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Overview

In support of the mission of the American Indian and Alaska Native (AIAN) Liaison Committee of the National Association of Insurance Commissioners (NAIC), the Committee agreed to explore three topics with the aim of exploring best practices and fostering an ongoing dialogue on insurance issues.

This paper is intended as a general briefing to explore opportunities related to access and outreach of health care services through Indian Health Services (IHS) and the Affordable Care Act (ACA).

AIAN Population Approach to Health Care

Approximately 1.8% of the United States' (US) population (5.8 million people) identify as being AIAN alone or in combination with another race. Of those individuals, 2.8 million identify as AIAN alone.

Nearly half of AIAN people reside in 10 states:

1. Alaska
2. Arizona
3. California
4. New Mexico
5. New York
6. North Carolina
7. Oklahoma
8. South Dakota
9. Texas
10. Washington

When looking at the percent of population, five states have AIAN alone as the second largest racial or ethnic group after Whites (Alaska, New Mexico, South Dakota, Montana, and North Dakota).¹

Increasingly, AIAN people live outside of tribal areas. In 2010, 78% lived outside tribal statistical areas, compared to 38% in 1970. Nearly 70% of AIAN individuals live in metropolitan areas. Nearly one quarter, or 23%, of AIAN people live in poverty, almost double the national poverty rate. AIAN people also have significantly higher rates of unemployment, lower rates of home ownership, and are less likely to have a bachelor's degree. AIAN people report being in poor or fair health at nearly twice the rate of American adults overall (20.6% versus 12.1%).²

Compared to Americans overall, AIAN people are less likely to report having a usual source of care or provider and are more likely to report avoiding or delaying medical care due to cost or other reasons. Many AIAN people face barriers to care such as living in remote rural areas, lack of transportation, and cultural and language barriers. Such barriers affect both those with and without IHS eligibility or

¹ [2020 Census: Native population increased by 86.5 percent - ICT \(indiancountrytoday.com\)](https://indiancountrytoday.com/news/2020-census-native-population-increased-by-86-5-percent-ict)

² <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>

insurance coverage. In 2019, the uninsured rate for AIAN people was nearly 20% in 2019, more than double the uninsured rate for Americans overall (9.2%).³

Affordable Care Act (ACA) and the AIAN Population

Under the ACA, specific portions intended to improve access to health services for the AIAN population. Access to ACA coverage on the Marketplace (insurance coverage offered by private/public health insurance companies) provides an option for AIAN people who are geographically distant from or live outside an IHS-funded facility service area.

For AIAN individuals, the ACA means:

- Less likely to report if it is always or usually easy to get needed medical care, tests, or treatments;
- Those who purchase health insurance through an exchange do not have to pay co-pays or other cost-sharing (also identified as a cost-sharing exemption). These subsidies are available if the members' incomes do not exceed 400% of the federal poverty level.
- AIAN members who reside outside of the service areas provided by IHS receive additional access to coverage for care.
- AIAN members may claim an exemption to the shared responsibility payment if the covered member receives care from an Indian Health Care Providers (IHCP).
- Open enrollment year-round on state or federal Marketplaces.

Understanding how the ACA – as well as Medicaid – affects the AIAN population is critical to addressing the improvement of the overall access, quality, and cost of health care within AIAN communities. In Indian Country, the ACA and Medicaid are often spoken of together with little to no distinction. Medicaid is a government program providing health coverage to low-income individuals who meet the federal Medicaid eligibility standards. The ACA originally included expanded provisions for Medicaid, which was later ruled unconstitutional. Medicaid expansion is now a state option program. For the AIAN population, Medicaid eligibility is not affected by IHS eligibility.

Specific to healthcare access in rural areas of Alaska, ACA Section 5104, the Interagency Task Force to Assess and Improve Access to Health Care in the state of Alaska called for a membership of agencies, including the IHS, to develop a strategy for the federal government to improve health care delivery to federal beneficiaries in Alaska.

³ <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>

Understanding the Indian Health Service (IHS) Care Delivery System

For the AIAN population, the federal trust responsibility is the basis for the US government's provision of health services to AIAN people. It is grounded in obligations under numerous treaties and other legal actions to provide such services to eligible AIAN individuals.

FIVE IMPORTANT FEDERAL INDIAN HEALTH CARE STATUTES

Snyder Act of 1921

Indian Self-Determination & Education Act of 1975

Indian Health Care Improvement Act of 1976

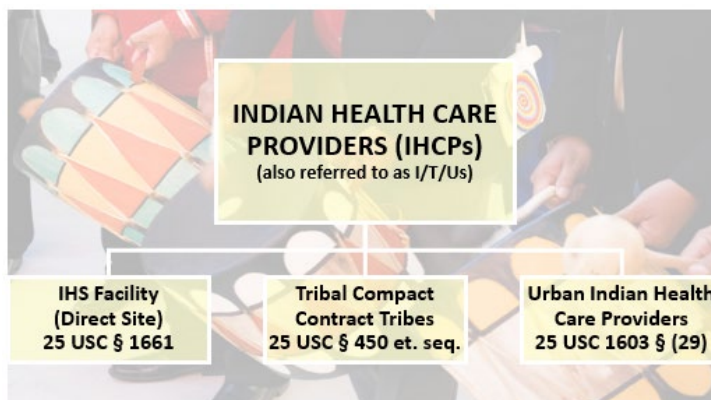
Indian Health Care Improvement Act Reauthorization & Extension Act of 2009

Patient Protection & Affordable Care Act of 2010

AIAN individuals residing on or near reservations are eligible to receive health care from the IHS, an agency operated by the US Department of Health and Human Services. IHS provides a comprehensive health service delivery system for approximately 2.6 million AIAN individuals who belong to 574 federally recognized tribes in 37 states.⁴ It's important to understand that IHS is a health care delivery system (a provider of services) and is not form of insurance.

When accessing care, AIAN people are accustomed to using one of the three IHCPs:

1. IHS facilities (or direct site);
2. A health program under a tribal contract or compact to carry out IHS programs; and/or
3. An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract.



Of note, it's been reported the majority of AIAN people who live in urban areas are not served by IHS.⁵

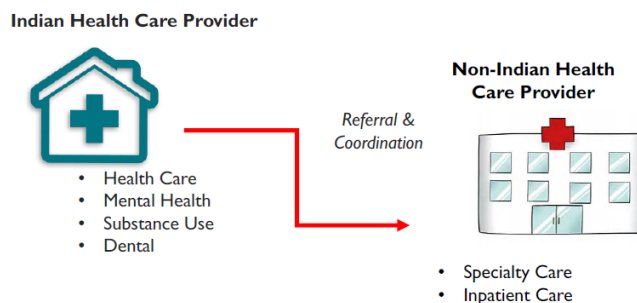
Through IHS, available services vary by facility but consist largely of primary and emergency care services; few specialty or ancillary services are available. When patients need other services, they may be referred to receive services from private providers through the Purchased/Referred Care (PRC)

⁴ <https://www.ihs.gov/aboutihs/>

⁵ Regional Differences in Coverage Among American Indians and Alaska Natives Before and After the ACA, 10.1377/hlthaff.2019.00076, HEALTH AFFAIRS 38, NO. 9 (2019): 1542–1549

program. Funding for this program is often limited to serve the highest priority cases (emergency services for the preservation of life or limb).

PURCHASED AND REFERRED CARE PAYING FOR CARE REFERRED OUTSIDE THE INDIAN HEALTH CARE SYSTEM



When PRC referrals are unavailable or denied, patients must pay out of pocket unless they have another source of coverage. Additionally, when accessing care, AIAN patients may also experience long wait times, due in part to persistent provider shortages at many IHS facilities.

In Alaska, most of the funding for IHS services (99%) now goes to tribal non-profit health organizations around the state. The Alaska Tribal Health Compact is the self-governance agreement with the IHS. The tribal health organizations negotiate annually as a group with the IHS for the following year's funding. This group of tribal health providers makes up the Alaska Tribal Health System (ATHS), a multi-level system of birth-to-death care. Comprised of a Tribal network of over 160 village clinics, 36 health centers, seven hospital facilities, and two nursing homes, the ATHS is divided into eight major geographic regions covering a land mass approximately one-fifth that of the 48 contiguous US. The user population consists of approximately 140,000 Alaska Native people, 70% of whom are dispersed among more than 200 rural remote villages with no connecting road or rail system. The other 30% reside in more urbanized areas, primarily around Anchorage.⁶

ACA and AIAN Access

The factors contributing to the health disparities experienced in the AIAN population are complex. There are several known challenges to enrolling eligible AIAN people in ACA (as well as Medicaid), including:

- Geographical remoteness
- Limited access to internet or phone service
- Language barriers
- Cultural factors
- Distrust of government programs
- Lack of knowledge of the benefits of coverage

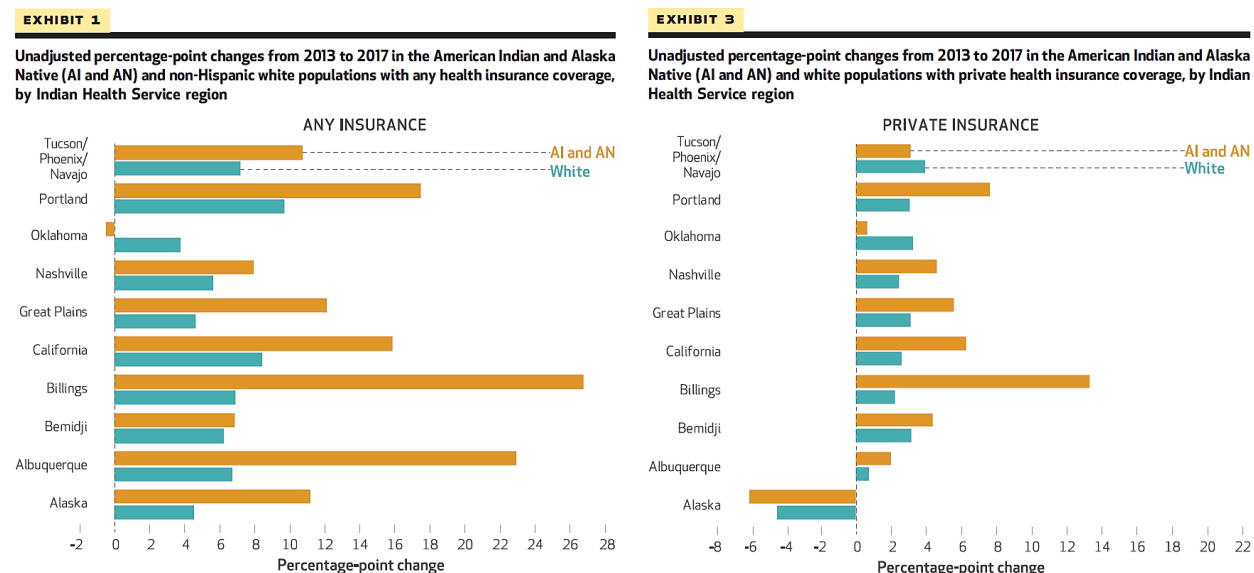
⁶ <https://www.opm.gov/healthcare-insurance/tribal-employers/hr-personnel/outreach-documents/fehb-program-for-tribes.pdf>

Many AIAN people are eligible, but not enrolled despite collaborative efforts to promote enrollment.

AIAN patients may also experience long wait times, due in part to persistent provider shortages at many IHS facilities. IHS budget constraints also manifest in aging or inadequate facilities, medical equipment, and information technology, e.g., the average age of IHS hospitals is 37.5 years, compared to 10 years for hospitals nationwide.⁷

In a 2019 study for the period of 2010-2017 evaluating the effects of the ACA on insurance coverage among AIAN populations, it was noted there were increases in insurance coverage across most regions of the US, but improvements were not consistent across all regions.

Regional differences are especially relevant for AIAN groups because there are historically distinct regional differences in their relationships with the US government. In the West, there were significant improvements, following enactment of the ACA, in the public insurance among AIAN populations with disparities (compared to non-Hispanic whites) being reduced. There were no significant post-ACA changes in public or private health insurance coverage among AIAN populations in midwestern or Alaska regions. The study noted the importance of considering how insurance policies are implemented and their potential to interact with contextual influences across regions (for instance, differences in culture and historical relationships with governmental institutions).⁸



Source: Regional Differences in Coverage Among American Indians and Alaska Natives Before and After the ACA, 10.1377/hlthaff.2019.00076, HEALTH AFFAIRS 38, NO. 9 (2019): 1542–1549

Concerning access as it relates to care, compared to Americans overall, AIAN people are less likely to report having a usual source of care or provider and are more likely to report avoiding or delaying medical care due to cost or other reasons. Many AIAN people face barriers to care such as living in

⁷ <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>

⁸ Regional Differences in Coverage Among American Indians and Alaska Natives Before and After the ACA, 10.1377/hlthaff.2019.00076, HEALTH AFFAIRS 38, NO. 9 (2019): 1542–1549

remote rural areas, lack of transportation, and cultural and language barriers. For example, AIAN Medicaid beneficiaries, compared to White, non-Hispanic beneficiaries, are significantly:

- Less likely to report if it is always or usually easy to get needed medical care, tests, or treatments;
- Less likely to report if it is always or usually easy to get needed mental or behavioral health services; and
- More likely to report if they are never able to see a specialist as soon as needed.

Such barriers affect both those with and without IHS eligibility or insurance coverage.⁹

Realities; Conclusion

Many AIAN populations historically have experienced challenges related to access and use of health care services, e.g., geographical remoteness, limited access to Internet or phone service, language barriers, cultural factors, provider shortages, distrust of government programs, lack of knowledge of the benefits of coverage, or lack of understanding of traditional AIAN healing practices.

There are cultural, language, distance, trust, and lack of knowledge barriers that limit robust access. The realities of these barriers indicate a greater need for outreach and education programs to help bridge the gaps and misconceptions around access. Community based outreach with trusted community leaders should be explored to help ease the general mistrust of government programs and increase the general understanding of the services available to AIAN communities.

The general AIAN communities should also be encouraged to voice their experience in these programs to help better understand where improvements should be made. Both off reservation and on reservation tribal outreach programs could help bridge these knowledge gaps and foster greater adoption of the programs available in AIAN communities.

When constructing outreach programs, it is important that cultural awareness and AIAN community leaders are used and leveraged. Cultural awareness fosters better communication and understanding and using community leaders will help build the necessary trust. This foundation of trust will be important in growing education and outreach programs to the at large communities.

⁹ <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>