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EXAMINING THE FEDERAL TAX TREATMENT OF HEALTH CARE BENEFITS PROVIDED BY TRIBAL GOVERNMENTS TO THEIR CITIZENS

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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EXAMINING THE FEDERAL TAX TREATMENT OF HEALTH CARE BENEFITS PROVIDED BY TRIBAL GOVERNMENTS TO THEIR CITIZENS

FRIDAY, SEPTEMBER 18, 2009

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:00 a.m. in room 628, Dirksen Senate Office Building, Hon. Tom Udall, U.S. Senator from New Mexico, presiding.

OPENING STATEMENT OF HON. TOM UDALL, U.S. SENATOR FROM NEW MEXICO

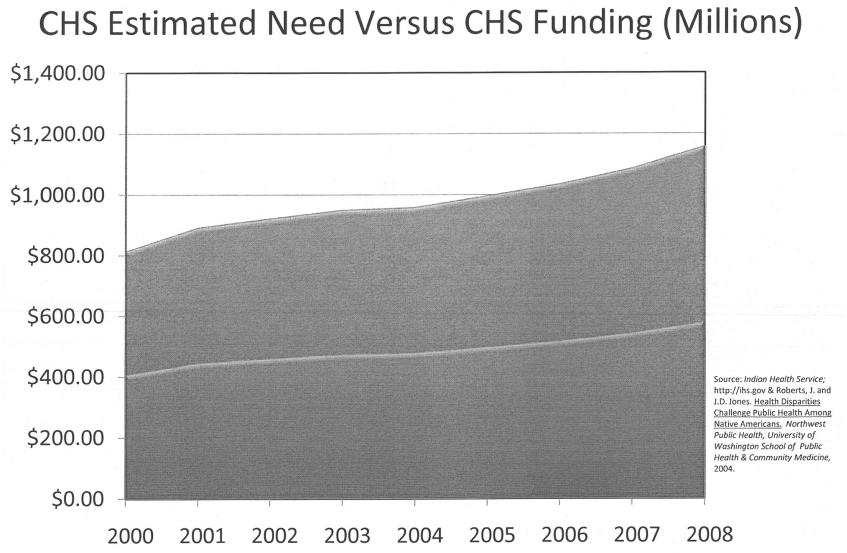
Senator UDALL. Good morning, everyone. It is good to have you all here. I would at this point ask the Committee to come to order.

First, I would like to pass on Senator Dorgan's apologies for the inconvenience in scheduling this hearing and want to thank our witnesses for their great flexibility in being here today.

The Committee meets today to examine the Federal tax treatment of health care programs the tribal governments provide to their citizens.

It is well documented that we as the Federal Government are failing in meeting our obligation to provide health care to Native Americans. Native Americans face health disparities at almost every level. American Indians and Alaska Natives face lower birth rates, shorter life spans, and significantly higher rates of disease such as diabetes, suicide, and substance abuse. The Indian Health Service attempts to address these disparities by delivering health services to tribal communities. However, many times the services offered by the IHS are outdated and chronically underfunded.

We have a chart that is being raised that depicts some of that underfunding in the form of contract health services. As you can see, contract health is only funded at 50 percent of need. As a result, contract health funding is depleted half way through the fiscal year. It is common in Indian country to hear the phrase, don't get sick after June, in reference to the fact that funding has run out. When contract health funds run out, the Indian Health Service is forced to ration services and limit treatment to those patients who face immediate loss of life or limb.



Because of the Federal Government's failure to meet these obligations, a number of tribal governments are taking matters into their own hands. We will hear about some of those today. Some tribes are using their own revenue to reimburse individuals for services that do not meet the life and limb requirement. Other tribes are using revenue to supplement services offered by the IHS or to make improvement to the local IHS facility. Still other tribes provide private health coverage for their members to help offset the failures of the Indian Health system. Tribes are taking these steps because their communities are suffering an unnecessary loss of life due to the lack of access to adequate health care.

We have another chart here that we are putting up. I have a story to share about a young man from Isleta Pueblo in New Mexico named Russell Antonio Lente. Russell was a talented young artist and a student at the Institute of American Indian Arts. He loved to paint and his artwork was featured on billboards, murals, and even skateboards. Despite the advancement in modern medicine, Russell lost his life to cancer at 23 years of age. Russell was diagnosed with cancer but it went untreated because contract health services funds were not available. He was told that his cancer didn't meet the priority one life or limb requirement. Russell's cancer had reached stage IV and was untreatable when he was finally eligible for contract health services and referred to an oncologist. Russell died a short time later.

Russell wasn't given a chance because of this broken system that doesn't consider cancer treatment a priority. It is because of stories like Russell's that tribes are trying to become a part of the solution by attempting to improve their health care programs.

As the Committee will hear today, these tribal efforts are being met with some resistance by the Federal Government. Some tribal health programs are now under review to determine whether they should be treated as taxable income.

It is my understanding that the Internal Revenue Service is attempting to follow the black letter of the tax code. However, as a Member of this Committee, I also understand the great obligation of this Government to Indian people. The United States has treaty and statutory obligations to not only maintain but to improve the health status of Native Americans. There must be room to consider these competing Government obligations when making these decisions about taxability.

In my mind, we should be relieved that some tribal governments are able to fill the void where the Federal Government has failed. At the very least, we should not penalize tribal governments for meeting our obligation and for exercising the right to self-governance that Congress supports.

I want to again thank our witnesses for their flexibility in being here. I look forward to hearing your testimony. I know that Mark Macarro, the Pechanga Chairman, has a plane to catch and so he is going to have to head to the airport after he gives his statement.

We are going to start from the left. Mark, you will go second. We understand you have a commitment to make on that.

Sarah Hall Ingram, please?

STATEMENT OF SARAH H. INGRAM, COMMISSIONER, TAX EXEMPT AND GOVERNMENT ENTITIES, INTERNAL REVENUE SERVICE

Ms. INGRAM. Thank you. Good morning, Mr. Chairman and my fellow witnesses. I appreciate the opportunity to be here this morning to explain the tax treatment of health care that tribal governments choose to provide to their members.

Before delving into the tax rules, I want to acknowledge the unique government-to-government relationship between the Federal Government and Indian tribal governments as set forth in our United States Constitution, treaties, statutes, executive orders, and court decisions. The responsibility to provide health services to American Indians and Alaska Natives derives from this relationship as well as from specific statutes. However, in addition to the services provided through that avenue, many tribal governments in the exercise of their sovereignty have developed other innovative approaches to providing health care to their members.

As I focus on the Federal tax treatment of health care benefits provided by tribal governments, I would like to note that these tax rules have existed for decades. They also apply to benefits provided by non-tribal governments including Federal, State, and local authorities. The provisions in Title 26 of the U.S. Code, which governs Federal taxation, apply equally to all types of citizens and employers. The administrative exclusion, the general welfare exclusion, applies equally to all governments, tribal and non-tribal.

Now I would like to address the basic tax rules and how they apply under two key scenarios, where the tribal government is providing benefits to its own employees, and I will cover that briefly, and then where the tribal government is providing benefits to a broader group of its tribal members. For this discussion, we need to focus on two types of benefits, the up-front provision of health insurance coverage and the back-end provision of medical services.

To begin, Section 61 of Title 26, a foundational rule in Federal tax law, provides that gross income includes all income from whatever source derived unless a specific exception applies to expressly exclude it from taxation. Although Title 26 contains many health care related sections, today I would like to focus on three provisions in Title 26 and on the application of what is known as the general welfare exception.

So let me touch briefly on where the tribal government is the employer. If the tribal government is the employer of the individual, it is possible to exclude from the employee's income both the value of the up-front health coverage under section 106(a) and the back-end benefits under 105(b). This tax treatment can work in a number of formats including self insurance, the purchase of a group policy, or the payment of premiums. These statutory rules apply to all types of employers, governmental and private.

I do want to note that some people have raised to us the situation in which the tribe pays for medical benefits to employees on an ad hoc basis. In the absence of a consistently applied tribal program that addresses who and what is covered, an ad hoc arrangement would not tend to constitute a health plan under section 105 so the amounts paid for medical services under that kind of an arrangement would not be excludable.

Now I would like to turn to the situations in which the tribal government would like to provide health benefits to tribal members who are not employees of the tribal government. The first thing to note is that there is no statutory parallel to section 106 that would give tax favored treatment to the tribal member when the tribal government provides up-front health benefits to all of its tribal members without regard to the employee issue. Section 106(a) excludes the value of up-front health coverage from income only if it is employer-provided. With no parallel exclusion for non-employees, these tribal members would have no means under the statue to exclude the value of tribally-provided health care coverage, that up-front coverage.

In contrast, there may be ways under Title 26 to exclude the payment of the back-end medical benefits. Section 104(a)(3) provides that as long as the arrangement is or has the effect of accident and health insurance, then it may be possible to exclude the value of the medical services from the tribal member's income. In some sense, provision 104(a)(3) parallels the section 105(b) treatment on the employee side.

Again, Title 26 itself provides that for non-employee tribal members, the value of the up-front health coverage would not be excluded but the value of the back-end medical services could be excluded as long as the arrangement meets the requirements of 104(a)(3).

The final component I want to touch on is the general welfare exclusion. This is a non-statutory administrative exclusion that has developed over more than 50 years in IRS revenue rulings and notices. It has been recognized by a number of courts.

Although section 61 broadly defines the items that are included in gross income, the Service has consistently concluded that payments made to individuals by government units, tribal or non-tribal, under legislatively provided social benefit programs for the promotion of the general welfare are not includable in a recipient's gross income. The decades of rulings have generally followed three basic principles in determining whether a program may qualify for the general welfare exclusion. The payments need to be made from a governmental fund; they need to be for the promotion of general welfare, generally based on a demonstrated needs criteria; and they need to not represent compensation for services.

Whether this exclusion would apply to a tribal government providing health coverage or benefits to tribal members would depend on how the program is structured and administered. If the tribe provides such assistance only in cases of demonstrated need pursuant to consistently applied standards of financial need, the general welfare exclusion might well apply. The financial needs standard and the nature of the expenses being covered would tend to be among the factors that we would look at.

We have seen many programs both in Indian country and with other governments that work within the principles of the general welfare exclusion and successfully provide needed benefits without generating income to recipients. However, the Service generally has not applied the general welfare exclusion to programs that benefit persons with significant income or assets. Any such extension would represent a departure from well established administrative

practice. Over the past decades, the IRS has declined to apply the general welfare exclusion to programs that fail to tie benefits to some needs-based criteria. There are a number of examples, for example in the State government area.

Finally, Mr. Chairman, I would like to thank you again for this opportunity to come this morning. I am aware of this Administration's commitment to strengthen and build on the government-to-government relationship between the United States and tribal nations. I appreciate your interest in this matter.

This concludes my testimony. I would be glad to answer any questions.

[The prepared statement of Ms. Ingram follows:]

PREPARED STATEMENT OF SARAH H. INGRAM, COMMISSIONER, TAX EXEMPT AND GOVERNMENT ENTITIES, INTERNAL REVENUE SERVICE

Good afternoon, Mr. Chairman, and members of the Committee.

I appreciate the opportunity to be here this afternoon to explain the tax treatment of health care that tribal governments choose to provide to their members.

At the outset of my testimony before delving into the tax rules, I want to acknowledge that the United States has a unique legal relationship with Indian tribal governments as set forth in the Constitution of the United States, treaties, statutes, executive orders, and court decisions. Our responsibility to provide health services to American Indians and Alaska Natives derives from the government-to-government relationship between the Federal Government and tribal governments, as well as specific statutes, such as The Snyder Act and the Indian Health Care Improvement Act, that provide the authority for Congress to appropriate Federal funds to provide health care to our First Americans.

The Indian Health Service, a federal agency within the Department of Health and Human Services, provides clinical and public health services to American Indians and Alaska Natives often in remote, economically depressed locations with limited access to health facilities. In the face of these challenges, many tribal governments have developed innovative approaches to providing health care to their members.

I recognize that tribes and tribal members may have a variety of non-tribal health resources available to them. Depending upon location and other considerations, these may include employer provided insurance, Medicare, the Indian Health Service, and federal, state and local health programs, insurance arrangements, hospitals and clinics.

Within this health care environment, tribes, in the exercise of their sovereignty, may wish to create new health care opportunities for their members, or to expand or augment the health care presently available to their members. This afternoon, I will address the tax aspects of a number of methods tribes may have used, or have considered using, to provide medical benefits or health insurance coverage to their members.

Allow me, Mr. Chairman, to note that the tax rules that apply to health care provided by tribal governments are the same rules that have existed for decades and that apply to such care and benefits provided by non-tribal governments, including federal, state, and local authorities.[1] There are no special tax rules that apply uniquely to tribal government health care programs.

I would also like to note that the Internal Revenue Service does not have a special program to examine tribal health programs. Nor are we emphasizing this area at the moment. That said, the issue of the taxability of medical benefits and health insurance coverage can arise from time to time in the normal course of an audit as we look at whether a tribe, or any other type of government or employer, is following appropriate information reporting and withholding practices as it administers its various programs. Moreover, the issue can arise when a government or employer comes to the IRS seeking a legal ruling about the tax treatment of a proposed plan or arrangement.

[1] The statutory rules are included in the Internal Revenue Code (the "Code"), Title 26 of the United States Code.

The Principal Questions at Issue

In considering the tax treatment of health care that a tribe might provide for its members, we need to focus principally on two types of benefits and two categories of tribal members.

The first type of benefit is health insurance coverage that the tribe provides to the tribal member. The tribe may pay the insurance carrier directly, or self-insure. I will refer to this benefit as health insurance coverage, or "up-front coverage." The second type of benefit is funds paid out for medical services provided to the tribal members and their family members, either from a third party insurance company or directly from the tribe itself. These amounts may be paid directly to the tribal member as reimbursement, or to the health care provider who performed the medical service. In this testimony, I will refer to these medical services benefits as "back-end benefits."

The two categories of tribal members we need to consider are tribal members who are also tribal employees, and tribal members who are not employees. The significance of this distinction will become apparent rapidly.

In this context, when a tribe provides or pays health insurance coverage or medical services for its members, two principal income tax questions arise:

- Is the value of the health insurance coverage—up-front coverage—paid for or provided by the tribe includable in the tribal member's income?
- Is the value of any medical services—back-end benefits—paid for or provided by the tribe, directly or by tribe-purchased insurance, includable in the tribal member's income?

To answer these questions, Mr. Chairman, I think it would be helpful if I began with a brief summary of key tax provisions that apply to health care in general. I will then address in more detail three provisions of the Internal Revenue Code and an administrative exclusion that have particular relevance here.

As I do so, I'd like to emphasize that the Code provisions apply equally to all citizens and all employers, and that the administrative exclusion—the general welfare exclusion—applies equally to payments of all governments, tribal and non-tribal.

Following that summary, I will discuss, in several contexts, the tax treatment of health benefits that tribes provide to tribal members who are employees, and the taxation of benefits to members who are not employees.

Summary of the Code's Treatment of Health Care

Section 61 of the Code is the starting point for our discussion. Under section 61, gross income includes all income, from whatever source derived, unless a specific exception applies. This seminal provision establishes the important principle that income will be taxed unless it is expressly excluded from taxation.

Of course, the Code does exclude many forms of health-care-related income.

An employer's contribution to a plan providing health coverage, and direct or indirect payments to reimburse the employee for expenses incurred for medical care for the employee and his or her spouse and dependents, are excludable from the employee's income for both income and payroll tax purposes (secs. 105, 106 and 3121).

Self-employed individuals may deduct the cost of health insurance for themselves and their spouses and dependents (sec.162(I)).

All individuals may claim an itemized deduction for unreimbursed medical expenses, to the extent that such expenses exceed 7.5 percent of adjusted gross income (sec. 213).

Individuals who are covered by a high-deductible health plan are able to contribute tax-free to a health savings account (sec. 223).

The Controlling Law

To answer the question about the inclusion or exclusion of health insurance coverage provided by a tribe and the value of medical services under that coverage or direct payment of medical services, however, we need to look more closely at three provisions of the Internal Revenue Code and at the application of what is known as the general welfare exclusion.

Let me begin with the three Code provisions: sections 106(a), 105(b), and 104(a)(3).

Sections 106(a) and 105(b) allow tribes to provide health coverage and medical benefits—up-front coverage and back-end benefits—to their employees on a tax-free basis.

Section 106(a). Section 106(a) provides, generally, that gross income of an employee does not include employer expenditures for coverage provided to an employee through an accident or health plan.

This section excludes from an employee's income the value of health coverage paid by an employer. It applies to tribal members who are tribal employees, but not to tribal members who are not employees of the tribe.

Section 105(b). Section 105(b) states that except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical expenses) for any prior taxable year, gross income does not include amounts paid, directly or indirectly, by an employer to the taxpayer to reimburse the taxpayer for expenses incurred by the taxpayer for the medical care (as defined in section 213(d)) of the taxpayer or the taxpayer's spouse or dependents (as defined in section 152).

This section provides an exclusion from income for payments for medical services provided through an employer-provided plan. Like section 106(a), it applies to tribal members who are tribal employees, but does not extend to tribal members who are not employees of the tribe.

Section 104(a)(3). The third key provision is Code section 104(a)(3). This section comes into play only when there is no employer in the picture.

It provides, generally, that gross income does not include "amounts received through accident or health insurance (or through an arrangement having the effect of accident or health insurance) for personal injuries or sickness (other than amounts received by an employee, to the extent such amounts (A) are attributable to contributions by the employer which were not includable in the gross income of the employee, or (B) are paid by the employer)."

Neither the Code nor the regulations defines "insurance." The accepted definition, for purposes of federal income taxation, dates back to *Helvering v. Le Gierse,* 312 U.S. 531 (1941), in which the Supreme Court stated that "[h]istorically and commonly insurance involves risk-shifting and risk-distributing." Insurance must shift the risk of economic loss from the insured and the insured's family to the insurance program and must distribute the risk of this economic loss among the participants in the program. Risk shifting will occur when an insurer agrees to protect the insured (or a third-party beneficiary) against a direct or indirect economic loss arising from a defined contingency involving an accident or health risk. *See, Allied Fidelity Corp. v. Commissioner,* 572 F.2d 1190, 1193 (7th cir. 1978); *Haynes v. U.S.,* 353 U.S. 81, 83 (1957) (Broadly speaking, health insurance is an undertaking by one person for reasons satisfactory to him to indemnify another for losses caused by illness.).

The parenthetical language, "(or through an arrangement having the effect of accident and health insurance)" in section 104(a)(3) was added to the Code by section 31 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 1996–43 I.R.B. 7, effective for taxable years beginning after December 31, 1996.

The House Conference Report noted that "payments for personal injury or sickness through an arrangement having the effect of accident or health insurance (and that are not merely reimbursement arrangements) are excludable from income. In order for the exclusion to apply, the arrangement must be insurance (*e.g.,* there must be adequate risk shifting). This provision equalizes the treatment of payments under commercial insurance and arrangements other than commercial insurance that have the effect of insurance." H.R. Rept. No. 104–736, 104th Cong., 2d Sess. 293.

In short, this section provides an exclusion from income for payments for medical services received from an insurance plan, or a similar arrangement, that is not provided by an employer. It thus provides an exclusion for payments from an insurance plan or similar arrangement purchased or created by the tribe for those tribal members who are not employees. In some sense, this provision parallels section 105(b) for non-employees.

Let me point out that there is no Code provision that parallels section 106(a) for non-employees. Where there is no employer involved, the Code contains no provision that would allow a tribal member who is not a tribal employee to exclude the value of tribally-provided health care coverage, the up-front coverage.

The General Welfare Exclusion. The final component of the prevailing law in this area is the general welfare exclusion. This is an administrative exclusion that has developed over more than 40 years in revenue rulings and notices and has been recognized by the courts. *See, e.g.,* Rev. Rul. 63–136, 1963–2 C.B. 19; *Graff v. Commissioner,* 673 F.2d 784 (5th Cir. 1982), *affg. per curiam* 74 T.C. 743 (1980); *Bailey v. Commissioner,* 88 T.C. 1293 (1987). The exclusion applies to payments made by governmental units—tribal or non-tribal. Although Code section 61 defines broadly the items that are included in gross income, the Service has consistently concluded that payments made to individuals by governmental units, under legislatively provided social benefit programs, for the promotion of the general welfare, are not includable in a recipient's gross income ("general welfare exclusion"). *See, e.g.,* Rev. Rul. 74–205, 1974–1 C.B. 20; Rev. Rul. 98–19, 1998–1 C.B. 840.

To qualify under the general welfare exclusion, payments must: (1) be made from a governmental fund, (2) be for the promotion of general welfare (*i.e.,* be based generally on individual or family needs), and (3) not represent compensation for services. The Service generally has not applied the general welfare exclusion to persons with significant income or assets, and any such extension would represent a departure from well-established administrative practice dating back decades and respected by courts.

Whether this exclusion would apply to a tribal government providing coverage or benefits to tribal members would depend on how the program is structured and administered.

How Tribes are Providing Health Care to Members

I would like to illustrate how these rules apply in a number of situations. This is not an exhaustive list, but reflects some of the questions we have received.

The Tribe is the Employer of the Tribal Member

If the tribal government is the employer of the individual, it is possible to exclude both the value of the health coverage under Code section 106(a)—the up front coverage—and the amounts actually paid out to cover medical expenses under Code section 105(b)—the back end benefits.

Self-Insurance. One option might be for the tribe to self-insure. By this I mean that the tribal government promises to pay for the health care costs of their employees out of the tribe's resources. All tribal employees are covered, and all receive coverage with uniform terms and conditions. The coverage may be very extensive, and may even cover expenses that commercial health insurance typically does not cover. The tribe may provide health insurance coverage, medical benefits, or both.

Looking first at the up-front provision of coverage, Code section 106(a) provides that gross income of an employee does not include employer-provided coverage under an accident and health plan. So, assuming the tribal members are employees, they may exclude the value of their tribally-provided health coverage from gross income.

Looking at the provision of the actual medical benefits, Code section 105(b) provides an exclusion for amounts paid, under employer-provided coverage, to reimburse the employee for medical services. Therefore, tribal government employees may exclude the value of the medical benefits paid for by the tribe.

Insurance policies. Next, what happens if the tribal government pays premiums on insurance policies, or purchases a commercial group health insurance policy to cover its employees? Again, Code sections 106(a) and 105(b) may operate to exclude both the up-front value of coverage and the later payments for medical benefits.

The tribe pays for health care costs on an ad hoc basis. Some tribal governments have raised the situation in which the tribe pays for medical benefits on an *ad hoc* basis. In the absence of consistently applied tribal policies that address who and what is covered, an *ad hoc* arrangement would not constitute a "health plan." Treas. Reg. § 1.105–5(a). Thus, amounts paid for medical services under such an arrangement to any tribal employee would not be excludable from income under a specific Code provision. Under an *ad hoc* approach, the issue of health care coverage does not arise since the tribe typically pays directly for medical benefits and does not provide health care coverage.

Tribal Members Who are not Employees of the Tribal Government

Now, I'd like to turn to the situations in which the tribal government would like to provide health benefits to tribal members who are not employees of the tribal government. While assistance can be provided, the options for excluding it from the tribal members' income are more limited.

The significance of the distinction between employees and non-employees is not unique to health care benefits provided by tribes to their members. The same employee—non-employee distinction applies across the country, to all citizens, all employers, all units of government.

Value of up-front coverage. There is no parallel to Code section 106(a) that would allow the tribal government to provide up front health coverage on a tax-preferred basis to all of its tribal members, without regard to whether they are employees. Code section 106(a) excludes the value of the up-front health coverage from income if it is employer-provided, regardless of whether the employer is providing premiums for third party insurance or is covering employees in a self-insured plan. With no parallel exclusion for non-employees, these tribal members would have no means under the statute to exclude that value from income.

Value of back-end benefits. There may be ways to exclude the payment of medical benefits even for tribal members who are not employees of the tribal government. Code section 104(a)(3) provides that as long as the arrangement is insurance, or has

the effect of accident and health insurance, then a variety of formats may operate to exclude the payments for medical services from the tribal member's income. For example, the tribal government could self-insure and pay the benefits itself. Or, it could purchase a group policy or pay individual premiums and the medical benefits flowing from that policy would not be included in the tribal member's gross income. Again, the value of the up front health coverage or health insurance premiums would not be excluded, but the value of the medical services would be excluded as long as the arrangement meets the requirements of Code section 104(a)(3).

The General Welfare Exclusion

Some people have suggested that the general welfare exclusion could be applied to exclude these amounts from income of tribal members. If the tribe provides such assistance only in cases of demonstrated need, pursuant to a consistently applied standard of financial need, the general welfare exclusion arguably could apply. The financial need standard and the nature of the expenses being covered would be among the factors that we would look at to determine whether the general welfare exclusion applied to a particular program.

As I mentioned earlier, this administrative exclusion generally has not been applied to persons with significant income or assets. Whether this exclusion would apply to a particular tribe and its members would depend on the factual circumstances. But any extension of the general welfare exclusion to tribal members with significant income or assets would represent a departure from well-established practice.

If the general welfare exclusion does not apply, the value of the health insurance plan coverage for non-employees must be included in gross income. We recognize that it may be difficult to determine how such coverage should be valued under a self-insured plan. Alternatively, if the general welfare exclusion does not apply and there is no health insurance plan that satisfies the requirement of section 104(a)(3), but instead benefits are paid on an ad hoc basis, then the provision of back-end benefits would be included in tribal members' income.

Conclusion

Mr. Chairman, I would like to summarize my testimony and conclude.

As my prior discussion demonstrates, in the case of a tribe providing coverage and health benefits to its employees, the Code—sections 105 and 106—provides exclusions from gross income for both the value of the up-front coverage (*e.g.,* coverage under a commercially purchased insurance policy or self-insurance) and the benefits provided under the coverage.

In the case of a tribe providing coverage and health benefits to tribal members who are not employees, the Code—section 104—provides an exclusion from gross income of the value of the health benefits if provided under an insurance arrangement. However, the Code does not provide any exclusion from gross income of the value of the up-front health coverage outside the employer-provided context.

In certain cases, the administratively-based general welfare exclusion may provide an exclusion from gross income for these amounts, but only if the program meets the need standards.

I am aware of this Administration's commitment to strengthen and build on the government-to-government relationship between the United States and tribal nations and I appreciate your interest in this matter. Thank you for your patience as I worked through the technical aspects of current law. I look forward to working with Congress to examine this issue further.

This concludes my testimony this afternoon I would be happy to try to answer any questions you might have.

Senator UDALL. Thank you very much for your testimony.

I would just remind each of our witnesses to please keep their testimony to five minutes. Your full written testimony will become part of the permanent record. We will take all the testimony first.

Chairman Macarro?

STATEMENT OF HON. MARK MACARRO, CHAIRMAN, PECHANGA BAND OF LUISEÑO INDIANS

Mr. MACARRO. Senator Udall, good morning. [Phrase in native tongue.] It is good to be here with you this morning.

The homeland of the Pechanga people is the Pechanga Indian Reservation located near Temecula, 60 miles north of San Diego. Our people have called the Temecula Valley home for over 10,000 years. We think this is your homeland, too, for we believe that the world was created in the Temecula Valley, known as Exva Temeeku.

In 1847, 18 treaties were negotiated in sequence with tribes throughout the State of California. We Luiseño Indians were party to the 17th of these treaties. It is called the Treaty of Temecula. In good faith, huge land cessions were made involving most of southern California in exchange for a permanent inviolable homeland and the provision of goods and services to improve the health, education, and welfare of my great grandfathers.

Shortly after ceding these huge tracts of land and within one month of arriving back in Washington, D.C. with the 18 treaties, gold was found for the first time in California near the town of Julian, about 40 miles away from my reservation. The timing was unfortunate for us because the Senate, upon hearing of the gold, elected not to ratify these 18 treaties. Nonetheless, our land was still taken from us. Most of the goods and services that were promised in our treaty never materialized.

But there is more. Twenty-six years later in 1873, sheep farmers laid claim to the land our village was on. They obtained a Federal court decree of ejectment and on a summer day in 1875, a posse led by the San Diego County sheriff evicted my ancestors from their village at gunpoint. In one fell swoop, 300 elders, women, and children were loaded onto wagons with only a few personal effects and just dumped in a dry wash two miles away. Their former tule brush homes were burned and their livestock herds were seized to pay for court costs and the cost of the eviction itself.

On June 27, 1882, President Chester Arthur signed an executive order that established the Pechanga Indian Reservation finally as a homeland for my people. Today, approximately 66 percent of our tribal citizens currently live on or near the reservation.

Over the years, we have lost much land and resources because of now-repudiated Federal policies. We have paid dearly for the Federal Government's trust obligation to provide health care to our citizens.

Many of our Pechanga citizens face the same health problems associated with other American Indian communities: diabetes, obesity, tuberculosis, accidents, and mental health crises. The only Indian hospital to have operated in southern California was on the Soboba Indian Reservation and it closed permanently in 1949. Between 1949 and 1970, no official Indian health care existed in our region for my tribe. So between 1970 and 2002, our people relied primarily on the IHS for health care with a few members eligible to receive VHA care or covered by private insurance.

Beginning in 1970, tribes in the region began pooling their paltry IHS dollars to establish a consortium for funding health care benefits for Indians on reservations. Pechanga joined this tribal health

care consortium, called the Riverside San Bernardino County Indian Health Consortium, Incorporated. Today there are 12 tribes in the consortium, including ours. The consortium is headquartered on the Morongo Reservation. It operates a small clinic on the Pechanga Reservation for our tribal citizens and is open five days a week. The clinic staff is comprised of a general practitioner, floating nurse practitioners, floating podiatrists, and other medical technicians. Special visits and hospitalizations are referred out to a local health care provider.

In 2002 and before, the IHS was not able to provide many medical procedures which Pechanga citizens desperately needed due to the limited contract health funds that ran out early in the fiscal year. I appreciate and honor the work that these professionals provide to our Pechanga people and Indians from other tribes but, like other IHS facilities, it is underfunded, understaffed, and its hands are tied when it comes to more modern medicine, thus allowing for the provision of only substandard care at the Pechanga clinic.

In addition to the specific health care portrait at Pechanga, the provision of Indian health care in the State of California is unique. For example, in spite of having one of the highest American Indian populations in the Country, there are no IHS direct service clinics or hospitals in California. All IHS services are provided through tribal health consortiums and urban Indian health clinics. The nearest IHS funded hospital is in Phoenix, 350 miles away.

IHS funding for the members of our consortium is inadequate in all areas including the areas of contract health services, specialty services, diagnostics, or in-patient services. Chronic underfunding in the area of contract health services had negatively impacted the delivery of comprehensive health care services to our tribal citizens. Specifically, tribal citizens that needed care outside of the limited direct services offered in the Pechanga clinic were forced to access treatment through the already overburdened public health care system and were offered no continuum of care. This forced our tribal citizens to often ignore symptoms for preventable diseases until the symptoms became chronic.

In 2002, this insufficient health care structure spurred my tribe to purchase a group health policy for all tribal members. This decision was made following a two year study of the tribe's need for health care coverage by a seven member tribal committee that explored a number of options including where to build our own brick and mortar medical facility, which in the end proved too costly for us to pursue. The committee's initial concern was to provide coverage for tribal citizens 55 years of age and older. However, it found that no health insurance companies were willing to cover a group of elders, so it was determined that the solution could best be resolved through mandatory group coverage for all tribal members.

The health insurance initially approved by the tribe was purchased from Blue Shield. It covered all medically necessary health care except dental and optical care. The health insurance plan's effective date was January 1, 2003. The health insurance contract required all tribal citizens to sign up for the plan. Only citizens able to prove that they had other insurance were allowed to opt out of this mandatory coverage.

This approach to Pechanga's health care has led to measurable improvement in the physical health of our tribe. Pechanga's commitment to improving health can be measured by the commitment of millions of dollars annually to pay for these health plan premiums. For example, in the coming fiscal year 2010 we expect we will pay $10 million in premiums for coverage. These sizable annual expenditures should be regarded as proof of my tribe's commitment to improving the health and wellness of our citizens and our willingness to take internal responsibility for ourselves and our community.

In November 2006, we first heard from the IRS that it was concerned about the tribe's purchase of health care policies for our people. In an ongoing audit, we are being pressed to demonstrate how the law exempts this coverage from being taxable income to tribal citizens.

The IRS has indicated to us that we need to demonstrate that our tribal governmental programs are needs-based and not provided to all citizens regardless of need. It appears to us that the IRS is interpreting need as meaning only financial need. Did the IRS become the arbitrator of what the health needs of my people are?

When you measure what the IRS is trying to do against the history of Pechanga's relationship with the United States, the Senate's failure to ratify our treaties, the ensuing dispossession and theft of our homeland, and the failure to follow through on the health, education, and social welfare promises said treaty purported but failed to make good on, the IRS's recent actions add insult to historical injury.

From our perspective, this makes absolutely no sense. The Pechanga government has stepped in where the Federal Government has fallen short for our people. Federal statues have been enacted stating that a major 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 level possible.

Further, HHS found that the funds appropriated for IHS programs have been consistently inadequate to meet even the basic health care needs. To remedy this problem, tribes have been encouraged by Congress to use their governmental gaming revenues to provide for the health care needs of their members, including through universal coverage programs.

Our Indian people deserve the best health care and Pechanga has decided not to wait on the Federal Government to fulfill its trust obligations to our people. Waiting for the Federal Government has not been a winning strategy. The health of our people is at stake.

Mr. Udall, the rest of my testimony is written and has been submitted.

But the situation cries out for a Congressional fix. There is a bill that has been introduced on the House side. We would like your consideration so that both houses can work on a solution for this for the benefit of all Indian people throughout Indian country.

Thank you very much.

[Mr. Macarro's prepared statement follows:]

PREPARED STATEMENT OF HON. MARK MACARRO, CHAIRMAN, PECHANGA BAND OF LUISEÑO INDIANS

Chairman Dorgan, Vice Chairman Barrasso, other Members of the Committee, it is an honor to be here to testify concerning this issue. This hearing is the latest demonstration that this Committee is willing to fight for the advancement of health care for American Indians and Alaska Natives. With the health care reform debate raging on, this Committee's willingness to address the unique problems Indian country faces does not go unnoticed by tribal leaders. Thank you.

The homeland of the Pechanga people is the Pechanga Indian Reservation located near Temecula, California. Our people have called the Temecula Valley home for more than 10,000 years. Approximately 66 percent of our tribal citizens currently live on or near the Reservation. Over the years, we have lost much land and resources because of now-repudiated federal policies. We have paid dearly for the Federal Government's trust obligation to provide health care to our members.

Today, many of our Pechanga citizens face the same health problems associated with other Native American communities: diabetes, obesity, tuberculosis, accidents and mental health issues. Until 2002, our people relied primarily upon the Indian Health Service for health care, with a few members eligible to receive care from the Veterans Health Administration or covered by private health insurance. Pechanga is a member of a tribal health consortium funded by the IHS. The consortium operates a clinic on the Pechanga Reservation for tribal citizens that was and continues to be open five days a week. The clinic staff is comprised of a general practitioner, floating nurse practitioners, floating podiatrist and other medical technicians. Specialist visits and hospitalizations are referred out to a local (Temecula) health-care provider. In 2002 and before, the IHS was not able to provide many medical procedures that Pechanga citizens desperately needed due to the limited contract health funds than ran out early into the fiscal year. I appreciate and honor the work that these professionals provide to our Pechanga people and Indians from other tribes, but, like other IHS facilities, it is underfunded, understaffed, and its hands are tied when it comes to more modern medicine—thus allowing for the provision of only substandard care at the Pechanga Clinic.

In addition to the specific healthcare portrait at Pechanga, the provision of Indian health care in the state of California is unique. For example, in spite of having one of the highest Native American populations in the country, there are no IHS direct service clinics or hospitals in CA. All IHS services are provided through tribal health consortiums and urban Indian health clinics. The nearest IHS funded hospital is the Phoenix Indian Medical Center (PIMC) in Phoenix, AZ, 350 miles away. The Pechanga Clinic is operated by the Riverside San Bernardino County Indian Health Consortium Inc. (RSBCIHC), a health consortium of 12 tribes. IHS funding for the members of this consortium is underfunded in all areas, including the area of contract health services, the purchase of specialty services, diagnostics or inpatient services. Chronic underfunding in the area of contract health services has negatively impacted the delivery of comprehensive health care services to our tribal citizens specifically. Should we have a tribal citizen that needs care outside of the limited direct services offered in the Pechanga Clinic, they become forced to access treatment through the already overburdened public health care system and are offered no continuum of care. This forces our tribal citizens to often ignore symptoms for preventable diseases until the symptoms became chronic.

In 2002, this insufficient health care structure spurred the Tribe to purchase a group health policy for all tribal members. This decision was made following a two-year study of the Tribe's need for health care coverage by a seven-member committee that explored a number of options. The Committee's initial concern was to provide coverage for members 55 years or older. However, it found that no health insurance companies were willing to cover a group of elders, so it was determined that the solution could best be resolved through mandatory group coverage for all tribal members.

The health insurance initially approved by the Tribe was purchased from Blue Shield. It covered all medically necessary health care, except dental and optical care. The health insurance plan's effective date was January 1, 2003. The health insurance contract required all members to sign up for the plan. Only members able to prove that they had other insurance were allowed to "opt out" of this mandatory coverage.

This has led to measurable improvement in the physical health of our Tribe. Earlier this year, we opened a new exercise facility that both contributes to and facilitates the health and wellness of our tribal citizens.

In November, 2006, we first heard from the IRS that it was concerned about the Tribe's purchase of health care policies for our people. In an ongoing audit, we are

being pressed to demonstrate how the law exempts this coverage from being taxable income to tribal citizens. The IRS has indicated to us that we need to demonstrate that our tribal governmental programs are needs-based and not provided to all citizens regardless of need. It appears to us that the IRS is interpreting "need" as meaning only "financial" need.

From our perspective, this makes absolutely no sense. The Pechanga government has stepped in where the Federal Government has fallen short for our people. Federal statutes have been enacted stating that a major "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"[1] Further, the U.S. Department of Health and Human Services found that funds appropriated for IHS programs have been consistently inadequate to meet even basic health care needs.[2] To remedy this problem, Tribes have been encouraged to use gaming revenues to provide for the health care needs of their members, including through universal coverage programs.[3]

Our tribal citizens deserve the best health care, and Pechanga has decided not to wait on the Federal Government to fulfill its trust obligations to our people. Waiting for the Federal Government has not been a winning strategy and the health of our people is at stake.

The fact that my Tribe provides health insurance for our members has a direct benefit not only to them but also to the United States. When a Pechanga tribal member visits the IHS clinic on our reservation or any other reservation, that clinic can actually bill our insurance for the service provided. This alleviates the U.S. Government's financial burden of providing health care to Pechanga tribal members, even though we are entitled to it. In addition, IHS, which, as previously mentioned, is perpetually underfunded, is able to use its allocated funds on Indians from other tribes that may not have the means to provide supplemental coverage.

We also understand that federal law is not as clear as it should be about this issue.

The Internal Revenue Code and Treasury regulations say that gross income includes all income from whatever source derived, unless specifically exempted. The IRS and federal courts have consistently ruled that payments made under legislatively-provided social benefit programs for the promotion of general welfare, including health care, are not includable in the recipient's gross income.[4] Consistent with this position, the IRS has ruled that government-provided health care benefits for the elderly, commonly known as Medicare benefits, were nontaxable to recipients.[5]

Although the general welfare doctrine provides a "common law" exclusion for government social welfare programs, the test is based on facts and circumstances and is difficult to apply. A statutory exclusion is needed to clarify that medical care provided by tribal governments to their members is not subject to income taxation.

This situation cries out for a Congressional fix.

On the House side, Congressman Xavier Becerra and Congressman Devin Nunes are expected to introduce a bipartisan bill this week, the "Tribal Health Benefits Clarification Act of 2009," that we hope and expect will be a part of the House health care reform legislation. This bill would make clear that medical care tribes and tribal organizations provide for tribal citizens is excluded from gross income. Importantly, it also states that enactment of the bill cannot be construed to create an inference against health benefits provided by tribes prior to the passage of the bill, or benefits provided by tribes, such as education assistance, that is not within the scope of this legislation.

I specifically ask that this Committee's Members strongly consider introducing and supporting a companion bill so that both chambers could be actively involved in clarifying this situation.

Thank you.

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[1] 25 U.S.C. § 1601(b).

[2] *See* Overview of Federal Tax Provisions Relating to Native American Tribes and Their Members (JCX–61–08) (stating that "the average funding of an IHS site was found to be 40 percent less than an equivalent average health insurance plan").

[3] *See* NIGC Bulletin No. 05–1 (Subject: Use of Net Gaming Revenue) (January 18, 2005) (available at *http://www.nigc.gov* under the "Reading Room" tab and "Bulletins" sub-tab).

[4] *See, e.g.,* Rev. Rul. 57–102, 1957–1 C.B. 26 (payments to the blind); Private Letter Ruling 200845025 (November 7, 2008) (ruling that payments made by an Indian tribe to elderly tribal members who were displaced by a flood were general welfare payments); *Bailey v. Commissioner,* 88 T.C. 1293 (1987) (considering whether grants to restore a building facade were excludable from income as general welfare payments).

[5] Revenue Ruling 70–341, 1971–2 C.B. 31.

Senator UDALL. Thank you very much. We understand you have to catch a plane. Certainly stay as long as you can but we will excuse you when you choose to leave.

Mr. MACARRO. Thank you, Senator.

Senator UDALL. Thank you very much.

Vice President Keel, it is good to have you here. Please proceed.

STATEMENT OF HON. JEFFERSON KEEL, VICE PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS (NCAI)

Mr. KEEL. Thank you, Mr. Chairman. Senator, on behalf of the National Congress of American Indians, I want to thank you for the opportunity to provide views on issues critical to our people.

The Internal Revenue Service is now engaged in a broad and unprecedented effort to tax the basic human services that Indian tribal governments provide to their members. This is a relatively new issue that has honestly baffled tribal leaders across the Country. We cannot understand why a Federal agency would create a disincentive for tribal governments to provide services for our members. It is also a direct affront to tribal sovereignty, a violation of the Federal trust responsibility, and at best a terrible Federal policy.

Our chief concern is that the IRS is targeting health care benefits and services provided by tribal governments. The Federal Government has treaty and trust responsibilities to provide health care to American Indians and Alaska Natives. As you noted, the Indian Health Service is terribly underfunded and, in many places, the IHS services are outdated or simply unavailable. In response, tribal governments throughout the Country have implemented a variety of supplemental health care programs. Now the IRS is attempting to require the tribes to issue 1099 forms and withhold tax for health care we provide to tribal members. Our people ask, why should we pay Federal taxes on health benefits that should have been provided by the Federal Government in the first place?

The IRS is not targeting only health care services. The IRS also proposes that tribes withhold taxes on basic educational services, meals for elders, housing assistance, the provision of safe drinking water, and waste disposal services. All of these are services that are commonly provided by other governments. We also have heard from our members that IRS personnel have instructed a pueblo to issue 1099 forms for the meals provided at a traditional feast day.

These absurdities raise very serious questions for tribal leaders. We urge Congress to engage in a two track effort to address these problems.

First, Congress should immediately pass legislation that will specifically amend the tax code to clarify that health care benefits provided by tribal governments are excludable from gross income. This legislative clarification should be included in the national health care reform bill.

We are particularly grateful to Chairman Baucus of the Senate Finance Committee and Chairman Rangel of the Ways and Means Committee, along with Representatives Becerra, Nunes, and many others for their support and encouragement of this proposal. Although NCAI would prefer to exempt all tribally provided social welfare benefits, our supporters in Congress are indicating that it

will be difficult to include all general welfare issues as part of a health care bill.

Second, Congress needs to exercise oversight over the Treasury Department and the IRS to ensure that adequate policy guidance is provided. Indian tribal governments have a unique status in our Federal system under the U.S. Constitution and numerous Federal laws, treaties, and Federal court decisions. Tribes have the power and responsibility to provide a broad range of governmental services to our citizens. The IRS has never attempted to tax the thousands of Federal, State, and local government services that are provided to all citizens regardless of income.

It is common for Federal, State, and local governments to provide health care, education, transportation, trash and recycling collection, snow removal, public libraries, nutrition programs, museums, and public parks. The list goes on. In practice, the general welfare doctrine has exempted a huge range of public benefits. We can think of no legitimate reason why the IRS would choose to discriminate against tribal government services.

It appears the IRS is confused because of the source of tribal revenues. Although tribal governments collect taxes, most tribes lack an adequate tax base on the reservations. Instead, tribes rely on revenue from natural resources, Federal appropriations, and tribal business enterprises to fund our programs.

NCAI urges Congress to immediately pass legislation that would exclude tribal health benefits from income for Federal tax purposes. Even with this legislative fix, we anticipate that Indian tribes will be subject to IRS audits on other social welfare programs that will create uncertainty and delay tribal progress for years to come. Oversight and engagement is needed to ensure that proper policy guidance is provided and that Indian tribal governments are treated equitably.

We thank you for your diligent efforts on behalf of Indian country on these and many other issues. Thank you, Mr. Chairman.

[The prepared statement of Mr. Keel follows:]

PREPARED STATEMENT OF HON. JEFFERSON KEEL, VICE PRESIDENT, NATIONAL CONGRESS OF AMERICAN INDIANS (NCAI)

On behalf of the National Congress of American Indians, thank you for the opportunity to provide our views on an issue of critical importance to tribal governments and tribal citizens throughout the United States. It is often said that there are no new issues in Indian country—that the same old issues re-circulate again and again. However, thanks to enterprising auditors at the Internal Revenue Service, this has been proven untrue. The IRS is now engaged in a broad and unprecedented effort to tax the basic human services that Indian tribal governments provide to their members. This is a direct affront to tribal sovereignty, a violation of the federal trust responsibility, and at best is utterly bad federal policy. We cannot understand why the Federal Government would choose to create a disincentive for Indian tribal governments to provide basic human services to their members.

One of our major concerns is that there has been little or no policy guidance from the Treasury Department, and instead IRS auditors are creating policy through the rote application of a tax code that was never intended to reflect the fundamental federal-tribal relationship embodied in the U.S. Constitution. Moreover, we are concerned that the IRS actions are highly discriminatory in impact if not in intent. The IRS is subjecting tribal governments to audits on issues that have never been raised when substantially similar benefits have been provided by other government entities. The IRS has initiated 139 examinations during the past two years that focused

specifically on the use of tribal government revenues used to provide governmental services to tribal citizens.[1]

This Committee has noted that the IRS is targeting health care benefits and services provided by tribal governments. This is our chief concern. The Federal Government has treaty and trust responsibilities to provide health care to American Indians and Alaska Natives. The Indian Health Service is the federal agency responsible for providing this care, yet the IHS is funded at only 60 percent of need. Most tribal communities cannot readily access health care services and, even when services are available, they are often subject to decades-old, outdated practices and services. As detailed in the statement submitted by the National Indian Health Board, across every indicator, American Indian and Alaska Natives face massive disparities in health.

In response to the need for adequate health care, Indian tribal governments throughout the United States have implemented a wide variety of supplemental measures, including the following:

- Direct health care in the form of tribally-funded health care clinics;
- Tribal subsidies for programs that the tribe operates under a contract or compact with the Indian Health Service (IHS);
- Tribal health care reimbursement programs or plans that pay for the cost of care not covered by IHS (because of funding shortfalls) or other sources; and
- Self-insured tribal health care plans and group health insurance policies that cover tribal members and their dependents.

Yet, it is our understanding that in the scenarios described above (all of which involve dedication of tribal government revenues to supplement the inadequate IHS system), the IRS is attempting to require the tribe to issue 1099 forms to each tribal member. This makes no sense from a policy perspective as it reduces the net amount of health care expenditures that tribal governments will be able to fund. It also compounds the violations of federal trust and treaty responsibilities, as tribal members would be required pay federal taxes on health benefits that should have been provided by the Federal Government in the first place.

Moreover, we understand that the IRS is not targeting only health care services. The IRS is also proposing that tribe withhold or report on basic educational services, job training, meals for elders, housing assistance, the provision of safe drinking water, and waste disposal services. All of these are government services that are commonly provided by other governments. We have also heard from our members that IRS personnel have instructed a pueblo to issue 1099 forms for the meals provided at a traditional feast day. All of these raise issues raise very serious concerns for tribal leaders.

We would urge Congress to engage in a two-track effort to address these problems. First, Congress should consider legislation that would specifically amend the IRS to exempt health care services provided by Indian tribes. Second, Congress needs to exercise oversight over the Treasury Department and the IRS to ensure that adequate policy guidance is provided.

Legislation Needed

NCAI and many tribes have proposed a legislative fix that would clarify that health care benefits provided by tribal governments are excludable from gross income. This legislative clarification should be included in the national "Health Care Reform" bill. (NCAI is proposing several other health care amendments to protect IHS and tribal health care systems.) We are particularly grateful to Chairman Baucus of the Senate Finance Committee, Chairman Rangel of the Ways and Means Committee, along with Representatives Becerra and Nunes and many others, for their support and encouragement of this proposal.

Although NCAI would prefer to exempt all tribally provided social welfare benefits, our supporters in Congress are indicating that it will be difficult to include all general welfare issues as part of a health care bill. Instead, they are asking that we consider excluding only tribal health care benefits as a part of this legislation, and we use that to build momentum for a broader exclusion of all tribally provided social welfare benefits. NCAI will continue to push for a broad exclusion, but at this point NCAI is supporting a narrower exclusion of tribal health care benefits as a first step.

There is a concern that if we address health care in the legislation, the IRS will be even more likely to challenge other welfare programs provided by tribal govern-

[1] IRS Letter to The Honorable Senator Charles Grassley, Ranking Member of the Finance Committee, June 28, 2009.

ments. To guard against this we are urging Congress to include "no-inference" language in both the statute and committee reports, to make sure that the legislative history is clear that there are many tribal government programs that are not subject to tax, and to continue oversight with Treasury and IRS officials at the highest levels to curb the overly aggressive approach to tribal government social welfare benefits.

Oversight Needed on Application of "General Welfare" Doctrine

Indian tribal governments have a unique status in our federal system under the U.S. Constitution and numerous federal laws, treaties and federal court decisions. They have a governmental structure, and have the power and responsibility to enact civil and criminal laws regulating the conduct and affairs of their members and reservations. They operate and fund courts of law, police forces, and fire departments. They provide a broad range of governmental services to their citizens, including education, transportation, public utilities, health, economic assistance, and domestic and social programs. Like states and local governments, tribal revenues and property are not treated as taxable income—but as the governmental revenues of a distinct sovereign. Tribes are generally treated in the same manner as states under the IRS Code, 26 USC Sec. 7871, the Indian Tribal Governmental Tax Status Act of 1982. In contrast, individual tribal members, whether they live on or off-reservation, are generally subject to federal taxes.

Internal Revenue Code Section 61 provides that, gross income includes all income from whatever source derived unless excluded by law. The IRS and the federal courts have consistently held that payments made under legislatively provided social benefit programs for the promotion of general welfare are not includable in the recipient's gross income.[2] Revenue Ruling 76–131, 1976–1 C.B. 16 explicitly lists health as a need that promotes the general welfare. The problem is that the IRS seems to have narrowed its interpretation of the general welfare doctrine in the context of tribal governments to require that the recipient demonstrate financial need, and not simply that the benefit contribute to the welfare of the community.

This is where we sharply disagree with the discriminatory application of the general welfare doctrine by the IRS. First, the general welfare doctrine originated in a 1938 decision by the IRS to exempt the Social Security system, which is not a means tested program.[3] Second, in Revenue Ruling 70–341, 1971–2 C.B. 31, the IRS ruled that government provided health care benefits for the elderly, commonly known as Medicare benefits, are nontaxable to all recipients, not only to those in financial need. Third, federal and state governments commonly provide vaccinations and basic health tests to all citizens free off charge. Fourth, the Federal government has a longstanding policy of providing tax-free medical care to Indians. To effect this policy, federal statutes have been enacted stating that a major "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 providing specific authorization for the Indian Health Service, a federal agency that administers funds provided by Congress for the promotion of Indian health care services.[4]

In addition, the IRS has never attempted to subject to income tax the value of myriad non-medical federal, state and local government services that are provided to all citizens regardless of income. It is common for state and local governments to provide refuse and trash collection, recycling collection, snow removal, and hazardous waste disposal to all citizens. For example, the City of San Diego has provided free trash collection for the last 96 years without a challenge by the IRS. Cities and local governments also provide free access to benefits with clear value to individuals, such as public libraries, public education, pest eradication programs, museums and public parks, and public concerts and events. Free government services range from National Public Radio and Television, to the local pancake breakfast provided by a Parent Teacher Association.

As indicated by past IRS rulings and administrative practice, the general welfare doctrine is clearly much broader than simply those programs provided to low-income individuals. In practice, the general welfare doctrine has exempted all legislatively provided public benefits that do not inure simply to the individual, but improve the entire community.

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[2] *See, e.g.,* Rev. Rul. 57–102, 1957–1 C.B. 26 (payments to the blind); Private Letter Ruling 200845025 (November 7, 2008) (ruling that payments made by an Indian tribe to elderly tribal members who were displaced by a flood were general welfare payments); *Bailey v. Commissioner,* 88 T.C. 1293 (1987) (considering whether grants to restore a building facade were excludable from income as general welfare payments).

[3] *See* I.T. 3194, C.B. 1938–1 114, which concluded that lump sum payments made to individuals as Social Security benefits not subject to federal income tax in the hands of the recipients.

[4] 25 U.S.C. § 1601(b) and 25 U.S.C. § 13.

Health care is a classic example of a government service that does not benefit only an individual. In the treatment and prevention of infectious diseases it is essential that all members of a community receive treatment in order to protect the entire community. Beyond this, a healthy workforce is necessary for the economy, and healthy children are a prerequisite for successful education. Moreover, medical researchers are proving that more and more medical conditions are in effect "contagious"—obesity, smoking, diabetes, drugs and alcohol—all of these are examples where an individual's social interactions with the rest of the community have a significant effect on the entire community's health. An Indian tribe, just like any government, has an enormous interest in ensuring that its citizens share in the benefits of excellent community health.

We can think of no legitimate reason why the IRS would choose to discriminate against tribal government services, but it appears to be that the IRS is confused because of the source of tribal revenues. Although Indian tribal governments are tax collecting entities and tribes often collect sales and excise taxes, unlike States, tribes typically lack an adequate tax base on the reservations, and have traditionally relied on revenue from their own natural resources, federal appropriations, and tribal business enterprises to fund their governments and government programs.

Indian gaming has grown to be the most significant source of revenue for tribal governments, in much the same way that state lotteries and other forms of state gaming have grown significantly in recent years. The source of tribal revenues provides no rationale for discriminating against tribal general welfare programs. Congress's intent that general welfare benefits for tribal members should not be treated as income is made clear in the Indian Gaming Regulatory Act, where Congress distinguished between revenues used to provide for the general welfare and per capita payments.

25 USC 2710 provides that:

> (B) net revenues from any tribal gaming are not to be used for purposes other than—
>
> (i) to fund tribal government operations or programs;
>
> (ii) *to provide for the general welfare of the Indian tribe and its members;*
>
> (iii) to promote tribal economic development;
>
> (iv) to donate to charitable organizations; or
>
> (v) to help fund operations of local government agencies;
>
> (3) Net revenues from any class II gaming activities conducted or licensed by any Indian tribe may be used to make per capita payments to members of the Indian tribe only if . . .
>
> (D) *the per capita payments are subject to Federal taxation and tribes notify members of such tax liability when payments are made.*

In fact, the in the only clear guidance provided to Indian tribes on the appropriate uses of gaming revenue under the Act, tribal governments have been encouraged to use gaming revenue to provide for the health care needs of their members, including through universal coverage programs.[5]

Conclusion

NCAI urges Congress to immediately pass legislation that would specifically exclude tribal health benefits from income for federal tax purposes. Even with this legislative fix, we anticipate that Indian tribes will be subject to vexatious IRS audits on other social welfare programs that will create uncertainty and delay tribal progress for years to come. Oversight and engagement with the Treasury Department is needed to ensure that proper policy guidance is provided to the IRS to ensure that Indian tribal governments are treated equitably. We thank you for your diligent efforts on behalf of Indian country on these and many other issues.

Senator UDALL. Thank you for your testimony.

Chairman Joseph, go ahead.

[5] *See* NIGC Bulletin No. 05–1 (Subject: Use of Net Gaming Revenue) (January 18, 2005) (available at *http://www.nigc.gov* under the "Reading Room" tab and "Bulletins" sub-tab).

STATEMENT OF HON. ANDREW JOSEPH, JR., BOARD MEMBER, NATIONAL INDIAN HEALTH BOARD (NIHB)

Mr. JOSEPH. Senator Udall and distinguished Members of the Senate Committee of Indian Affairs, [greeting in native tongue]. Badger is my name in my language. I am Andrew Joseph, Jr. I appear today as a Portland Area Representative to the National Indian Health Board, NIHB. I am also accompanied by our NIHB Chairman, Reno Franklin, from the California Area. Thank you for inviting NIHB here today to help the Committee in its efforts to examine the Federal tax treatment of health care benefits provided by tribal governments to their citizens.

Indian health care is provided for in the Federal law and the Constitution of the United States through a complex web of law and regulations. This is described in detail in my written testimony.

First, the provision of health care to tribes is funded on a formalized trust responsibility with our people. The receipt of health care services or benefits has been consistently held in Federal policy in case law to not be included as income to individual beneficiaries. Likewise, funding from the Indian Health Service, IHS, has never been classified as income for individual beneficiaries.

The IHS has been the primary provider of health care to our people since 1955 and has been grossly underfunded since its birth. The IHS is currently funded at approximately 54 percent of identified need. Until the IHS is fully funded, many tribes will continue to find it necessary to supplement Federal funding to provide needed health care services to their people.

All of the 564 tribes of the United States provide health care services under some level of self-determination contracting. This is needed to provide health services and assume a portion of the health care delivery obligations of the Federal Government. Due to the chronic underfunding of the Indian self-determination line item of IHS appropriations, these contracts are grossly underfunded from day one.

Recent concerns have been raised regarding the Federal Government's efforts to tax the value of health care services provided to individual American Indians and Alaska Native people, particularly in the area of contract health services. Health benefits are defined under the Internal Revenue Code as general welfare assistance programs and are not subject to taxation. As such, health benefits payments like these derived through IHS contract health service programs are not subject to Federal income tax. Tribal financial assistance provided to meet IHS shortfalls should be treated the same.

The benefits should not be subject to the gross income calculation for the purposes of Federal income tax. Taxation of health benefits steps beyond the authorities and requirements of the Indian Health Care Improvement Act and frustrates the Congressional intent of law to elevate the health status of American Indians through expansion of participation, entitlement programs, and programs offered by the IHS tribal health providers.

IHS is defined clearly in the Indian Health Care Improvement Act and no limitations are placed on the source or amount of ben-

efit payments under the Act. Tribal supplemental funds to support CHS program payments are one type of cost incurred by tribes.

Transportation costs tribes assume to assure that their members can receive health care services are a significant financial burden. Two significant reasons for these tribal investments include the extreme poverty and unemployment in tribal communities and the remote locations where tribes and Alaska Natives occur. These costs are required of nearly every tribe in the United States. Many tribes transport members out of town at least once a week to receive necessary medical care not available in tribal communities.

It is a given that IHS is grossly underfunded. This makes supplemental funding to IHS care delivery systems drastically needed regardless of whether the supplemental funding comes from additional Federal appropriations, tribal generated revenue sources, or other sources. All such funding is utilized to meet the Federal Government's trust responsibility to provide health care to American Indian and Alaska Native people. It should never be taxed.

The taxation of funds to provide health care services to individual American Indians and Alaska Natives has never occurred nor should it. All attempts to tax the value of health care services provided to tribal citizens should be abandoned. Rather, the sacred trust between the Federal Government and tribes should stand.

The tribes purchased this trust through forfeiture of land, resources, American Indian lives, and our way of life. This has already been negotiated. Appropriate funding commitment from the Federal Government to honor its responsibility to provide health care to tribes would end this discussion quite effectively.

Thank you for this opportunity to provide these comments. I am pleased to answer your questions. [Phrase in native tongue.]

[The prepared statement of Mr. Joseph follows:]

PREPARED STATEMENT OF HON. ANDREW JOSEPH, JR., BOARD MEMBER, NATIONAL INDIAN HEALTH BOARD (NIHB)

Chairman Dorgan, Vice-Chairman Barrasso and distinguished members of the Senate Committee on Indian Affairs, I am Andrew Joseph Jr. and I appear today as the Portland Area Representative to the National Indian Health Board (NIHB). I am also the Chairman of the Northwest Portland Area Indian Health Board. In addition, my fellow NIHB board member, Reno Franklin, NIHB Chairman and California Area Representative, is here with me to assist with answering any questions. I thank you for inviting NIHB here today to help with the Committee's efforts to examine the federal tax treatment of health care benefits provided by tribal governments to their citizens.

Since its establishment in 1972, the National Indian Health Board serves federally recognized American Indian/Alaska Native tribal governments by advocating for the improvement of health care delivery to American Indian/Alaska Natives (AI/AN). It is the belief of the NIHB that the Federal government must uphold its trust responsibility to AI/AN populations in the provision and facilitation of quality health care to our people. The end results that we all wish to achieve are the enhancement of the level and quality of health care, the adequacy of funding for health services that are operated by Tribal Governments, the Indian Health Service and other programs. Our Board Members represent each of the twelve Areas of the Indian Health Services (IHS) and are elected to serve on our Board by the respective Tribal Governmental Officials within their Area. The NIHB is the only national organization solely devoted to the improvement of Indian health care on behalf of all Tribes. As health care is the top priority of Tribes across the nation, and delivery of health care is unique and individual to each Tribal nation in the United States, it is fitting that the National Indian Health Board provides comments regarding the federal tax treatment of health care benefits provided by Tribal Governments to their citizens. Thank you for inviting us to do so.

First and foremost, the provision of health care to AI/AN tribes is founded on a sovereign government-to-government relationship between the United States and Tribes. This provision of health care is formalized as a federal trust responsibility to AI/AN people that has been guaranteed through numerous treaties and federal law. Health care for AI/AN people was permanently authorized in the Snyder Act of 1921 (25 U.S.C. § 13).

The Indian Self-Determination and Education Assistance Act reiterate the trust obligations of the United States to provide for the health and welfare of AI/AN people. Likewise, Tribal Governments establish in their constitutions similar commitments to provide for and protect the health and welfare of the citizens they govern.

The Indian Health Care Improvement Act (IHCIA), (P.L. 94–437, as amended), is another cornerstone to the health care delivery system for AI/AN people. The IHCIA has provided numerous benefits to the AI/AN health care delivery system by authorizing Tribes to participate in federal entitlement programs, among other things. Under the authorities of Title IV of the IHCIA, Tribes have been allowed to participate in the U.S. Medicare, Medicaid and State Children's Health Insurance Program entitlements through the enrollment of AI/AN people and billing for reimbursement of covered services. S. 1200, introduced in the 110th Congress sought to expand participation of AI/AN individuals in the federal entitlement programs; Medicare, Medicaid and SCHIP. This language was inserted in an effort to improve the "quantity and quality" of health services, to "permit the health status of Indians to be raised to the highest level possible." This legislation further defines Contract Health Services (CHS) "as services provided at the expense of the Service (IHS) or a Tribal Health Program by public or private medical providers other than the service unit or Tribal health program at whose expense the services are provided." No limitations were placed in the legislation relative to the level or source of funds to pay for those services; essentially the funds may be derived from multiple sources. The receipt of such benefits (*i.e.,* health care services) has been consistently held in federal policy and case law to not be included as income to the individual beneficiary. Likewise, funding appropriated to the Indian Health Service (IHS) has never been classified as income for individual AI/AN beneficiaries.

The IHS has been the primary provider of health care to AI/AN people since 1955, and the overall value of health care services provided to individual AI/AN people is immeasurable. Much has been accomplished since 1955 in terms of improvements in public health and health care delivery, but much more improvement is still needed. The AI/AN population still suffers vast disparities in overall health status, and the funding appropriated to the IHS is abysmal relative to the per capita health care amounts provided to other federally-funded population groups (*e.g.,* federal employees, Medicaid beneficiaries and even federal prisoners). Moreover, the IHS has been characterized as a "broken" system. The truth is that the IHS system is not so much broken, as it is "starved." The IHS has been grossly under-funded for the past several decades, and as such, cannot be expected to perform optimally. The IHS is currently funded at approximately 54 percent of the identified need. Until the IHS is fully-funded (*i.e.,* 100 percent of documented need), many tribes will continue to find it necessary to supplement federal trust funding to provide needed health care services to their people.

All of the 564 Tribes in the United States operate under self-determination contract to provide some level of services, assuming a portion of the health care delivery obligation of the Federal Government. This assumption of services is underfunded from the first day of the contract agreement. This is due to the lack of funding in the Indian Self-Determination (ISD) line item of the IHS appropriations, which is consistently under-requested in the President's budget.

The shortfall demonstrated in IHS funding is over $1 billion and in excess of $121.8 million per 2008 contract support cost data annually. Clearly, the care delivered to Native Americans and Alaska Natives through the Indian Health Service system is provided on chronically deficient funding, and this requires Tribes to supplement funds to provide the care they provide through external revenue resources such as Tribal revenue support, third party collections and grants. By virtue of the limits on annual appropriations, 1.9 million American Indians are affected by the Tribe's efforts to supplement IHS services when they take on some degree of their own service delivery.

Recent Concerns Regarding Taxation of Health Benefits

Recent concerns have been raised regarding the Federal Government's efforts through the United States Internal Revenue Service seeking to tax the value of health care services provided to individual AI/AN people, particularly in the area of contract health services.

Section 7701(a)(40) of the IRS Code defines Tribal governments as the governing bodies of an Indian Tribe, band, community, village or group of Indians, and recognizes that these bodies exercise government functions. In general, where Tribal governments act in a capacity to provide general welfare type services, similar to those traditionally provided by federal, state or local governmental bodies, federal tax treatment of those benefits is equivalent and those payments are not subject to taxation under the Code.

Health benefits are by their nature, general welfare assistance programs; they provide for the continued improved health status of the individual to enhance the quality of life of the person, and ultimately, the wellbeing of the community. It is within the ability of Tribal governments to assess the needs of the community and create programmatic opportunities to address those priorities. In the instance of health benefit programs, Tribal governments must pass and accept either funding for, or implementation of, programs by Tribal authorizing resolution or ordinance.

Health benefit payments, like those derived through the Indian Health Service Contract Health Service program, are not subject to federal income tax. Health benefit payments are a benefit established by the Federal Government by law and through the exercise of Tribal sovereignty by the acceptance of the program funds. Similar programs established by Tribal statute designed to assist with meeting the shortfalls of this program and other health care programs should be treated the same. The benefits should not be subject to the gross income calculation for the purposes of federal income tax. Tribes redirect their revenue to support the shortfall gap in federal trust funding in an attempt to provide basic health care delivery to their citizens. The goal of the funding is to prevent further erosion of services provided for Indian health programs. These challenges are multiplied in the face of recent dramatic increases in operating cost of health care while IHS funding fails to keep pace with medical inflation.

Tribes that provide CHS payments in an effort to reach beyond the life and limb definition of CHS Priority I services into basic primary care, are dependent on Tribal supplemental funding. They seek supplemental insurance to reduce the burden of cost to existing CHS programs, and in turn generate revenue that supports direct service operations, or creates programs to provide insurance premium co-payments Tribal members purchase or are mandated to purchase. These types of benefits are provided in the interest of the general welfare of the citizens Tribes serve based on the needs of individuals and the priorities of the Tribal government. To add the burden of factoring these benefit structures into the gross income of the individual falls outside of current IRS structures and place an unfair burden on an economically disadvantaged population. The contract health services funding is an extension of health care services funds provided directly within IHS or tribal facilities, and cannot justifiably be presumed as the personal income of individual tribal citizens any more than can the funding allocated to provide Medicare health care services to the elderly. CHS is one facet of costs associated with providing medical care to AI/AN people that Tribes assume and supplement under Tribal Self-Determination at less than whole costs. That is not the only cost.

Transportation costs Tribes assume to ensure that their members can receive health care services are a significant financial burden. It is necessary for these costs to be covered by the Tribes due to the lack of federal funding for these purposes. Two significant reasons for these Tribal investments include extreme poverty and unemployment in Tribal communities and the remote locations where Tribes and Alaska Native Villages occur. These costs are required of nearly every Tribe in the United States but many Tribes transport members out of town at least once a week to receive necessary medical care not available in the Tribal community.

An additional demonstration of the cost burden to the Tribes is found in health information technology. It is estimated that the per capita expenditure for health information technology in Indian Country is $28 per IHS user, as reported by the IHS Data Quality Workgroup in 2008. After meeting the cost to implement government mandated records management and security, $14.00 remains to support patient care information. A tribe with an annual budget of $15,000,000 spends an average of 5 percent of the total budget on health information technology implementation (electronic health records); $750,000 or $82.00 per user. The IHS spends approximately $28.00 per user; 2 percent of the total IHS budget. Based on this example, the Tribe spends $54.00 per user to support information technologies. This is another example of the types of costs Tribes incur. This is not a direct payment to the Tribal citizen; however, it is part of the cost of doing business to support the individual Tribal patient.

As stated, the IHS is grossly under funded. Therefore, supplemental funding to the IHS health care delivery system is drastically needed, and regardless of whether such supplemental funding comes from additional federal appropriations, Tribally-

generated revenue sources or other sources, all such funding is utilized to meet the Federal Government's trust responsibility to provide health care to AI/AN people.

The taxation of these funds, whether appropriated or Tribally contributed, to provide health care services to individual American Indian and Alaska Natives has never occurred, nor should it. Taxation frustrates the intent of Congress as stated in the Indian Health Care Improvement Act to "permit the health status of Indians to be raised to the highest level possible." This action creates a slippery slope; increasing the burden of costs to the individual and eroding the intent of honoring the federal trust responsibility to American Indians. All attempts to tax the value of health care services provided to tribal citizens should be abandoned; rather the sacred trust between the Federal Government and Tribes should stand. The Tribes purchased this trust through forfeiture of lands, resources, American Indian lives and our way of life. This has already been negotiated. Appropriate funding commitments from the Federal Government to honor its responsibility to provide health care to the Tribes would end this discussion quite effectively.

I wish to thank the Committee for the opportunity to provide these comments and will be pleased to answer any questions the Committee may have.

Senator UDALL. Thank you, Chairman Joseph.

Our final witness today, Professor Taylor, it is good to have you here. I am sorry that we at the University of New Mexico lost you as a law professor in past years and you moved on to Minnesota. But it is great to have you in front of the Committee today. Please proceed.

STATEMENT OF SCOTT A. TAYLOR, PROFESSOR, UNIVERSITY OF ST. THOMAS SCHOOL OF LAW

Mr. TAYLOR. Thank you very much, Senator Udall. I don't know if you recall but when you were in law school there was a law student who was one year behind you. That was me.

[Laughter.]

Mr. TAYLOR. I thank you for how you enriched my educational experience when we were law students together at the University of New Mexico School of Law.

Senator UDALL. Yes, I do remember. Thank you.

Mr. TAYLOR. You have my statement. Instead of me reading it, I think I will just leave it for the record and provide you with some responses to the testimony that I have heard thus far.

In terms of the testimony of Commissioner Ingram, she stated that the general welfare exclusion generally has not been applied to persons with significant income or assets. I just wanted to state that I think that is not true.

If you look at Revenue Ruling 79–172, the IRS by its ruling provided an exclusion for Medicare benefits. But Medicare benefits are not means-tested. They are based on age. That is an incredible area of health care. It is one of the biggest sources of the Federal budget. So if what she says is correct, perhaps that revenue ruling should be revoked. If it were, we know that there would be dire consequences for the Internal Revenue Service.

In addition, it is the practice of the Internal Revenue Service to exclude medical benefits provided by the VA. So that is another area where, by practice not by ruling, there is an exclusion.

By practice, there is an exclusion for medical care provided under the Indian Health Service. The Indian Health Service provides medical care based on status, not based on need. So if someone who is a Native American happens to be a wealthy individual, if that person does go to the Indian Health Service and receives care, the

value of the care or the value of the coverage is not included in gross income.

So those are examples that are really quite pervasive.

I think it is not correct to say that the need is based on income. I want to refer to a private letter ruling. It is in my testimony. It is Private Letter Ruling 200632005. It says, "The general welfare exclusion applies only to governmental payments out of a welfare fund based upon the recipient's identified need, which need not necessarily be financial." In other words, it doesn't need to be financial. It can be based on health. It can be based on education. It can be based on employment status. These are different articulations of need.

It is my position in my testimony that someone who needs health care has a need. They need to be treated for their sickness, for their illness. If someone has a predisposition for a particular condition, they need to be screened for that to see if the condition has arisen. To me, it seems that whenever an insurance plan provides for health care, it is only given if someone has the articulated need. If someone does not have a health condition, they are not going to receive treatment for it. Therefore it is self-defining as a personal need.

So if I were in Commissioner Ingram's position, what I would do, knowing the ruling history of the IRS, to provide clarity and guidance to tribes, I would issue a revenue ruling just like the Medicare ruling which says that tribally provided health care through insurance or reimbursement plans is excluded from gross income. I think that the rulings history of the Internal Revenue Service is clear enough to provide a basis for such a ruling.

Now, in the absence of the Service's willingness to provide such a ruling, it seems to me that the legislative fix that Vice President Keel has recommended and suggested is actually a good idea. In addition, I think that Chairman Joseph's testimony showed that health care is a pervasive need for Native Americans. Therefore, to tie up or impede the provision of tribally provided health care, health insurance, or reimbursement plans through audits by the IRS is not really good policy. It actually impedes that.

As I said, a revenue ruling could easily clarify this. In the absence of a revenue ruling, I guess it is up to the legislative branch of our Government to fix the problem which could be fixed through administrative practice. It has been fixed in almost all the other areas, as I said, with the VA, IHS, and Medicare.

I will take any questions. Thank you.

[The prepared statement of Mr. Taylor follows:]

PREPARED STATEMENT OF SCOTT A. TAYLOR, PROFESSOR, UNIVERSITY OF ST. THOMAS SCHOOL OF LAW

Application of the General Welfare Exclusion to Health Care Provided by Federally Recognized Indian Tribes to Their Members

Mr. Chairman and members of the Committee allow me to thank you for the invitation to present testimony on the question of whether the value of tribally provided health care is included in the gross income of tribal members for purposes of the federal income tax. I have concluded that the general welfare exclusion, an administrative practice that the Internal Revenue Service (IRS) has developed through rulings, operates to exclude the value of tribally provided health care from the gross income of members. In addition, I have concluded that exclusion of these benefits is justified as a matter of federal Indian law because the United States has under-

taken the obligation to provide health care to Native Americans as a general treaty obligation through the Indian Health Service (IHS). If tribes determine that, compared to IHS, they can provide better health care through private health insurance or direct reimbursements for health care, then tribal health care should receive the same federal income tax treatment as medical care provided through IHS. IRS has provided no explanation of why it excludes the value of IHS care coverage from the gross income of Native Americans receiving such care.

Some Federal Income Tax Background

In terms of understanding the federal income tax questions involved, we need to focus on the benefits that IRS may treat as gross income. The underlying transaction involves a federally recognized Indian tribe that purchases health insurance for its members. Under this health insurance arrangement, an individual tribal member may receive health care that the health insurance pays for directly or through reimbursement. Under section 104(a)(3) of the Internal Revenue Code, amounts received through health insurance to cover medical care are excluded from the gross income of the person receiving the health care. Section 104(a)(3) does not apply to employer provided health care. The rules for employer provided health are contained in section 105 and, generally speaking, provide rules of exclusion similar to those in section 104(a)(3). As a result, section 104(a)(3) operates to exclude the value of the health care that a tribal member actually receives under the health insurance arrangement.

However, no federal income tax provision deals with the cost of health care that a tribe purchases on behalf of individual members. For example, if a tribe pays a health insurance provider $7,000 per year for comprehensive health insurance for each tribal member requesting such coverage, then IRS may assert that the tribe is conferring a benefit on the member in the amount of $7,000 each year. This $7,000 is gross income, IRS would argue, because the benefit goes to the tribal member and because Congress has provided no statutory rule of exclusion. The result is different if a tribal member receives health insurance coverage as an employee of the tribe. In the case of a tribal employee, section 105 excludes the cost of the health insurance from the member's gross income. Likewise, if a tribal member is self-employed, then section 162(l) allows the individual to deduct the cost of the health insurance as an above-the-line business expense effectively giving the same treatment as the exclusion provided in section 105. *See* IRC § 62(a)(1) (allowing the health insurance cost of self-employed individuals as an above-the-line deduction; see IRS Form 1040 for 2008, line 29).

Without a specific statutory exclusion to protect a tribal member from an aggressive IRS auditor, the amount a tribe pays for health insurance on behalf of a tribal member may be treated as the gross income of that member. IRS, however, has discovered that many types of governmental payments not covered by a specific statutory rule of exclusion should be excluded. The most often used theory of exclusion is the "general welfare exclusion" (sometimes also described as the "general welfare exemption").

The General Welfare Exclusion

Most law professors teach their students that gross income includes all income from whatever source derived. As a general concept, income is any realized benefit or accession to wealth over which the taxpayer has dominion and control. This concept comes from the Supreme Court case of *Commissioner v. Glenshaw Glass,* 348 U.S. 426 (1955), and applies to all potential income unless the taxpayer can find a specific statute that provides a rule of exclusion. *See Vincent v. Commissioner,* T.C. Memo 2005–95 (construing rules of statutory exclusion narrowly). This sweeping characterization of the federal income tax is so over inclusive that IRS has been forced to develop some explicit and some implicit rules of exclusion, without which our federal income tax would collapse.

The broadest explicit administrative rule of exclusion that IRS uses is the "general welfare exclusion" (GWE). IRS, back when it was called the Bureau of Revenue, developed this doctrine in 1938 to provide for the exclusion of lump sum payments made under the Social Security Act. *See* I.T. 3194, 1938–1 C.B. 114. By 1971 IRS referred to GWE as a long-standing doctrine. *See* GCM 34506 (May 26, 1971) (providing exclusion of federal mortgage assistance payments). The United States Tax Court seems to acknowledge that GWE may provide a basis of exclusion in appropriate cases. *See Bannon v. Commissioner,* 99 T.C. 59 (1992) (refusing to apply GWE in a case where a relative was paid to care for a disabled relative but acknowledging its possible application under appropriate facts).

In applying the general welfare exclusion, the IRS generally requires that the payments (1) come from a governmental general welfare fund, (2) be spent to pro-

mote general welfare, and (3) not be based on payment for service rendered. *See* Rev. Rul. 98–19, 1998–1 C.B. 840 (excluding relocation payments made by local governments to those whose homes were damaged by floods). The second requirement (promotion of general welfare) must be based on the need of the recipient; however, the need can be based on a variety of considerations including "financial status, health, educational background, or employment status." IRS CCA 200021036 (May 25, 2000) (excluding state adoption assistance payments made to those individuals adopting special needs children even though not based on any financial means test applied to the adoptive parents). IRS has applied GWE to tribal payment and has acknowledged that tribes are governments within our legal system and capable of setting aside and making payments out of a "governmental welfare fund." *See* PLR 200632005 (April 13, 2006) (excluding tribal funds expended for housing assistance allocated based on multiple factors of need); compare Tec. Adv. Memo. 9717007 (Jan. 13, 1997) (including as gross income those per capita payments made by a tribe to its members when the amount of the payments were made without regard to the health, education, or employment status of individual members) .

The question here is whether tribes can provide health care, through health insurance or through a reimbursement plan, to all members without regard to the financial needs of their members. IRS, in some of their audits, is asserting that tribal health plans provided to all members may produce gross income to recipients because the benefits are not based on financial need. If IRS is making such an assertion, then such an assertion is wrong. Health care is provided to prevent and treat disease. Those receiving medical treatment receive such treatment because they have a need for it. Those at risk of contracting breast cancer, for example, should receive regular screening. Those not at risk do not require such screening. Those who have a chronic disease, such as diabetes, require and need medical treatment to mitigate the effects of such a disease. It is entirely appropriate for IRS to treat all health care as need based because it treats or prevents illness. Providing this health care through health insurance is a prudent way for a tribe to manage costs. Such an arrangement benefits from risk pooling and should lower the overall costs of health care.

IRS currently treats the value of health care received through Medicare, the Veterans Administration, and the Indian Health Service as excluded from gross income. Except in the case of Medicare, IRS has not provided any rulings and Congress has not enacted any statutes providing a specific exclusion for these benefits. *See* Rev. Rul. 79–172, 1979–1 C.B. 86 (applying the general welfare exclusion to Medicare benefits). Health care under these federal plans is not provided based on financial need. Medicare is based solely on age. Coverage through the Veterans Administration is based on past military service, although some medical services are based on financial need. Care though IHS depends on an individual's status as an Indian without regard to wealth or income. *See* 42 C.F.R. § 136.12 (describing eligibility based on status as a Native American and not based on financial need).

Senator John McCain, a member of your Committee, qualifies for health insurance through his service as a United States Senator, through the VA based on his military service, and through Medicare based on his years on this earth. None of these programs is means tested. Nonetheless, the value of these benefits, if equated to health insurance, is not included in his gross income. To single out Native Americans as the only group of Americans who should treat as gross income the value of governmentally provided health care would be unfair. The health care needs of Native Americans are just as real and substantial as those over 65, those who have served in the military, and those Native Americans who are members of tribes that cannot afford health care for their members and who must seek care through the Indian Health Service.

Treaty Exemption

IRS takes the position that tribal members are subject to the federal income tax unless specifically exempted by treaty or statute. *See* Rev. Rul. 67–284, 1967–2 C.B. 55. Congress has provided no statutory rule of exclusion for the benefit a member receives when the tribe pays for the member's health insurance. *See* IRC §§ 105 & 106 (applying rules of exclusion to employer provided health care but not to tribes or other health care provided through government programs, such as Medicare).

The Indian Health Service exists primarily because many treaties obligated the United States to provide health care to the members of tribes. The Indian Health Service explains that treaties "between the United States Government and Indian Tribes frequently call for the provision of medical services, the services of physicians, or the provision of hospitals for the care of Indian people." *See* IHS Facts Sheets, available at *http://info.ihs.gov/BasisHlthSvcs.asp.* If health care is a federal treaty obligation and if tribes are willing to provide their members with better

health care through the purchase of private health insurance, then it makes sense to honor the treaty obligation and to treat tribally provided health care benefits as excluded from gross income for purposes of the federal income tax. It would be strange to allow tribal members to exclude the value of IHS medical care but to tax the value of tribally provided care, especially when it lessens the federal obligation owed.

Conclusion

The general welfare exclusion is a sufficient and adequate legal theory to exclude the benefits of health care provided by tribes to their members. The difficulty comes from IRS auditors and revenue agents who view all tribal benefits as gross income unless provided based on financial need. The criteria of need used by IRS acknowledge that an allocation of benefits based on health, education, or employment status is just as appropriate as one based on financial status. In this case, the health of a tribal member is the need, and tribal health insurance meets the health needs of tribal members. Therefore, the general welfare exclusion clearly applies. To clarify this situation and to instruct IRS agents in the field, IRS should issue a revenue ruling. This ruling should hold that the cost of health insurance provided by tribes to their members is excluded from gross income under the general welfare exclusion.

In addition, the federal treaty obligation to provide health care to Native Americans is an independent legal basis for excluding the cost of health care provided by tribes. Tribes that choose to purchase health insurance for their members should be allowed to step into the shoes of the Federal Government and provide medical services to members. Treating tribal health benefits the same as those that the Indian Health Services provides is just and fair. This treatment would validate tribal sovereignty and enhance the government-to-government relationship that the United States has with Native American governments.

Senator UDALL. Thank you very much, Professor Taylor.

We will proceed now with questions. I will allow all of you to comment as we move along here.

Ms. Ingram, thank you for your testimony. I understand you are constrained to informing us about the black letter of tax law and how the IRS is implementing that law. With that in mind, I will ask some questions about the activity of your Division. I understand that the IRS Chief Counsel in June of 2007 stated that the IRS had initiated 139 examinations of tribal government programs. Is that correct?

Ms. INGRAM. I am sorry, Senator. I am not familiar with that statement. If I look at our level of activity in terms of cases that have been completed with tribal entities, that number seems high. But I would have to check and get back to you for an answer on the record.

Senator UDALL. We would like to have that pinned down for the record, both on the 2007 date and the statement of the Chief Counsel but also on what you have going today. So you can't tell us specifically how many tribal governments are under audit today?

Ms. INGRAM. I do not have the exact number of how many are underway at the moment. I will say that if I look at how many we have completed per year, I would have said it was below 100. But I would rather be more precise in getting back to you.

Senator UDALL. One of the things I am wondering is, you have State and local governments and then you have tribal governments. What would be the comparison of the two in terms of audits for general welfare programs? Do you have a rough sense on those? You thought the number was a little lower. Do you have a rough sense on how much the IRS is proceeding with State and local governments?

Ms. INGRAM. If you will allow us a two part answer, Senator?

Senator UDALL. Yes.

Ms. INGRAM. The numbers that we put in our annual data book for the Internal Revenue Service and the numbers that appear in our annual work plan that go on our website every year for both Federal, State, and local government audits and then also for Indian tribal audits are numbers that come from the number of returns that have been pulled and closed. So for any one examination with an entity, there may be quite a few returns because of employment taxes, quarters, and things like that.

So backing out of those numbers into the number of entities, my information indicates that the rate at which we reach out to members of each of those populations is quite comparable, one to the other.

Senator UDALL. Is it the practice of the IRS to audit a State or local government without first providing some guidance or bulletin on the subject of the audit?

Ms. INGRAM. Well, we audit many State and local governments and Federal agencies. We try to have a continuous flow of information about what the laws are or what issues we think might be of concern in the conversation for examinations. So I am at a loss as to what specific bulletin you would have in mind, Senator.

Senator UDALL. Well, any kind of guidance or bulletin, any guidance before you carry out an audit.

Ms. INGRAM. We have quite a lot of educational activity that goes on across the board. In fact, when we established our Indian Tribal Governments Office almost 10 years ago, we spent a great deal of time in the first part of the last decade doing almost exclusively outreach and educational activities, trying to figure out how to make sure that the laws that applied equally to everybody could be explained or educational materials could be prepared and put into the context of Indian country. We do the same thing for State and local and Federal agency governments.

As time passed, we tried to see what the impact of that educational process and outreach process was on the voluntary compliance of our constituents. Over time, we have gone in and looked at actual compliance with some of our 2,700 entities that we are responsible for to see how that is playing out on the ground. So the current rate of audit coverage is something that has evolved.

We are always in the business of trying to figure out what the right balance is in terms of how we spend our time and how we interact with the community, whichever community it is. That continuous evaluation of do we need to spend more time on the education versus on the checking on filing compliance is an ongoing conversation.

Senator UDALL. You mentioned in your answer this Indian Tribal Governments Office that I think was established in 1999. Can you explain the role that that Office has today, 10 years later? How does it look into the trust responsibility and the responsibilities under the treaties and statutes that are out there with regard to Native Americans?

Ms. INGRAM. Yes, Senator. The role of the Indian Tribal Governments Office is only as wide as the responsibility of the Internal Revenue Service with the specialization of trying to understand, dialogue, and listen to the interests of Indian country in particular. But its responsibilities start and end with the issues of the tax-

ation, particularly of the 2,700 entities that come within that umbrella.

It is a continuous process of trying to make sure that as we administer the tax laws that we are given and as we understand how to consistently apply the general welfare exclusion to all kinds of governments that we try to understand the context in which we are doing that. It is a rich and complicated historical context in this context. We are continuously trying to understand that and administer it appropriately.

But the jurisdiction is only as to taxes.

Senator UDALL. So are you saying that this Tribal Office doesn't look into matters except for taxes? Is it excluded from looking into these other things where you have a much different relationship with tribes than with the Federal Government?

Many of the tribes would argue, and I think they have a pretty strong argument in Indian law, that the trust responsibility applies to all of the Federal Government. So your agency and the Treasury Department has an obligation to understand the treaties and the context of these treaties. You have an obligation to understand the statutes and then to try to reflect in your policy what you see from those. But you say this Tribal Office isn't even looking at those kinds of issues?

Ms. INGRAM. The Tribal Office never walks away from trying to understand these things more deeply. The difficulty that faces the tax administrator is understanding where and when, as a tax administrator without more specific guidance as to the Internal Revenue Code, we have adequate maneuvering room, shall I say, to go beyond that black letter.

The general welfare exclusion is a place where the Service has tried vis-à-vis governments in general to find ways to go beyond the black letter law. The variety of rulings and, may I say, the variety of statutes underlying the actual words of the rulings show how challenging it is as we go beyond those parameters and how much clearer it can be for both the administrator and the constituents to navigate these things when we do have bright lines and black letter rules. That is a continuing conversation.

There are many conversations going on in terms of tribal governments or entities coming to us to ask for rulings who come and talk to us about our views about the general welfare exclusion. They are able to craft what they would like to do within that and often then don't bother going through with that private letter ruling process so there is no public document at the end.

It is a more challenging conversation the farther we get away from the traditional 50 years of rulings. But it is a very fact driven process when it is not actually in Title 26.

Senator UDALL. I want to focus a little bit more on this Tribal Office because I would think that is the one focal point for tribes to be able to have a voice in terms of the general welfare exclusion, exemption.

Look at the history that the tribes have with the United States and that relationship, the treaty relationship, the statutes that have been put in place, specifically with regard to health care, trying to provide the very best health care. We know they aren't doing that. The Indian Health Service, because of the resources and the

various circumstances, is not able to do that. Now you have tribes stepping forward and doing that in cases where they have the ability to do so.

I would hope that that Tribal Office would see its mandate as reviewing all of these things and educating the Treasury Department, the IRS, and everybody within the Department. Maybe at some point we should talk with them about it.

But Professor Taylor raises something which I think I would like you to explain if it is true that we have this Medicare exemption and a Veterans exemption. Senator McCain sits on this Committee. His medical care through the Veterans Administration is not taxed. You have applied the exemption in this one area. Yet tribal health care, which I think stands alone because of the trust responsibility—you haven't initiated an effort to go forward on that. The burden is now on the tribes and many of them don't have the resources to hire the lawyers, and to go through the process.

Could you speak to what he pointed out, that you do have the ability? You could issue a ruling with regard to these tribal health policies. Why aren't they like Medicare and like Veterans?

Ms. INGRAM. Well, if I could mention a couple of things without the Professor and I doing dueling revenue rulings and private letter rulings, I have a couple of thoughts and then a comment and an offer.

Since I assumed this job recently, I have tried to understand what is behind the printed word of what is available on the public record when you read these rulings. What is of interest to me is that so often the results depend on the underlying statute. The ruling might not have a needs filter in it but if you go to the statute, it is in the statute. So I think it is very hard for all of us to look at those rulings and understand everything we need to know about why they came out the particular ways they did.

That said, I will say there is a very strong sense amongst the people who work on these rulings, this doesn't go to the next topic, but there is a strong sense that we need to be very careful to make sure that we are treating all governments equivalently because the general welfare exclusion is not for one kind of government versus another.

To the extent people feel like that has not been what we are doing, we would like to pursue that thought because we are totally committed to applying it equitably across all kinds of governments. That does not respond to the point about whether there is this special trust relationship that ought to provide an additional policy backdrop either to the general welfare exclusion or to any legislative efforts.

The last thought I would share is that I am very flattered but I don't personally control the issuance of revenue rulings. That is a collaborative process. It includes a great many policy people in the process.

I certainly can sit here today and say that it is in the best interests of both the administrators and the communities to have as much clarity as possible. To the extent that that should be embodied in more rulings, which is a very messy road to try to do that with, or whether that should be in legislation or in a revenue ruling that draws a bright line of some kind in this community would

require more discussion with people beyond myself for sure. I will pursue that discussion.

Senator UDALL. We are hoping to educate people through you.

Ms. INGRAM. Thank you, Senator.

Senator UDALL. But you didn't comment on the Medicare or Veterans. Tell us the difference. Applying the black letter of the law, what is the difference here? You have a tribe, as Chairman Macarro talked about, that wasn't getting health care so they went out and got health care for all their tribal members. What is the difference there with Medicare and the health care provided by the Veterans Administration? What would you argue would be the difference based on the law?

Ms. INGRAM. Well, there are some things that are not different. There are some things that are. I think it is an important comparison to continue discussion on after today.

If you go back through the history of the rulings on Medicaid and Medicare, they are grounded back in the 1940s in a comparison to Social Security. Now, all those programs have evolved in those many years. But the rationale in the long line of rulings appears to be those portions that are particularly focused on the needs safety net and those portions for which citizens use post-tax dollars for premiums to get extra coverage. Whether those theories actually answer the question for every piece of those programs, I am not going to claim expertise today to respond to.

But if you look at the portion, for example, where I could provide an extra premium through payroll withholding at the moment since I am employed, those are post-tax dollars. I have paid on that up-front piece as I described and so the back-end would not be includable in income.

But the underlying statutes are terribly important for trying to figure out how to apply these things. I certainly am committed to and take away from today the commitment to look at how those line up across the board. I would just say that it is hard to do that by looking at just the revenue rulings.

Senator UDALL. Thank you, thank you.

Professor Taylor, do you have any thoughts on what you have just heard?

Mr. TAYLOR. Yes, I have of a couple of thoughts. One, in terms of the pre-tax/post-tax dollars at least in the employment context, it is true that there were no statutes covering the situation where people would have out of pocket expenses or buy supplemental insurance. Those were post-tax dollars that had to go through medical expense rules and things like that. But the IRS has allowed employers to set up flexible spending accounts where deductibles and things like that can be paid for with pre-tax dollars. That has been done administratively as a convenience to employers. That is an example.

Then, in terms of a revenue ruling, I do agree with her that a revenue ruling is a consultative process. But when I served as Professor in Residence in the Chief Counsel's Office of the Internal Revenue Service, one of my projects was a speed regulation. Someone wanted a regulation that relieved crime stoppers from the obligation of issuing 1099s for the rewards they were paying. That regulation was drafted, approved, and adopted within one week. I

don't know that that was an incredible national emergency but it was done quickly. So where there is a will there is a way.

Maybe that is a record that can never be beaten. Maybe it needs to go into the Guinness Book of World Records for the fastest regulation ever promulgated in the history of the United States. But my point is that a revenue ruling could be opened as a project.

When I was Professor in Residence there also was a revenue ruling that I was reviewing, recommending that it be published and issued. It was initially proposed in 1955 and I reviewed it in 1988. I was the fifth person to recommend publication and it is still not published. I guess that may be the world's record for the longest revenue ruling project that never saw the light of day. No, there are older ones than that? Okay.

Senator UDALL. You made the argument in your testimony that Medicare and Veterans were very similar to what the tribes are doing. Based on the testimony that you heard here, do you still feel pretty strongly that the tribes' facts fit into that scenario?

Mr. TAYLOR. Yes, absolutely. The benefits that are involved with Medicare are not based on financial need, they are age-based. In the case of Veterans, it is service based. Again, it is not based on financial need. If you look at the medical benefits that are available to veterans, there are very few that are based on financial need. Most of them are status-based. That is, you are veteran and therefore you are entitled to those. You may seek your health care elsewhere.

The one we haven't talked about is the Indian Health Service. I cited the regulation and Commissioner Ingram is free to look at that regulation. It is absolutely, fundamentally clear that Indian Health Service rights to service are based on status, not based on financial need. I don't see any effort on the part of the Internal Revenue Service to determine the value of the coverage or the value of the benefits that are received.

I think that the value of the health care benefits should be excluded under 104(a)(3). She and I probably agree on that. But the value of the coverage is something that is just like the tribal coverage where the tribe purchases insurance. I really don't see any difference at all. I don't see the Internal Revenue Service wanting to take on the task of trying to value the coverage of the Indian Health Service and then including that in the gross income of all the recipients of Indian Health Service coverage.

Then to go out and audit the million and a half people, I don't know how many are covered by the Indian Health Service but someone probably knows, that would be an awful lot of audits to go back and correct just because it is not needs-based financially. It is based on medical need.

Senator UDALL. Vice President Keel, your testimony indicates that the IRS may be looking into other tribal government programs such as education, housing, or even benefits provided to help participation in religious and cultural activities.

Of particular interest to me, you mentioned the fact that the IRS is requiring some New Mexico pueblos to provide 1099 forms to their tribal members if the tribal government helps offset the cost of the pueblo's religious feast day. Now, I have been to a few pueblo

feast days and I can tell you that it is quite a production. Each family in the pueblo feeds well over 100 visitors.

Can you please share any additional information about some of these additional programs that you believe the IRS is looking into?

Mr. KEEL. Thank you, Senator. You are absolutely correct. The pueblo feast days are part of their religious activities. For instance, the families who provide those meals that feed sometimes in excess of 100 people, they go and purchase food and other goods to accomplish that and to accommodate those folks who come in. They are simply reimbursed so there is no gain on those services. We would say that to be reimbursed for the food that they purchase and provide for other tribal members and other folks, there is no gain there and so there is no need to provide or to require 1099s for that or to tax that type of service.

In terms of the trash and recycling collection and other types of services, the City of San Diego has been doing that for 100 years. They have never been audited and they have never been required to issue 1099s to folks who live within the city for trash collection and other types of services. So that would be the equivalent.

For the IRS to come to some of our member tribal programs, for instance, educational benefits, and attempt to tax those, again, we are simply providing services. In fact, in many ways the scholarships and funds that we provide for many of our students are reimbursement-type programs. So again, there is no gain for that.

Senator UDALL. Thank you. Ms. Ingram, do you have any thoughts on that particular part of this in terms of other governmental services or programs?

Ms. INGRAM. No, I don't think I am prepared today to talk about the array of other governmental services.

But I have been taking many notes, Mr. Keel. I would be curious as to exactly how the arrangements, both in the tribal setting and in the government setting, the State government or the city government in your example, are actually structured and administered. I would like to make sure we are doing it correctly.

Senator UDALL. Great, thank you.

Chairman Joseph, do you have any thoughts on what you have heard at this point? I want to give you a chance here as we get ready to conclude.

Mr. JOSEPH. Yes, sir. Earlier we had some charts that were brought up. They are very good charts. They show that our people are funded at very low levels. What they didn't show is a comparison of the different programs like the VA or Medicaid, or like the Federal prisoners who receive almost twice the amount of funding in health care as what is needed for our people. I don't see the IRS going there and giving those people the 1099s.

Our people are unique. We are mentioned in the Constitution of the United States. There are treaties and executive orders. The ones that our Chief signed, there is no language about any out of pocket expenses. There is no language about being taxed. As a tribal leader, I don't think any of our tribes have agreed to pay any of this.

We are struggling with the economy, with the way it is going, and having to supplement and help our people from the high rates of disparities in health and the average age of Native American

men. I am going to be 50 next week and according to the data, I have 13 more years. That is what an average Native American male lives to be. These are hard words. We have got children, K–8, on my reservation that were at a pre-diabetic stage. We are just trying to do our part to try to prevent our people from dying at these young ages.

Like I said in my testimony, if IHS was fully funded to its need then we wouldn't even have to worry about this. It should be fully funded. I would much rather have our tribe spending money on other things like our housing shortfalls. On my reservation there are about 1,400 families needing homes, young people that got an education and are starting their families. But instead we are having to take care of what our priorities are. Living is one of our priorities. Thank you.

Senator UDALL. Chairman Joseph, thank you very much. I think you make a very good point. Compare the resources that the Indian Health Service has with other medical care. Federal prisoners are one comparison. I think actually it is even worse than you said. I think it is about three to one. The last time I saw the numbers, it was about $1,300 per patient for the Indian Health Service and for a Federal prisoner it was $3,900. If you go to the society in general and look at Medicare, those numbers are much, much higher. So we need to put the resources behind the Indian Health Service. There is no doubt about that.

Now, because we moved the hearing to today I think you were all told we were going to try to keep this to an hour. So I want to thank all of you for your time and for your flexibility.

The United States Tax Code is complicated. When we consider Federal Indian law, we are looking at two unique areas of the law. On one hand we have the black letter of the tax code and on the other we have this flexible doctrine of the general welfare exclusion. We must include the Indian Health Care Improvement Act in this debate as well as the hundreds of treaties and laws that make promises to Indian tribes.

It seems to me that Indian tribes need much clearer guidance on this issue before IRS audits continue. Ms. Ingram, I hope you can pass that message back to the Treasury. I know that you have been listening here. It was great to have you as a part of this panel.

In addition, I think the Treasury Department should have a discussion with the Interior Department, which has a better understanding of the United States' obligations to Indian tribes. I hope that that specific unit within the IRS also keeps that same kind of focus. Through those communications, I hope we can then meet with tribal leaders themselves and develop guidance that respects the tax code and respects the promises made to the tribes.

At the same time, I think Congress will also consider proposals to address this issue, which is timely given the current national debate on health reform. Several of the witnesses have mentioned bills in the House, Xavier Becerra, and other colleagues. We are certainly going to be taking a look at those.

Again, thank you for your flexibility and willingness to be here. With that, the hearing is adjourned.

[Whereupon, at 11:15 a.m., the Committee was adjourned.]

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