

TESTIMONY OF
CHAIRMAN MARK MACARRO
PECHANGA BAND OF LUISENO INDIANS
BEFORE
THE SENATE INDIAN AFFAIRS COMMITTEE
OVERSIGHT HEARING ON
FEDERAL TAX TREATMENT OF HEALTH CARE BENEFITS PROVIDED BY
TRIBAL GOVERNMENTS TO THEIR CITIZENS

September 17, 2009

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% 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 that 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

¹ 25 U.S.C. §1601(b).

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

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 façade were excludable from income as general welfare payments).

⁵ Revenue Ruling 70-341, 1971-2 C.B. 31.

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.