Indian child's health care expenses resulting from his premature birth, each asserting that its responsibility was residual to the other's primary obligation. Finding in favor of the state, the court ruled that the relevant federal statutes, read in light of the federal government's trust responsibility to American Indians, imposed the financial responsibility in the first instance on the United States. As in *White*, the ruling in *McNabb* was a limited one, adjudicating the health care responsibilities of the United States in a discrete case.

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[1] The district court, but not the appellate court, in *White* also relied on 42 C.F.R. § 36.12(c) (1956) to hold that the IHS is bound to allocate its funds in accordance with its own regulations. 437 F. Supp. at 556. However, the cited regulation (currently codified as 42 C.F.R. § 136.12(c)), does not advance plaintiffs' case here, because it references only services available "at hospitals and clinics of the [Indian Health] Service, and at contract facilities...." and includes the caveat that the IHS "does not provide the same health services in each area served." 42 C.F.R. §§ 136.12(b), (c).

Plaintiffs' trust theory cannot hold sway in this case. First, although the United States has special responsibilities to the American Indian population, such obligations are creatures of statute. Citation to a trust responsibility does not talismanically create a specific financial obligation where one does not otherwise exist by virtue of statute, except in circumstances not present here, where the Federal government assumes control or supervision over tribal monies or property, *i.e.*, a tangible trust corpus. *See, e.g., United States v. Cherokee Nation of Oklahoma*, 480 U.S. 700, 707 (1987) (government's "fiduciary obligations" "do not create property rights where none would otherwise exist but rather presuppose that the United States has interfered with existing tribal property interest"); *cf. United States v. Mitchell*, 463 U.S. 206, 225 (1983) (with respect to government's responsibility to manage timber on Indian lands for the benefit of Indians, "fiduciary relationship necessarily arises when the Government assumes such elaborate control over forests and property belonging to Indians"); *Navajo Tribe of Indians v. United States*, 224 C. Cl. 171, 183, 624 F.2d 981, 987-88 (1980) ("In particular, where the Federal Government takes on or has control or supervision over tribal monies or properties, the fiduciary relationship normally exists with respect to such monies or properties (unless Congress has provided otherwise) even though nothing is said expressly in the authorizing or underlying statute (or other fundamental document) about a trust fund, or a trust or fiduciary connection."[2]); *see also Reuben Quick Bear v. Leupp*, 210 U.S. 50, 80 (1908) (distinguishing between appropriations for the benefit of Indians, which are gratuitous, and specific treaty obligations

[2] This language follows immediately after, and modifies, the statement from *Navajo Tribe* that plaintiffs quote in their response brief (at p. 10 n.14). That is, when the court said that the trust "relationship can be inferred" and no express provision of a treaty, statute, or agreement is necessary, it was speaking "[i]n particular" about circumstances in which the government assumes control over tribal property or funds. 624 F.2d at 987-88.

under which funds have been set aside for the benefit of Indians). Nothing in the language of any of these cases supports an enforceable trust obligation in the arena of health care services.

Second, neither of plaintiffs' health care services cases involved relief as open-ended and wide-ranging as that which is sought in this case. Whereas *White* and *McNabb* involved responsibility for payment for the care of a single individual, in this case plaintiffs ask the court to order the government to pay for the medical bills of an unknown number of individuals, for an unknown universe of medical conditions, for an unknown period of time. Asking the court to do so where Congress has not so directed is to ask the court to perform a legislative rather than an adjudicative function. While plaintiffs couch their case in terms of the government's trust obligations to the Indian people, this is not a zero-sum game. Congress appropriates a finite amount of money for Indian health care every year. A court order directing the government to spend more of that money on urban Indians' health care would by necessity be an order directing the government to spend less of that money on the health care of Indians living on or near reservations. While such a result may be what the plaintiffs in this case desire, it hardly would inure to the benefit of the American Indian population as a whole.

II. PLAINTIFFS' CONSTITUTIONAL CLAIM MUST BE DISMISSED BECAUSE THE IHS'S ALLOCATION OF ITS LUMP SUM APPROPRIATION IS CONSISTENT WITH CONGRESSIONAL INTENT AND HAS A RATIONAL BASIS.

For their claim that the IHS has violated their right to equal protection under the Fifth Amendment, plaintiffs play a numbers game. Essentially, they contend that it is *per se* irrational to allocate one percent of IHS's appropriated funds to urban Indian programs when approximately 66 percent of American Indians reside in urban areas. (Resp. Br. at 5-6)

However, plaintiffs' math ignores the very real distinctions between urban and rural areas and between Title V of the IHCIA, which authorizes urban Indian programs, and the other titles of the IHCIA that authorize (and mandate) the provision of health care services to Indians on or near reservations. Plaintiffs' argument by the numbers also ignores a key fact pled in their complaint (¶ 37): in many cases all or part of an urban area in which Indians reside also is within the service delivery area of an IHS health care facility situated on or near a reservation.

Certainly, there are no suspect classifications in this case, and it is even questionable whether plaintiffs can demonstrate that there is a sufficient difference between urban and rural Indian populations for the purpose of showing unequal treatment. Thus, the threshold question arises whether urban Indians and Indians living on or near a reservation even constitute separate classes for the purpose of equal protection analysis. In a case involving a Wisconsin jury selection procedure that operated to exclude all reservation, but not urban, Indians, the United States Court of Appeals for the Seventh Circuit found that such a classification likely could *not* be made. *United States v. Raskiewicz,* 169 F.3d 459, 465 (7th Cir. 1999) ("patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservation and urban Indians are two well-defined independent groups"). Moreover, as long as there is a rational basis for distinguishing between urban and rural populations, courts have found that legislation treating such populations differently for the purpose of allocating government benefits does not raise constitutional concerns. *See, e.g., Good Samaritan Medical Ctr. v. Heckler,* 605 F. Supp. 19, 24-26 605 24 (N.D. Ohio 1984), *aff'd on other grounds,* 775 F. 2d 594 (6th Cir. 1985) (rejecting equal protection challenge to Medicare statute distinguishing between rural and urban hospitals for purposes of calculating reimbursement); *see also Rhode Island*

Chapter, Associated General Contractors of America, Inc. v. Kreps, 450 F. Supp. 338, 349 (D.R.I. 1978) ("Nor is there any doubt that Congress may . . . choose to concentrate on urban poverty or rural poverty or that it may attack certain sources of poverty without challenging others.")

The IHS does not dispute that the agency historically has allocated approximately one percent of its lump sum appropriation to urban Indian programs. However, given the statutory scheme that governs IHS operations, this allocation is eminently rational. First, it would be incorrect to conclude that urban Indians receive no benefit from the remaining 99 percent of IHS's appropriation. On the contrary, out of the approximately 1.3 million Indians living in urban areas, 427,000 are active users of IHS-operated clinics and IHS-funded tribal clinics located on or near reservations. See IHS Urban Program Overview, available at http://www.ihs.gov/NonMedicalPrograms/Urban/Overview.asp (last modified Nov. 26, 2004). In other words, these 427,000 urban Indians live in the service delivery area of an IHS or tribal clinic and have access to the full range of direct and contract health services that are provided through that facility – meaning that *fully one-third* of urban Indians receive the same level of services as Indians who live on or near reservations.[3] These services are funded by the 99 percent of the IHS budget that is not dedicated to urban Indian programs. Plaintiffs' myopic focus on the allocation of IHS funding between urban Indian programs and other IHS programs fails to recognize this fact.

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[3] Pursuant to the agency's eligibility policies, regardless of where they reside, the remaining two-thirds of urban Indians also are entitled to receive all direct services offered by any IHS-operated clinic if they present themselves at such a facility. See IHS Urban Program Overview, available at http://www.ihs.gov/NonMedicalPrograms/Urban/Overview.asp (last modified Nov. 26, 2004).

Plaintiffs' simplistic focus on population numbers also ignores very real differences between conditions in urban areas and those around Indian reservations. These differences support the need for a higher level of IHS funding to furnish health services on or near reservations. Indian reservations are often in isolated, sparsely populated rural areas, and this is especially so in Michigan, where almost half of the federally recognized tribes served by the IHS in the State are located on or near the upper peninsula. *See* http://www.usdoj.gov/usao/miw/indnat.html (last modified Mar. 6, 2006) (map showing location of federally recognized tribes in Michigan). Consequently, while IHS facilities and IHS-funded tribal clinics may be the *only* source of health care on or near many isolated reservations, urban areas necessarily have a variety of health care providers available to serve the population, including urban Indians. Among those are providers offering care that is paid for or subsidized by other federal resources, such as Medicare and Medicaid, and funding for health centers provided by the Health Resources Services Administration (HRSA) which, like the IHS, is also an agency within HHS, as well as charitable care that is offered by many hospitals and clinics. In its Fiscal Year 2007 Budget Justification, the IHS noted that HRSA-funded health centers "currently operate in all of the 34 cities served by the Urban Indian Health Program and in hundreds of other cities where Indian people live." IHS FY 2007 Budget Justification, at 50, found by accessing links at http://www.ihs.gov/AdminMngrResources/Budget/FY_2007_Budget_Justification.asp.

Moreover, while urban governments fund infrastructure to support their populations, this is not the case in many isolated areas where reservations are located. Thus, in addition to authorizing the provision of health services on or near reservations, Congress requires the IHS to

fund public health activities there that in urban centers are part of the urban infrastructure, such as construction, operation and maintenance of sanitation facilities in areas that otherwise would have no water or sewer systems. *See* 25 U.S.C. §1632. When Congress reauthorized and amended the IHCIA in 1988, the Senate Report accompanying the bill stated that the IHS's responsibilities for serving Indians on or near reservations was greater for this very reason:

> Currently, the mission of the IHS, in carrying out the policy established by Congress in the Indian Health Care Improvement Act, is to raise the health status of American Indians and Alaska Natives to the highest possible level. IHS defines its service delivery responsibilities to include a comprehensive range of inpatient and ambulatory medical services, dental care, mental health and alcoholism services, preventive health (immunizations and environmental services such as sanitation and water safety), health education, and Indian health manpower development programs. A broader definition of IHS responsibilities is applied in isolated rural areas on or near Indian reservations, because the infrastructure of roads, utilities, and public services that support health care delivery to non-Indian rural residents is often lacking on Indian reservations.

S. Rep. No. 100-508 (1988), *reprinted in* 1988 U.S.C.C.A.N. 6183, 6185 (emphasis added). The IHS regulation at 42 C.F.R. § 136.11(c), discussing allocation of health care services among the areas served by the IHS, reflects this Congressional policy:

> *Determination of what services are available.* The [IHS] does not provide the same health services in each area served. The services provided to any particular Indian community will depend upon the facilities and services available from sources other than the [IHS] and the financial and personnel resources made available to the [IHS].

42 C.F.R. § 136.11(c) (italics original; emphasis added).[4]

[4] In their response brief, plaintiffs mistakenly cite 42 C.F.R. § 136a.11(d). The IHS's Part 136a regulations are not in effect; Congress suspended them in 1987. *See* note 7, *infra*, and accompanying text. While many of the provisions in suspended Part 136a are similar or identical to those in Part 136, it happens that § 136a.11(d) has no analogue among current IHS regulations.

In its rational allocation of its lump-sum budget, the IHS has taken its cue directly from Congress. Congress never intended for urban Indian programs to be comparable to the much more extensive (and expensive) programs offered on or near reservations. Under Title V of the IHCIA, funds may be awarded to urban Indian organizations for such purposes as providing health care and referral services; estimating current health status and needs of urban Indians; identifying alternative resources available to urban Indians in the urban center; and assisting urban Indians in accessing such resources. 25 U.S.C. § 1653(a). In contrast, Title II of the IHCIA authorizes funds for, *inter alia*, clinical care (including eye and vision care), dental care, preventive health, emergency medical services, community health representatives, and home health care, 25 U.S.C. § 1621(a); for mental health prevention and treatment services, 25 U.S.C. § 1621h; for emergency and nonemergency air transportation of patients, 25 U.S.C. § 1621*l*; for health education programs in schools located on Indian reservations, 25 U.S.C. § 1621n; and for design, construction and renovation of IHS and tribally operated facilities located on or near reservations. 25 U.S.C. § 1631. There is no comparable authority in Title V for this range of health care services, and certainly not for constructing health care facilities for urban Indians.

Title V of the IHCIA does not include appropriations authority for constructing, staffing, and maintaining full-service hospitals and clinics in urban areas on a par with the more expansive authority cited above. Instead, when it adopted Title V of the IHCIA, Congress authorized a much more modest program intended to provide little more than seed money in the form of grants and contracts to be made available to urban Indian organizations. In addition to supporting studies regarding the unmet health care needs of urban Indians and reporting on these needs to Congress, one of the primary goals of this seed money, as reflected in the plain text of 25 U.S.C. § 1653, is to assist these non-profit urban Indian organizations in seeking out *other*

(i.e., non-IHS funded) "public and private health services resources . . . which are or may be available to urban Indians." 25 U.S.C. § 1653(a)(4). Title V specifies that urban Indian organizations are to directly provide, or enter into contracts to provide, health care services only "where necessary," 25 U.S.C. § 1653(a)(12), and Congress expressly directed the IHS to take into consideration whether the funding of an urban Indian organization "would duplicate any previous or current public or private health services project." 25 U.S.C. § 1653(b)(4).

Thus, when Congress adopted Title V of the IHCIA in 1976, it recognized that while urban Indians were in need of improved health care services, funding limitations required that urban Indian programs authorized by the IHCIA be only *supplemental* to other health programs already serving urban Indian populations. Congress also made clear that the unmet health needs of Indians living on or near reservations would continue to make services to these Indians the priority. The House Report accompanying Title V states:

> Limitations on funds and jurisdiction have precluded direct care to urban Indians. Federal policy has placed the urban Indian beyond the jurisdiction of the Indian Health Service. Furthermore, the critical backlog of unmet health needs on Indian reservations requires the full attention of all financial and human resources available to the IHS. Accordingly, during the last seven years Congress has expressed on at least four occasions a desire to provide some form of separate health care assistance to urban Indians which would not compete with assistance already available to the reservation Indians.

H.R. Rep. No. 94-1026, Part I, at 114 (1976), *reprinted in* 1976 U.S.C.C.A.N. 2652, 2752 (emphasis added). In other words, in enacting Title V of the IHCIA, Congress refused to do precisely what plaintiffs ask this Court to do, *i.e.*, require the IHS to provide greater funding for urban Indian programs in a manner that necessarily would come at the expense of IHS programs for Indians on or near reservations.[5]

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[5] Plaintiffs' prayer for relief asks for this Court to order IHS to increase funding for urban Indians "in a manner that does not reduce the care, or adversely affect the level of care,

Since Congress enacted Title V, it has seldom intervened to dictate the manner in which the IHS should allocate its appropriations with regard to urban Indian programs. In those few instances where it has done so, or proposed to do so, it has advocated funding levels for urban programs in line with the approximately one percent of the general appropriation for Indian health historically allocated to urban programs by the agency, and challenged by plaintiffs in this action. For example, in deliberations over the bill that would authorize the IHS's appropriations for fiscal year 2007, the Senate Appropriations Committee has proposed to earmark $32,744,000 for urban programs out of a total IHS appropriation of $2,835,544,000 (representing less than 1.2 percent of the agency's appropriation). See S. Rep. No. 109-275, at 104 (2006).[6] Were this proposed earmark adopted, this Court could not grant the relief sought by plaintiffs without contradicting an express instruction from Congress regarding the amount of IHS funds that should be provided to urban Indian programs. By proposing the urban program earmark for fiscal year 2007, and by including similar earmarks in other legislation enacted and proposed in the past, Congress has shown that it is perfectly capable of acting to keep IHS appropriations and policies in line with Congressional priorities for Indian health care. *See, e.g.*, 25 U.S.C. § 1660b Note (fiscal year 2005 appropriations provision protected funding for service units in Tulsa and

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available to those living on reservations." (Complt p. 16) However, this would be impossible unless the Court ordered Congress to increase the overall appropriation for the agency, something this Court is not empowered to do. *See, e.g., Office of Personnel Management v. Richmond*, 496 U.S. 414, 431 (1990) ("respondent asks us to create by judicial innovation an authority over funds that is assigned by the Constitution to Congress alone, and that Congress has not seen fit to delegate").

[6] The Senate's proposal, which would provide the same level of funding for urban programs that was provided in fiscal year 2006, came in response to the Administration's budget request that did not include any fiscal year 2007 funding for urban programs. *Id.; see also* IHS FY 2007 Budget Justification, at 49, found by accessing links at http://www.ihs.gov/AdminMngrResources/Budget/FY_2007_Budget_Justification.asp.

Oklahoma City and prohibited tribes from taking over the service units from IHS pursuant to the Indian Self-Determination Act); Department of Interior, Environment, and Related Agencies Appropriations Act of 2006, Pub. L. No. 109-54, Title III (IHS appropriations restriction, reinstated annually, suspends the implementation of the regulations published at 42 U.S.C. Part 136a that the agency proposed on September 16, 1987[7]). There is no need for this Court to intervene to enforce Congressional intent regarding services for urban Indians when the agency currently is carrying out that intent and when Congress itself has shown the will and ability to redirect the agency when it does not.

A rational basis supports the manner in which the IHS allocates funding between programs on or near reservations and those for urban Indians. No more than this is required by the case that plaintiffs characterize as "the most applicable precedent" (Resp. Br. at 5). *Rincon Band of Mission Indians v. Harris*, 618 F.2d 569 (9th Cir. 1980), *affirming on other grounds*, 464 F. Supp. 934 (N.D. Cal. 1979). *Rincon* was a challenge to the IHS's having funded programs in California only minimally, following approximately two decades when California Indians were excluded from IHS programs altogether. The court of appeals held that under the Snyder Act the IHS has a duty to distribute funds rationally. 618 F.2d at 573.[8] In a footnote, the court expressly disavowed the notion that rational distribution of funds requires allocation of "a per capita proportionate share." *Id.* n.4. Given the rationality of the IHS's allocation of funding to the

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[7] In their response brief plaintiffs cite these suspended regulations as authority for their claim under the APA. (Resp. Br. at 15-16) *See* note 4, *supra*. Comparison of those suspended regulations in 42 C.F.R. Part 136a upon which plaintiffs place reliance with the currently effective regulations in 42 C.F.R. Part 136 reveals that plaintiffs find the most support for their lawsuit in the very amendments to IHS regulations that Congress squelched.

[8] Plaintiffs rely primarily on the district court decision in *Rincon*, which reached the same conclusion on constitutional, rather than statutory, grounds. (Resp. Br. At 5-7)

urban programs authorized by Title V of the IHCIA, *Rincon* does not advance plaintiffs' case here.[9] This Court should dismiss plaintiffs' statutory and constitutional claims.[10]

III. PLAINTIFFS FAIL TO STATE A CLAIM COGNIZABLE UNDER THE APA.

Plaintiffs contend that this case is distinguishable from *Lincoln v. Vigil*, 508 U.S. 182 (1983), because the plaintiffs in that case were challenging a decision to end a "tiny program," whereas plaintiffs here are seeking to represent a large group of urban Indians claiming a "denial of essential and potentially life-saving services." (Resp. Br. at 12-14 (emphasis added)) This contention must fail because, regardless of the breadth of the relief sought, there is no disguising that what plaintiffs are asking this Court to do is to step in where Congress has not and direct the IHS to spend its lump sum appropriation in a manner that would contradict the agency's rational reasons for prioritizing funding for health care for Indians to areas on or near reservations. It is well settled that determining how best to allocate government benefits is a role for the legislature and not for the courts. *See, e.g., Schweiker v. Wilson*, 450 U.S. 221, 238 (1981). This is especially true where, as here, there are no suspect classifications that would implicate equal protection concerns. *See, e.g., Good Samaritan Medical Ctr. v. Heckler*, 605 F. Supp. at 24. *Lincoln v. Vigil*, 508 U.S. 182 (1993), discussed at length in defendants' opening brief (at pp. 8-

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[9] *Rincon* is also factually distinguishable in that there plaintiffs complained of distribution of funds among the states for the *same* programs for AI/ANs whereas plaintiffs here complain of distribution of funds between wholly different programs arising under different titles of the IHCIA.

[10] Plaintiffs assert that the court should defer decision on their constitutional claim until "after discovery." (Resp. Br. at 7). No discovery prior to a ruling on the pending motion to dismiss is required or warranted. *See Good Samaritan Medical Center*, 605 F. Supp. at 25 (holding that a motion to dismiss a constitutional attack upon economic or social legislation can properly be granted where the advanced basis supporting an alleged distinction "is at least debatable") (*citing United States v. Carolene Products Co.*, 304 U.S. 144, 154 (1938)). Notably, plaintiffs fail to explain what facts they expect to develop through discovery.

11), is controlling precedent for the proposition that the IHS's allocation of its lump sum appropriation for Indian health services is committed to agency discretion by law and not subject to judicial review under the APA.

Although they attempt (unsuccessfully) to distinguish *Lincoln v. Vigil*, plaintiffs concede that when there "is no meaningful standard against which to judge the agency's exercise of discretion," there is no APA review. (Resp. Br. at 12, citing *Heckler v. Chaney*, 470 U.S. 821, 838 (1985)) This concession is fatal to their claim. The court can scour plaintiffs' complaint and brief without finding discussion of, or even allusion to, a single meaningful standard by which to judge the IHS's allocation of its resources among the programs authorized by Congress. Plaintiffs claim they have brought this action because the IHS has violated "its legal obligation to provide health care to plaintiffs." (Resp. Br. at 1) However, they proffer no definition of this legal obligation, and certainly not with reference to any statute or regulation. Plaintiffs assert in both their complaint and their brief that the IHS has "an absolute legal duty" to furnish "the adequate and accessible health care to which they are entitled."[11] (Resp. Br. at 9 (quoting Complt ¶ 72)) However, this statement circles back on itself: it may be axiomatic that government has "an absolute legal duty" to provide an "entitlement," but plaintiffs here have cited no authority to support the existence of any "entitlement." Plaintiffs can point to no statutory requirement that the IHS fund, within metropolitan Detroit, all resources necessary to meet their stated health care needs.

Whether plaintiffs are "entitled" to health care beyond what they allege is available and accessible to them is a legal, and not a factual, question, and in the absence of an entitlement,

[11] For purposes of this motion, defendants defer the question of what does and does not constitute "adequate" health care or "accessible" health care.

how to allocate its resources for furnishing health care services among eligible AI/AN populations is committed to agency discretion by law. Under the heading "DEFENDANTS' LEGAL OBLIGATION TO PROVIDE HEALTH CARE" plaintiffs quote subparagraph (a) of the introductory section of the IHCIA, 25 U.S.C. § 1601, which articulates the Congressional findings underlying this legislation. (Resp. Br. at 9) In their quotation, plaintiffs emphasize the language that says that "Federal health services to maintain and improve the health of the Indians are...required....." (*id.*) There is, of course, a vast difference between a requirement for health services to maintain and improve health, generally, and the *entitlement* that plaintiffs claim to health care services in urban centers sufficient to meet all their needs.

Congress imposed no such duty on the IHS. To the contrary, in the very same IHCIA statement of findings, in a subparagraph plaintiffs chose not to quote in their response brief, Congress declared that although "[f]ederal health services to Indians have resulted in a reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians," 25 U.S.C. § 1601(c), Indian health needs remain unmet. 25 U.S.C. § 1601(d). In the very next section of the IHCIA, headed, "Declaration of health objectives," Congress stated the general objective "to assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy," 25 U.S.C. § 1602(a) (subparagraph quoted in full in Resp. Br. at 10). However, Congress followed this general statement with specific "health status objectives" which are modest, indeed, and call for reducing, but not eliminating, the health care disparities between AI/ANs and the general population. 25 U.S.C. § 1602(b). Not surprisingly, the Supreme Court has cautioned against judicial reliance on statements of legislative findings and objectives:

> [N]o legislation pursues its purposes at all costs. Deciding what competing values will or will not be sacrificed to the achievement

> of a particular objective is the very essence of legislative choice – and it frustrates rather than effectuates legislative intent simplistically to assume that *whatever* furthers the statute's primary objective must be the law.

Rodriguez v. United States, 480 U.S. 522, 525-26 (1987) (per curiam) (italics original); *see also Westside Mothers v. Olszewski*, 454 F.3d 532, 543 (6th Cir. 2006) (broad, nonspecific statutory language "ill-suited to judicial remedies" and call for "policy decisions for which a court has little expertise and even less authority").

Thus, plaintiffs' citation to some select statutory provisions in the IHCIA, under the subheading, "Congress Has Spoken," begs the question. (Resp. Br. at 15) The issue raised by their complaint is not whether the IHS is legally obliged to fund programs for urban Indians under Title V of the IHCIA, because this, plaintiffs concede, the IHS has done.[12] Rather, the issue before the court is whether the IHS has a legal duty to fund these programs differently – *i.e.*, to reallocate health care dollars from other IHS programs for the benefit of Indians residing in urban centers. The Supreme Court's opinion in *Lincoln v. Vigil* holds that neither "the special trust relationship existing between Indian people and the Federal Government," the Snyder Act, nor the IHCIA, circumscribes agency discretion to allocate funds from the lump-sum appropriations for Indian health care among the programs authorized by statute. 508 U.S. at 192-95.[13] Plaintiffs fail to state a claim under the APA.

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[12] The "governing federal regulations" they tender to the court in this section of their argument as "control[ling] priorities" are those that Congress has forbidden the IHS to implement. *See* notes 4 and 7, *supra*.

[13] The cases that plaintiffs cite for the proposition that the federal government's obligation to them is "plenty concrete" do not arise under the APA. They all involve allegations of unconstitutional government action. (Resp. Br. at 17) Here, as shown in section II above, there is no cognizable constitutional claim alleged.

IV. PLAINTIFFS LACK STANDING BECAUSE THEY FAIL TO PLEAD FACTS SHOWING THAT THE INJURIES THEY COMPLAIN OF WERE CAUSED BY DEFENDANTS, OR WOULD BE REDRESSED BY THE RELIEF REQUESTED.

Plaintiffs respond to defendants' showing that they lack standing to maintain this action by making conclusory statements about a causal relationship between the injuries they allege and the policies they complain of. But it is not enough for plaintiffs simply to allege that they were denied medical services "due to" the IHS's actions or inactions; rather, they must allege *facts* consistent with this conclusion. Here, as discussed in support of defendants' motion to dismiss, the facts alleged do not bear out the conclusory allegations, particularly since there is no allegation that plaintiffs would fare any better if they resided on or near a reservation. In fact, plaintiff Stone alleges just the opposite: he alleges that he returned to his reservation and still was not able to obtain the hernia operation he needed. Plaintiffs are thus wrong when they claim that their case is no different from *Heckler v. Matthews,* 465 U.S. 728 (1984), a case that by their own description involved an applicant for individual benefits under the Social Security Act. Here, in contrast, plaintiffs have neither applied for, nor been denied, any benefits available to similarly situated American Indians living on or near reservations.

Finally, plaintiffs' response brief ignores wholly the third requirement for Article III standing, redressability . They fail even to *attempt* to explain how the relief they seek – essentially, allocation of a greater share of the IHS budget to urban Indian programs authorized by Title V of the IHCIA – would resolve the health care problems described by the individual plaintiffs, much less arrest the drain on the resources of the corporate plaintiff that it attributes to

assisting urban Indians in meeting their health care needs.[14] This failure alone warrants dismissal of the complaint for lack of subject matter jurisdiction.

CONCLUSION

For the reasons set forth above, as well as those set forth in defendants' opening brief, this case should be dismissed.

Respectfully yours,

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[14] This is another basis for distinguishing *Heckler v. Matthews*, where the remedy plaintiff sought for the alleged denial of benefits because of gender was a declaration that the statute that allegedly favored women over similarly situated men was unconstitutional. The Court acknowledged that although it could not direct Congress to treat men differently, it could nullify the statute. 465 U.S. at 738-39. Here, plaintiffs do not challenge the constitutionality of any statute.

CERTIFICATION OF SERVICE

I hereby certify that on September 8, 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:

David A. Santacroce

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

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