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To the U.S. Senate Committee on Indian Affairs

Hearing on the Indian Health Care Improvement Act

March 8, 2007

INTRODUCTION

Good morning, Chairman Dorgan, Vice Chairman Thomas, and distinguished members of the Committee. Thank you for inviting me to testify about the constitutionality of the proposed amendments to the Indian Health Care Improvement Act (the IHCIA; as amended, "the Act").[1] In particular, I have been asked to address: (1) whether Congress has the constitutional authority to amend the Act to provide benefits and services to "Indians"[2] and "Urban Indians"[3]

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[1] Unless otherwise specified, section citations in this testimony refer to the amendments proposed in S. 1057, 109th Congress (2005).

[2] Section 4(12) of the Act defines "Indians" as:

> The term 'Indian', unless otherwise designated, means any person who is a member of an Indian Tribe or is eligible for health services under section 806, except that, for the purpose of sections 102 and 103, the term also means any individual who—
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> (A)(i) irrespective of whether the individual lives on or near a reservation, is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside; or
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> (ii) is a descendant, in the first or second degree, of any such member;
>
> (B) is an Eskimo or Aleut or other Alaska Native;
>
> (C) is considered by the Secretary of the Interior to be an Indian for any purpose; or
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> (D) is determined to be an Indian under regulations promulgated by the Secretary.

[3] Section 4(28) of the Act defines "Urban Indians" as:

as those terms are expected to be defined, and (2) whether the Act's support for traditional health care practices offends the First Amendment's ban on establishments of religion.

Last year, the Department of Justice (the "Department") issued a "White Paper" suggesting that the Act's definitions of Indian and Urban Indian would transform the legislation into a constitutionally disfavored racial preference and thus trigger potentially fatal "strict" judicial scrutiny. With respect, I have concluded that the Department's concerns, though not entirely without foundation, do not reflect the best reading of the Constitution given the wide latitude Congress has always enjoyed when legislating on behalf of Indian peoples. Moreover, even if the Department is right that courts may subject the Act to strict scrutiny, Congress need not hesitate to pass the proposed legislation because it is narrowly tailored to the compelling governmental interest – recognized by Congress since the early days of the Republic – to provide for the health of the indigenous peoples that this nation dispossessed as it expanded across the continent. I have further concluded that the Department's Establishment Clause concerns, which the White Paper does not explain, are largely unfounded.

I. THE ACT DOES NOT CREATE AN UNCONSTITUTIONAL RACIAL PREFERENCE

A. The Proposed Legislation Creates A Political, Not A Racial, Classification

The starting point for analyzing the constitutionality of the proposed amendments must be the Indian Commerce Clause, which explicitly authorizes Congress "to regulate Commerce with . . . the Indian Tribes."[4] As recognized in an unbroken wall of Supreme Court precedent

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> The term 'Urban Indian' means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:
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> (A) Irrespective of whether the individual lives on or near a reservation, the individual is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member.
>
> (B) The individual is an Eskimo, Aleut, or other Alaska Native.
>
> (C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose.
>
> (D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

[4] U.S. Const. Art. I, § 8, cl. 3.

stretching back more than 175 years, through this textual commitment, the Constitution's Framers vested in Congress "broad," "plenary and exclusive" power to legislate in this field.[5]

With this great power has come great responsibility. By dint of history, much of it sorry and tragic, Indian tribes became dependent upon the United States. As a result, the nation – and Congress in particular – assumed a "duty of protection" and an obligation to look after the health and welfare of its indigenous communities.[6] Pursuant to this responsibility, Congress has passed a host of statutes "that single[] out Indians for particular and special treatment."[7] And the law books are replete with cases upholding these preferential statutes against constitutional challenge in essence because the Constitution expressly singles out Indians for unique legislative treatment.[8] As the Supreme Court summarized the point in *Morton v. Mancari*: "As long as the special treatment can be tied rationally to the fulfillment of Congress' unique obligation towards the Indians, such legislative judgments will not be disturbed."[9]

Without question, legislation providing health programs and benefits is a classic example of Congress attending to its responsibility to Indians pursuant to its authority under the Indian Commerce Clause. Since the 1830s at the latest, treaties between the United States and Indian tribes contained promises of hospitals, medical supplies, and other health services.[10] Over time, as the health of Indian populations declined, the provision of health services became a necessary and fundamental part of the relationship between Indians and the United States. As long ago as the passage of the Snyder Act in 1921, Congress stated its commitment to fund health conservation programs for "Indians throughout the United States."[11] More recently, in passing the IHCIA, Congress mandated "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the American Indian people, to meet the national goal of providing the highest possible health status to Indians and urban Indians and to provide all resources necessary to effect that policy."[12]

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[5] *See, e.g.*, *United States v. Wheeler*, 435 U.S. 313, 319 (1978); *Lone Wolf v. Hitchcock*, 187 U.S. 553, 564-565 (1903); *United States v. Kagama*, 118 U.S. 375, 383-384 (1887).

[6] *United States v. Kagama*, 118 U.S. 375, 384-85 (1886); *see also United States v. Sandoval*, 231 U.S. 28, 45-46 (1913).

[7] *Morton v. Mancari*, 417 U.S. 535, 554-55 (1974).

[8] *United States v. Antelope*, 430 U.S. 631, 645 (1977).

[9] *Mancari*, 417 U.S. at 555.

[10] Cohen's Handbook of Federal Indian Law 1376 (Neil J. Newton, et al. eds., 2005).

[11] 25 U.S.C. § 13.

[12] 25 U.S.C. § 1602(a).

In light of this history, it is virtually self-evident that the proposed amendments to the IHCIA and its existing provisions meet the standard test applied to legislation benefiting Indians – that the legislation be rationally tied to the fulfillment of Congress's obligations. From a constitutional perspective, then, the only issue is whether something about the Act is so extraordinary that it exempts the legislation from the usual rules of judicial review.

In its White Paper, the Department purports to have discovered just such an extraordinary circumstance in the fact that the Act does not limit the benefits it confers to members of a federally-recognized tribal entity or to persons having what the Department deems to be a clear and close relationship with such a tribal entity. As the Department observes, the Act would award grants and other benefits to members of state-recognized tribes, descendents in the first or second degree of members of federally- and state-recognized tribes, and Eskimos, Aleuts, or other Alaska Natives even if not affiliated with a recognized Village. In the Department's view, because of the scope of the Act's intended beneficiaries, courts would likely view the legislation as creating a "racial" classification subject to strict judicial scrutiny under *Adarand Constructors, Inc. v. Pena*[13] rather than a "political" classification based on tribal affiliation subject to the deferential rule enunciated in *Morton v. Mancari*.

In my view, and as explained further below, the line the Department seeks to draw between "political" and "racial" classifications is misplaced. Congress's plenary authority under the Indian Commerce Clause is not limited to federally-recognized tribes and their members. Nor does a congressional act benefiting Indians who are members of no recognized tribe (federal or state) necessarily involve a "racial" classification, especially when federal Indian policy was itself the main cause for attenuating the connection between these Indians and their tribes.

With respect to the Act's extension of benefits to members of state-recognized tribes, it must be observed that the Indian Commerce Clause – which simply speaks of "Indian Tribes" – makes no such distinction.[14] After all, the concept of "federal recognition" is a modern creation.

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[13] 515 U.S. 200 (1995).

[14] One of Congress's earliest acts in the field of Indian affairs, the 1790 Indian Trade and Intercourse Act, illustrates the absence of any distinction as well as Congress's authority to legislate with respect to all Indians. There, Congress mandated "that no sale of land made by *any Indians, or any nation or tribe of Indians within the United States*, shall be valid . . . unless the same shall be made and duly executed at some public treaty, held under the authority of the United States." Although this first enactment was a temporary measure, Congress subsequently amended the 1790 Act and made its protections permanent. This congressional protection applies to lands held by "Indian tribes" that exist as distinct political entities, even though a particular tribe may not be federally recognized. *See Passamaquoddy v. Morton*, 528 F.2d 370 (1st Cir. 1975).

And I am aware of no case law disempowering Congress from acting on behalf of state-recognized tribes.

To the contrary, Congress has repeatedly passed legislation encompassing both state- and federally-recognized tribes. For example, in addition to providing health care services for members of state-recognized tribes,[15] Congress has authorized state-recognized tribes to participate in Indian housing and education programs,[16] has included state-recognized tribes within the protections of the Indian Arts and Crafts Act,[17] and has authorized the Department of Agriculture to make tribes with state reservations eligible for various programs.[18]

The legal underpinning for such congressional action is strong. The Supreme Court has repeatedly affirmed the power of Congress to recognize tribes and legislate on their behalf and also to recognize tribes for some purposes but not for others.[19] Indeed, the Court has gone so far as to say that Congress's constitutional authority over tribes is "a continuing power of which Congress could not divest itself. It could be exerted at any time and in various forms during the continuance of the tribal relation . . . ."[20] In view of this broad authority, Congress can confer benefits on state-recognized tribes and their members. Surely, Congress's ultimate authority to recognize Indian tribes in the first instance contains the lesser authority of providing services or programs for non-federally-recognized tribes – as Congress has seen fit to do on many occasions.

As particularly relevant here, there is no reasonable basis for concluding that, when Congress chooses to confer benefits on both federally-recognized and state-recognized tribes and their members, it crosses a line between legislation creating a political classification and legislation creating a racial classification. State-recognized tribes are political entities no less than federally-recognized tribes. State-recognized tribes are Indian tribes acknowledged by State governments as maintaining political authority over their members and their territory. Like

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[15] 25 U.S.C. §§ 1601 *et seq*.

[16] 25 U.S.C. § 4103 (defining "Indian tribe" as "a tribe that is a federally recognized tribe or a State recognized tribe"); 20 U.S.C. § 7491. Congress has also included state-recognized tribes under various Native American programs administered by the Secretary of Health and Human Services. *See* 42 U.S.C. § 2992c.

[17] 18 U.S.C. § 1159(c)(3)(B).

[18] 7 U.S.C. §§ 1926, 1932, 2009cc, 2661.

[19] *United States v. Sandoval*, 231 U.S. 28, 46 (1913); *Menominee Tribe v. United States*, 391 U.S. 404 (1968).

[20] *United States v. Nice*, 241 U.S. 591, 600 (1916). *See also* Cohen's Handbook of Federal Indian Law 815 (1982 ed.) ("Indian tribes can be recognized by the United States for some purposes and not for others."); and Cohen's Handbook of Federal Indian Law 272 (1942 ed.) ("It remains true, however, that an Indian tribe may 'exist' for certain purposes, and not for others.").

federally-recognized tribes, many state-recognized tribes entered into treaties with independent states prior to the formation of the Union; state governments recognized other tribes through executive or legislative actions.[21] Today, many states provide an administrative process for recognition of tribal governments.[22] Moreover, just like members of federally-recognized Indian tribes, members of state-recognized tribes may renounce their affiliation. In sum, the relationship between Congress and state-recognized tribes – a status that is often a precursor to federal recognition[23] – is a political one. And, accordingly, Congressional enactments benefiting their members are best seen as based on a political classification.

As the Department notes, the proposed legislation also benefits urban Indians who are not themselves members of any tribe, but who are descended in the first or second degree from a tribal member. Contrary to the implication of the Department's White Paper, however, current case law provides no definitive answer as to whether extending benefits in this way transforms the classification from political to racial.

In *Morton v. Mancari*, the Supreme Court rejected a claim that the law providing Indians with a hiring preference for positions at the BIA constituted invidious racial discrimination. The Court construed the preference to be "political" rather than racial in nature in part because it was limited to members of federally-recognized tribes who would be overseeing programs aimed at exactly that constituency.[24] But the Court never suggested that a preference benefiting a group of Indians broader than simply members of federally-recognized tribes would necessarily be considered racial in nature and, moreover, stated unequivocally that special legislation for Indians would be upheld if reasonably linked to Congress's "unique obligation toward the Indians" without reference to membership status.[25]

In *Rice v. Cayetano*,[26] the case on which the Department principally relies, the Court held that the Fifteenth Amendment prohibited Hawaii from limiting voters for positions on a state

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[21] *See* Treaty of 1677 between Virginia and the Indians, May 29, 1677 (discussed in Virginia Op. Att'y Gen, February 7, 1977, 1977 WL 27313); N.Y. Indian Law § 120; Conn. Gen. Stat. § 47-59a; Mass. E.O. No. 126 (1976); La. Con. Res. No. 60 (1974).

[22] *See* Ala. Code § 41-9-708; Va. Code § 2.2-2629; N.C. Gen. Stat. § 143B-406; Md. Code Ann., Art. 83B, § 5-406.

[23] Importantly, there are many tribes currently seeking federal recognition, which can be an agonizingly slow process. It would be quite arbitrary to say that Congress cannot provide special health benefits to members of such tribes without transforming its program into a racial classification.

[24] *Mancari*, 417 U.S. at 554.

[25] *Id.* at 554-555.

[26] 528 U.S. 495 (2000).

agency solely to Hawaiians and Native Hawaiians as defined by statute. As part of that decision, the Court rejected attempts to analogize the challenged law to the hiring preference in *Mancari* because nothing in *Mancari* suggests that Congress may empower a state to override the Fifteenth Amendment and disenfranchise non-Indian citizens from an election involving the selection of state officials.[27] While the Court described *Mancari* as involving a preference limited to tribal members, here, too, the Court was not called upon and did not seek to define precisely the line between political and racial classifications.

At least one lower federal court has held, with respect to certain housing benefits, that Congress's plenary powers extend to a broad class of urban Indians without reference to tribal affiliation.[28] According to this court, Congress's power pursuant to its trust relationship with the Indians necessarily must be flexible enough to account for the changing needs of Indian communities, including urbanization. Applying that principle, the court concluded that "in light of the broad scope of the trust doctrine, it is not surprising that it can extend to Indians individually, as well as collectively, and off the reservation as well as on it."[29]

But determining whether Congress creates a racial classification when it provides benefits to urban Indians descended one or two degrees from a tribal member is more a matter of logic than of precedent. There is no secret about how this group of unaffiliated urban Indians came into being. They are the product of Congress's previous *political* interactions with the tribes. From the Dawes Act through termination and relocation, the federal government imposed upon the tribes policies that aggressively encouraged or forced the migration of Indians into urban areas and sought to sever ties between those Indians and their tribes. The failure of economic development on many reservations – also a manifestation of political decisions – further swelled the urban migration.

The question, then, is whether Congress has authority to treat these Indians – who are no more than two degrees removed from actual tribal membership – as still having a political relationship with the United States, given that Congress's political dealings with their tribes largely created their state of alienation. In my view, the answer to this question should be yes. Given Congress's broad authority in the field of Indian affairs, Congress ought not to be prohibited from considering itself as having a derivative political relationship with a community of Indians its political decisions created, where the individual Indians have significant blood ties

[27] *Id.* at 520.

[28] *St. Paul Intertribal Housing Bd. v. Reynolds*, 564 F. Supp. 1408 (D. Minn. 1983).

[29] *Id.* at 1413.

back to a recognized tribal community. Put simply, when Congress, in exercising its Indian Commerce Clause power, legislates to protect the health and welfare of Indian tribes by dispersing their members, Congress's subsequent programs designed to take responsibility for and ameliorate the failures of that political judgment remain political (and not racial) in character.

Congress itself followed exactly this logic when it first created the current definitions of "Indian" and "Urban Indian" in the IHCIA of 1976.[30] And Congress discussed the underlying rationale when it enacted the IHCIA amendments of 1987. As the Senate Report declared:

> The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation.* Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and *the responsibility for the provision of health care services follows them there*.[31]

I see no reason grounded in the Constitution to second-guess this considered and long-standing congressional judgment in an area in which congressional judgment has always been paramount.

At the same time, there are some significant reasons not to second-guess this judgment by deeming the Act to have created a racial classification – as the Department would have it. As a practical matter, such second-guessing risks hamstringing Congress in its efforts to deal with an urban Indian population with uniquely Indian problems by creating rather arbitrary and entirely ahistorical distinctions between those Indians who can readily benefit from Congressional programs and those who cannot. Moreover, the Department's approach would obliterate the deep ancestral distinctions between Indians with different tribal backgrounds by lumping all Indians without a tribal affiliation into an undifferentiated "race" of Indians. I see no constitutional mandate forcing such a perverse result.[32]

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[30] Indeed, these definitions date back as far as the Transfer Act of 1954.

[31] S. Rep. 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, at 25 (emphasis added).

[32] Essentially the same analysis applies to Eskimos, Aleuts, and other Native Alaskans unaffiliated with native villages. As Congress recognized when it created a separate Native Corporation for these persons in the Alaska

B. Even If Deemed To Be A Racial Classification, The Proposed Legislation Is Constitutional

As discussed above, the proposed Act should be reviewed under the rational basis standard of review. Even assuming, however, that the Department is correct in suggesting that strict scrutiny applies, a persuasive argument can nonetheless be made that the Act should pass constitutional muster.

1. The Strict Scrutiny Standard

The Due Process Clause of the Fifth Amendment includes a guarantee of equal protection[33] that is coterminous with the Equal Protection Clause of the Fourteenth Amendment.[34] Given our nation's history, we take a cautious approach to classifying persons according to their race, a practice that, as the Supreme Court has noted, "is more likely to reflect racial prejudice than legitimate public concerns."[35]

Accordingly, the Supreme Court has held that government classifications that expressly distinguish among citizens because of their race must be narrowly tailored to further a compelling governmental interest,[36] even when they are part of measures designed to redress racial discrimination.[37]

The Court has recently confirmed, however, that strict scrutiny is not fatal: "Although all governmental uses of race are subject to strict scrutiny, not all are invalidated by it . . . When race-based action is necessary to further a compelling governmental interest, such action does not violate the constitutional guarantee of equal protection so long as the narrow-tailoring requirement is also satisfied."[38]

Native Claims Settlement Act, Congress bears a responsibility for their diaspora – and it has shouldered that responsibility in enacting programs such as those contemplated here.

[33] *See Bolling v. Sharpe*, 347 U.S. 497, 499 (1954).

[34] *Johnson v. Robison*, 415 U.S. 361, 364 (1974).

[35] *Id.* at 432 (citing *Personnel Admin. of Mass. v. Feeney*, 442 U.S. 256, 272 (1979)).

[36] *Shaw v. Reno*, 509 U.S. 630, 643 (1993) (citation omitted).

[37] *Adarand Constructors v. Pena*, 515 U.S. 200, 227 (1995).

[38] *Grutter v. Bollinger*, 539 U.S. 306, 326-37 (2003); *see id.* at 327 ("Not every decision influenced by race is equally objectionable[;] … strict scrutiny is designed to provide a framework for carefully examining the importance

2. The Government Has a Compelling Interest in Promoting Indian Health

As a preliminary matter, it is clear that the Act serves a compelling government interest. As discussed above, the federal government has a unique relationship with and responsibility to the American Indian people. This relationship and corresponding duty are set forth in the Act, which states in its Findings that:

> (1) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people.
>
> (2) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.
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> (3) Federal 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.
>
> (4) Despite such services, 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.[39]

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and the sincerity of the reasons advanced by the governmental decisionmaker for the use of race in that particular context.").

[39] *See* § 2 of the proposed Act; *See also* § 3 of the proposed Act, entitled "Declaration of National Indian Health Policy," which states that it is the policy of the United States, in fulfillment of its special trust responsibilities and legal obligations to Indians:

> (1) to assure the highest possible health status for Indians and to provide all resources necessary to effect that policy;
>
> (2) to raise the health status of Indians by the year 2010 to at least the levels set forth in the goals contained within the Healthy People 2010 or successor objectives;
>
> (3) to the greatest extent possible, to allow Indians to set their own health care priorities and establish goals that reflect their unmet needs;

Given the history of our relationship with the Indians, which, to say the least, has not always been a proud one, the federal government has properly recognized its duty to address the health needs of Indians, whose plight is directly linked to that history. While race-based classifications are often deemed suspect because of the tenuous nature of the link between the problems the government seeks to redress and the persons who actually stand to benefit from the proposed measure,[40] that concern is allayed here. The Act is aimed at meeting the needs of the very persons whose difficulties arise from the government policies responsible for the health crisis the Act seeks to redress. The following are just a few well-known examples of policies and events that are largely and directly responsible for the flight of Indians to urban areas and the current health plight of urban Indians.

- The General Allotment Act of 1887 resulted in the transfer of the majority of Indian land to non-Indians, disrupting tribal culture and resulting in massive relocation of Indians to urban areas.

- More recent efforts by the federal government to break down tribal governments and force Indians to assimilate have resulted in a loss of community and a diaspora characterized by poverty, alcoholism, and disease.

- On the reservations, the failure of federal initiatives to stimulate economic development created an environment plagued by poverty. This too has led many Indians to leave the reservation in the hopes of finding a better way of life in metropolitan areas.

As the Supreme Court noted in *Grutter v. Bollinger*, it is important to consider context "when reviewing race-based governmental action under the Equal Protection Clause."[41] Viewed

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(4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;

(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and Urban Indian Organizations to implement this Act and the national policy of Indian self-determination; and

(6) to provide funding for programs and facilities operated by Indian Tribes and Tribal Organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

[40] *City of Richmond v. J.A. Croson Co.*, 488 U.S. 469, 493 (1989) (To be narrowly tailored, "there must be a sufficient nexus between the compelling governmental interest" and the challenged measure.).

[41] *Grutter*, 539 U.S. at 327.

in historical context, there can be no question but that the proposed Act serves a compelling government interest. Assuming it can be shown that the Act "use[s] the least restrictive reasonable means to achieve its goals," it should pass muster even under the strict scrutiny test.[42]

3. The Proposed Act Is Narrowly Tailored to Meet the Government's Compelling Interest

The Supreme Court considers various factors in the narrow tailoring analysis, including, as relevant here: (1) the necessity of relief; (2) the efficacy of alternative, race-neutral remedies; (3) the impact of relief on the rights of third parties; and (4) the over-inclusiveness or under-inclusiveness of the racial classification.[43]

While the Findings in the Act do not address all of the relevant factors explicitly, the path they chart demonstrates that the Act is narrowly tailored to meet its stated goal, namely, "to increase, to the maximum extent feasible, the number of Indians entering the health professions and providing health services, and to assure an optimum supply of health professionals to the Indian Health Programs and Urban Indian Organizations involved in the provision of health services to Indians."[44]

The first factor used to assess whether a measure is narrowly tailored – necessity of relief – is present here. As noted in the Findings of the Act, disease is rampant among Indians, notwithstanding federal efforts to provide health care.[45] The findings could easily be amplified to include such specifics as the following:

- Indians have a shorter life expectancy – nearly six years less – and higher rates of disease than the general population.[46]

- American Indian and Alaska Native infants die at a rate of 8.5 per every 1,000 live births, as compared to 6.8 per 1,000 for the general population.[47]

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[42] *Dunn v. Blumstein*, 405 U.S. 330, 343 (1972).

[43] *United States v. Paradise*, 480 U.S. 149, 171 (1987); *Croson*, 488 U.S. at 506 (including over- and under-inclusiveness in the narrow tailoring factors); *Adarand*, 515 U.S. at 237-38 (noting that the lower court on remand should consider whether the legislative body had tried race-neutral alternatives and whether the program was limited in duration).

[44] *See* § 101 of the proposed Act.

[45] § 2 of the proposed Act.

[46] *See* U.S. Commission on Civil Rights (USCCR), *Broken Promises: Evaluating the Native American Health Care System* (2004), at http://www.usccr.gov/pubs/nahealth/nabroken.pdf)

- Indians suffer significantly higher rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries.[48]

- Cardiovascular disease is now the leading cause of mortality among Indians, with a rising rate that is significantly higher than that of the U.S. general population.[49]

- The prevalence of type 2 diabetes amongst Indians and Alaska Natives has been documented as being one of the highest in the world.[50]

- Rates of substance dependence and abuse among persons age 12 and older is highest among Indians and Alaska Natives.[51]

- Access to health care and to competent providers remains a critical problem for Indians.[52]

The second factor, race-neutral remedies, cannot be viewed as a reliable alternative in view of the fact, noted in the Findings of the Act, that even programs specifically designed to address the peculiar health care needs of Indians have failed to date.[53]

The third factor, the impact of relief on the rights of third parties, is negligible. The Act does not discriminate among individuals vying for the same program. Rather, it is designed to address problems specific to Indians.

Fourth and finally, the classification of urban Indians is neither over- nor under-inclusive. As a result of historic federal policies touched on above, the Indian tribal culture has been widely dispersed, giving rise to diverse urban Indian communities. The Government retains its responsibility to these non-reservation Indians – who comprise over half of the Indian population

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[47] *See* U.S. Department of Health and Human Services, Indian Health Service, *Facts on Indian Health Disparities* (Jan. 2006) at http://info.ihs.gov/Files/DisparitiesFacts-Jan2006.pdf.

[48] *See* USCCR, *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country* (2003).

[49] *See* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Heart Disease Facts and Statistics* (Feb. 2007) at http://www.cdc.gov/HeartDisease/facts.htm; *see also* http://www.medicalnewstoday.com/medicalnews.php?newsid=24326 dated May 13, 2005.

[50] *See* http://www.ahsc.arizona.edu/nartc/articles/young98.htm.

[51] *See* U.S. Department of Health and Human Services, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health – The NSDUH Report* (Jan. 2007) at http://www.drugabusestatistics.samhsa.gov/2k7/AmIndians/AmIndians.htm.

[52] *See* GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans* (2005).

[53] § 2 of the proposed Act.

according to the 2000 census – just as it does to Indians who retain their tribal affiliation and remain on the reservation. The health problems associated with the Indian population as a whole cannot be addressed unless health services are provided to the urban Indian population, as well as to the reservation population.

It cannot be gainsaid that our history is marred by racism and hostility against Indians, nor that the effects of those past wrongs are still being felt by Indians wherever they reside. Indians, both on the reservation and off, remain deeply affected by incidents of state-sponsored racism and discrimination. Accordingly, the classification of Indians and Urban Indians in the Act is relevant and necessary to fulfilling the federal government's unique obligation to Indians.[54] In *Grutter v. Bollinger*, the Supreme Court noted that racial preferences to support diversity in higher education may be unnecessary in 25 years. The sun will not set any sooner on Congress's trust obligation to the American Indian people.

In sum, the Findings included in the Act may suffice to establish that it is narrowly tailored to fulfill its goal of redressing the health crisis facing Indians today. To the extent the Findings fall short, they could easily be augmented to meet the demands of strict scrutiny.

II. THE ACT DOES NOT VIOLATE THE ESTABLISHMENT CLAUSE

The Department's White Paper contends that portions of the proposed Act may violate the First Amendment's Establishment Clause due to the Act's support of "traditional health care practices" and practitioners. The Justice Department offers no support for this position. It simply asserts that there is an Establishment Clause problem, without referencing the bill's provisions it believes raise concerns or analyzing the provisions under Establishment Clause precedent. The Justice Department's position is overstated. I will first explain how the Act supports traditional health care practices. I will then explain why this support is unlikely to violate the Establishment Clause.

A. The Act Invokes "Traditional Health Care Practices" in Several Ways

The Act defines "traditional health care practices" (THCP) in non-religious terms:

> The term "Traditional Health Care Practices" means the application by Native healing practitioners of the Native healing sciences (as opposed or in

[54] *Croson*, 488 U.S. at 510 ("Proper findings [to support the need for remedial action] are necessary to define both the scope of the injury and the extent of the remedy necessary to cure its effects.")

> contradistinction to Western healing sciences) which embody the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness and which call upon these influences or forces in the promotion, restoration, preservation, and maintenance of health, well-being, and life's harmony.[55]

The Establishment Clause proscribes certain forms of government support for religion. But nothing in this definition ties the definition of THCPs to religious beliefs or practices, and so, at least on its face, the Act would not appear to raise Establishment Clause concerns.

The provisions in the Act that refer to THCPs can be divided into three general groups. The first group of provisions merely requires the Secretary to consider THCPs in formulating health care policies under the statute.[56] The second group of provisions permits the Secretary to support or implement THCPs directly. For example, § 704(d) requires the Secretary to ensure that the Indian Health Service's mental health technician program "involves the use and promotion of the Traditional Health Care Practices of the Indian Tribes to be served."[57] The third group of provisions permits the Secretary to "incorporate" THCP practitioners in government grant programs.[58]

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[55] § 4(23) of the proposed Act.

[56] § 109(b)(6) (requiring Community Health Representative Program to "promote Traditional Health Care Practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention"); § 126(c)(2) ("Position specific training criteria . . . shall ensure that appropriate information regarding Traditional Health Care Practices is provided."). The former provision, § 109(b)(6), is already codified in the U.S. Code. *See* 25 U.S.C. § 1616(b)(6). It was enacted as part of the Indian Health Care Amendments of 1988, Pub. L. No. 100-713, 102 Stat. 4784, and does not seem to have been subject to any litigation since.

[57] *See also* § 201(a)(5)(K) (permitting Secretary to expend funds to "augment[] the ability of the Service to meet the following health service responsibilities . . . Traditional Health Care Practices"); § 701(c)(1)(I) (requiring Secretary to provide "[a] comprehensive continuum of behavioral health care," including "Traditional Health Care Practices"); § 703(a)(1) ("The Secretary . . . shall provide a program of comprehensive behavioral health, prevention, treatment, and aftercare, including Traditional Health Care Practices . . . ."); § 711(b)(5) ("The project may deliver services in a manner consistent with Traditional Health Care Practices."); § 713(b)(3) ("Funding provided pursuant to this section shall be used . . . [t]o develop prevention and intervention models which incorporate Traditional Health Care Practices . . . .").

[58] § 211(b)(1)(A) ("Funds made available under this section may be used to . . . develop prevention and treatment programs for Indian youth which promote mental and physical health and incorporate . . . traditional health care practitioners . . . ."); § 712(a)(2)(E) ("Funding provided pursuant to this section shall be used . . . [t]o develop prevention and intervention models which incorporate practitioners of Traditional Health Care Practices. . . ."); § 715(3) ("An aftercare plan may use such resources as . . . traditional health care practitioners . . . .").

B. The Act's Use of "Traditional Health Care Practices" Complies with the Establishment Clause

The Supreme Court's test for evaluating whether government action amounts to impermissible support for religion in violation of the Establishment Clause has been described in a number of ways. *Lemon v. Kurtzman*[59] articulated the original test for determining whether a statute effects an unconstitutional establishment of religion. To pass muster under the *Lemon* test, a statute must meet three factors: "First, the statute must have a secular legislative purpose; second, its principal or primary effect must be one that neither advances nor inhibits religion; finally, the statute must not foster an excessive government entanglement with religion."[60] The Court later provided several modifications of the *Lemon* test. In *Agostini v. Felton*,[61] the Court held that the last two prongs of the *Lemon* test are identical, and in *County of Allegheny v. ACLU*,[62] the Court held that the last two prongs essentially inquire into whether a statute "has the purpose or effect of 'endorsing' religion"[63] – *i.e.*, if the statute promotes religion or "convey[s] a message that religion or a particular religious belief is favored or preferred."[64]

There can be little doubt that the Act has a primarily secular legislative purpose: to provide for "the highest possible health status for Indians" without intruding on Indian self-determination.[65] Thus, the only question remaining is whether the Act impermissibly advances or endorses religion.

The answer to this question depends in large part on whether the phrase "traditional health care practices" is construed as being inherently religious. The best reading of the Act is that THCPs are *not* inherently religious. The Act's definition of a THCP does not expressly tie such practices to religious beliefs or practices; rather, the definition sweeps broadly to include practices that are influenced by any aspect of Indian culture regarding "the influences or forces of innate Tribal discovery, history, description, explanation and knowledge of the states of wellness and illness."[66] Thus, THCPs could reflect such non-religious influences as superstition,

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[59] 403 U.S. 602 (1971).

[60] *Id.* at 612-13 (internal quotation marks and citations omitted).

[61] 521 U.S. 203, 233 (1997).

[62] 492 U.S. 573, 597 (1989).

[63] *Id.* at 592.

[64] *Wallace v. Jaffree*, 472 U.S. 38, 70 (1985) (O'Connor, J., concurring in judgment).

[65] § 3 of the proposed Act.

[66] § 4(23) of the proposed Act.

historical customs, and culturally appropriate gender roles.[67] Moreover, even THCPs motivated by religious beliefs or originating from religious traditions are not necessarily religious in character.[68] For example, herbal medicines may be administered in a non-religious manner even if they are or have been connected in some way to religious beliefs. Of course, some THCPs – such as healing prayers and rituals – may be inseparable from religious beliefs and practices, but such inherently religious THCPs are only a subset of the practices covered by the Act.

Given this understanding of THCPs, the first group of provisions listed above – requiring the Secretary to consider THCPs – is almost certainly constitutional. These provisions do not require the Secretary to subordinate non-traditional programs and practices in favor of THCPs. At most, they permit the Secretary to take THCPs into account in implementing the statute. Requiring such an awareness of potential cultural differences does not violate the Establishment Clause.[69] Rather, it merely reflects the statute's goal of providing health care services to Indian tribes in a way that respects their cultures and traditions.

Because THCPs are not inherently religious, the second group of provisions – relating to direct government funding or implementation of THCPs – will also likely be constitutional, if the federal government itself only funds or implements non-religious THCPs. The Establishment Clause does not restrict the federal government's power to provide non-religious services and programs itself. The government's implementation of the non-religious cultural health practices of Indian tribes will neither advance nor endorse religion, for the simple reason that religion will not be involved in the government's programs.

The Secretary could also directly fund THCP practitioners – including religious THCP practitioners – so long as (1) the money was not used for religious activities,[70] and (2) the practitioners were not so "pervasively sectarian" that "'a substantial portion of [their] functions are subsumed in the religious mission.'"[71] For example, the Supreme Court has allowed

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[67] *Cf. Cholla Ready Mix, Inc. v. Civish*, 382 F.3d 969, 977 (9th Cir. 2004) ("Native American tribes are not solely religious in character or purpose. Rather, they are ethnic and cultural in character as well.").

[68] *See Bowen v. Kendrick*, 487 U.S. 589, 604-05 (1988) (noting that counseling and education services provided by religious organizations "are not religious in character"); *McGowan v. Maryland*, 366 U.S. 420 (1961) (upholding Sunday closing laws because they served secular purposes despite originally being religiously motivated).

[69] Indeed, this conclusion would be true even if THCPs were inherently religious. *See Bowen*, 487 U.S. at 607 (upholding statute that required recipients of federal funds to "to describe how they [would] involve religious organizations in the provision of services").

[70] *See Hunt v. McNair*, 413 U.S. 734, 743 (1973) ("Aid normally may be thought to have a primary effect of advancing religion . . . when it funds a specifically religious activity.").

[71] *Bowen*, 487 U.S. at 610 (quoting *Hunt*, 413 U.S. at 743).

religious schools to receive federal grants for building construction when the statute made clear that "the federally subsidized facilities would be devoted to the secular and not the religious function of the recipient institutions."[72] Similarly, the Court has allowed religious groups – but not pervasively sectarian ones – to be the recipients of federal funds when "[t]he services to be provided" under the statute by the groups were "not religious in character."[73] Thus, in funding THCPs, the Secretary will have to ensure that direct government funding flows only to the non-religious activities of non-pervasively sectarian THCP practitioners.

The third group of provisions – relating to the incorporation of THCP practitioners into the activities of government grantees – should also pose no problems under the Establishment Clause. Two of these provisions authorize the Secretary to provide grants to non-governmental organizations which, in turn, are permitted to incorporate THCP practitioners,[74] and the third provision allows "behavioral health aftercare plans" to "use such resources as" THCP practitioners.[75] Under these provisions, THCP practitioners – including religious ones – may ultimately benefit from government aid, but they do so only if the immediate or direct recipients of federal funds choose to incorporate THCP practitioners.

That the third group of provisions does not directly fund inherently religious THCPs places these provisions within the Establishment Clause boundaries of *Bowen v. Kendrick*,[76] which considered the constitutionality of similar provisions in the Adolescent Family Life Act (AFLA). AFLA provided grants to non-governmental organizations for services and research in the area of premarital adolescent sexual relations and pregnancy. Along with expressly acknowledging the benefits of involving "religious organizations" to further its mission, the statute required grant applicants to show "how they [would] involve religious organizations, among other groups, in the provision of services under the Act."[77] The Supreme Court upheld these provisions of the statute, noting that there was no Establishment Clause violation because the statute simply "recognize[d] that 'religious organizations have a role to play' in addressing the problems associated with teenage sexuality."[78] A similar argument would seem to apply here. Just as the AFLA permitted non-governmental organizations to use federal funds to

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[72] *Tilton v. Richardson*, 403 U.S. 672, 679-80 (1971).

[73] *Bowen v. Kendrick*, 487 U.S. 589, 604-05 (1988).

[74] § 211(b)(1)(A) of the proposed Act; § 712(a)(2)(E) of the proposed Act.

[75] § 715(3) of the proposed Act.

[76] 487 U.S. 589 (1988).

[77] *Id.* at 606.

[78] *Id.* at 605-06.

incorporate religious groups in programs regarding teenage sexuality, so this Act permits non-governmental organizations to use federal funds to incorporate potentially religious THCP practitioners in health programs. The upholding of AFLA in *Bowen* against an Establishment Clause challenge suggests that analogous provisions of this Act will pass constitutional scrutiny as well.

These provisions would also likely be constitutional even if the non-governmental grantees passed federal funds to THCP practitioners who then engaged in religious practices. So long as the immediate recipients of government aid are not chosen due to their religion, there is no Establishment Clause violation if those recipients in turn "direct government aid to religious [institutions] wholly as a result of their own genuine and independent private choice," even when those institutions use the funds for religious activities.[79] To the extent that religion is advanced or endorsed due to the religious institutions' indirect receipt of government funds, that advancement or endorsement "is reasonably attributable to the individual recipient, not to the government, whose role ends with the disbursement of benefits."[80] This reasoning applies to the provisions of the Act involving THCP practitioners. None of these provisions conditions receipt of federal funds on the religious nature of the recipient. Moreover, none of these provisions requires recipients to apply federal funds to religious THCP practitioners, nor are recipients who do so rewarded.[81] Instead, each of these provisions lists a large number of other institutions and practices that may be incorporated, and of course recipients are always free to involve non-religious THCP practitioners. Given the freedom of choice and range of options provided by the Act, any diversion of federal funds to religious THCP practitioners and activities would be the result of a "genuine and independent private choice." The Establishment Clause does not forbid such a scheme of federal funding.

Finally, I would like to draw your attention to one possible objection that opponents of the Act may raise. The Establishment Clause flatly forbids government action that advances or endorses "one religious denomination . . . over another."[82] The Act may appear to violate this rule by expressly involving THCP practitioners – but no other potentially religious groups – in the Act's implementation. However, the mere fact that the Act mentions THCP practitioners

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[79] *Zelman v. Simmons-Harris*, 536 U.S. 639, 653 (2002) (upholding such indirect government aid to parochial schools).

[80] *Id.*

[81] *Witters v. Wash. Dept. of Servs. for the Blind*, 474 U.S. 481, 488 (1986) ("[The statute] does not tend to provide greater or broader benefits for recipients who apply their aid to religious education, nor are the full benefits of the program limited, in large part or in whole, to students at sectarian institutions.").

[82] *Larson v. Valente*, 456 U.S. 228, 244 (1982).

does not necessarily imply that it excludes non-THCP practitioners who are religious. Nothing in the Act prevents the Secretary or grant recipients from incorporating religious organizations who do not engage in THCPs – subject, of course, to the same restrictions that apply to religious THCP practitioners. Indeed, § 715(3) of the Act expressly recommends the use of "community-based therapeutic group[s]" and "other community-based groups," without restricting those terms to non-religious or THCP-specific organizations. Thus, the Establishment Clause's prohibition on sectarian preferences should not apply to the Act.

CONCLUSION

In conclusion, I would like to thank you, Chairman Dorgan, Vice Chairman Thomas, and the members of the Committee for taking so seriously your responsibility to independently evaluate the constitutionality of these amendments to the Indian Health Care Improvement Act. Your concern will ensure that the Act can continue to perform its important role of maintaining and improving the health of American Indians.