The Impact the Affordable Care Act on American Indian and Alaskan Native Uninsured Rates: Reducing Disparities through Increased Affordability and Access to Health Care Services

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Introduction

American Indians and Alaskan Natives (AI/AN) have long experienced poorer health status and report poorer health outcomes than other racial or ethnic groups in the United States.[1] The overall life expectancy of AI/ANs is 4.2 years less than the overall U.S. all races population[2]. According to the Indian Health Service (IHS), AI/ANs who are members of federally recognized tribes die at significantly higher rates than other ethnic or racial groups in the U.S. as a result of many conditions, including chronic liver disease and cirrhosis (368% higher), diabetes (177% higher), unintentional injuries (138% higher), assault/homicide (82% higher), and intentional self-harm/suicide (65% higher)[3]. The health outcomes of AI/AN populations mark pronounced health disparities symptomatic of structural issues in the affordability and access of health care among AI/ANs.

Unlike other U.S. citizens, AI/AN are legally entitled to health care services provided by the federal government as a result of treaties between the U.S. government and AI/AN tribes.[4] However, in 2013, the uninsured rate of AI/AN was 24%, while the national uninsured rate was only 14.5%.[5,6] The Indian Health Care Improvement Act (IHCIA) of 1976 and the Snyder Act of 1921 provide Congress with the legal authority to distribute funds specifically for the health care of AI/ANs who are citizens of federally recognized tribes.[7] There are currently 573 federally recognized tribes in the U.S., the citizens of these tribes residing on or near reservations are eligible to receive health care from Indian Health Services: a government agency established in 1955 to meet the federal government's commitment and responsibility to provide health care to AI/AN individuals[8]. Currently, the IHS provides services to 2.6 million AI/AN individuals.[8] The Indian Health System refers to the delivery of health and behavioral health services through the IHS, tribally run facilities, and urban located facilities; collectively, this system is referred to as the ITU[9].

The Affordable Care Act, signed into law in law in 2010 and implemented through 2015, should directly increase coverage of AI/AN individuals through the exchanges. The exchanges provide eligible individuals the ability to purchase health insurance coverage.[10] AI/AN individuals who purchase health insurance through an exchange do not have to pay co-pays or other cost-sharing if their incomes are below 300% of the federal poverty level[11]. In this policy brief we will examine the impact of the ACA on the AI/AN uninsured rate to evaluate the efficacy of the program in expanding access to health care among AI/AN populations in states that adopted Medicaid expansions under the ACA, compared to states that opted not to implement the expansions.

Background and Research Findings

Although the majority of nonelderly AI/ANs are in working families, they are less likely than the overall nonelderly U.S. population to be in the workforce and have significantly higher poverty rates than the total nonelderly population[5]. Among all nonelderly AI/ANs 63% are in a family with at least one full-time worker, compared to 74% of the US nonelderly population. Representative of this employment pattern, according to the 2015 American Communities Survey, the poverty rate for AI/AN is more than one and half times the overall rate for the nonelderly population[12].

As discussed, the US government has a responsibility to provide health care services for AI/ANs which is the primarily responsibility of IHS. However, IHS has funding restrictions that limit the arrangement of care to the population.[13] With consideration to the limitations of IHS, health insurance coverage remains important for providing access to health care for AI/AN, with Medicaid playing a particularly important role[5].

As a discretionary program, IHS funding is constrained and must be allocated by Congress each year. The allocated funds are distributed to IHS facilities across the country and serve as their annual budget[8]. In 2013, the amount of $4.3 billion was allocated for IHS services, with $3.1 billion going to health care services and the remaining to support preventive health and other services.[14] More than half or $1.8 million of the $3.1 million going to direct health services was appropriated to tribally-operated facilities, with the remaining going toward facilities directly operated by IHS[15]. Only 1% of total program funding was directed toward urban Indian health[15].

IHS has historically been underfunded in meeting the health care needs of AI/ANs. Although the IHS budget has increased over time, funds are not evenly distributed across IHS facilities and remain inadequate to meet health care needs.[5] Accordingly, access to services through IHS varies significantly across locations, and AI/ANs who rely on IHS for care often lack access to needed care, including preventive care and treatment of chronic diseases.[16]

Although the 700,000 AI/AN Medicaid beneficiaries make up a small portion of total Medicaid beneficiaries, Medicaid is a vital source of health insurance coverage for the population.[9] Medicaid assists in filling in the substantial gaps in private coverage for AI/ANs and provides an important source of financing for IHS providers[3].

In 2013, prior to significant adoption of ACA in Medicaid expansion states, nearly one in three AI/ANs were uninsured[17]. AI/ANs have limited access to employer-sponsored coverage as they have a lower employment rate and those working are often employed in low-wage jobs and industries that typically do not offer health coverage[18]. Also in 2013, less than four in ten nonelderly AI/ANs had private health insurance coverage, compared to over six in ten nonelderly in the U.S.[17]. Medicaid helps fill this health care insurance gap that is not met by private or employer-sponsored health insurance.

Medicaid serves a more significant role for AI/AN children than adults, covering more than half of AI/AN children 50% compared to 27% of nonelderly adults[5]. Accordingly, the uninsured rate for nonelderly AI/AN adults is nearly twice that of children.[20]

Under the ACA, Medicaid is expanded to adults with incomes at or below 138% of the Federal Poverty Line in states that implement the Medicaid expansion, which was made a state option by the Supreme Court ruling on the ACA.[11] The federal government will cover 100% of the cost for all individuals made newly eligible by the expansion for the first three years, phasing down to 90% over time.[17]

The Medicaid expansion granted increased Medicaid revenues for IHS and Tribally-operated facilities[15]. As discussed, Medicaid is a key source of revenue for IHS providers. In states that expanded Medicaid, the proportion of patients served by IHS providers with Medicaid expanded, resulting in increased revenues for the facilities that are able to expand their capacity to provide services.[15] Overall, total IHS program funding from Medicaid revenue increased from $720 million in 2013 to nearly $810 million in 2017.[20] Some facilities have also pointed to positive effects of the Medicaid expansion[10]. For example, in Arizona, one Tribally-operated health system reported that about half of visits were by patients covered by Medicaid in 2016.[11] Additionally, an Urban Indian Health Program in Arizona indicated that its uninsured rate at one clinic fell from 85% pre-ACA to under 10%.[9] In Montana, one study finds that the Medicaid expansion improved access to care for AI/ANs and allowed facilities broader ability to refer patients for services from private providers.[5]

The states that expanded Medicaid through the ACA experienced a decrease in the AI/AN uninsured rate at twice that of non-expansion states[4]. Nationwide, from 2013 to 2015, Medicaid expansion states saw a decrease in the AI/AN uninsured rate from 23% to 15% of the population, while non-expansion states experienced a significantly smaller decline in the AI/AN uninsured rates from 25% to 21%.[5]

While AI/AN remain significantly more likely to be uninsured at a 21.7% uninsured rate compared to other U.S. citizens with a 10% uninsured rate, the significant decrease in the uninsured rate among Medicaid expansion states indicates that affordability is a significant barrier in way of AI/AN health care access and steps should be taken to address these disparities.[21]

Policy Implications and Recommendations

From the research presented we have observed how the ACA had varying levels of impact dependent on whether a particular state decided to opt into the expansion of Medicaid services on the AN/AI uninsured rate. On balance, states that opted into the Medicaid expansions observed a decrease in the AN/AI uninsured rate, accordingly, I propose the following policy recommendations:

1. States should opt into the ACA, with a particular obligation set on states with a high percentage of AI/AN populations.
2. The federal government should uphold the obligation to AI/AN treaty rights to health care services through sufficiently funding Indian Health Services, tribally run health care services, and urban located facilities.

Although the policy recommendations presented are not exhaustive of the steps necessitated to address health outcome disparities among AI/ANs, they will assist in filling in the uninsured rate gaps between AI/AN populations and other groups in the US, as well as facilitate meeting the health care needs of AI/AN that are not currently addressed in access and affordability of health care services and resources.

References:

1. "Disparities: Fact Sheets." *Indian Health Services*, Disparities, Oct. 2019, www.ihs.gov/newsroom/factsheets/disparities/.
2. *Summary Health Statistics: National Health Interview Survey*. Centers for Disease Control and Prevention, US Department of Health and Human Services , 2018, ftp.cdc.gov/pub/Health_Statistics/NCHS/NHIS/SHS/2018_SHS_Table_P-1.pdf.
3. Ross, Raven E, et al. "The Affordable Care Act and Implications for Health Care Services for American Indian and Alaska Native Individuals." *Journal of Health Care for the Poor and Underserved*, US National Library of Medicine, Nov. 2015, www.ncbi.nlm.nih.gov/pmc/articles/PMC4824684/.
4. "Basis for Health Services: Fact Sheets." *Indian Health Services*, Jan. 2015, www.ihs.gov/newsroom/factsheets/basisforhealthservices/.
5. Ubri, Petry, and Samantha Artiga. "Medicaid and American Indians and Alaska Natives." *KFF*, 14 May 2018, www.kff.org/medicaid/issue-brief/medicaid-and-american-indians-and-alaska-natives/.
6. "Census Data Show Uninsured Rate Edged Down Slightly in 2013." *Center on Budget and Policy Priorities*, 11 Oct. 2017, www.cbpp.org/research/census-data-show-uninsured-rate-edged-down-slightly-in-2013.
7. McLeigh JD. What are the policy issues related to the mental health of Native Americans? American Journal Of Orthopsychiatry. 2010;80(2):177–182. doi: 10.1111/j.1939-0025.2010.01021.x.
8. "Indian Health Service (IHS)." *About IHS*, www.ihs.gov/aboutihs/.
9. "IHS, Tribal, and Urban Indian LTSS Programs Databases." *CMS*, www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/ihs-tribal-and-urban-ltss-programs.
10. "Affordable Care Act Timeline." *American Lung Association*, 3 Feb. 2020, www.lung.org/policy-advocacy/healthcare-lung-disease/healthcare-policy/affordable-care-act-timeline.
11. "How Medicaid Health Care Expansion Affects You." *HealthCare.gov*, www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/.
12. Bureau, US Census. "2015 Data Release Schedule." *The United States Census Bureau*, 31 July 2020, www.census.gov/programs-surveys/acs/news/data-releases/2015/release-schedule.html.
13. Warne, Donald, and Linda Bane Frizzell. "American Indian Health Policy: Historical Trends and Contemporary Issues." *American Journal of Public Health*, American Public Health Association, June 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC4035886/.
14. "Increase Proposed for Indian Health Service Budget: 2013 Press Releases." *Indian Health Services*, 18 Apr. 2013, www.ihs.gov/newsroom/pressreleases/2013pressreleases/increaseproposedforindianhealthservicebudget/.
15. Department of Health and Human Services, *Indian Health Service: Fiscal Year 2014 Justification of Estimates for Appropriations Committees*, March 12, 2013. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/documents/FY2013BudgetJustification.pdf.

16. *Reclaiming Tribal Health: A National Budget Plan to Rise Above Failed Policies and Fulfill Trust Obligations to Tribal Nations*. The National Tribal Budget Formulation Workgroup, Apr. 2020, www.nihb.org/docs/05042020/FINAL_FY22%20IHS%20Budget%20Book.pdf.
17. Artiga, Samantha, and Rachel Arguello. "Health Coverage and Care for American Indians and Alaska Natives - Issue Brief." *KFF*, 30 Oct. 2013, www.kff.org/report-section/health-coverage-and-care-for-american-indians-and-alaska-natives-issue-brief/.
18. Austin , Algernon. "Native Americans and Jobs: The Challenge and the Promise." *Economic Policy Institute*, 17 Dec. 2013, www.epi.org/publication/bp370-native-americans-jobs/.
19. Schneider, Andy, et al. "The Future of Coverage for American Indian and Alaska Native Children." *Center For Children and Families*, 17 Sept. 2019, ccf.georgetown.edu/2019/09/17/the-future-of-coverage-for-american-indian-and-alaska-native-children/.
20. Bylander, Jessica, et al. "Propping Up Indian Health Care Through Medicaid: Health Affairs Journal." *Health Affairs*, 1 Aug. 2017, www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0849.
21. "Uninsured Rates for the Nonelderly by Race/Ethnicity." *KFF*, 23 Oct. 2020, www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?currentTimeframe=0.
22. Institute of Medicine (US) Committee on the Consequences of Uninsurance. "Effects of Health Insurance on Health." *Care Without Coverage: Too Little, Too Late.*, U.S. National Library of Medicine, 1 Jan. 1970, www.ncbi.nlm.nih.gov/books/NBK220636/.

Additional Sources of Interest:

1. Indian Health Services: https://www.ihs.gov/newsroom/factsheets/ihsprofile/
2. Centers for Disease Control and Prevention Health Disparities: https://www.cdc.gov/tribal/data-resources/health-disparities/index.html
3. Native American Health Insurance Coverage Under the ACA: https://www.healthinsurance.org/faqs/how-can-native-americans-get-coverage-under-the-aca-are-there-specific-plan-options-for-them/
4. CMS Health Care Reform: Tracking Tribal, Federal, and State Implementation: https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/CMSHealthCareReform5202011.pdf