National Indian Health Board

TESTIMONY OF ANDREW JOSEPH, JR.

NATIONAL INDIAN HEALTH BOARD
(PORTLAND AREA BOARD MEMBER, NIHB, EXECUTIVE COMMITTEE)

CHAIRMAN, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

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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. S1200, 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% of the identified need. Until the IHS is fully-funded (i.e., 100% 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 under-funded 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% 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% 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.