

Chapter 2

The Federal= Indian Relationship

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HISTORICAL OVERVIEW

Most colonial powers followed some variation of the “doctrine of discovery” and “aboriginal title” in their land dealings with Indians. Europeans considered Indian political-tribal units as holding something akin to “use rights” over their traditional territories, with the ability to transfer valid title to the arriving nations. Under the “doctrine of discovery,” the nation with the first contact could acquire title from individual Indian tribes. Individual settlers had no rights to acquire land from Indians and could only acquire land through their sovereign.

This land acquisition system was a critical part of the relationship that eventually was established between the United States and the Indian tribes. Tribes and their members were treated as separate and legally different from other people inhabiting the continent. Great Britain and, later, the United States, assumed the obligation to protect the tribes. (For example, the Royal Proclamation of 1763 acknowledged tribal rights to protection of their lands, borders, and the removal of non-Indians.) In addition to practices maintaining tribal separatism, the Federal Government sought to “civilize” Indians, which included European forms of education and farming, and conversion to Christianity. Thus, non-Indian governments gradually assumed responsibilities that went beyond overseeing only the physical assets of the tribes.

The policies that the United States would adopt toward Indian tribes and their members were carefully considered by the Founding Fathers. George Washington was of the view that the United States needed to protect Indians from the “avarice” of non-Indians and observed that it also was good policy to be on friendly terms with the Indians (103). This viewpoint was codified in the Northwest Ordinance and the Indian Trade and Intercourse Act of 1790 and was reflected in the series of treaties that the United States entered into with the tribes following the Revolutionary War.

Treaties became a major basis for the legal relationship of the newly formed United States with the Indian tribes, including the obligation of the Federal Government to provide services. Having a treaty that specified some form of health care was, however, not a prerequisite for a tribe to receive health services. By the mid-19th century, appropriations for Indian health care had become routine. About half of the approximately 70 Indian agencies had a doctor on its staff (217). Indian agents, the local representatives of the Federal Government, were judicially determined to have inherent or discretionary authority to provide medical services to tribes under their control (125).

Treaties were the exclusive responsibility of the Senate, but by 1871, the treaty-making period had ended as the House of Representatives sought increased involvement in the agreements with Indian tribes. Thereafter, both the House and the Senate would deal with the tribes by statute rather than by treaty (23,210). It is important to note that at the time treaty-making ended, the States were almost entirely excluded from any involvement in Indian affairs, and Indian tribes functioned as political units in their relationships with the government of the United States. Moreover, almost no attention was paid to individual Indians by the United States; they were the responsibility of their tribes. Indians were not citizens of the United States and as individuals had almost no rights within the legal system of the United States.

The allotment period began a decade after the end of treaty-making, with the Federal relationship with Indians shifting from that of a government dealing with another government to a new stratagem that was anti-tribal government. Allotment essentially broke up tribally held communal lands. (Although there were a number of allotment acts, the classic is the Dawes Act [24 Stat. 388 (1887)].) Although many tribes existed in de-

plorable conditions, they existed on lands wanted by settlers, miners, and other economic interests.

Assimilation, often referred to as “civilization” of individual Indians, became the dominant thrust of the Federal allotment policy (35,102). Each adult was assigned a specific amount of land (usually 160 acres), and some relatively small amount of land was set aside for tribal purposes (schools, cemeteries, and the like). The “excess lands” remaining were opened to non-Indian settlement. Indian land was to be held in trust, as were the proceeds from the sale of “excess lands,” for a limited period of years. The theory was that during this trust period individual Indians would become farmers and leave their Indian ways. They were to be emancipated from their tribes and become eligible for U.S. citizenship.

During the allotment period, the Bureau of Indian Affairs (BIA) became the dominant institutional force on Indian reservations (54). The bureau, along with missionaries, were to civilize the Indians. Along with the expansion of social services to the tribes, the bureau actively suppressed traditional modes of tribal governance, Indian languages, and Indian religious and cultural practices. Thus, education, medical services, law enforcement, and all components of government became an aggressive part of the Federal definition of its trustee role to “civilize” Indians.

The first Indian hospital was built in Pennsylvania, where there were no reservations, in connection with the Carlisle Indian Boarding School. Carlisle was the prototype boarding school where Indian children who had been removed from their reservations were to be “civilized” in the absence of tribal influences. By the turn of the century, a total of five hospitals had been constructed to serve Indians. None of the five had a specific authorization or appropriation from Congress (217). Health services were seen as a natural and necessary part of the “civilizing” function that the Nation had adopted.

By the early 1900s Congress began to pass disease-specific legislation. In 1906, Congress be-

gan the effort against tuberculosis among Indians (34 Stat. 325, 328 [1906]). In 1909, programs against trachoma were begun (35 Stat. 269, 271 [1909]).

The 1920s provided several events of significance to Indians. They became citizens of the United States through the Citizenship Act of 1924 (8 U.S.C. section 1401 b). The Snyder Act, the major basis for Federal health and social services for Indians, was enacted in 1921 (25 U.S. C. section 13), and the congressionally commissioned Meriam Report of **1928** was influential in changing the course of Federal-tribal relations.

The Snyder Act of 1921 was passed to provide authorizing legislation for appropriations that Congress had been providing for some time, but without specific statutory authority. The entire act (except for a 1976 amendment making post-secondary Indian schools eligible for participation in the Higher Education Act of 1965) reads as follows (25 U.S.C. section 13):

The Bureau of Indian Affairs, under the supervision of the Secretary of the Interior, shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States for the following purposes:

- General support and civilization, including education.
- For relief of distress and conservation of health.
- For industrial assistance and advancement and general administration of Indian property.
- For extension, improvement, operation, and maintenance of existing Indian irrigation systems and for development of water supplies.
- For the enlargement, extension, improvement, and repair of the buildings and grounds of existing plants and projects.
- For the employment of inspectors, supervisors, superintendents, clerks, field matrons, farmers, physicians, Indian police, Indian judges, and other employees.
- For the suppression of traffic in intoxicating liquor and deleterious drugs.

For the purchase of horse-drawn and motor-propelled passenger-carrying vehicles for official use.

And for general and incidental expenses in connection with the administration of Indian affairs.

Utilizing the Meriam Commission's report, the New Deal proposed extensive legislation for the long-term renewal of tribal governments. Assimilation was still an underlying, ultimate goal, but it was to be achieved by Indians operating through their own systems.

A number of legislative proposals were enacted into law by Congress in the 1930s. The Indian Reorganization Act of 1934 (25 U.S. C. sections 461, et seq.) ended allotment, extended the trust indefinitely, established federally chartered corporations for tribes to reorganize into, and established economic development programs for tribes. The Johnson O'Malley Act of 1934 (25 U.S.C. sections 452, et seq.) authorized the Federal Government to contract with agencies, including State agencies, to provide services (including medical services) to Indians. The Johnson O'Malley Act did two things of major consequence: it provided for expanded health services to Indians and established the first real mechanism for State involvement with Indian health care.

Following World War II, Federal-Indian policy again changed course, reversing the policies of the New Deal toward what was eventually condemned as "termination. " Termination had several components: 1) the induced resettlement of thousands of reservation Indians into urban centers where they were to be trained and employed; 2) the transfer of major functions, responsibilities and jurisdiction over Indians to States from the Federal Government (18 U.S. C. section 1162; 28 U.S. C, section 1360); and 3) termination of the Federal relationship with specific tribes, including ending services and distributing tribal assets to individual tribal members.

Indian hospitals were closed, and there was increased emphasis on transferring service responsibilities to the States. California, for example, requested that the Federal Government cease pro-

viding health care to Indians residing in that State. In part, the terminationist thrust was responsible for the transfer of the responsibility for Indian health care away from BIA in the Department of the Interior to the Public Health Service in what was then the Department of Health, Education, and Welfare (42 U.S. C. sections 2001, *et seq.*).

The termination period was in turn replaced by the current phase of Federal-Indian relationships, commonly known as Indian Self-Determination. But termination had created profound changes in the demographics and definitions of Indians. Hundreds of thousands of Indians who were members of recognized tribes no longer resided on reservations or even near reservations. Thousands of other Indians had been declared to have been terminated by acts of Congress and no longer were federally recognized Indians.

The modern self-determination era began at roughly the same time as the major expansion of Federal programs and services that characterized the "Great Society. " This recent self-determination era has been characterized by a general revitalization of tribal governments and a large increase in Indian-related litigation. Two statutes have been of special importance. The Indian Self-Determination and Education and Assistance Act of 1975 (25 U.S. C. sections 450, et seq.) provided for the transfer to tribes of functions that were previously performed by the Federal Government, including the provision of health services. The other statute, the Indian Health Care Improvement Act of 1976 (25 U.S.C. sections 1601, *et seq.*), was the only Federal statute to clearly reflect Congress' view on health care for Indians and was, in effect, a clarification of the Federal responsibilities recognized by the Snyder Act. The Indian Health Care Improvement Act states that (25 U.S.C. section 1602):

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 meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all resources necessary to effect that policy.

ELIGIBILITY FOR FEDERAL SERVICES

Federally Recognized Tribes

Membership in a federally recognized tribe is the single most common standard for determining eligibility for Federal services. Therefore, the questions of what is a tribe, and for what purposes, need to be addressed.

Tribes were defined early in the Nation's judicial history in *Worcester v. Georgia* (220), and although modified by many cases, the definition remains applicable:

Indian tribes are "distinct, independent political communities possessing and exercising the power of self government . . ."

The tribe, whether denoted as a band, nation, rancheria, Pueblo, community, or native village, is the only self-governing political unit that represents Indians within the Federal-Indian relationship. Conceptually, whatever rights exist for individual Indians in the Federal-Indian relationship are derived from tribal membership.

The seeming purity of the concept, however, has been muddled by the pendulum swings in Federal laws and policies toward Indians. The allotment period left a legacy of vested rights in individual Indians with respect to part of the reservation lands. The 1934 Indian Reorganization Act created additional definitions of Indians in its attempt to assist tribes. Still later, termination created a situation in which persons who racially and culturally had remained Indian no longer had a political entity (the tribe) representing them that had any legal/political relationship with the United States. As a result, these Indian individuals for the most part lost their rights to services provided to Indians. Relocation created a situation in which Indians who retained their tribal membership might no longer be located near the network of reservation-based services that had been created. Finally, the explosion of social service and poverty-oriented programs in the 1960s and 1970s sometimes included tribes and sometimes did not. Some of these programs extended eligibility to Indian individuals who did not qualify for Federal services that were directed at tribally affiliated Indians.

With the exception of non-Indians appointed to represent Indians in some trustee capacity, the entity that represented Indians was whatever governing body the particular band, tribe, or confederacy of Indians set for itself. In dealing with the Federal Government, however, competing or even bogus entities became an issue in determining who spoke for particular groups of Indians. During the treaty period, unscrupulous negotiators on the part of the United States would sometimes choose or bribe individual Indians to serve as "official" representatives for the tribe involved in the treaty. The treaty that **was so** negotiated was allowed to stand, even though the individuals involved often did not in fact represent the tribe in question. Whomever the United States chose to deal with became the official tribe in the eyes of the U.S. legal system. This outcome is not dissimilar to those in international relations, where the United States or other governments may deny formal recognition to a government if they prefer to recognize a different or prior government. (For example, for more than 20 years the United States recognized the Nationalist Chinese Government of Taiwan, but not the People's Republic of China, as representing "China.") Such matters are viewed by the courts as political questions and generally are not held to be reviewable. Currently, there still are tribes with governing bodies that have been recognized by the United States but which have other, often-times traditional, governing bodies in existence.

Individual bands and tribes that were placed on a single reservation have also been consolidated into new political units corresponding to the larger reservation community, such as the Confederated Tribes of the Colville Reservation or the Three Affiliated Tribes of the Fort Berthold Indian Reservation. Generally, the treaty, statute, executive order, and/or constitution of the tribe or tribes involved will delineate who is the responsible governing body, and that document or documents will be controlling in determining who is the official tribal government. These mergers or consolidations of preexisting tribes or bands, however, have not always been successful. There are situations that have completely

paralyzed reservation communities and prevented any entity from effectively serving as a tribal government. Such situations may require congressional adjustment of the affected reservation.

Once a tribe has been recognized as a tribe by the United States, it does not lose its status unless the United States terminates the political relationship. Although it is not always clear how some tribes became federally recognized and others did not, Federal recognition of a tribe is the key ingredient for access to most Federal services that are provided on the basis of the Federal-Indian relationship. Early statutes rarely provided definitions of Indians or tribes and simply referred to either a particular tribe or to Indians generally. It was quite clear to everyone involved in those earlier days who the tribes were and who was an Indian.

Most of the modern statutes that provide services to Indians as part of the Federal-Indian relationship follow a fairly standard definition of an Indian tribe. The Indian Health Care Improvement Act contains the following definition (25 U.S.C. section 1603d):

“Indian tribe” means any tribe, band, nation, or other organized group or community, including any Alaskan Native Village or group or regional or village corporation as defined or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) [43 U.S.C. sec. 1601 et seq.], which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Given this somewhat circular definition of an Indian tribe as one recognized by the United States as an Indian tribe, the issue is: Who are the recognized tribes? Where either a statute, treaty, or historical relationship clearly has linked the United States with the governing body of a tribe, that tribe is usually a recognized tribe for the purposes of the Federal-Indian relationship. For the rest of the groups of Indians, the issue is more complicated.

One case that addressed this issue was *United States v. Washington* (126), in which the court found that neither Congress nor the executive branch has prescribed any standardized definition

for either the term “Indian” or “Indian tribe” in terms of the special Federal relationship with Indians (126). The case involved a determination of which descendants of groups that were parties to the various western Washington fishing treaties were tribes for the purpose of sharing in the treaty rights. The Federal District Court Judge stated in his conclusion (126):

In determining whether a group of persons have maintained Indian tribal relations and a tribal structure sufficient to constitute them as an Indian tribe having a continuing special political relationship with the United States, the extent to which the group’s members are persons of Indian ancestry who live or were brought up in an Indian society or community, the extent and nature of the members’ participation in tribal affairs, the extent to which the group exercises political control over a specific territory, the historical continuity of the foregoing factors and the extent of express acknowledgment of such political status by those Federal authorities together with the power and the duty to prescribe or administer the special political relationships between the United States and Indians are all relevant factors to be considered.

The judge found on the basis of this reasoning that none of the Indian groups petitioning to intervene in *United States v. Washington* (126) were Indian tribes. They were Indian descendants or groups that had participated in the treaties, but they were not tribes, and their members, although racially Indian, were not Indians with respect to the Federal-Indian relationship. To the extent that these individuals were eligible for any Federal services, specific statutory authorization would need to be found.

Contemporaneous with the decision in *United States v. Washington*, in 1978 the Department of the Interior issued in final form its first formal mechanism for determining whether a group was an Indian tribe for the purpose of the Federal-Indian relationship (25 CFR 54). (Congress, of course, did not give up its authority to recognize specific tribes by statute; e.g., the Maine Claims Settlement Act [25 U.S.C. sections 1721, et seq.].) These regulations created what is known as the Federal Acknowledgment Process and set out the criteria that petitioning groups would have to

meet to receive Federal recognition. In general terms, petitioners would have to show that the Indian group (141):

- had been identified as Indian from historic times to the present on a substantially continuous basis;
- had occupied a specific geographic area or community distinct from other populations in the area, and its members are descendants of an Indian tribe that historically inhabited a specific area;
- had maintained tribal political authority over its members as an autonomous entity throughout history;
- had governing procedures pertaining to membership;
- had a membership role that was historically traceable to the historical entity defined above;
- had no members who were primarily of any other tribe; and
- had not been legislatively terminated.

The criteria have not been easy to meet, and the Acknowledgment Process has not resulted in the speedy determination of which Indian groups should be recognized as tribes.

In addition to federally recognized tribes and groups that have not been recognized, there are tribes that have been terminated. Termination was a legal process where by statute, the United States severed its ties with particular tribes. Termination is now a discredited Federal policy, but, as with all Federal Indian policies of the last two centuries, the negative effects linger. Many terminated tribes remain terminated; their members are not “Indians” for the purpose of Federal programs. Several tribes, however, have been statutorily restored by Federal legislation to their previous status as federally recognized tribes (e. g., the Menominee Tribe of Wisconsin). In addition to those few tribes that have been statutorily restored, the termination of many of the California tribes and rancherias has been held to be defective by the Federal courts, and these tribes retain their service rights.

There are also a host of Indian organizations—formal, informal, statutorily created, statutorily acknowledged, or creatures of tribal government

—that are not tribes. Membership in any such organization is not the same as membership in a federally recognized tribe, and no generic rights are conferred by membership. To the extent that a role is provided for any particular organization, that role is specific and, unlike tribes, no inherent governmental power is inferred. For example, the statute on Indian education (25 U.S. C. section 2019) defines both agency school boards and Indian organizations and delineates the specific functions each will assume in the BIA education system. In the health area, the Indian Health Care Improvement Act acknowledged urban Indian health programs (they were begun under the general authority of the Snyder Act) and authorized funds for them. Urban Indian organizations operating these programs are recognized as having distinct and specific roles in the delivery of health care to Indian people in urban settings (25 U.S. C. sections 1651-1658).

Eligibility of Indian Individuals for Federal Services

For most of the years that the Federal Government has been providing services to Indians, the question of who was an Indian was not particularly significant. Such questions most frequently arose in determining whether a particular individual or class of individuals had been emancipated from their tribal ways, or whether a particular individual or class of individuals was subject to Federal criminal statutes that asserted Federal jurisdiction over Indians for some offenses.

Who was an Indian for the provision of health services was definitely not a significant issue. Frequently, appropriations language was so vague that it was BIA that determined who received benefits. The Federal bureaucracy that had developed to provide services to Indians became accustomed to determining the nature and scope of services that the tribes were to receive.

Historically, during the period when tribes were distinct and separate, who was an Indian was not a particularly difficult factual or legal question. Congress in the Snyder Act did not see any need to define “Indian” because at the time of the act (1921), services were only provided to those In-

dian tribes that were recognized as having a political relationship with the United States.

Today, however, several hundred years of shifting law and policy have generated different categories. For example there are, among other categories, terminated, nonrecognized, and urban Indians. The post-1960 statutes that authorize services pursuant to the Federal-Indian relationship do not really address the issue of who is an Indian because of the somewhat circular definition described above,

Generally speaking, the political definition of “Indian” is the province of each Indian tribe. This power of tribes to define their membership has been repeatedly recognized by Federal courts (20,28,98). Each tribe may use its own criteria, but for the most part, tribes have required some level of Indian blood of the particular tribe for membership. With the exception of a number of tribes without blood quantum requirements, most tribes have at least a one-eighth blood quantum requirement (129). Without specific Federal legislation that overrides or controls the membership determination, the courts defer to the tribes (75). This is true even under the Indian Civil Rights Act of 1968 (25 U. S.C. sections 1301-1303), which states that no Indian tribe shall “deny any person within its jurisdiction the equal protection of the laws or deprive any person of liberty or property without due process of law . . .” The courts would not interfere in a case where only the children of male tribal members were eligible for tribal membership in mixed marriage situations, and held that such matters were within the authority of the tribe to determine (74).

Congress, however, can and does expand or narrow the definition of “Indian.” Thus, it is important to examine the specific purposes for which the definition of Indian is being used in given circumstances.

Statutes that define who is an Indian may have broad implications. A prime example is a statute that either acknowledges the Federal-Indian relationship with a tribe, or terminates that relationship. Other statutes that are part of the Federal-Indian relationship are more limited in their scope. For example, the definition that Congress used for Native Alaskans concerning the importation of

reindeer (25 U.S. C. section 500), although appropriate for this purpose, should have no particular implications for the delivery of health services. Moreover, rolls established for the distribution of monetary judgments awarded in cases of ancient Indian claims may include persons who are not eligible for tribal membership according to the criteria that the tribe currently has in place.

There are also a host of Federal statutes that provide services to Indians and that contain varying definitions of Indians and/or Indian tribes. Many of these statutes are not premised on the Federal-Indian relationship, and the services provided to Indians are usually part of a larger program of which Indians are but one beneficiary class.

The Snyder Act contains no express statutory language on who shall be eligible for Indian Health Service (IHS) services other than “Indians throughout the United States.” In the absence of clear congressional direction, the question becomes to what degree agencies can restrict or alter the definition of who is an Indian.

The leading case in the area of agency discretion is the 1974 decision of *Morton v. Ruiz* (89). *Ruiz*, a member of a federally recognized tribe, had close ties with his reservation but lived off the reservation in a nearby Indian community located on the former aboriginal lands of his tribe. He was denied benefits from a BIA program known as General Assistance. The denial was based solely on the fact that he did not live on the reservation. BIA’s authority to provide general assistance to Indians is the Snyder Act, which does not contain any express limitations with respect to reservation residency. The Supreme Court, however, did not consider *Morton v. Ruiz* as a case where the statutory language was clear and controlling. Such an analysis by the Court would have struck down any agency construction of the statute that had the effect of narrowing the statutorily designated group of beneficiaries. Instead, the Supreme Court viewed the Snyder Act as an enabling act under which an agency would be allowed significant discretion in determining the scope of programs.

The Government urged in *Morton v. Ruiz* that under a previous ruling giving great discretion to

administrative agencies (42), agencies should be allowed great latitude in implementing their governing statutes. The Government also asserted that the limitation of services to reservation residents was required, given the limited appropriations that Congress had provided for the program, and that Congress by not overturning the regulations had ratified the agency's actions over the course of the years.

The Supreme Court found that Ruiz was an individual within the class of intended beneficiaries, and in effect struck down the reservation-only service criteria. Its decision seems to be based more on the lack of consistency between BIA's own policy and its representations to Congress than on any other factor. In reaching its conclusions, however, the Court did set out a fairly permissive standard for agency decisionmaking (89):

(I)t does not necessarily follow that the Secretary is without power to create reasonable classifications and eligibility requirements in order to allocate the limited funds available . . . (I)f 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 . . . The power of an administrative agency to administer a congressionally created and funded program necessarily requires the formulation of policy and the making of rules to fill any gap left implicitly or explicitly by Congress.

Morton v. Ruiz is therefore extremely relevant to the issue of who is an Indian for the delivery of health care services because of the latitude it gives to agencies to determine eligibility.

Shortly after the *Morton v. Ruiz* decision, IHS attempted to limit the eligibility of Indians for contract care to Indians living on or near reservations. Since IHS chose to codify its policy by fiat, its initial attempt was struck down (65) for failure to follow the publication and notice requirements of the Administrative Procedure Act (APA) (5 U.S. C. section 601e). However, similar regulations were subsequently published under APA that contained the same contract care restrictions. These regulations, which have not been challenged on a substantive basis, are currently operational.

Therefore, adequate notification and opportunity to comment must take place before a regulation implementing a statute is formalized. However, under APA, the Federal agency's action is presumed to be valid and must be confirmed if its actions were not "arbitrary, capricious, or otherwise not in accordance with law" (5 U.S. C. section 706[2][A]). The action is valid if all the relevant factors were considered, and any discernible rational basis existed for the agency's actions (22).

Another standard for judicial review of agency rulemaking is applicable to constitutional claims under the equal protection clause of the 14th amendment. Under this standard, a "rational basis" must exist for the agency's actions (25). This standard is similar to, but not a substitute for, the statutory standard set out in APA. A stricter standard is applicable when suspect classifications (e.g., ancestry [96], race [81], alienage [41]) or fundamental constitutional rights (e.g., right of interstate travel [108], right to vote [14], right of privacy with respect to abortion [105]) are involved.

In the 1980 case of *Rincon Band of Mission Indians v. Califano* (104), a band of California Indians sued for their fair share of IHS resources. They argued that, in examining IHS's method of allocation, the stricter constitutional standard of reviewing IHS's conduct be applied. IHS, on the other hand, argued that a "rational basis" test be used, claiming that no constitutional rights were involved.

The district court found that IHS's allocation system had no rational basis, thereby violating California Indians' right to equal protection of the laws as guaranteed by the due process clause of the fifth amendment. Because it found that the allocation system had no rational basis, the court did not find it necessary to decide whether the "strict scrutiny" standard was appropriate.

On appeal, the ninth circuit affirmed the district court's decision, but on the basis that IHS had breached its statutory responsibilities to the California Indians, so it did not find it necessary to address the constitutional question. Thus, at least the minimum requirements of APA must be

met, with the application of a higher constitutional standard yet to be fully adjudicated.

The California Indians had also contended that the Snyder Act and the Indian Health Care Improvement Act of 1976 created a trust obligation between the United States and Indians, and that IHS had breached its fiduciary duty as trustee by failing to provide California Indians with a level of health services comparable to that provided Indians elsewhere in the United States. The ninth circuit indicated that it would not make such a finding, but stated that it did not have to rule on the applicability of the trust responsibility to the two statutes to make its decision,

Turning next to the degree of Indian blood an individual must have in order to be eligible for Federal benefits, the issue of a blood quantum requirement beyond the level that a tribe sets for itself is a conceptually difficult one, because the Federal-Indian relationship is based on political, not racial, factors. Moreover, blood quantum as a standard for providing services comes factually close to a suspect racial classification under constitutional law.

Congress, in its attempt to revitalize the tribes, provided in the Indian Reorganization Act (25 U.S. C. section 45) for preference in employment for Indian persons in the Federal Indian Service. (Earlier statutes also contained preference provisions.) The act set out a several-part definition of eligibility (25 U.S. C. section 45):

All persons of Indian descent who are members of any recognized tribe now under Federal jurisdiction, and all persons who are descendants of such members who were on June 1, 1934, residing within the present boundaries of any Indian reservation, and shall further include all other persons of one-half or more Indian blood.

The clear language of the statute created three categories. *However*, for over 40 years, BIA took the third category, one-half or more Indian blood, and used it as an overlay governing the other categories. Thus, to qualify for Indian preference, one had to be a half-blood member or a half-blood descendant of a member. The action of BIA was outside the plain language of the law, and the half-blood requirement was finally dropped following a legal challenge (213).

While IHS considers its eligible population to be persons of Indian descent (42 CFR 36.12), some of the programs provided by BIA under the authority of the Snyder Act require that individual Indians be a member of a federally recognized tribe or have one-fourth degree or more Indian blood to receive services (25 CFR section 20.1[n]). However, unlike the Indian Employment Preference legislation, which contained a statutory definition of who was eligible that BIA had clearly violated, there is no express statutory language in the Snyder Act other than "Indians throughout the United States." Under these circumstances, therefore, the rational basis test of *Morton v. Ruiz* (89) is probably operable.

Finally, there *is* the question of whether Alaska Natives stand in any different position than Indians generally with respect to the Federal provision of health services. The issue comes up because of the unique land claims settlement and corporate structure created by the Alaska Native Claims Settlement Act (ANCSA) (43 U.S. C. sections 1601, et seq.). Under ANCSA a complex system of corporations has been set up to hold and invest both the land and monetary aspects of the settlement, Alaskan native people received stock in these corporations. Undeveloped lands were to remain nontaxable until the year 1991, the year that Native-held stock would also become freely transferable. These provisions resemble aspects of the Federal trust relationship with respect to the physical assets of tribes in the "lower 48" States. ANCSA, however, is a land claims settlement and not legislation that defines *or* limits in any way the preexisting special trust relationship that Alaska Natives have with the United States.

ANCSA by its own terms provides that it is for the extinguishment of land claims and shall not be deemed to substitute for any governmental programs otherwise available (43 U.S. C. section 1626a). Most commentators agree that ANCSA neither created a new trust relationship nor terminated the preexisting trust relationship between the United States and Alaska Natives. (ANCSA, however, did provide a definition of Alaskan Natives that has been adopted in other Federal statutes.)

IS THE INDIAN HEALTH SERVICE A PRIMARY OR RESIDUAL HEALTH CARE PROVIDER?

Indians are U.S. citizens and also are eligible for services provided to other U.S. citizens, including both Federal and State services. Through regulations, IHS services are residual to other sources; i.e., other governmental and private sources of care for which the Indian patient is eligible must be exhausted before IHS is obligated to pay for medical care. The residual payer role of IHS is discretionary for direct IHS services (42 CFR 36.12 [c]); and as a matter of policy, IHS generally will provide services to a patient in IHS facilities regardless of other resources, but will seek reimbursement from these other sources for the care provided. In contrast, IHS's residual payer role is mandatory for contract care obtained from non-IHS providers (42 CFR 36.23 [f]); and IHS will not authorize contract care until other resources have been exhausted or a determination has been made that the patient is not eligible for alternative sources of care.

One issue that has arisen from this "residual payer" situation is the question of who is the primary, and who is the residual payer, when State or local governments also have a residual payer role. This situation arose in litigation between IHS and Roosevelt County, Montana, with the county arguing that it was not discriminating against Indians, but merely applying its alternate resource policy across the board to all eligible citizens who have double coverage, thereby meeting the "rational basis" test for judicial review (79).

The vetoed Indian Health Care Improvement Act Amendments of 1984 provided for a "Demonstration Program Regarding Eligibility of Certain Indians for Medical and Health Services" (section 204[a]). The provision, commonly known as the "Montana amendment," was designed to relieve what several Montana counties saw as their financial burden in providing and paying for medical services to indigent Indians. The amendment was converted into a Montana-only demonstration project in the House-Senate conference and would have made IHS financially responsible for medical care to indigent Indians in Montana. This responsibility was to exist only where State or local indigent health services were funded

from taxes on real property and the indigent Indian resided on Indian property exempt from such taxation. Senator Melcher of Montana analogized his amendment to the type of services that BIA provides to Indians for education or general assistance. The conference report on the bill stated that the provision would not preclude an Indian from receiving State or county-provided health care services or financial assistance for health care services that are provided to all State citizens; nor that it would preclude an otherwise eligible Indian from participating in Medicaid, even where those benefits were paid for in part by State or local funds derived from revenues raised from real estate property taxes (133).

President Reagan disagreed with such an approach and vetoed the legislation. Two concepts underlie the President's veto. The first is that the amendment would allow States to deny services to Indians, an act that would be unconstitutional under the equal protection clause of the 14th amendment. Indians, as State citizens, are constitutionally entitled to State and local health benefits on the same basis as other citizens. The other concept is that, under IHS's contract care eligibility standards, the Federal Government can place its provision of services to Indians in a secondary, or residual position. The State or county cannot presume that Indians have a right or entitlement to IHS contract care services so that it can deny assistance on the grounds of double coverage. In fact, the Federal regulations on contract care expressly deny that such a right exists. In such a conflict, the supremacy clause of the Constitution would resolve the issue in favor of the IHS regulation (79).

In January 1986, in *McNabb v. Heckler, et al.* (82), the United States District court for the District of Montana, Great Falls Division, ruled that the Federal Government, and not Roosevelt County, was primarily responsible for the care of the Indian plaintiff. Though the court did not find the trust doctrine, the Snyder Act, or the Indian Health Care Improvement Act as individually entitling Indians to Federal health care, the court found that the two statutes, read in con-

junction with the trust doctrine, placed the burden on IHS to assure reasonable health care for eligible members. The court, however, did not address the equal protection and supremacy clause arguments outlined above, and the decision is being appealed (80). Furthermore, the court invited Congress to address the issue by stating that:

The better avenue for resolution of disputes of the type presented here rests with the legislative branch. This court can only interpret the limited legislative enactments and statements of congressional intent available to it. Congress could quickly resolve a question which this court has wrestled with for many months (82).

CONCLUSIONS

Federal law and policy have evolved through a complex mixture of practice, court decisions, and congressional legislative and appropriations activities. Periodic shifts, including complete reversals, in Federal-Indian policy have created unclear responsibilities as well as various categories of Indians. Several generalizations are, however, relatively clear. Indian affairs is predominantly a Federal and not a State responsibility. The operative relationship is between the Federal Government and the tribal government. On the Federal side, the power is constitutionally assigned to Congress; however, until recently very few of the health-related statutes have contained specific congressional directives on how they should be implemented. This situation has long favored decisionmaking and policy development by the administrators of Indian programs. For most of the history of Federal-Indian relationships, the power of administrators was not able to be legally challenged by dependent Indian tribes. Only in the last several decades has litigation begun to define the perimeters of agency power.

The trustee role adopted by the Federal Government has its origins in more than the United States being the technical legal owner of Indian land. Among other roles, the Federal Government was to protect tribes against non-Indians (States) and to provide necessary services. The operative documents for determining the scope of the Federal responsibility in any given situation are the treaties and statutes. In situations where the statutes or treaties are unclear, the courts have developed special rules of interpretation—rules that give the most favorable interpretation or construction to the Indian parties.

With the exception of specific congressional directives, whatever rights exist for individual In-

dians in the Federal-Indian relationship are derived from membership in a federally recognized tribe, even though it is not always clear how some tribes became federally recognized and others did not. Federal recognition is the key ingredient for access to most Federal services that are provided on the basis of the Federal-Indian relationship. Although Congress has the power to determine who is eligible for benefits, it expresses that power infrequently and has usually deferred that determination to the executive branch.

As noted, for the most part rights within the Federal-Indian relationship derive from an individual Indian's membership in a federally recognized tribe. The definition of that membership is a tribal prerogative. Although Congress routinely uses the tribal membership definition, it can add additional definitions, or use specific definitions of Indian eligibility for specific programs. Courts will defer to these congressional determinations as long as they have the overall purpose of furthering the Federal-Indian relationship. It is important to distinguish, however, whether Congress is or is not acting pursuant to the Federal-Indian relationship. There are many Federal statutes that may provide services to individuals who are defined as Indian for the purposes of the particular statute but who are not Indians for purposes of the Federal-Indian relationship.

In addition to the issue of what definition Congress is adopting for the provision of services, is the issue of agency discretion to modify, expand, or limit the congressional definition. Where Congress has provided no definition, what is the scope of agency discretion to create service eligibility criteria that in effect define Indians for that particular service? To date, litigation has addressed these questions in only a limited fashion. Mor-

ton v. Ruiz (89) is probably the leading case. It evaluated the agency determination of service eligibility by determining if the agency action had any “rational basis.”

Reid Chambers, formerly the Associate Solicitor for Indian Affairs at the Department of the Interior, in his classic 1975 article on the trust responsibility (18), came to the conclusion that it is unlikely that the judiciary would, in the absence of a specific treaty, agreement, or statute, find the social services provided by the Federal Government to be a trust obligation to Indians. An exception is perhaps provided, he reasoned, where the denial of services is so extreme that a right somewhat analogous to “the right of treatment” developed in prisoners’ rights cases may arise.

Several factors existing at the time of the Chambers article invariably led to such conclusions. No case had held that the trust responsibility required that social services be provided. The one case in point at the time was the 1970 decision in *Gila River Pima Maricopa Indian Community v. United States (37)*, which held that the United States had no legally enforceable duty in the absence of a specific provision in a treaty, statute, or other legally controlling document. In addition to cases that directly consider the scope of the trust obligation, another factor was the plenary power doctrine. Pursuant to the plenary power doctrine, the courts defer to congressional judgments in Indian affairs; this deferral had permitted Congress to unilaterally alter, modify, or eliminate the Federal Government’s obligations to Indians.

The judiciary had been clinging to the narrow role that had been defined for it in the 1903 classic case on congressional plenary power, *Lone Wolf v. Hitchcock (66a)*. *Lone Wolf* had stood for the proposition that Congress has extraordinary power in Indian affairs and that the judiciary, while it will interpret the actions of Congress, will only rarely scrutinize on a constitutional basis the exercise of the power of Congress. In *Lone Wolf*, the Kiowas and Comanches had by treaty with the United States provided for a specific mechanism to control the sale of Indian lands. Congress subsequently enacted a statute containing a process different from that in the treaty. The

tribes sued to have the land sales set aside for violating the treaty. Allegations of fraud were also made by the tribes. The Supreme Court refused to look behind the action of Congress in passing the statute, but, fortunately for the complaining tribes, also held that the statute had abrogated the treaty.

The Lone Wolf doctrine has been somewhat modified in recent years (127). The two modifying cases are *Delaware Tribal Business Committee v. Weeks (28a)*, where the Supreme Court reached the merits of a due process challenge, and *United States v. Sioux Nation (125a)*, where the Supreme Court indicated that it would determine in what capacity the United States was acting, rather than following the conclusive presumption in *Lone Wolf* of congressional good faith. *Weeks* requires that congressional efforts to affect its trust obligation to Indian tribes must be rationally tied to its “unique (trust) obligation.” *Sioux Nation* found the United States to be exercising the traditional function of a trustee and therefore held the United States to the usual standards of a traditional trustee. These modifications, which involve the utilization of constitutional standards analogous to those standards used in equal protection/due process analyses, have potential implications for any definition of the Federal Government’s health obligation to Indians. For if Congress is to be held to any constitutional standard of fairness that ties the scope of its responsibilities to the purpose of its obligation—e.g., to benefit Indians—then the executive branch must be held to at least as stringent a standard in determining the scope of its authority.

There has been only one case, *White v. Califano (212)*, that considered directly the Federal Government’s obligation to provide health services. *White v. Califano*, like most cases, has a unique factual and jurisdictional setting, in which the court answered a relatively narrow question. An indigent Indian residing on the Pine Ridge Reservation in South Dakota was held to be incompetent by the Pine Ridge Tribal Court. The tribal court then entered an order seeking to have the “incompetent Indian” committed to a South Dakota State mental institution. South Dakota refused to accept the patient, arguing that under

applicable Federal law, it lacked jurisdiction over her and could not take custody. South Dakota also asserted that an “incompetent” Indian was the responsibility of the Federal Government. The United States had also refused to provide any services to the patient. Her guardians sued the United States and South Dakota to provide services. Interestingly, the U.S. Government viewed the case as primarily one of a State violating the “civil rights” of an individual Indian, and the case was in large part the responsibility of the Civil Rights Division of the Department of Justice. The Justice Department used the same conceptual argument on dual entitlement contained in the President’s veto message on the Indian Health Care Improvement Act amendments.

White v. Califano does not settle the issue of primary versus secondary responsibility, since the eighth circuit sustained South Dakota’s assertion that it lacked jurisdiction over incompetent Indians and as such could not provide custodial services. The court rejected the argument that the United States had no duty to provide facilities for mental health and found that instead the United States had the duty to provide care under its trust responsibility and, specifically, that it was pursuant to the Indian Health Care Improvement Act.

White v. Califano has been criticized by at least one Indian commentator, Pine Ridge Tribal Judge Mario Gonzalez (40). Judge Gonzalez does not accept the analysis that begins with Indians being State citizens; he argues that even though Indians became U.S. citizens in 1924, it is not necessary for them to be State citizens to enjoy constitutional protections. He argues that under the full faith and credit clause of the constitution, South Dakota should have accepted the tribal court decree and provided services. He also notes that South Dakota mental health services were in any event 68 percent federally funded. The attempt of the Federal Government to evade its responsi-

bilities also was severely criticized by Judge Gonzalez.

If *White v. Califano* is followed, an eligible Indian who has no other alternative probably would not be denied health services by the Federal Government. Any award of damages under present law would seem to require specific statutory authorization. However, where breaches are provable, equitable relief should be available against the appropriate Federal agency and its officials.

White v. Califano was also cited by the judge in the 1986 *McNabb v. Heckler, et al.* (82) decision discussed above, where an alternative source of payment, Roosevelt County, was available. The judge stated that:

... the court believes that the real importance of *White* lies in its extended discussion of the (F)ederal Government’s trust responsibility to Indians. Further, this court believes that the trust analysis employed in *White* was equally responsible for the result reached therein, to be accorded equal footing with the court’s conclusion that local governments had no authority to involuntarily commit mentally ill Indian persons (82).

Whatever difficulties the legal profession may have in defining the perimeters of the trust obligation, it is within Congress’ powers to define those perimeters, and Indian people have consistently maintained that health care is part of the trust obligation of the United States. According to a report in the mid-1970s by the American Indian Policy Review Commission (130):

Indian people are unanimous and consistent in their own view of the scope of the trust responsibility. Invariably they perceive the concept to symbolize the honor and good faith, which historically the United States has always professed in its dealings with the Indian tribes. Indian people have not drawn sharp legal distinctions between services and custody of physical assets in their understanding of the applications of the trust relationship.