ASPE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION | OFFICE OF HEALTH POLICY

ISSUE BRIEF
July 22, 2021

HP-2021-18

Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges

KEY POINTS

- The uninsured rate among American Indians and Alaska Natives (AI/AN) under age 65 decreased 16 percentage points since the passage of the Affordable Care Act (ACA), from 44 percent in 2010 to 28 percent in 2018.
- However, according to 2019 Census data, the AI/AN population continues to have the highest uninsured rate compared to other populations.*
- The American Rescue Plan Act of 2021 (ARP) offers expanded financial assistance for purchasing Marketplace health insurance, and the ARP has made zero-premium plans available to an estimated 26,000 additional uninsured AI/AN people.
- Oklahoma expanded Medicaid as of July 1, 2021; prior to expanding Medicaid, Oklahoma had the largest uninsured AI/AN population of any state - more than 79,000 people.[1] If remaining non-expansion states were to adopt the ACA Medicaid expansion, approximately 55,000 more uninsured AI/AN non-elderly adults would be eligible for Medicaid coverage.
- Significant disparities remain, as AI/AN people are disproportionately affected by chronic conditions and die at higher rates than other Americans from chronic liver disease, diabetes, and chronic lower respiratory diseases, as well as non-chronic causes of death such as suicide and accidents.
- AI/AN have experienced higher rates of COVID-19 infection, hospitalization, and death compared to White persons during the pandemic. However, after COVID-19 vaccines became available, AI/AN communities have achieved higher COVID-19 vaccination rates compared to other racial and ethnic groups.
- Strengthening the Indian health care system, together with broader efforts across the federal government and cross-sector partnerships, can promote health equity by addressing social determinants of health such as housing, education, and employment.

INTRODUCTION

American Indians and Alaska Natives (alone or in combination with one or more race) comprised 1.7 percent (5.7 million) of the total population in 2019.[2] The AI/AN population increased by approximately 413,000 since 2013, representing an 8 percent increase in population size.[3] Alaska Natives (alone or in combination with

* Census does not classify the Indian Health Service as health coverage.

more than one race) represent a smaller portion of the AI/AN population, totaling approximately 172,000 in 2019. The AI/AN population estimate more than doubles when including individuals identifying with more than one race, from 2.8 million for AI/AN alone to 5.7 million AI/AN individuals reporting more than one race or ethnicity.[4]

A higher percentage of AI/AN people ages 18 and over are in fair or poor health (20.6 percent) compared to all people ages 18 and over in the U.S. (12.1 percent).[5] Social determinants such as high poverty and unemployment rates, stemming from longstanding historical discrimination and structural inequities, are key contributors to AI/AN health disparities.

The Affordable Care Act (ACA) expanded coverage options for AI/ANs via Medicaid expansion and Marketplace coverage, as it did for all groups within the U.S. The Marketplace also provides special health coverage protections and benefits for members of federally recognized tribes, including the ability to enroll in Marketplace coverage throughout the year rather than just during the yearly Open Enrollment Period and additional cost sharing reductions (CSRs) that can mean no copays, deductibles or coinsurance when receiving care from Indian health care providers or when receiving essential health benefits (EHBs) through a qualified health plan (QHP) with a referral from an Indian health care provider.

This Issue Brief is part of a series analyzing trends in coverage for different racial and ethnic groups since the implementation of the ACA. This brief describes how the uninsured rate, health coverage, and access to care for the AI/AN population have changed and discusses key policies for this population, including how the American Rescue Plan Act of 2021 (ARP) builds on the ACA, along with permanent reauthorization of the Indian Health Care Improvement Act, and invests additional resources into the Indian health care system.

BACKGROUND

There are 574 federally recognized tribes across the U.S. and 63 state-recognized tribes located in 11 states.[6, 7] The five largest federally recognized tribes and their share of AI/AN population are Cherokee (26.3 percent), Navajo (11.42 percent), Choctaw (5.49 percent), Blackfeet (3.62 percent), and Muscogee (2.81 percent).[8]

Approximately 70 percent of AI/ANs live in urban areas, and 25 percent live in counties served by urban Indian health programs funded through the Indian Health Service (IHS).[9] In the 2010 Census, 40.7 percent of the AI/AN population lived in the West; the South had the second-largest proportion (32.8 percent); followed by the Midwest (16.8 percent) and the Northeast (9.7 percent).[10] The states with the largest percentages of 2010 Census respondents who self-identified as American Indian and Alaska Native (alone or in combination with another race) were California (13.9 percent of AI/AN respondents), Oklahoma (9.2 percent), and Arizona (6.8 percent).[11] People reporting multiple races represent a growing share of the overall AI/AN population.[12]

METHODS

The American Community Survey (ACS) conducted by the Census Bureau is the largest national survey of households. The Census Bureau surveys almost 300,000 households each month for the ACS and collects health insurance and demographic information, including race and ethnicity, along with other types of information. This brief uses ACS data from 2013 and 2019 for population, health insurance coverage and demographic estimates. Race and ethnicity estimates using ACS or the U.S. Census rely on survey participants self-identifying as an AI/AN and are not based on official tribal membership rolls. This brief also uses 2019 State-based Marketplace enrollment data from California and Washington and federal Marketplace enrollment data as reported by the Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC).

Throughout this brief, unless otherwise specified, we use the term "American Indians and Alaska Natives" to describe the population reporting AI/AN as their race, either alone or in combination with another race/ethnicity.

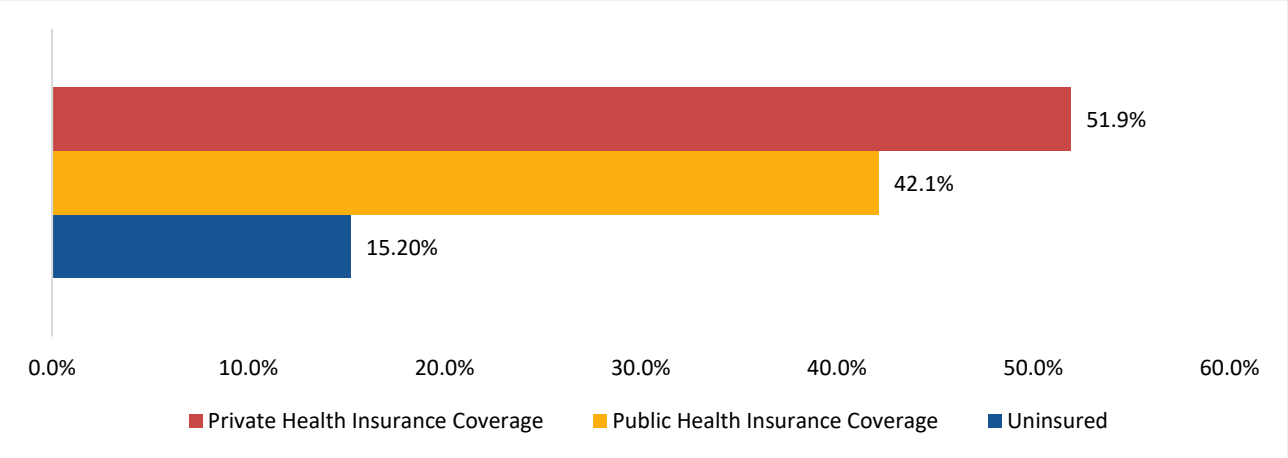
There are several limitations with these data, including potential non-response bias for both race and ethnicity data and source of health insurance. More specifically, both the ACS and the Census data historically undercount the AI/AN population, and our results should be interpreted accordingly.[13]

RESULTS

Health Coverage

In 2019, 15.2 percent of AI/AN individuals (all ages) were uninsured, 51.9 percent had private health insurance coverage, and 42.1 percent of AI/ANs had Medicaid/CHIP, Medicare, or other public health coverage (Figure 1), according to the ACS.[†] This compares to non-Hispanic Whites, where the analogous figures were 6.3 percent, 74.7 percent, and 34.3 percent, respectively.[14] Individuals who receive their care through the Indian Health Service (IHS) but do not have any health insurance are considered uninsured by Census surveys.[15]

Figure 1. Health Insurance Coverage in American Indian/Alaska Native Population (All Ages), 2019

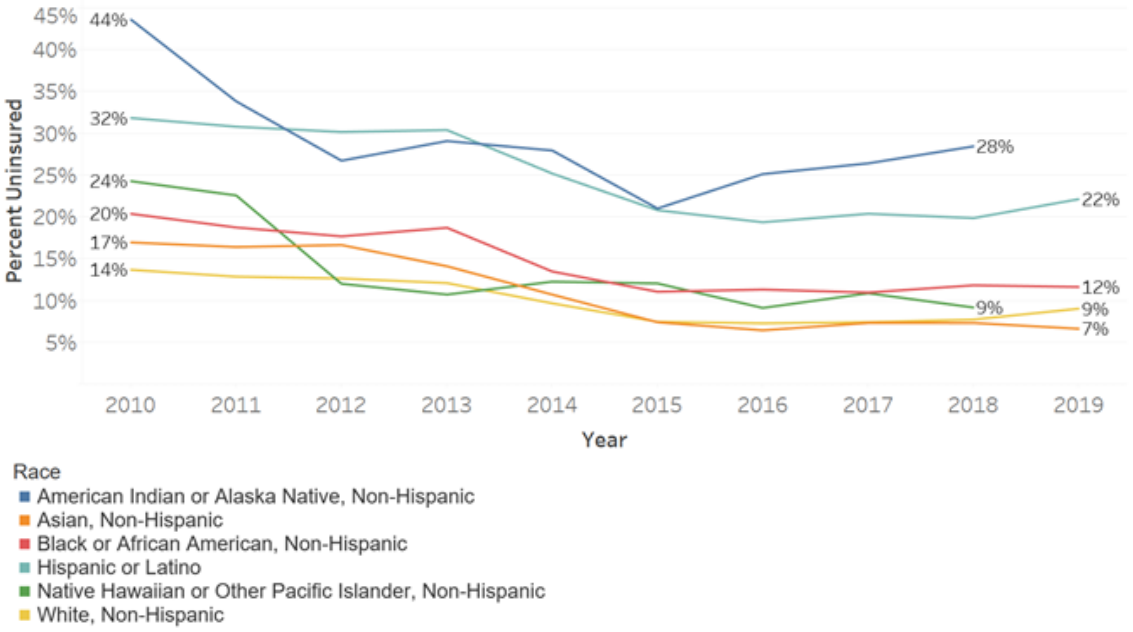


Source: 2019 American Community Survey 1 Year Estimates Selected Population Profiles
Note: Estimates sum to more than 100 percent since participants were able to report more than one form of health insurance coverage. Private coverage includes employment-based, direct purchase and TRICARE. Public coverage includes Medicare, Medicaid/CHIP, and VA coverage.

The uninsured rate among non-elderly AI/AN (under age 65) decreased by 16 percentage points between 2010 and 2018, after implementation of the ACA's major coverage provisions (from 44 percent to 28 percent, see Figure 2). Given the relatively small sample size in the National Health Interview Survey, however, this estimate fluctuates more widely from year-to-year than for other racial and ethnic groups. Also, sociodemographic differences across national surveys such as the NHIS and ACS can produce differing estimates of the AIAN population.

[†] Estimates sum to more than 100 percent since survey participants were able to report more than one form of health insurance coverage.

Figure 2. Uninsured Rate for Nonelderly (under 65) US Population and By Race and Ethnicity, 2010-2019



Source: National Center for Health Statistics, National Health Interview Survey, 2010-2019
Notes: In this analysis, individuals were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Data are based on household interviews of a sample of the civilian non-institutionalized population. Native Hawaiian or Other Pacific Islander and American Indian or Alaska Native populations did not have estimates available for 2019 due to sample size considerations.

Marketplace Coverage

Opportunities for affordable health coverage through Marketplace health insurance plans have benefited the AI/AN population. For purposes of the Marketplace, only members of federally recognized Indian tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders (regional or village) are referred to as AI/ANs. Under AI/AN Marketplace protections:[16]

1. AI/ANs can enroll in coverage through the Marketplace any time during the year, not just during the yearly Open Enrollment period. Non-tribal members applying on the same application as a tribal member also are eligible for this special enrollment period.
2. AI/ANs have additional cost-sharing protections that differ from the standard CSRs available to Marketplace enrollees with household incomes at or below 250 percent of the Federal Poverty Level (FPL)(which are only available when enrolled in silver plans).
    - AI/ANs with income between 100% and 300% of the FPL can enroll in a **zero** cost sharing plan, which means no copays, deductibles, or coinsurance when receiving care from Indian health care providers or when receiving essential health benefits (EHBs) through a qualified health plan (QHP).
    - AI/ANs with income below 100% and above 300% of the FPL can enroll in a **limited** cost sharing plan, which means no copays, deductibles, or coinsurance when receiving care from Indian health care providers. With a referral from an Indian health care provider, AI/ANs in these income groups also can have zero cost sharing when receiving EHBs through a QHP.

- AI/ANs can enroll in a zero cost sharing or limited cost sharing plan at any metal level (Bronze, Silver, Gold, Platinum), unlike the general population that only can receive CSRs in a Silver plan.

The TSGAC reports that more than 99,000 AI/ANs were enrolled in Marketplace coverage in 2019, based on CMS data.[17] The majority of enrollees (nearly 55,000) in states using the HealthCare.gov platform received official CSRs for meeting the ACA definition of Indian. The remaining HealthCare.gov AI/AN Marketplace enrollees (approximately 37,000 AI/AN enrollees) were eligible for CSRs under the standard eligibility criteria, requiring a household income less than 250 percent FPL and enrollment in a silver plan. We estimate nearly 165,000 of the remaining uninsured AI/ANs have incomes between 100-400% FPL, which qualifies them for CSRs under the standard eligibility criteria (See Appendix Table 1).

Overall, most AI/AN enrollees (62 percent) are enrolled in a bronze plan, which is a higher share than for the general population. Under the ACA, members of federally recognized tribes receive cost-sharing reductions regardless of the metal tier plan they are enrolled in, and bronze plans offer the lowest premium options. The percentage of AI/AN enrollees in bronze plans steadily increased since 2015, whereas the proportion of enrollees in silver plans has decreased beginning in 2018 (45 percent in 2017 to 29 percent in 2019). This shift in silver plan enrollment is likely explained by the change in CSR eligibility. AI/AN individuals who are eligible for IHS services but do not meet the ACA definition of Indian are more likely to be enrolled in silver plans since enrollees with an annual household income less than 250 percent of the FPL are eligible for CSRs. A growing number of AI/AN Marketplace enrollees receive CSRs as members of federally recognized tribes, and those enrollees without CSRs declined to an all-time low of 6 percent of enrollees. According to TSGAC, a possible explanation for the growth in CSR eligibility and plan enrollment is in part due to a new "help box" on HealthCare.gov that better explains CSR eligibility for Tribal members and how best to maximize savings when the household contains both Tribal and non-Tribal members.

In 2019, approximately 8,000 AI/AN enrollees received coverage through a State-based marketplace, which operated in 12 states and the District of Columbia that year.[‡] Of those states, only two publicly reported information on AI/AN enrollment – California and Washington. California reported that 0.3 percent of its 1.4 million Marketplace enrollees were AI/AN. The majority (88 percent) of AI/AN enrollees received premium tax credit subsidies for help affording coverage. Washington reported that 1 percent of its Marketplace enrollees were AI/AN. [18]

The ARP enhances and expands eligibility for premium tax credits to help people afford Marketplace coverage. An estimated 26,000 uninsured AI/AN people gained access to zero-premium plans and 25,000 gained access to low-premium plans (less than $50 per month) under the ARP, after application of premium tax credits.[19] This increase in availability of affordable plans presents an opportunity for uninsured AI/AN persons to gain coverage.

Medicaid Coverage

Medicaid expansion under the ACA also helps improve health care access for AI/AN people.[20] According to the Centers for Medicare & Medicaid Services (CMS), more than 1 million AI/AN people are enrolled in coverage through Medicaid and CHIP, and many more are eligible for coverage as a result of the ACA's Medicaid expansion.[21] In 2017, over 50 percent of all AI/AN children were covered under Medicaid/CHIP.[22]

[‡] During the 2019 Marketplace Open Enrollment period 39 states used the federal platform, Healthcare.gov, and the remaining 12 states and the District of Columbia operated their own state-based marketplace.

The ACA Medicaid expansion allows states to extend Medicaid coverage to certain non-elderly, non-pregnant adults with incomes up to 138 percent of the FPL. One analysis shows that a year after the ACA Medicaid expansion went into effect, the national uninsured rate among AI/ANs dropped nationally from 24.8 percent in 2013 to 20.6 percent in 2014, and the largest gains in coverage occurred among those living on or near reservations in states that expanded Medicaid.[23] As discussed further below, Medicaid expansion increased the number of AI/ANs who have both access to both IHS services and Medicaid coverage, which allows IHS and Tribal health agencies to bring in additional needed revenue to provide care. AI/AN Medicaid beneficiaries do not have to pay premiums or enrollment fees, and Indian Health Service, Tribal, or Urban Indian (ITU) providers can receive Medicaid reimbursement for services provided to AI/AN beneficiaries enrolled in Medicaid managed care, even if the ITU provider is not in a Medicaid managed care plan's network.[24] However, we estimate there still remain approximately 173,000 non-elderly, uninsured AI/AN adults eligible for Medicaid in expansion states (See Appendix Table 2).

Oklahoma became the most recent state to expand Medicaid, which is notable since before the expansion it had the largest uninsured AI/AN population (79,200) of any state in the country.[25] Oklahoma adopted Medicaid expansion and began enrolling eligible individuals as of June 1, 2021, with coverage effective as of July 1, 2021.[26]

As of July 1, 2021, 13 states still have not expanded Medicaid to adults with incomes up to 138 percent FPL. If the remaining 13 states were to expand Medicaid eligibility, approximately 55,000 more uninsured non-Hispanic AI/AN non-elderly adults would be eligible for Medicaid coverage, a seven-fold increase in the number of people eligible for Medicaid in the AI/AN population.[27]

State expenditures for eligible Medicaid-covered services provided to AI/AN Medicaid beneficiaries by IHS federal or tribally run facilities – and by non-IHS/Tribal providers pursuant to the terms of a care coordination agreement between an IHS/Tribal facility and the non-IHS/Tribal provider – can be reimbursed at a rate of 100 percent Federal Medical Assistance Percentage (FMAP).[28] In addition, the ARP temporarily authorizes a 100 percent FMAP for eight fiscal quarters beginning April 1, 2021, for Medicaid services provided by Urban Indian Organizations that have grants or contracts with IHS.

Impact of ACA Medicaid Expansion on the Indian Health Service

IHS is an agency within the Department of Health and Human Services responsible for providing federal health services to AI/ANs. IHS is a health care delivery system that serves 2.6 million AI/ANs who belong to 574 federally recognized tribes in 37 states.[29] IHS providers are authorized to bill third-party payers and collect reimbursements, which IHS refers to as third-party "collections," from third-party payers such as Medicaid, Medicare, the Department of Veterans Affairs, and private insurance plans. IHS federally run and tribally run facilities are allowed to retain third-party collections without an offset to the annual IHS appropriations. In recent years, third-party collections have increased for federally and tribally operated IHS facilities, which use third-party collections to maintain their operations and expand the services they offer.[30]

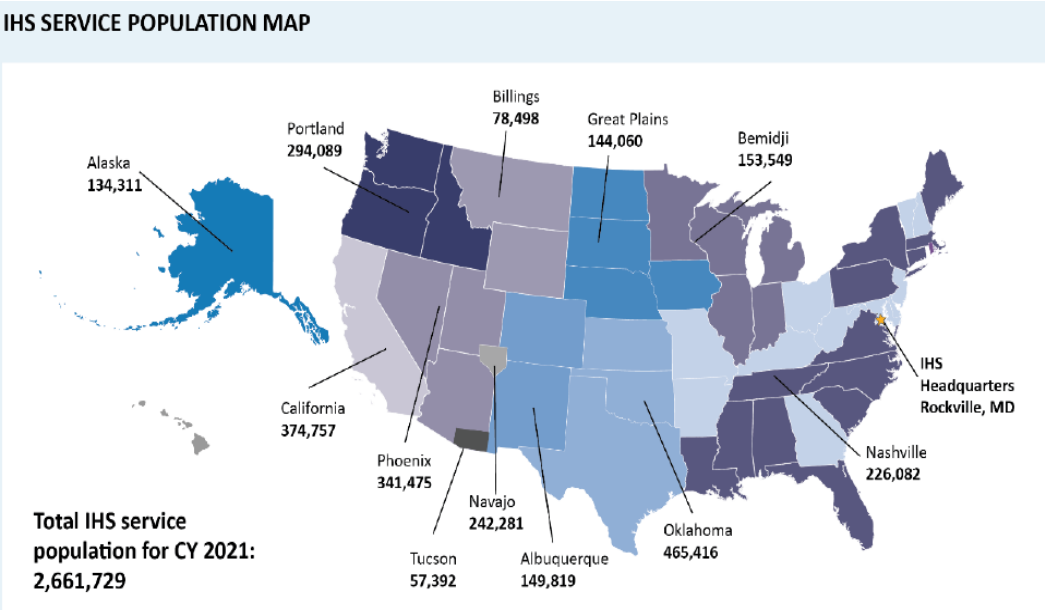
In fiscal year 2019, federally operated IHS facilities collected $1.1 billion in third-party reimbursements, according to IHS data.[31] Medicaid collections at IHS-operated facilities grew from $496 million in FY 2013 to $729 million in FY 2018. The proportion of patients with insurance at federally operated IHS facilities grew from 64 percent to 78 percent from fiscal years 2013 through 2018, and IHS facilities in states that expanded Medicaid saw the largest increases.[32]

Access to Care

IHS is responsible for providing federal health services to AI/AN people and provides funds for tribal and urban Indian health programs across the country (Figure 3).[33] IHS is not a health insurance program, but IHS services

are delivered through a system of federally run, tribally run, and Urban Indian health programs, and individuals who are eligible to receive care at IHS-funded facilities are encouraged to enroll in health insurance coverage.[34] Marketplace Navigators help increase the awareness of health care coverage, educate AI/AN patients about health plan options, and assist people with the Marketplace enrollment process.[35] The Indian Health Care Improvement Act (IHCIA), a cornerstone legal authority for the provision of health care to AI/ANs, was made permanent as part of the ACA. The IHCIA authorizes IHS providers to bill Medicare, Medicaid, and other third-party payers.[36]

Figure 3. Indian Health Service (IHS) Service population, by IHS Area



Source: HHS, https://www.hhs.gov/sites/default/files/fy-2021-budget-in-brief.pdf

Location of tribal communities in rural, remote, or isolated areas also creates challenges to accessing care. AI/AN Medicaid enrollees, compared to white non-Hispanic Medicaid enrollees, are much less likely to report easy access obtaining needed medical care, tests, treatments, or mental or behavioral health services; and they are more likely to report never being able to see a specialist as soon as needed.[37] Although health insurance coverage rates improved overall among AI/ANs following ACA implementation, disparities in health care access for this population remain.[38, 39]

Disparities in Health Outcomes

AI/AN people are disproportionately affected by chronic conditions and die at higher rates than other Americans from chronic liver disease and cirrhosis, diabetes, chronic lower respiratory diseases, as well as non-chronic causes of death such as suicide and accidents.[40] Drivers of health disparities include poor infrastructure, lack of adequate sanitation facilities, and lack of access to a safe water supply – problems more common in tribal communities compared to the U.S. general population.[41] Historical trauma – the long term, intergenerational impact of colonization, cultural suppression, and historical oppression of Indigenous peoples – is a key underlying factor contributing to negative outcomes in AI/AN communities.[42] Recognizing that Tribes are a political entity, research shows that racism in the U.S. has had a significant negative impact on communities of color over centuries, affecting a range of social and economic factors including housing, education, wealth, and employment.[43] Continuing efforts to enroll eligible AI/ANs in Medicaid and Marketplace coverage can help address disparities in access to care. To increase access to care, it is also necessary to build the IHS and Tribal health workforce by increasing number of physicians, nurses, pharmacists, dentists, and other health professionals in tribal communities. Strengthening the Indian health

care system, together with broader efforts across the federal government and cross-sector partnerships can promote health equity by addressing social determinants of health such as housing, education, and employment.

COVID-19 Pandemic

Analyses of available data indicate that AI/ANs experienced higher COVID-19 incidence and risk for infection, hospitalization, and death compared to White persons during the pandemic.[44,45] However, after COVID-19 vaccines became available, AI/AN communities have achieved higher COVID-19 vaccination rates compared to other racial and ethnic groups.[46] As of July 9, 2021, more than 55 percent of AI/AN adult IHS patients have received at least one dose of COVID-19 vaccine.[47]

During the pandemic, actions taken by CMS provided new flexibilities allowing payment for previously non-billable services and made it possible for IHS to significantly increase the use of telehealth (from an average of about 1,300 visits per month in early 2020 to over 40,000 visits per month in July of 2020).[48] Telehealth can help address certain barriers to care such as living in remote rural areas, lack of transportation, and cultural or language barriers.

The ARP increased resources to support COVID-19 response, access to mental health care, substance abuse prevention and treatment programs, facilities improvements, and activities to strengthen the public health workforce in Tribal communities.[49]

CONCLUSION

Since coverage expansions under the ACA were implemented, rates of health coverage among AI/ANs have improved significantly, although AI/ANs continue to have the highest uninsurance rate (15 percent in 2019), compared to most other racial and ethnic populations. The ARP and additional state Medicaid expansions offer the possibility of further coverage gains in this population. However, significant health disparities remain. Increased resources for the Indian health care system and other policies to address social determinants of health can help strengthen access to care and improve health outcomes among American Indians and Alaska Natives.

Appendix Table 1. Uninsured AI/AN Nonelderly Population, By Income, by State (2019)

AMERICAN INDIAN/ALASKA NATIVE UNINSURED, BY INCOME, BY STATE			
STATE	Income 100-400% FPL	Income > 400% FPL	Income < 100% FPL
ALABAMA	800	**	1,100
ALASKA	9,200	2,200	11,400
ARIZONA	22,700	6,000	41,600
ARKANSAS	1,800	**	2,500
CALIFORNIA	5,700	3,700	8,400
COLORADO	1,300	700	2,400
CONNECTICUT	**	**	**
DELAWARE	**	**	**
DISTRICT OF COLUMBIA	**	**	**
FLORIDA	3,100	1,100	2,800
GEORGIA	1,600	**	2,400
HAWAII	**	**	**
IDAHO	1,800	1,200	1,300
ILLINOIS	**	**	600
INDIANA	1,200	**	400
IOWA	**	600	1,500
KANSAS	1,200	**	1,300
KENTUCKY	**	100	200
LOUISIANA	600	300	800
MAINE	500	**	100
MARYLAND	300	**	**
MASSACHUSETTS	**	**	**
MICHIGAN	2,300	1,600	2,800
MINNESOTA	2,700	400	4,300
MISSISSIPPI	2,300	**	2,900
MISSOURI	1,500	200	1,600
MONTANA	6,100	2,700	10,700
NEBRASKA	1,300	400	2,400
NEVADA	900	800	1,100
NEW HAMPSHIRE	**	**	**
NEW JERSEY	**	**	**
NEW MEXICO	16,300	4,500	18,800
NEW YORK	1,400	400	2,800
NORTH CAROLINA	7,200	800	9,300
NORTH DAKOTA	3,300	1,000	5,400
OHIO	600	600	200
OKLAHOMA	36,900	7,300	35,100

OREGON	1,500	1,400	2,400
PENNSYLVANIA	**	**	400
RHODE ISLAND	**	**	**
SOUTH CAROLINA	500	**	1,000
SOUTH DAKOTA	7,600	700	13,900
TENNESSEE	1,200	**	1,500
TEXAS	7,300	2,600	5,000
UTAH	4,100	800	6,700
VERMONT	**	**	**
VIRGINIA	400	**	800
WASHINGTON	3,000	900	6,100
WEST VIRGINIA	**	**	**
WISCONSIN	2,300	700	3,600
WYOMING	1,700	100	3,400
US TOTAL	164,600	48,300	221,800

Source: ASPE analysis of 2019 American Community Survey Data, details on definition of income used for these estimates can be found in the Methodological Description page. https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features

Note: Cells labeled ** have been suppressed for having fewer than 3 observations

Appendix Table 2. Uninsured AI/AN Nonelderly Population, Number of People, by State (2019)

Medicaid Eligible Uninsured AI/AN in Medicaid Expansion States	
State	Uninsured (#)
Alaska	11,400
Arizona	41,600
Arkansas	2,500
California	8,400
Colorado	2,400
Connecticut	**
Delaware	**
District of Columbia	**
Hawaii	**
Idaho	1,300
Illinois	600
Indiana	400
Iowa	1,500
Kentucky	200
Louisiana	800
Maine	100
Maryland	**
Massachusetts	**
Michigan	2,800
Minnesota	4,300
Missouri	1,600
Montana	10,700
Nebraska	2,400
Nevada	1,100
New Hampshire	**
New Jersey	**
New Mexico	18,800
New York	2,800
North Dakota	5,400
Ohio	200
Oklahoma*	35,100
Oregon	2,400
Pennsylvania	400
Rhode Island	**
Utah	6,700
Vermont	**
Virginia	800
Washington	6,100
West Virginia	**
Total	172,800

Source: ASPE analysis of 2019 American Community Survey Data, details on definition of income used for these estimates can be found in the Methodological Description page https://aspe.hhs.gov/reports/state-county-local-estimates-uninsured-population-prevalence-key-demographic-features
Note: Cells labeled ** have been suppressed for having fewer than 3 observations.
*The estimate for Oklahoma is from data that predate the state's 2021 Medicaid expansion.

REFERENCES

[1] Office of the Assistant Secretary for Planning and Evaluation. (2021, March). *State, County, And Local Estimates of the Uninsured Population: Prevalence and Key Demographic Features.* Accessed at: https://aspe.hhs.gov/pdf-report/estimates-of-the-qhp-eligible-uninsured

[2] U.S. Census Bureau. (2019) American Community Survey (ACS): 2019 1-Year Estimates. Table S0201: Selected Population Profile in the United States. Accessed at: https://data.census.gov/cedsci/

[3] U.S. Census Bureau. (2013) American Community Survey (ACS): 2013 1-Year Estimates. Table S0201: Selected Population Profile in the United States. Accessed at: https://data.census.gov/cedsci/

[4] U.S. Census Bureau. (2019) American Community Survey (ACS): 2019 1-Year Estimates. Table S0201: Selected Population Profile in the United States. Accessed at: https://data.census.gov/cedsci/

[5] Villaroel, M, Clarke, T and Norris, T. (2020, August). *Health of American Indian and Alaska Native Adults, by Urbanization Level: United States, 2014-2018.* CDC: National Center for Health Statistics Data Brief, No. 372. Accessed at: https://www.cdc.gov/nchs/data/databriefs/db372-h.pdf

[6] U.S. Department of the Interior: Indian Affairs. Accessed at: https://www.bia.gov

[7] Salazar, M. (2016, Oct). *State Recognition of American Indian Tribes.* National Conference of State Legislatures: Vol. 24, No. 39. Accessed at: https://www.ncsl.org/legislators-staff/legislators/quad-caucus/state-recognition-of-american-indian-tribes.aspx

[8] *Tribal Population*. (Updated 2018, Dec). Center for Disease Control and Prevention: Public Health Professionals Gateway. Accessed at: https://www.cdc.gov/tribal/tribes-organizations-health/tribes/state-population.html

[9] *Urban Indian Health Program*. (2018, Oct). Indian Health Service: Fact Sheet. Accessed at: https://www.ihs.gov/newsroom/factsheets/uihp/

[10] Norris, R, Vines, P and Hoeffel, E. (2012, Jan). *The American Indian and Alaska Native Population: 2010*. 2010 U.S. Census Bureau Brief. Accessed at: https://www.census.gov/history/pdf/c2010br-10.pdf

[11] Norris, R, Vines, P and Hoeffel, E. (2012, Jan). *The American Indian and Alaska Native Population: 2010*. 2010 U.S. Census Bureau Brief. Accessed at: https://www.census.gov/history/pdf/c2010br-10.pdf

[12] Norris, R, Vines, P and Hoeffel, E. (2012, Jan). *The American Indian and Alaska Native Population: 2010*. 2010 U.S. Census Bureau Brief. Accessed at: https://www.census.gov/history/pdf/c2010br-10.pdf

[13] Elliott, D, Santos, R, Martin, S, and Runes, C. (2019, June). *Assessing Miscounts in the 2020 Census.* The Urban Institute : Center on Labor, Human Services and Population. Research Report. Accessed at: https://www.urban.org/sites/default/files/publication/100324/assessing_miscounts_in_the_2020_census.pdf

[14] *Profile: American Indian/Alaska Native.* (Updated 2021, May 21). HHS: Office of Minority Health. Accessed at: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=62

[15] DeWeaver, N. (2010, Oct 11). *The American Community Survey: Serious Implications for Indian Country*. National Congress of American Indians Policy Research Center. Accessed at: https://www.ncai.org/policy-research-center/initiatives/ACS_Serious_Implications.PDF

[16] Working with American Indians and Alaska Natives Information and Tips for Agents and Brokers. Centers for Medicare & Medicaid Services. Accessed at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/American-Indians_Alaska-Native-Fact-Sheet.pdf

[17] *AI/AN Enrollment in Marketplace & Medicaid*. (2021, June 15). The Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) Brief. Accessed at: https://www.tribalselfgov.org/wp-content/uploads/2021/06/TSGAC-Brief-AI-AN-Marketplace-Medicaid-Enroll-2019-2020-dated-2021-06-15-1.pdf

[18] *Health Coverage Enrollment Report Spring 2019* (2019, May). Washington Health Benefit Exchange. Accessed at: https://www.wahbexchange.org/content/dam/wahbe/2020/02/HBE_EB_190531_Spring-2019-Enrollment-Report_190530_FINAL_Rev2.pdf

[19] Office of the Assistant Secretary for Planning and Evaluation. (2021, April). *Count Estimates of Zero- and Low- Premium Plan Availability, Healthcare.gov States Pre and Post ARP.* HHS. Accessed at: https://aspe.hhs.gov/pdf-report/count-estimates-of-zero-and-low-premium-plan

[20] *Ten Important Facts about Indian Health Service and Health Insurance for American Indians and Alaska Natives.* (2016, Aug). Centers for Medicare & Medicaid Services. MCMS ICN No 909322-N. Accessed at: https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/10-Important-Facts-About-IHS-and-Health-Care-.pdf

[21] Indian Health & Medicaid. Accessed at: https://www.medicaid.gov/medicaid/indian-health-medicaid/index.html

[22] Roygardner, L, Schneider, A and Steiger, D. (2019, Sep) *Promoting Health Coverage of American Indian and Alaska Native Children*. Georgetown University: Center for Children and Families. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2019/09/AI-AN-health-coverage.pdf

[23] Frean M, Shelder S, Rosenthal MB, Sequist TD, Sommers BD. (2016) *Health Reform and Coverage Changes Among Native Americans*. JAMA Intern Med.;176(6):858–860. Accessed at: doi:10.1001/jamainternmed.2016.1695

[24] *Medicaid & CHIP For American Indians/Alaska Natives.* (2017, Feb). Centers for Medicare & Medicaid Services. CMS Product 909442-N. Accessed at: https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Medicaid-and-CHIP-Pocket-Card.pdf

[25] Office of the Assistant Secretary for Planning and Evaluation. (2021, March). *State, County, And Local Estimates of the Uninsured Population: Prevalence and Key Demographic Features.* Accessed at: https://aspe.hhs.gov/pdf-report/estimates-of-the-qhp-eligible-uninsured

[26] *Oklahoma's Medicaid Expansion will Provide Access to Coverage for 190,000 Oklahomans.* (2021, July). Centers for Medicare & Medicaid Services, Press Release. Accessed at: https://www.hhs.gov/about/news/2021/07/01/oklahomas-medicaid-expansion-will-provide-access-to-coverage-for-190000-oklahomans.html

[27] Branham DK, Peters C, and Sommers BD. (2021, May 28). *Estimates of Uninsured Adults Newly Eligible for Medicaid If Remaining Non-Expansion States Expand.* Data Point No. HP-2021-12. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Accessed at: https://aspe.hhs.gov/reports/estimates-medicaid-eligibility-non-expansion-states

[28] Federal Funding for Services "Received Through" an IHS/Tribal Facility and Furnished to Medicaid-Eligible American Indians & Alaska Natives. (2016, Feb 26). Center for Medicaid & CHIP Services (CMS): Federal Policy Guidance, SHO #16-002. Accessed at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf

[29] About IHS. U.S. Department of Health and Human Services: Indian Health Service. https://www.ihs.gov/aboutihs/

[30] *Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage & Collections.* (2019, Sep). Government Accountability Office (GAO): Report to Congressional Requesters. GAO 19-612. Accessed at: https://www.gao.gov/products/gao-19-612

[31] *Indian Health Service: Actions Needed to Improve Oversight of Federal Facilities' Decision-Making About the Use of Funds.* (2020, Nov). Government Accountability Office (GAO): Report to Congressional Requesters. GAO-21-20. Accessed at: https://www.gao.gov/assets/gao-21-20.pdf

[32] *Indian Health Service: Facilities Reported Expanding Services Following Increases in Health Insurance Coverage & Collections*. (2019, Sep). Government Accountability Office (GAO): Report to Congressional Requesters. GAO 19-612. Accessed at: https://www.gao.gov/products/gao-19-612

[33] Under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA), Tribes can choose to assume responsibility for health care services that would otherwise be administered by the federal government. Tribes may contract with the IHS through self-determination contracts and annual funding agreements under Title I of ISDEAA or self-governance compacts and funding agreements under Title V of ISDEAA.

[34] Under 42 CFR 136.12, services will be provided "to persons of Indian descent belonging to the Indian community served by the local facilities and program" and "an individual may be regarded as within the scope of the Indian health and medical service program if he/she is regarded as an Indian by the community in which he/she lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction."

[35] *HHS Announces the Largest Ever Funding Allocation for Navigators and Releases Final Numbers for Marketplace Open Enrollment*. (2021, April 21). Centers for Medicare & Medicaid Service: Press Release. Accessed at: https://www.cms.gov/newsroom/press-releases/hhs-announces-largest-ever-funding-allocation-navigators-and-releases-final-numbers-2021-marketplace

[36] *Indian Health Care Improvement Act: Legislative History.* Indian Health Service. Accessed at: https://www.ihs.gov/ihcia/history/

[37] *Medicaid's Role in Health Care for American Indians and Alaska Natives*. (2021, Feb). MACPAC. Issue Brief. Accessed at: https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf

[38] Frerichs, L, Bell, Lich, KH, Reuland, D and Warne, D. (2019, Sep) *Regional Differences in Coverage Among American Indians & Alaska Natives Before & After the ACA*. Health Affairs: Volume 38, No. 9: Neighborhoods & Health. Accessed at: https://doi.org/10.1377/hlthaff.2019.00076

[39] Sequist TD. *Improving the Health of the American Indian and Alaska Native Population.* JAMA. 2021;325(11):1035-1036. Accessed at: doi:10.1001/jama.2021.0521

[40] *Indian Health Disparities.* (2019, Oct). Indian Health Service: Fact Sheet. Accessed at: https://www.ihs.gov/newsroom/factsheets/disparities/

[41] *Safe Water and Waste Disposal Facilities*. (2021, May). Indian Health Service. Fact Sheet. Accessed at: https://www.ihs.gov/newsroom/factsheets/safewater/

[42] Kirmayer, L.J., J.P. Gone, and J. Moses. *Rethinking Historical Trauma.* Transcultural Psychiatry, 2014: 51(3): 299-319. Accessed at: https://journals.sagepub.com/doi/full/10.1177/1363461514536358

[43] *Racism and Health*. (2021, July). Centers for Disease Control and Prevention. Accessed at: https://www.cdc.gov/healthequity/racism-disparities/index.html

[44] Williamson LL, Harwell TS, Koch TM, et al. (2021, April 9). *COVID-19 Incidence and Mortality Among American Indian/Alaska Native and White Persons — Montana, March 13–November 30, 2020*. MMWR Morb Mortal Wkly Rep 2021;70:510–513. Accessed at: http://dx.doi.org/10.15585/mmwr.mm7014a2externalicon.

[45] *Risk for COVID-19 Infection, Hospitalization and Death By Race/Ethnicity.* (Updated 2021, June 17). Centers for Disease Control and Prevention. Accessed at: https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

[46] COVID Data Tracker: Vaccination Demographics Trends. (Updated 2021, July 12). Centers for Disease Control and Prevention. Accessed at: https://covid.cdc.gov/covid-data-tracker/#vaccination-demographics-trends

[47] *Bi-Weekly COVID19 Update for Indian Country.* (2021, July 9). Newsroom: Press Release. Indian Health Service. Accessed at: https://www.ihs.gov/sites/coronavirus/themes/responsive2017/display_objects/documents/Bi-WeeklyCOVID-19UpdateforIndianCountry07092021.pdf

[48] *COVID-19 Pandemic Impact in Native Communities.* (2021, April 14). Retrieved from Senate Committee on Indian Affairs Oversight Hearing. Transcript. Accessed at: https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/testimony/117/117th-Apr-14-2021.pdf

[49] *Biden Administration Invests Additional $1.8 Billion in American Rescue Plan Funding to Combat COVID-19 In Indian Country*. (2021, June 16). Newsroom: Press Release. Indian Health Service. Accessed at: https://www.ihs.gov/sites/coronavirus/themes/responsive2017/display_objects/documents/Press-Release-Additional-1.8-billion-in-ARP-funding-6162021.pdf

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Assistant Secretary for Planning and Evaluation

200 Independence Avenue SW, Mailstop 447D
Washington, D.C. 20201

For more ASPE briefs and other publications, visit:
aspe.hhs.gov/reports

SUGGESTED CITATION
Issue Brief No. HP-2021-18 "Health Insurance Coverage and Access to Care for American Indians and Alaska Natives: Current Trends and Key Challenges."https://aspe.hhs.gov/reports/health-insurance-coverage-changes-aian Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. July 2021.

COPYRIGHT INFORMATION
All material appearing in this report is in the public domain and may be reproduced or copied without permission; citation as to source, however, is appreciated.

DISCLOSURE
This communication was printed, published, or produced and disseminated at U.S. taxpayer expense.

———————————————————

Subscribe to ASPE mailing list to receive email updates on new publications:
https://list.nih.gov/cgi-bin/wa.exe?SUBED1=ASPE-HEALTH-POLICY&A=1

For general questions or general information about ASPE:
aspe.hhs.gov/about