UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TONYA HAMMITTE, DAVID STONE, JOSEPH STEWART, and AMERICAN INDIAN SERVICES, INC., on behalf of themselves and all others similarly situated,

Plaintiffs,

vs.

MICHAEL O. LEAVITT, in his official capacity as Secretary of the Department of Health and Human Services, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, CHARLES W. GRIM, in his official capacity as director of Indian Health Service, and INDIAN HEALTH SERVICE,

Defendants.
_____/

File No. 2:06cv11655
Hon. Avern Cohn
Mag. Judge Donald A. Scheer

PLAINTIFFS' BRIEF IN OPPOSITION
TO DEFENDANTS' MOTION TO DISMISS

MICHIGAN CLINICAL LAW PROGRAM
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INTRODUCTION

This is a lawsuit against the federal government – through its designated agencies – for violating its legal obligation to provide health care to plaintiffs. Defendants do not contest this obligation, but rather seek to avoid it by dismissal on grounds that are contrary to the great weight of authority. Their motion should be denied.

STATEMENT OF FACTS

A. THE TRUST OBLIGATION AND DEFENDANTS' FAILURE TO MEET IT

Prior to European arrival, there were 7 - 10.5 million Native Americans (NAs) in what is now the United States.[1] By 1900, just over 237,000 survived.[2] "Old World" disease was the overwhelming cause of this decline.[3] During roughly the same period, by force and treaty, the federal government acquired 400 million acres of NA land. (Compl. at ¶3)

Based on this history and numerous treaties, the federal government assumed the obligation of ensuring NA survival and welfare, which includes healthcare. This healthcare obligation was recognized by Congress in the Snyder Act of 1921 (25 U.S.C. §13 *et seq.* (1921)), and codified in the Indian Health Care Improvement Act of 1976 ("IHCIA"), 25 U.S.C. §1601 *et seq.* Courts recognize the obligation as actionable. (*See Argument,* §B*, infra.*) And because, as a group, AI's are overwhelmingly poor and uninsured, many rely exclusively on the obligation (and thus the federal government) for their health care needs. (Compl. at ¶ 28)

The federal government has failed them. In delivering what it called an "indictment" of the federal NA health care, the bi-partisan U.S. Commission on Civil Rights (the "Commission")

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[1] Russell Thorton, *American Indian Holocaust and Survival: A Population History Since 1492*, xvii, 242 (University of Oklahoma Press, 1987). This is a *conservative* estimate. *Id.*

[2] Ward Churchill, *A Little Matter of Genocide,* 129 (City Lights Press 1997).

[3] Thorton, *supra* note 1, at xvii, 36.

found that in addition to "disturbingly high mortality rates," NAs suffer "disproportionate rates of disease . . . ." U.S. Commission on Civil Rights, *Broken Promises: Evaluating the Native American Health Care System*, iii, 21 (2004), http://www.usccr.gov/pubs/nahealth/nabroken.pdf. For example, as compared to whites and other minority groups, NAs are more likely to die from: (i) tuberculosis by 650%; (ii) diabetes by 420%; and (iii) pneumonia and influenza by 71%. (Compl. at ¶26) Infection rates are higher: strep by 1000%, meningitis by 2000%, and dysentery by 10,000%.[4] Hepatitis is at epidemic proportions and carries an 800% greater chance of death.[5] The rate of cardiovascular disease is twice that of all other Americans and the cancer survival rate is the lowest of any racial group in the United States. *Broken Promises,* at 15, 17. In short, as the bi-partisan Commission found, there is a "dire health care situation facing Native Americans." *Id.* at iii.

B. URBAN NATIVE AMERICANS

As a result of modern federal programs encouraging NAs to move off reservations, two-thirds of all NAs now live in urban areas. (Compl. at ¶4) This population continues to grow by about 2% per year. (*Id.*) And because they live apart from the reservation community, they are more likely to suffer ill health. COHEN'S HANDBOOK OF FEDERAL INDIAN LAW, §22.04(2)(e) (2005).

Despite these facts, over the last 25 years funding for *urban* NA health care has continued to fall. (Compl. at ¶25) Today it represents only 1% of defendants' overall NA healthcare expenditures. (*Id.* at ¶25) *See also, Broken Promises* at 106. Thus it comes as no

[4] Rennard Strickland, *Tonto's Revenge: Reflections on American Indian Culture and Policy,* 53 (University of New Mexico Press 1997).

[5] *Id.*

surprise that health disparities between NAs and all other Americans are *greater for urban NAs*. *Broken Promises* at 69. As the Commission found, "the underfunding of urban Indian programs is a crisis." *Id* at 70.

Plaintiffs are victims of this crisis. For the last 12 years plaintiff Tonya Hammitte's pap smears have been abnormal, a prime indicator of pre-cancerous cervical cells that requires testing every six months. (Compl. at ¶¶43, 44) Defendants' Detroit health care contractor American Indian Health Services ("AIHS") recommended this testing, but could not perform or pay for it. (*Id.* at ¶45) Poor, uninsured, and Medicaid ineligible, in 12 years Ms. Hammitte has been able to afford the test only twice. (*Id.* at ¶47) Each was positive for the pre-cancerous cells. (*Id.*) She lives in fear of what might be growing inside her.

Plaintiff Joseph Stewart has a serious liver ailment. (*Id.* at ¶63) He suffers from severe abdominal pain, dehydration and bloating. (*Id.*) AIHS doctors have urged him to consult a specialist, but do not have the resources to pay for it. (*Id.* at ¶64) Poor, uninsured, and Medicaid ineligible, he cannot afford to. (*Id.*) He too lives in fear.

Plaintiff David Stone suffered a hernia in 2002. (*Id.* at ¶49) AIHS advised him that he could die without surgery. (*Id.* at ¶53) Ineligible for immediate care on his tribe's reservation 1100 miles away, he found a local doctor to operate on credit for $5,000, which Mr. Stone still owes and cannot pay. (*Id.* at ¶57) He has continued to suffer severe abdominal pain since the surgery. *(Id.* at ¶58) AIHS doctors advised him the pain is likely the result of a botched surgery, but did not have the resources to help. (*Id.*) Without health coverage or money for treatment, he continues to suffer.

C. PLAINTIFFS' CLAIMS

Plaintiffs make two distinct, *independent* claims. First, that because two thirds of NAs live in urban areas, defendants' allocation of just 1% of their health care budget to urban areas violates plaintiffs' right to equal protection under the Fifth Amendment to the U.S. Constitution. Second, that defendants' failure to provide adequate health care to plaintiffs and similarly situated Detroit metro area NAs violates defendants' health care trust obligation.[6]

ARGUMENT

A. PLAINTIFFS STATE A VALID EQUAL PROTECTION CLAIM

Defendants argue that their allocation of 1% of their health care dollars to 66% of their constituency is "reasonable" and "rationale." Whether this is so is for the Court to decide after discovery. Defendants self-serving conclusions *of fact* are not grounds to dismiss

. *1. PLAINTIFFS' COMPLAINT IS WELL PLED*

Defendants argue that "nothing" in plaintiffs' complaint "supports their claim that Indians living on or near the reservations receive healthcare superior to that available to them." (Def's Br. 12) This is not true. Plaintiffs are not required to "set down in detail all the particularities" of the claim. *Westlake v. Lucas,* 537 F.2d 857, 858 (6th Cir. 1976). All they need do is provide "fair notice" of their claim "and the grounds upon which it rests." *Conley v. Gibson,* 355 U.S. 41, 47 (1957).

Plaintiffs have done this and more by alleging, *inter alia,* that: (i) 66% of NAs live in urban areas (Compl. at ¶4); (ii) 99% of defendants' health care appropriations go to those living on or near the reservations (*Id.* at ¶25); (iii) the health care needs of urban NAs are as great or

[6] There is no claim, as defendants suggest, that, *standing alone*, the Snyder Act and IHCIA require urban NA health care funding. (Def's Br. 11).

greater than those living on or near reservations and are urgent (*Id.* at ¶35); (iv) health care is provided to only 24% of urban NAs, and 46% of urban NAs live outside areas that defendants service (*Id.* at ¶37); (v) there is only 1 IHS clinic serving about 39,000 NAs in the Detroit metro area (*Id.* at ¶¶ 20(a), 39); (vi) plaintiffs are Medicaid ineligible urban NAs, they rely on IHS for medical care, and they have been denied essential testing and treatment for their medical needs (*Id.* at ¶¶41 - 66); and that (vii) defendants are violating plaintiffs' rights by failing to provide them with "health care equal to that provided to [NAs] living on or near reservation lands." (*Id.* at ¶76)

Plaintiffs have pled this claim well.[7] There is "fair notice" of the claim and its grounds. Defendants substantive argument to dismiss it belies any suggestion to the contrary. And turning next to that argument, it clear that relief could be granted under facts "consistent with the allegations." *Hishon v. King & Spalding,* 467 U.S. 69, 73 (1984).

2. *DEFENDANTS DO NOT GET TO DECIDE THE ISSUE OF WHETHER THEIR ALLOCATION OF FUNDS TO URBAN NAs IS REASONABLE*

Defendants want this claim dismissed because their allocation of 1% of their health care dollars to 66% of their constituency is *"reasonable"* and "*rational."* The issue of whether the allocation (and the way it is made) is reasonable is for the Court, not defendants, to decide.

Defendants fail to cite the most applicable precedent. In *Rincon Band of Mission Indians v. Califano*, the court held that IHS's system of allocating health care funds violated the California NA plaintiffs' due process rights because IHS, "without a rational basis, denied the vast majority of California Indians health services" as compared to the services received by NAs

[7] Even if there were, as defendants allege, errors in draftsmanship, the complaint must be "construed to do substantial justice." Fed R. Civ. P. 8(e)(1), 8(f). *See also, Ritchie v. United Mine Workers of Am.*, 410 F.2d 827, 832 (6th Cir. 1969).

elsewhere in country. 464 F. Supp. 934,939 (N.D. Ca. 1979), *aff'd on other grounds, Rincon v. Harris,* 618 F.2d 569 (9th Cir. 1980).

At the time of *Rincon*, IHS was distributing health care resources pursuant to internal resource allocation criteria. *Id.* at 937. Even though 10% of IHS's national service population resided in California, application of the criteria resulted in vast inequities between Californian and other NAs, including: (i) less than .60% of IHS health care professionals were assigned to California; and (ii) only .35% of IHS funds designated for health care facilities were earmarked for California in the coming seven years. *Id.* at 936.

For guidance, the *Rincon* court turned to *Morton v. Ruiz*, 415 U.S. 199 (1974). In *Morton,* the plaintiffs, who lived just off the reservation, challenged the Bureau of Indian Affairs' ("BIA")[8] denial of their request for general assistance benefits. *Id.* at 202. The denial was based on a BIA policy limiting benefits to NAs living on the reservation. *Id.* at 204. Because the limitation was not consistent with Congressional intent, the Supreme Court struck it down. *Id.* at 211. In *dictum,* the *Morton* Court noted that the BIA secretary, like any agency head, did have the power to

> create *reasonable classifications and eligibility requirements* in order to allocate the limited funds available to him for this purpose. Thus, if there were only enough funds appropriated to provide meaningfully for 10,000 needy Indian beneficiaries and the entire class of eligible beneficiaries numbered 20,000, it would be incumbent upon the BIA to develop an eligibility standard to deal with this problem, and the standard, *if rational and proper*, might leave some of the class otherwise encompassed by the appropriation without benefits. But in such a case the agency must, at a minimum, let the standard be generally known so as to assure that it is being applied consistently and so as to *avoid both the reality* and the appearance of arbitrary denial of benefits to potential beneficiaries. *Id.* at 230-31 (emphasis added) (citations omitted).

[8] *Morton* preceded passage of the IHCIA, thus the decision focuses on the BIA's distribution of funds appropriated under the Snyder Act, 25 U.S.C. §13 (1921). Funds distributed by defendants are now appropriated to them under authority of the Snyder Act and the IHCIA. *Rincon v. Harris,* 618 F.2d 569, 570 (9th Cir. 1980).

For the *Rincon* court, the critical import of this passage is that IHS's allocation criteria must provide for a "rational allocation." *Rincon,* 464 F.Supp. at 938. *See also, Dandrige v. Williams,* 397 U.S. 471, 485 (1970) (classification needs *reasonable* basis to pass Constitutional muster). The *Rincon* court also held that IHS had a duty under the Snyder Act to "distribute rationally and equitably all of the available program funds." *Rincon,* 464 F.Supp at 937. [9] Against this standard, the court found that IHS, "without rational basis, denied the vast majority of California Indians health services comparable to those available to Indians in other parts of the country," which violated the plaintiffs Fifth Amendment right to equal protection.[10]

Plaintiffs here claim that defendants' distribution of just 1% of its health care resources to 66% of their constituency is not rational or reasonable.[11] Defendants want to make this determination themselves. But as the holding in *Rincon* (and cases discussed below) make clear, the determination is for the Court to make after discovery. Plaintiffs have stated a cognizable claim and are entitled to gather evidence to prove it.

Defendants cite no authority to the contrary. In fact, the authorities they cite *support* the proposition that defendants must act reasonably. In *Dandridge v. Williams,* the Supreme Court

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[9] The 9th Circuit affirmed the grant of summary judgment on reasoning identical to the district court's, but did not reach the Fifth Amendment question because it found that the Snyder Act also required a rational distribution. *Rincon v. Harris,* 618 F.2d 569 (9th Cir. 1980). To the extent the Court is at all inclined to dismiss plaintiffs' Fifth Amendment claim, plaintiffs ask that they be allowed to amend to assert the Snyder Act claim endorsed by the 9th Circuit.

[10] *Rincon,* 464 F.Supp. at 939. Because the court held that the distribution was not rational, it passed on determining the appropriate level of scrutiny (strict or rational basis) to apply in its equal protection analysis. *Id.* at n. 5.

[11] Plaintiffs understand that a reasonable allocation may result in less than 66% of defendants' funds going to urban NAs. The claim is not one for perfect parity in funding. It is for a reasonable allocation based on reasonable criteria that account for the significant unmet health care needs of urban NAs. Indeed, when demand for health care services exceeds supply, defendants are to consider the "relative medical" needs of NAs. 42 C.F.R. §§136, 136a.

held that, if a classification for distribution of federal benefits was "reasonable," it did not violate the plaintiff's equal protection rights. 397 U.S. 471, 501-02 (1970). And the determination of reasonableness comes after discovery, not, as defendants seek here, on a motion to dismiss. *Williams v. Dandridge*, 297 F. Supp. 450, 452 (D. Md. 1968).

Morton v. Mancari is a reverse discrimination case where the Supreme Court considered whether, in government hiring, NAs could be preferred over *non-NAs* without violating non-NAs right to equal protection. 417 U.S. 535, 552-53 (1974). In upholding the preference, the Court simply noted in *dictum* that most NA legislation "single[d] out for special treatment" NAs living on and near reservations, and to hold that this violated *non-NAs* equal protection rights would erase most NA legislation. *Id.* at 553. And while the *Mancari* Court did hold that the classification was "reasonably and rationally designed," the holding was made on a *summary judgment motion after discovery.* 417 U.S. at 540 & 555. Defendants' use of this passage to suggest that they can, without a reasonable basis, discriminate against *urban* NAs is disingenuous at best.

In *Rice v. Cayetano*, the Court considered a challenge by a non-native Hawaiian to race-based voting classification that excluded him from voting for trustees of an agency that administered special programs for native Hawaiians. 528 U.S. 495, 498-99 (2000).
In striking down the restriction, the Court distinguished *Mancari* in rejecting the argument that native Hawaiians were similarly situated to NAs. *Id.* at 518-520. Like *Mancari, Rice* has nothing to do with the question of urban NA discrimination presented here.

In short, defendants claim that their allocation is reasonable. The authorities cited by plaintiffs – and several cited by defendants – make clear that this is a question of fact for the Court after the close of discovery. Plaintiffs' equal protection claim should stand.

B. PLAINTIFFS' BREACH OF TRUST CLAIM IS JUSTICIABLE

Plaintiffs' next claim does not, as defendants suggest, concern the allocation of funds among their NA health programs. Rather, and without reference to reservation based NAs, the claim is simply that defendants have breached their trust obligation by failing to provide plaintiffs and similarly situated metro Detroit AI's "the adequate and accessible health care to which they are entitled." (Compl. ¶ 72) Defendants argue that this claim meddles in agency discretion and is thus excepted from judicial review under § 701(a)(2) of the Administrative Procedure Act ("APA"), 5 USC § 701(a)(2). It does not and is not. Defendants do not have discretion to violate their trust obligation. It is an absolute legal duty, the violation of which is reviewable by this Court.

1. DEFENDANTS' LEGAL OBLIGATION TO PROVIDE HEALTH CARE

Defendants cite snippets of policy statements from a budget request, legislative history and tangential statutory minutiae to portray their health care assistance to NAs as an act of goodwill and anything *but* obligatory. (Def's Br. 2 - 6) In fact, defendants have a *legal* obligation – pre-existing any statutory enactment, but reaffirmed and strengthened by several – to provide plaintiffs health care. Section 1601(a) of the Indian Health Care Improvement Act provides:

> The Congress finds that – (a) Federal health services to maintain and improve the health of the Indians are consonant with **and required by** the Federal Government's historical unique legal relationship with, and resulting responsibility to, the American Indian people. 25 U.S.C. §1601(a)(emphasis added).

Section 1602(a) provides:

> The Congress hereby declares that it is the policy of this Nation, in fulfillment of its special responsibilities **and legal obligation** to the American Indian people, to assure the highest possible health status for Indians and **urban Indians** and to provide all resources necessary to effect that policy. *Id.* at §1602(a) (emphasis added).

Defendant IHS Director Grimm admits this obligation,[12] which plainly appears on defendant IHS's website [13] Indeed, the Commission noted this "legal obligation" as a simple matter of fact. *Broken Promises* at 21 - 22.

Courts also hold that this obligation is a *legal* one.[14] In *White v. Califano,* 437 F. Supp. 543 (D.S.D.), *aff'd* 581 F.2d. 697 (8th Cir. 1978), the court held IHS responsible for health care costs despite the absence of a specific statutory duty to the plaintiff.[15] The NA plaintiff in *White* argued that IHS had the primary responsibility to provide for her involuntary commitment. *Id.* at 553. As it does here, IHS defended on the grounds that: 1) its funds were limited and that its

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[12] Statement by Dr. Charles W. Grim, Director, Indian Health Service, Department of Health and Human Services, on S.1057 - Indian Health Care Improvement Act Amendments of 2005 before Committee on Indian Affairs Health, Education, Labor and Pensions Committee U.S. Senate, July 14, 2005, found at http://www.hhs.gov/asl/testify/t050714c.html.

[13] http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/ThisFacts.asp

[14] The existence of a legally actionable Federal trust obligation to NAs is well established in other areas. It "can be inferred from the provisions of a statute, treaty or other agreement, 'reinforced by the undisputed existence of a general trust relationship between the United States and the Indian people." *Blue Legs v. U.S. Bureau of Indian Affairs,* 867 F.2d 1094, 1100 (8th Cir. 1989) (trust obligations to remediate waste dumps on NA reservation). In *Navajo Tribe of Indians v. U.S.*, the court rejected the government's argument that there can be no trust obligation absent an express provision of a treaty, statute, or agreement: "[If] by this the Government means that the document has to say in specific terms that a trust or fiduciary relationship exists or is created, we cannot agree. The existence *vel non* of the relationship can be inferred from the nature of the transaction or activity." 224 Ct. Cl. 171, 183 (Ct. Cl. 1980) *See also, U.S. v. Mitchell,* 463 U.S. 206, 225 (1983); *Manchester Band of Pomo Indians, Inc. v. U.S.,* 363 F. Supp. 1238, 1245-46 (N.D. Cal. 1973).

[15] In affirming, the 8th Circuit expressly adopted the district court's rationale. 581 F.2d. 697, 698 (8th Cir. 1978).

decision not to treat the plaintiff was committed to agency discretion not subject to judicial review; and 2) that a duty to treat could not be "guessed at" by reference to a trust responsibility, but must be found in specific statute. *Id.*

The court rejected these arguments, holding that there was a clear legal obligation to provide NAs health care based on the federal government's historical assumption of it by deed and legislation, including, but not limited to, the IHCIA. *Id.* at 554-55. The court also rejected the argument that the trust obligation was too abstract, finding it was in fact a "congressionally recognized duty to provide services for a particular category of human needs." *Id.* at 557. *See also, Bullchild v. Schweiker,* No. C75-606V (W.D. Wash., Sept. 24, 1981)(copy attached) (off-reservation medical care a substantive entitlement derived from the Snyder Act, 25 U.S.C. § 12, and related regulations).

In *McNabb v. Heckler,* 628 F. Supp. 544 (D. Mont.), *aff'd* 829 F.2d. 787 (9th Cir. 1987), NA plaintiffs sued IHS and others for payment of their child's medical bills. The court held that, read together, the trust doctrine, the Synder Act and the IHCIA require IHS to *"assure reasonable health care for eligible members*." *Id.* at 549 (emphasis added). In affirming, the 8th Circuit was "struck by Congress' recognition of federal responsibility for Indian Health Care." 829 F.2d. at 792. And the district court held that the trust obligation to provide care was binding irrespective of whether or not Congress had allocated sufficient funds. 628 F. Supp. at 545.

2. PLAINTIFFS' TRUST CLAIM IS NOT BARRED BY THE APA

Relying on *Lincoln v. Vigil*, 508 U.S. 182 (1993), defendants read the APA's narrow exception to judicial review as an absolute bar to the trust claim. Their reading has the exception swallow the rule. It conflates non-reviewable exercises of discretion with reviewable violations

of legal obligations. It immunizes federal agencies from injunctive claims for legal wrongs which involve spending no matter how grievous the conduct or gross the violation. This reading of *Lincoln* should be rejected.

(a). The APA: The APA provides that a "person . . . adversely affected or aggrieved by agency action . . . is entitled to judicial review." 5 USC § 702. There is a "strong presumption that Congress intends judicial review of administrative action." *Bowen v. Michigan Academy of Physicians,* 476 U.S. 667, 670 (1986). Review is inappropriate only when a statute expressly excludes it or the "agency action is committed to agency discretion by law."[16] This second exception – upon which defendants here rely – is a "very narrow" one. *Citizens to Preserve Overton Park v. Volpe,* 401 U.S. 402, 410 (1971). It applies only when there is no "meaningful standard against which to judge the agency's exercise of discretion." *Heckler v. Chaney,* 470 U.S. 821, 838 (1985).

(b). *Lincoln v. Vigil*: The *Lincoln* plaintiffs challenged an IHS decision to end a tiny program in Albuquerque that provided specialized clinical services to disabled children. 508 U.S. at 187. In an effort to *re-focus the program nationally*, IHS closed the local program and reassigned its 16 employees as disabled children consultants to other national programs. *Id.* at 188. The *Lincoln* defendants argued that*, inter alia,* the choice to re-focus nationally was an

[16] 5 USC §701 (a)1 & (2). This exception has been traditionally limited to areas of traditional deference: national security issues and "review of refusal to pursue enforcement actions." *Franklin v. Massachusetts,* 505 U.S. 788, 818 (1992)(concurring opinion) Federal programs designed to serve NAs are not areas of traditional deference. *See, e.g., Morton v. Ruiz,* 415 U.S. 199 (1974); *McNabb v. Heckler,* 829 F.2d. 787 (9th Cir. 1987)*; Vigil v. Andrus,* 667 F.2d 931 (10th Cir. 1982); *Rincon Band of Mission Indians v. Harris,* 618 F.2d 569 (9th Cir. 1980); *White v. Califano,* 581 F.2d 697 (8th Cir. 1978); *Fox v. Morton,* 505 F.2d 254 (9th Cir. 1974).

administrative decision committed by law to agency discretion and thus was not reviewable under section of § 701(a)(2) of the APA.

The Court held that the "allocation of funds from a lump-sum appropriation is another *administrative decision* traditionally regarded as committed to agency discretion." *Lincoln* at 192 (emphasis added). For the Court, the lack of Congressional restrictions on the appropriation meant Congress recognized the agency's need for flexibility so it could "make necessary adjustments for 'unforseen developments' and 'changing requirements.'" *Id.* at 193*, quoting LTV Aerospace Corp.* 55 Comp. Gen. 307 (U.S. *Comp*. Gen. 1975). And, for the Court, the agency was better equipped to make those spending decisions in meeting its statutory mandate. *Id.*

The claim at bar for breach of trust obligation is different. Plaintiffs' claim is *not* that a specific local program should be started or maintained, or that defendants should change their allocations among programs.[17] It is *not* a claim by a *tiny* sub-class of NAs to *specialized, non-essential* services, the delivery of which rightly falls within defendants' discretion. In *Lincoln* there was *no* finding that basic, essential, potentially life-saving services were not being provided.

Here, plaintiff urban NAs, who comprise two-thirds of the total NA population in this country, claim that the denial of essential and potentially life-saving services violates the trust

[17] Plaintiffs Fifth Amendment claim does seek a shift in the balance of spending between programs. Because it is based on the Constitution, review is not barred by the APA. *Lincoln* at 195, *citing Webster v. Doe,* 486 U.S. 592, 603-04 (1988). This is why the *Lincoln* Court remanded the plaintiffs' Fifth Amendment claim. *Lincoln,* 508 U.S. at 195.

obligation.[18] And it is the denial of such essential services that constituted trust violations in *Califano, McNabb* and *Bullchild.*

This is also *not* about defendants' expertise or flexibility "to adapt to changing circumstances to meet [their] statutory responsibilities in what it sees as the most effective or desirable way." *Lincoln v. Vigil*, 508 U.S. at 192. It is *not* a claim about discretion at all.[19] Defendants do not have the discretion to so grossly breach their trust obligation.[20] Plaintiffs allege that breach. They should be allowed to gather evidence and prove it.

Clearly any breach committed by defendants – and any cure for it – at bottom involves resource allocation and spending, which plaintiffs acknowledge in their complaint. (Compl. at ¶72) Many injunctive claims that seek to compel an agency to meet its legal obligations will require spending. But to say that, because of this fact, it meddles in agency discretion and is thus unreviewable, stretches a very narrow exception to reviewability under the APA (and the holding

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[18] Plaintiffs do not, as defendants suggest, seek "full federal funding of all their health care needs." (Def's Br. 10). Each named plaintiff has a potentially life-threatening medical condition, which defendants' physicians have said requires further treatment. (Compl. at ¶¶ 40 - 66)

[19] In addition to seeking a declaration of breach of trust obligation and an injunction to cure the same (Compl. p. 16, ¶¶ (c) & (d)), plaintiffs do seek specific injunctive relief that, essentially, proposes the cure. At times, defendants seem to conflate these more specific items of *relief* with plaintiffs' trust *claim*. The Court has broad equitable power to shape relief within the scope of its authority, *Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 15 (1971), including ordering defendants to propose their own remedy. *Linton v. Comm'r of Health and Env't*, 65 F.3d 508 (6th Cir. 1995). All that need be established is a right and its violation. *Swann* at 15. None of this affects the viability of plaintiffs' *claim*.

[20] And even if there was some element of discretion involved, this does not immunize defendants under the APA. An agency's broad discretion under a statute does *not* make agency action "completely nonreviewable under the 'committed to agency discretion by law' exception unless the statutory scheme, taken together with other relevant materials, provides absolutely no guidance as to how that discretion is to be exercised." *Robbins v. Reagan,* 780 F.2d 37, 45 (D.C. Cir. 1985)(footnote omitted) Statutory goals and "background understandings that inform the substantive statute . . . may often supply sufficient law to apply." *Id.* at 45, n. 13.

in *Lincoln*) beyond recognition. The *Lincoln* court rightly decided not to meddle in a shift of non-essential services from a local to a national program. But that doesn't make the converse true. **Under defendants reading of *Lincoln*, they could give all of their health care budget to 1% of NAs, provide no health care for the other 99%, and escape review because their actions were an "administrative decision" committed to their discretion.** The APA's presumption of reviewability vanishes and the exception swallows the rule. Defendants do not have "discretion" to violate their trust obligation.

(c). Congress Has Spoken: The *Lincoln* Court found it significant that there was no express Congressional appropriation for the program and no statute or regulation mentioned it. *Id.* at 187 and 190. Congress has, however, had a lot to say about urban NAs and the conditions suffered by plaintiffs in the IHCIA.

In the IHCIA, Congress reaffirmed that the government's health care obligation to *urban* NAs is a "legal" one. 25 U.S.C. §§1602(a). Congress specifically defined "Urban Indians," "Urban Indian organizations," and "Urban center." *Id.* at §§1603(f)(g)&(h). There is an entire sub-chapter devoted to establishing "programs in urban centers to make health services more accessible to urban" NAs. *Id.* at §§ 1651 - 1660(c). Its focuses in detail on delivering health services to urban NAs by, *inter alia:* (i) creating within IHS the "Branch of Urban Health Programs" to carry out the sub-chapter's provisions and provide "central oversight" of urban programs (§1660(a)); (ii) providing grants and contracts for urban health-care facilities (§1652); and (iii) setting forth a host of criteria aimed at meeting the "unmet health care needs" of urban NAs (§1653). And there are numerous governing federal regulations. 42 C.F.R. §§136 & 136a. *et seq.* Among other things, they control priorities for care and treatment (§136a.11(d)); service

availability (§136a.11); service entitlement (§136a.12); and payment for contract services (§136a.13).

All of this, and the statutory mandate of the IHCIA, makes plain defendants' legal obligation to plaintiffs. If the health care Ms. Hammitte, Mr. Stewart, and Mr. Stone seek isn't necessary, little or nothing is. And as the courts said in *Califano* and *Mcnabb*, defendants cannot simply abandon them. *Califano,* 437 F. Supp at 555; *McNabb,* 628 F. Supp. at 549.

(d). There Are Standards: *Lincoln* was decided on the basis of administrative discretion and departmental expertise. Defendants do not argue that there are no standards to guide the Court in determining whether a breach has occurred. Still, in the APA context, it is important to note that there is ample guidance for the Court to determine whether a breach has occurred.

First, the above-cited statutory recitations of defendants' trust obligation to plaintiffs and the detailed statutory scheme for delivering health care to urban NAs, provides guidance to determine whether defendants are satisfying their trust obligation. This is so on a plain reading of the statutory language. It is even more so when one considers that "statutes are to be construed liberally in favor of the Indians, with ambiguous provisions interpreted to their benefit . . . ." *Mont. v. Blackfeet Tribe of Indians*, 471 U.S. 759, 766 (1985). *See also Alaska Pac. Fisheries v. U.S.*, 248 U.S. 78, 89 (1918); *McNabb v. Heckler,* 829 F.2d. at 792 (9th Cir. 1987).

Second, the trust obligation is clear here – indeed, defendants do not dispute it. And where the legal obligation is clear, there is a standard. In *Oneida Tribe of Indians v. U.S.,* the Court of Claims heard a trust claim against the United States for its failure to conserve timber on

a reservation. 165 Ct. Cl. 487 (Ct.Cl.), *cert. den.* 379 U.S. 946 (1964). Having determined that the trust obligation existed, the court found that it was

> unimportant . . . to characterize th[e] obligation precisely. * * * The measure of accountability depends, whatever the label, upon the whole complex of factors and elements which should be taken into consideration. The real question is: Did the Federal Government do whatever it was required to do, in the circumstances, to save the timber. *That is the standard*. *Id.* at 494 (footnotes omitted).

Similarly, the real question here is, given their medical needs, can it be said that the federal government is meeting its obligation to Ms. Hammitte, Mr. Stone, Mr. Stewart, and other similarly situated NAs?

And this is plenty concrete. Throughout our history courts have set standards for determining the satisfaction of legal obligations on fainter grounds than those at bar. *See, e.g., Sweatt v. Painter,* 339 U.S. 629, 633-34 (1950) (faculty size, course selection, specialization opportunities, and law review and similar opportunities were *standards* by which to test whether African Americans were receiving the equal education); *Brown v. Bd. of Educ.,* 347 U.S. 483, 493 (1954) (*Sweatt* standards and other "intangible" considerations used to determine whether educational opportunities were equal); *Estelle v. Gamble*, 429 U.S. 97, 102 -06 (1976) ("deliberate indifference to serious medical needs" to decide whether prison authorities were violating their obligation not to inflict "cruel and unusual punishment"). *See also, Moore v. East Cleveland*, 431 U.S. 494 (1977) (personal choice in marriage and family a due process liberty)*; U.S. v. Guest,* 383 U.S. 745 (1966) (right to interstate travel); *Chaplinsky v. New Hampshire*, 315 U.S. 568 (1942) ('fighting words' First Amendment standard'); *Meyer v. Nebraska*, 262 U.S. 390 (1923) (right to education).

Here the considerations are not nearly so intangible. As pointed out in the preceding sub-section, Congress has spoken loudly about urban NA health. In doing so they provided clear criteria for determining the state of urban NA health and health care (including unmet needs) in any given urban population.[21] There is a long list of objectives that relates to specific medical conditions Congress found important, including some that relate directly to the serious medical needs of the named plaintiffs. 25 USC §1602(b). All of this, taken together, puts the Court on firm ground to decide whether defendants are violating their obligation to meet plaintiffs' essential health care needs. Indeed, the courts in *Califano, McNabb,* and *Bullchild* explicitly relied on much less in finding a breach of the health care trust obligation.

C. PLAINTIFFS HAVE STANDING

Plaintiffs allege direct injury due to defendants' unlawful denial of benefits. Plaintiffs seek an injunction requiring, *inter alia*, the delivery of these benefits. This is a classic case of an intended beneficiary making a claim for benefits where standing is not an issue. Defendants' arguments to the contrary are without merit.

1. *PLAINTIFFS HAMMITTE, STONE AND STEWART HAVE STANDING*

To establish standing, plaintiffs Hammitte, Stewart and Stone must show a threatened or actual injury traceable to the alleged unlawful conduct that "is likely to be redressed by a favorable decision." *Heckler v. Matthews,* 465 U.S. 728, 738 (1984) (citations omitted). 'Injury'

[21] 25 U.S.C. § §1653(a) and (b). The criteria include: "(1) estimate the population of urban Indians residing in the urban center in which such organization is situated who are or could be recipients of health care or referral services; (2) estimate the current health status of urban Indians residing in such urban center; (3) estimate the current health care needs of urban Indians residing in such urban center; (4) identify all public and private health services resources within such urban center which are or may be available to urban Indians; [and] (5) determine the use of public and private health services resources by the urban Indians residing in such urban center." *Id.* at §1653(a). In §1653(b), unmet health care needs in urban areas is also a factor to be determined.

simply means that the person be "adversely affected" or "aggrieved." *U.S. v. Students Challenging Regulatory Agency Procedures*, 412 U.S. 669, 690 n.14 (1973). The injury is sufficient "even if it is shared by a large class of litigants." *Warth v. Seldin*, 422 U.S. 490, 501 (1975). And on a motion to dismiss, general allegations of injury caused by defendants' conduct presumptively "embrace those specific facts that are necessary to support the claim." *Nat'l Org. for Women v. Scheidler*, 510 U.S. 249, 256 (1994), *quoting Lujan v. Defenders of Wildlife*, 504 U.S. 555, 561, (1992).

Defendants argue that both 'injury causation' and 'redress' are too speculative to establish standing. (Def's Br. 16 - 19) They assert that plaintiffs do not establish a connection between defendants conduct and the denial of services, and that there is no guarantee that any increase in funding in Detroit would result in plaintiffs getting the care they seek. To support this argument, defendants ignore critical elements of plaintiffs' claims.

Plaintiffs allege concrete direct injury at defendants' hands. Each alleges they were denied essential medical treatment due to "defendants failure to provide adequate health services to" Detroit metro urban NAs. (Compl. ¶¶ 6, 10 - 12, 44, 45, 54, 58, 59, 63 - 65) Each also alleges that these denials were the "direct result of defendants' inappropriate and arbitrary actions." (*Id*. at ¶5) Each seeks, *inter alia,* a declaration that defendants' conduct violates the law and that defendants be permanently enjoined from "failing or refusing to make immediately available [to them] . . . the much needed health care services to which they are entitled under federal law."[22] (*Id.* at p. 16, ¶¶ (c) & (d)) These allegations of direct injury, causation, and

[22] Citing *Daimler-Chrysler v. Cuno*, _ U.S. _, 126 S.Ct. 1854 (2006), defendants assert that plaintiffs must have standing for each "form of relief sought" and claim that standing is lacking because the Court does not have jurisdiction to grant some of the requested equitable relief because it treads on agency discretion. (Def's Brief at pp. 16 & 19) Defendants conveniently leave the internal citations from *Daimler* out. *Daimler* cites *Friends of the Earth v.*

redressability are more than sufficient to defeat a motion to dismiss. *Nat'l Org. for Women v. Scheidler*, 510 U.S. at 256.

Simply put, plaintiffs are intended beneficiaries making a claim for benefits. This is the type of direct claim the Supreme Court has "long recognized as judicially cognizable." *Heckler,* 465 U.S. at 738. In *Heckler*, the plaintiff claimed that a gender classification denying him benefits violated his Fifth Amendment right to equal protection. *Id.* at 735. The Court held that there was a clear and "direct causal relationship between the government's alleged deprivation of appellee's right to equal protection and the personal injury appellee has suffered – denial of Social Security benefits solely on the basis of his gender." *Id.* at 740. *See also, Pediatric Speciality Care, Inc. v. Ark. Dep't of Human Servs*., 293 F.3d 472 (8th Cir. 2002) (right of intended beneficiaries to sue state for mandated health care services).[23] The case at bar is no different than *Heckler.* Plaintiffs have standing.

Nothing defendants cite or argue changes this conclusion. They rely on three cases denying standing because the injuries and/or redressability were too vague or speculative. None involved direct claims by intended beneficiaries. None are applicable here.

Laidlaw, 528 U.S. 167, 185 (2000). In *Laidlaw*, the "forms" of the claim plaintiff had to establish standing for were injunctive and monetary damages. *Id*. Plaintiffs here establish standing for equitable relief. There is no support for the claim that just because *some* elements of proposed relief might be beyond a court's power, there is no standing. As pointed out in footnote 19, *supra*, the Court has broad equitable power to shape relief within the scope of its authority. All that need be established is a right and its violation. *Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 15 (1971). None of this affects the viability of plaintiffs' *claims* or their standing to bring them.

[23] In fact, to establish standing in an equal protection context, a plaintiff does *not* have to allege that she would receive benefits absent the barrier. The "injury in fact . . . is the denial of equal treatment resulting from the imposition of the barrier, not the ultimate inability to obtain the benefit." *Northeastern Fla Chapter of Associated Gen. Contractors of Am. v. City of Jacksonville*, 508 U.S. 656, 666 (1993).

In *Daimler-Chrysler v. Cuno*, __ U.S. __, 126 S.Ct. 1854 (2006), taxpayers challenged a business tax waiver claiming their injury was their share of a *potential* increased tax burden. *Id.* at 1862. The Court denied standing finding that the injury (if it existed at all) was "indefinite," in "common with people generally," and speculative because the legislature might not increase taxes as a result of the waiver. *Id.* at 1862-63. In *Simon v. Eastern Kentucky Welfare Rights Org.*, the claim was that the IRS's favorable treatment of nonprofit hospitals that denied plaintiffs certain services "encouraged" the hospitals to continue to deny these services. 426 U.S. 26, 28, 33 (1976). Plaintiffs lacked standing because "it was purely speculative whether the denials of service" were the result of the defendants' 'encouragement' or resulted "from decisions made by the hospitals without regard to tax implications." *Id.* at 42-43. This uncertainty also meant that there was no likelihood that the relief sought (striking the ruling) would cure the claimed harm. *Id.* at 45-46. And in *Warth v. Seldin*, 422 U.S. 490 (1975), indigent plaintiffs claimed that a zoning ordinance had the "purpose and effect" of excluding low and moderate income residents. *Id.* at 495. They lacked standing because they could not show that, absent the ordinance, there was a "substantial probability" that they would have been able to afford housing. *Id.* at 504-06.

None of this has any bearing on the direct challenge at bar to the unlawful denial of benefits specifically designated for NAs like plaintiffs. Plaintiffs' claim is not a generalized *Daimler* claim of a "right possessed by every citizen, to require that the Government be administered according to law . . . ." *Baker v. Carr*, 369 U.S. 186, 208 (1962), *quoting Fairchild v. Hughes*, 258 U.S. 126, 129 (1922). There is no *Simon* or *Warth* type speculation required to connect plaintiffs' injuries to defendants' conduct. And there is no *Simon* doubt that the injuries plaintiffs claim are redressable by the relief sought: plaintiffs demand health care as relief. This

is the same type of direct, intended beneficiary claim made in *Heckler,* where the Court *expressly distinguished* the holding in *Simon. Heckler,* 465 U.S. at 740 n.9. The individual plaintiffs have standing.

2. PLAINTIFF AMERICAN INDIAN SERVICES HAS STANDING

Where one or more plaintiffs have standing, there is no need to determine whether others do because justicability is assured. *See, e.g., Bd. of Educ. v. Earls*, 536 U.S. 822, 827 n.1 (2002); *Doc v. U.S. House of Representatives*, 525 U.S. 316, 330 (1999). This is particularly so where the other party's "presence or absence makes no material difference" to the consideration of the merits or the court's authority to award relief. *Duke Power Co. v. Carolina Envtl. Study Group*, 438 U.S. 59, 72 n.16 (1978). Because the individual plaintiffs have standing, it is unnecessary to decide American Indian Services' ("AIS") standing. *Cf. Mills v. Rogers*, 457 U.S. 291, 305 (1982) (policy of avoiding unnecessary decisions supported by prohibition against advisory opinions.)

On the merits, it is important to note that AIS is not, as defendants imply, a membership organization seeking 'associational' standing to advocate its members' interests. (Def's Brief at 17). Rather, AIS seeks standing *in its own right* as a non-profit that provides social and emergency support services to NAs living in the Detroit metro area. (Compl. at ¶ 17) Mostly poor and uninsured, AIS's clients rely on defendants for health care. (*Id.* at ¶ 68) The unique harm AIS alleges is that defendants' unlawful conduct forces it to divert funds to health care and away from other social and emergency needs. (*Id.* at ¶¶ 69, 70)

This is sufficient injury for standing. In *Havens Realty Corp. v. Coleman*, 455 U.S. 363 (1982), a non-profit organization providing housing counseling and referral services claimed it

was injured by defendant realtors' unlawful racial steering. The injury was the frustration of the non-profit's services and the consequential drain on its resources. *Id.* at 369. The Court held this injury was sufficient and particular enough to give the non-profit standing in its own right. *Id.* at 379.

AIS' injury here is similarly real, concrete and direct. And it is redressible by requiring defendants to fulfill their obligations to plaintiffs. For the purposes of a motion to dismiss, AIS has pled sufficient facts to establish standing.

CONCLUSION

For the foregoing reasons, plaintiffs ask that defendants' motion to dismiss be dismissed with prejudice.

Dated: August 10, 2006

Respectfully submitted,

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

TONYA HAMMITTE, DAVID STONE, JOSEPH STEWART, and AMERICAN INDIAN SERVICES, INC., on behalf of themselves and all others similarly situated,

Plaintiffs,

vs.

MICHAEL O. LEAVITT, in his official capacity as Secretary of the Department of Health and Human Services, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, CHARLES W. GRIM, in his official capacity as director of Indian Health Service, and INDIAN HEALTH SERVICE,

Defendants.
_____/

File No. 2:06cv11655
Hon. Avern Cohn
Mag. Judge Donald A. Scheer

CERTIFICATE OF SERVICE

I hereby certify that on August 10, 2006, I electronically filed *Plaintiffs' Brief in Opposition to Defendants' Motion to Dismiss*, with the Clerk of the Court using the ECF system which will send notification of the filing to the following: Peter A. Caplan (P30643) @ peter.caplan@usdoj.gov, counsel for all defendants.

August 10, 2006

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