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# Health Insurance Coverage and Access to Care among American Indians and Alaska Natives: Recent Trends and Key Challenges

The uninsured rate among non-elderly American Indians and Alaska Natives (AI/ANs) decreased from 32.4 percent in 2010 to 19.9 percent in 2022 – however, the AI/AN population continues to have the highest uninsured rate compared to other racial and ethnic populations

## KEY POINTS

- The uninsured rate among American Indians and Alaska Natives (AI/ANs) under age 65 decreased 12 percentage points since the passage of the Affordable Care Act (ACA), from 32.4 percent in 2010 to 19.9 percent in 2022.
- AI/ANs at all income levels and in all age groups experienced decreased uninsured rates between 2010 and 2022.
- Although uninsured rates decreased in recent years, the AI/AN population continues to have the highest uninsured rate compared to other racial and ethnic populations according to 2022 Census data. Among the nonelderly, AI/AN individuals were nearly three times as likely as non-Latino Whites to be uninsured in 2022 (19.9 vs. 6.8 percent).
- Persistent health disparities include higher rates of certain chronic conditions such as diabetes and higher mortality from liver disease, diabetes, lower respiratory diseases, and suicides among the AI/AN population compared to other racial and ethnic groups.
- Increased access to health coverage brings additional resources into the Indian health care system, which is crucial for advancing health equity in Native communities.
- Proposed investments included in the President's Fiscal Year 2025 Budget aim to further increase health coverage, which could help address persistent health disparities in the AI/AN population.

## INTRODUCTION

American Indians and Alaska Natives (single race and American Indian or Alaska Native individuals reporting a combination of more than one race or ethnicity) comprised 2.6 percent of the total U.S. population in 2022.[1] Census data indicate that the American Indian and Alaska Native (AI/AN) alone (single race) population increased from 2.8 million in 2013 to 3.2 million in 2022.[2] Among individuals reporting American Indian alone, more than half (50.9%) lived in five states: Oklahoma (14.2%), Arizona (12.9%), California (9.9%), New Mexico (9.1%), and Texas (4.8%); and 77.1% of the Alaska Native alone population resided in Alaska.[3] According to the 2020 Census, the states with the largest percentage of the total population who are American Indian and

Alaska Native (alone or in combination with another race or ethnicity) are Alaska (21.9 percent), Oklahoma (16.0 percent), New Mexico (12.4 percent), South Dakota (11.1 percent), Montana (9.3 percent), North Dakota (7.2 percent), Arizona (6.3 percent), Wyoming (4.8 percent), Oregon (4.4 percent), and Washington (4.1 percent).[4] The 2020 Census estimates that more than 80 percent of people who identify as AI/AN live outside of tribal statistical areas.[5]

A higher percentage of AI/AN adults ages 18 and older are in fair or poor health (19.1 percent) compared to all adults in the U.S. (14.5 percent).[6] Social drivers such as poverty, limited access to health care, and high unemployment rates that stem from longstanding historical inequities are key factors contributing to AI/AN health disparities. Research shows that not having health insurance coverage can prevent tribal members from seeking health care services and from obtaining needed prescription medications.[7]

The Affordable Care Act (ACA) expanded coverage options through state Medicaid expansion to low-income adults with incomes up to 138 percent of the federal poverty level (FPL) and private coverage purchased through health insurance Marketplaces. The Marketplaces provide special protections and benefits for members of federally recognized tribes. These protections are based on the unique government to government relationship between the federal government and federally recognized tribes. These protections include the ability to enroll in health coverage through the Marketplace anytime throughout the year 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 of ASPE Issue Briefs examining the change in coverage rates and access to care among select racial and ethnic populations, including AI/ANs who are members or descendants of federally recognized tribes, after implementation of the ACA, the American Rescue Plan (ARP), and the Inflation Reduction Act (IRA). It is an update to an ASPE issue brief released in 2021.[8] This brief uses federal survey data from 2010-2022 to analyze changes in health insurance coverage and access to and affordability of care among AI/AN s and it highlights key policies affecting AI/AN populations and the Indian health care system.

## BACKGROUND

The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, is responsible for providing federal health services to eligible AI/AN people. IHS is not an entitlement program like Medicaid or Medicare nor is it health insurance. Annual appropriations from Congress enable IHS to fund a comprehensive health service delivery system of federal facilities, facilities operated by Tribes or Tribal organizations, and Urban Indian health programs.[9] IHS also funds the Purchased/Referred Care (PRC) program, which pays for services delivered by private providers to IHS-eligible patients in limited circumstances when those services are not available at IHS facilities.[10]

Having health coverage such as employer-based insurance, direct purchase (e.g., Marketplace plans), Medicare and Medicaid and Children's Health Insurance Program coverage provides greater access to health services Indian health care programs do not provide. In addition, when Indian health care programs bill third party coverage for services provided, the reimbursements help supplement the IHS appropriations and can be used to meet accreditation and certification requirements. Health coverage also can improve access to care for AI/AN people by covering the costs for specialists and care away from home. Finally, health insurance reimbursements to Indian health care facilities increase their capacity to enhance services for AI/AN communities.

## DATA SOURCES AND METHODS

This issue brief presents data from several data sources. Estimates of insurance coverage are from the American Community Survey (ACS), the largest national survey of households, which is conducted by the Census Bureau. 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 Issue Brief uses ACS data for select years between 2010 and 2022, for population, health insurance coverage and demographic estimates. Race and ethnicity estimates using data from the ACS or the Census rely on survey participants self-identifying as AI/AN and are not based on official tribal membership rolls. This Issue Brief also includes Marketplace enrollment data reported by the Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC).

We assess trends in several self-reported measures of health care access and affordability among AI/AN people using data from the National Health Interview Survey (NHIS) for selected years from 2010 to 2022. The measures we analyze are: not having a usual source of care, delaying medical care due to cost, worrying about medical bills, and delaying prescription refills to save money.

Throughout this brief, unless otherwise specified, we use the term "American Indians and Alaska Natives" to describe the population self-reporting AI/AN as their race, either alone or in combination with another race or ethnicity. Tribal Nations are distinct political entities whose inherent sovereignty predates the United States and is reflected in their government-to-government relationship with the U.S. government. As such, AI/AN tribal members have a political status that is unique among racial and ethnic populations. This brief uses the term "Latino" to refer to all individuals of Hispanic or Latino origin.

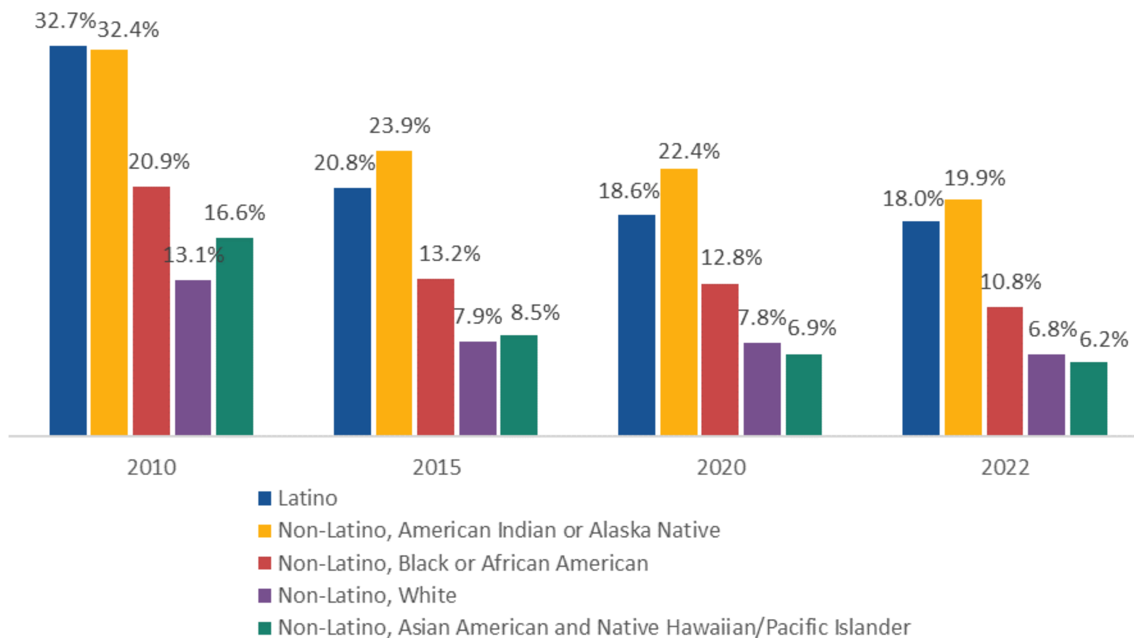
There are several limitations with these data, including potential non-response bias for both race and ethnicity data and source of health insurance. We acknowledge that both the ACS and the Census data historically undercount the AI/AN population, and our results should be interpreted accordingly.[11]

## RESULTS

### Health Coverage

Figure 1 presents the uninsured rate for ages 0-64 by race and ethnicity for select years. The uninsured rate among AI/AN individuals under age 65 decreased by 12 percentage points between 2010 and 2022, from 32.4 percent to 19.9 percent, after implementation of the ACA's provisions that expanded health coverage options. Note: Individuals who report no health insurance and who receive their care only through the IHS are considered uninsured by Census surveys.[12]

**Figure 1. Uninsured Rate Among U.S. Population (Ages 0-64) by Race and Ethnicity, Select Years**

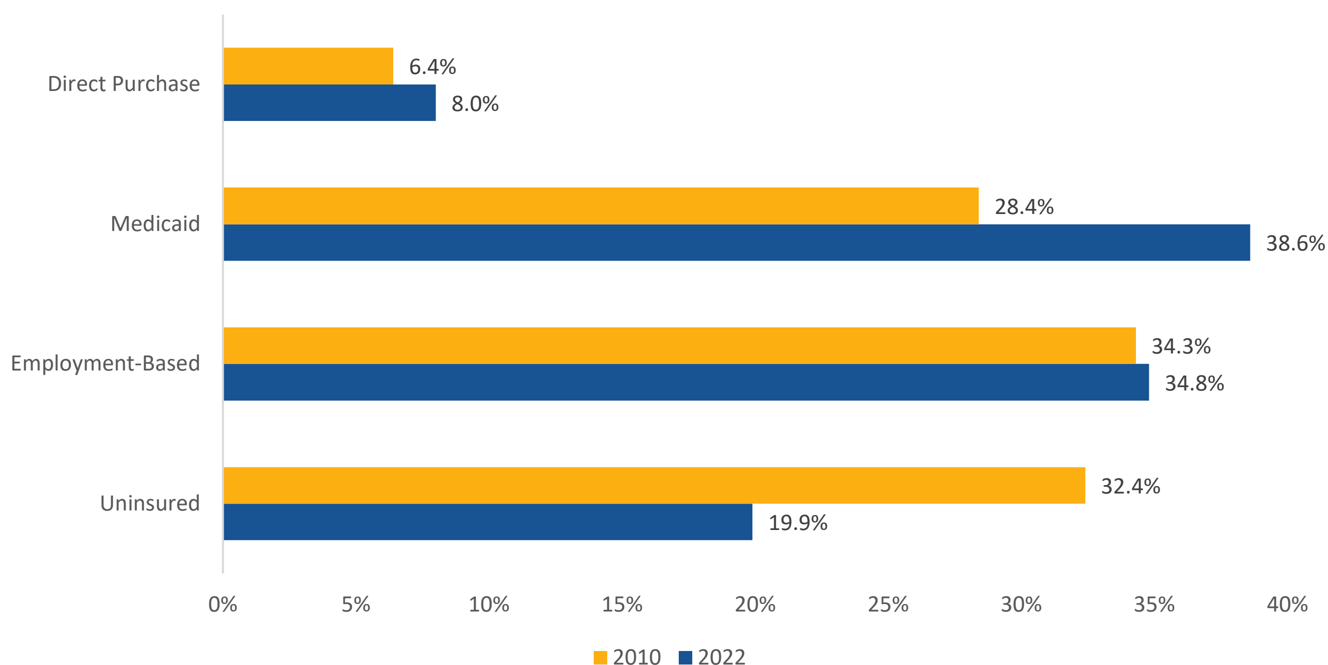



Source: American Community Survey Public Use Microdata, 2010-2022.
Notes: In this analysis, individuals were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Individuals were also defined as uninsured if they reported having only Indian Health Service or had only a private plan that paid for one type of service, such as care for accidents or dental care. Data are based on household interviews of a sample of the civilian non-institutionalized population.
Latino is defined as anyone who identified as Latino or Hispanic of any race. Non-Latino, American Indian or Alaska Native is defined as anyone who identified as non-Latino American Indian or Alaska Native alone without any other race. Non-Latino, White is defined as anyone who identified as non-Latino White alone without any other race. Non-Latino, Black or African American is defined as anyone who identified as non-Latino Black or African American alone without any other race. Non-Latino, Asian American and Native Hawaiian/Pacific Islander is defined as anyone who identified non-Latino Asian American or Native Hawaiian/Pacific Islander alone without another race.
Results are ACS survey-weighted estimates. Due to pandemic-related survey collection concerns, the Census Bureau urges caution when comparing the experimental 2020 ACS dataset to previous years.

Figure 2 presents sources of health coverage among AI/ANs in 2010 and 2022. Since 2010, the AI/AN population experienced increased coverage across all three sources of coverage – Direct Purchase, Medicaid, and Employment-Based. The largest increase in coverage by source was a 10.2 percentage point increase in Medicaid (from 28.4 percent to 38.6 percent) followed by a 1.6 percentage point increase in Direct Purchase coverage (from 6.4 percent to 8.0 percent) and a half percentage point increase in Employment-Based coverage (from 34.3 percent to 34.8 percent).

While AI/ANs experienced meaningful gains in health coverage from 2010 to 2022, coverage disparities relative to other racial and ethnic populations remain large. In 2022, AI/ANs under age 65 were much less likely than non-Latino Whites to have employment-based insurance—34.8 percent vs. 66.3 percent—and less likely to have direct purchase (private non-group) insurance—8.0 percent vs. 11.2 percent (data for Whites not shown).[13] This gap in private insurance coverage was only partially offset by higher rates of Medicaid coverage among nonelderly AI/AN adults. As a result, in 2022, among nonelderly adults, AI/AN individuals were nearly three times as likely as non-Latino Whites to be uninsured (19.9 vs. 6.8 percent).

**Figure 2. Health Insurance Coverage Type Among American Indian/Alaska Native Population (Ages 0-64), 2010 and 2022**




Source: American Community Survey Public Use Microdata, 2010 and 2022
Note: Uninsured is defined as a respondent not having any health insurance coverage or reporting only having Indian Health Service at the time of interview.

Table 1 presents the uninsured rates among the AI/AN population, by income level, age, and English language proficiency for select years. Uninsured rates dropped between 2010 and 2022 among AI/ANs across all income levels and age groups. The highest rates of uninsurance among AI/ANs in 2022 were among the lower income groups: 25.2 percent among AI/ANs with income less than 100 percent FPL, and 24.7 percent among AI/ANs with income between 101 and 200 percent FPL. Even though the uninsured rates decreased among AI/AN in all age groups, they were still much higher than the national average uninsured rates for those age groups. In 2022, for example, the uninsured rate for AI/AN children under age 19 was 10.9 percent compared to the 5.1 percent uninsured rate for all children under age 19 in the U.S.[14] English language proficiency appears to be associated with insurance status, as demonstrated by the high rates of uninsurance among AI/ANs who reported they do not speak English (65.6 percent were uninsured) and among AI/ANs who do not speak English well (43.2 percent were uninsured) in 2022.

### Table 1. Uninsured Rate Among American Indian/Alaska Native Population (Ages 0-64), by Select Characteristics, Select Years

| | Share in 2022 | 2010 | 2015 | 2020 | 2022 |
|---|---|---|---|---|---|
| *Percentage of Poverty Level* | | | | | |
| 0-100 | 20.6% | 37.2% | 28.7% | 27.0% | 25.2% |
| 101-200 | 22.8% | 38.2% | 27.1% | 26.0% | 24.7% |
| 201-400 | 33.2% | 31.0% | 21.7% | 22.4% | 21.4% |
| >400 | 23.3% | 17.6% | 14.0% | 12.9% | 13.0% |
| *Age Group* | | | | | |
| 0-18 | 30.2% | 20.2% | 14.0% | 12.6% | 10.9% |
| 19-25 | 12.8% | 47.3% | 31.4% | 29.0% | 28.6% |
| 26-34 | 15.3% | 44.6% | 34.4% | 29.3% | 28.0% |
| 35-50 | 24.8% | 36.9% | 28.0% | 27.2% | 26.6% |
| 51-64 | 16.9% | 27.4% | 20.4% | 20.6% | 18.7% |
| *English Proficiency* | | | | | |
| Does not speak English | 2.4% | 75.4% | 59.2% | 53.9% | 65.6% |
| Yes, but not well | 4.8% | 55.7% | 41.7% | 39.9% | 43.2% |
| Yes, well | 86.4% | 32.6% | 23.6% | 21.5% | 19.5% |

Source: ASPE analysis of 2010, 2015, 2020, and 2022 American Community Survey data.
Note: Share in 2022 refers to the share of AIANs in each of the subcategories in 2022.

Table 2 displays the number of uninsured AI/ANs by state, and it includes a comparison of the uninsured rates for 2010, 2020, and 2022, by state.

### Table 2. Uninsured American Indian/Alaska Native Population (Ages 0-64), by State, Select Years

| State | Number (2022) | AIAN Share (2022) | 2010 Uninsured Rate | 2020 Uninsured Rate | 2022 Uninsured Rate | Percentage Point Change (2010 to 2022) |
|---|---|---|---|---|---|---|
| Alabama | 10,033 | 0.3% | 17.4% | 11.6% | 12.4% | -5.0 |
| Alaska | 82,551 | 14.2% | 35.6% | 23.2% | 25.7% | -9.9 |
| Arizona | 214,583 | 5.7% | 34.1% | 25.1% | 22.2% | -12.0 |
| Arkansas | 11,094 | 0.5% | 29.0% | 23.0% | 19.1% | -10.0 |
| California | 78,946 | 0.4% | 25.4% | 16.1% | 14.3% | -11.1 |
| Colorado | 21,352 | 0.6% | 27.6% | 15.3% | 19.3% | -8.3 |
| Connecticut | 3,396 | 0.1% | 7.4% | 2.0% | 1.7% | -5.7 |
| Delaware | 980 | 0.1% | 50.0% | 5.4% | 0.0% | -50.0 |
| District of Columbia | 654 | 0.1% | 0.0% | 0.0% | 0.0% | 0.0 |
| Florida | 18,127 | 0.1% | 28.2% | 18.0% | 22.0% | -6.2 |
| Georgia | 10,685 | 0.1% | 27.5% | 21.9% | 24.0% | -3.5 |
| Hawaii | 1,034 | 0.1% | 12.3% | 24.8% | 12.4% | 0.1 |
| Idaho | 13,019 | 1.0% | 35.4% | 20.3% | 23.0% | -12.3 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Illinois | 7,778 | 0.1% | 18.2% | 6.2% | 9.5% | -8.7 |
| Indiana | 4,563 | 0.1% | 32.5% | 13.1% | 12.1% | -20.4 |
| Iowa | 4,171 | 0.2% | 37.7% | 16.4% | 13.9% | -23.8 |
| Kansas | 10,453 | 0.5% | 28.5% | 16.4% | 20.5% | -8.0 |
| Kentucky | 2,992 | 0.1% | 20.2% | 26.1% | 28.3% | 8.1 |
| Louisiana | 16,701 | 0.5% | 21.6% | 8.7% | 19.3% | -2.4 |
| Maine | 5,567 | 0.5% | 31.4% | 16.1% | 13.0% | -18.5 |
| Maryland | 7,095 | 0.2% | 11.2% | 0.0% | 1.8% | -9.4 |
| Massachusetts | 4,614 | 0.1% | 12.4% | 0.8% | 8.4% | -4.0 |
| Michigan | 24,029 | 0.3% | 16.8% | 12.1% | 12.3% | -4.5 |
| Minnesota | 37,053 | 0.8% | 24.8% | 15.1% | 18.0% | -6.8 |
| Mississippi | 10,602 | 0.5% | 30.9% | 30.3% | 23.3% | -7.6 |
| Missouri | 11,147 | 0.2% | 23.7% | 21.1% | 21.9% | -1.9 |
| Montana | 53,954 | 6.3% | 44.5% | 24.6% | 21.6% | -22.9 |
| Nebraska | 9,352 | 0.7% | 38.0% | 29.8% | 19.5% | -18.5 |
| Nevada | 13,756 | 0.8% | 42.1% | 25.5% | 21.5% | -20.6 |
| New Hampshire | 1,073 | 0.1% | 7.2% | 0.0% | 10.3% | 3.2 |
| New Jersey | 7,595 | 0.1% | 24.6% | 8.5% | 18.1% | -6.5 |
| New Mexico | 149,154 | 19.0% | 46.3% | 21.7% | 15.9% | -30.4 |
| New York | 29,196 | 0.2% | 27.5% | 11.5% | 12.8% | -14.7 |
| North Carolina | 76,650 | 1.0% | 32.0% | 15.1% | 16.5% | -15.5 |
| North Dakota | 28,733 | 4.7% | 46.2% | 30.1% | 22.8% | -23.5 |
| Ohio | 9,856 | 0.1% | 18.0% | 10.9% | 22.8% | 4.8 |
| Oklahoma | 246,620 | 8.5% | 33.0% | 31.6% | 24.1% | -8.9 |
| Oregon | 24,511 | 0.9% | 31.4% | 11.6% | 11.7% | -19.7 |
| Pennsylvania | 7,274 | 0.1% | 21.4% | 5.9% | 5.3% | -16.1 |
| Rhode Island | 913 | 0.1% | 30.4% | 0.0% | 0.0% | -30.4 |
| South Carolina | 11,231 | 0.3% | 27.1% | 18.8% | 9.2% | -17.9 |
| South Dakota | 61,115 | 8.7% | 44.4% | 37.4% | 31.1% | -13.3 |
| Tennessee | 5,565 | 0.1% | 32.6% | 16.9% | 20.1% | -12.6 |
| Texas | 38,193 | 0.3% | 27.7% | 25.4% | 20.6% | -7.0 |
| Utah | 21,166 | 0.8% | 35.7% | 31.8% | 22.7% | -12.9 |
| Vermont | 958 | 0.2% | 0.0% | 74.1% | 0.0% | 0.0 |
| Virginia | 9,019 | 0.1% | 19.4% | 15.2% | 13.6% | -5.8 |
| Washington | 61,246 | 1.1% | 28.0% | 16.8% | 16.5% | -11.5 |
| West Virginia | 1,643 | 0.1% | 12.8% | 20.9% | 34.4% | 21.6 |
| Wisconsin | 29,688 | 0.7% | 34.2% | 27.4% | 11.4% | -22.8 |
| Wyoming | 8,994 | 2.2% | 34.1% | 37.7% | 30.9% | -3.1 |

Source: ASPE analysis of American Community Survey (ACS) data

Note: AIAN Share (2022) refers the share of the state population that is AI/AN according to ACS data for 2022.

## Marketplace Coverage

In the ACA Marketplaces, there are special provisions for members of federally recognized Indian tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders (regional or village). They can enroll in coverage through the Marketplace any time during the year and they are eligible for additional cost-sharing protections that differ from the standard CSRs available to Marketplace enrollees with household incomes at or below 250 percent of the FPL. AI/ANs with income between 100 and 300 percent 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 or above 300 percent 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 who can receive CSRs only in a Silver plan.[15] In a prior Issue Brief, ASPE estimated that under the ARP, approximately 62 percent of uninsured QHP-eligible non-elderly AI/AN adults in HealthCare.gov states in 2021 could access a zero-premium plan, and 75 percent could access a plan for $50 or less per month.[16]

The Indian Health Service Tribal Self-Governance Advisory Committee (TSGAC) reports that a total of 114,522 Tribal members (who meet the ACA definition of "Indian" and qualify for comprehensive cost-sharing protections) and AI/AN non-Tribal members were enrolled in coverage through the Federally-facilitated Marketplace (FFM) or State-Based Marketplaces (SBMs) during 2022, an increase of 8.2 percent from 2021. From 2021 to 2022, five HealthCare.gov states (Alaska, Arkansas, Mississippi, South Carolina, and Wyoming) had an increase of 20 percent or more in enrollment of AI/ANs, and overall enrollment of Tribal members in Marketplace coverage increased by 14.7 percent in the 18 states operating SBMs.[17]

Over time, the percentage of Tribal member HealthCare.gov enrollees enrolling in the comprehensive Indian-specific cost-sharing protections (through either a zero or limited cost-sharing plan) has increased from 85 percent of Tribal member HealthCare.gov enrollees in 2015 to 92 percent in 2021, while the percentage of Tribal member enrollees receiving no cost-sharing protections has continued to decline.[18] In 2023, approximately 80,000 AI/ANs enrolled in health coverage through HealthCare.gov.[19]

## Medicaid Coverage

Medicaid expansion to low-income adults up to 138 percent FPL under the ACA has helped improve health care coverage and access for AI/ANs.[20] According to the Centers for Medicare & Medicaid Services (CMS), more than 1 million AI/ANs 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] However, the IHS reported in March 2024 that recent data from CMS and IHS indicate a 4 percent decrease in Medicaid coverage among IHS patients compared to one year ago, due to disruptions in coverage related to state Medicaid eligibility renewals processes after the end of the COVID-19 public health emergency.[22] Among people enrolled in Medicaid and CHIP in 2020, approximately 1.3 percent were non-Latino AI/AN.[23]

AI/AN Medicaid beneficiaries are exempt from premiums or enrollment fees and cost sharing, and Indian Health Service, Tribal, or Urban Indian (ITU) providers can be reimbursed by Medicaid 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] 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).[25] Medicaid and CHIP reimbursements for services provided by Indian health care providers bring resources into the Indian health

care system to support activities such as hiring doctors, nurses, and other health professionals, purchasing medical equipment, and renovating facilities.[26]

As of May 2024, there are 10 states that have not expanded Medicaid to adults with incomes up to 138 percent FPL.[27] A recent analysis estimates that if the remaining 10 states were to expand Medicaid, the number of AI/ANs without health coverage would decrease by 20 percent.[28]

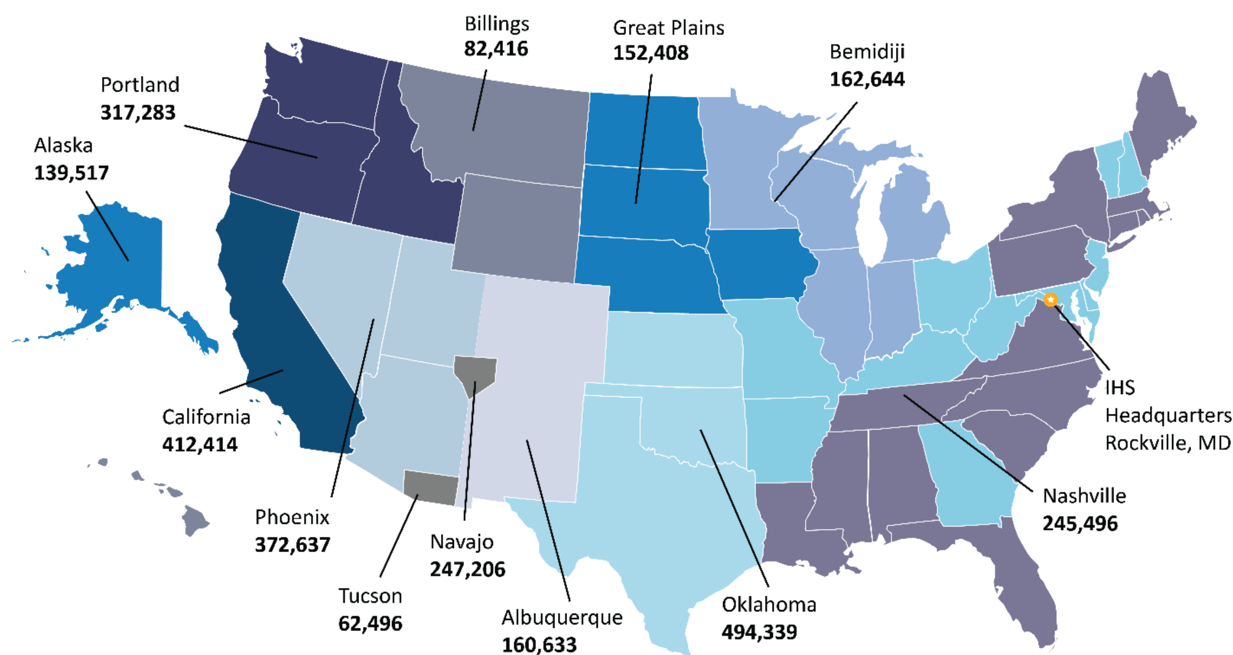
An estimated 44 percent of all AI/AN children have Medicaid or CHIP coverage compared to 23 percent of White children.[29] CMS continues to fund outreach and enrollment activities to increase coverage among people eligible for Medicaid and CHIP who are not enrolled, and CMS grants include awards specifically targeted to reach eligible AI/AN children.[30]

State Medicaid programs have the option to provide services to address many of the social drivers of health affecting Native communities. For example, under Medicaid managed care, contracted managed care organizations are allowed to provide services in addition to those covered under the Medicaid state plan ("value-added services") or to provide alternative services or settings in lieu of covered Medicaid services or settings ("in-lieu-of services").[31] This flexibility is available to enable targeted interventions such as housing assistance, case management, transportation and nutrition services to improve outcomes among Medicaid enrollees.

## Impact of ACA Medicaid Expansion on the Indian Health Service

The IHS health care system is comprised of hospitals, clinics, and health stations serving 2.8 million AI/ANs from 574 federally recognized tribes in 37 states (see Figure 3).[32] IHS providers are authorized under the Indian Health Care Improvement Act to bill Medicaid, Medicare, private insurance, and other third-party payers and to collect reimbursements, which IHS refers to as third-party "collections." IHS's annual appropriations and third-party collections are the main sources of funding for federally operated IHS facilities. Individuals who are eligible to receive care at IHS-funded facilities are encouraged to enroll in health insurance coverage.[33] Since the implementation of ACA coverage expansions, overall third-party collections have increased for IHS facilities, providing vital support for Indian health care program operations and service delivery. Third-party collections across all federally operated IHS facilities increased 79 percent between 2010 and 2019, from $614 million to $1.1 billion.[34]

**Figure 3. IHS Service Population, by IHS Area**




Source: HHS, https://www.hhs.gov/sites/default/files/fy-2025-budget-in-brief.pdf

Projected Fiscal Year 2024 third-party collections total almost $1.8 billion. Of this amount, $1.3 billion is from Medicaid reimbursement, $252 million from Medicare, and $213 million from private insurance.[35] Another source of third-party revenue is through a Reimbursement Agreement between IHS and the Department of Veterans Affairs (VA), which facilitates VA reimbursement for services IHS provides to eligible AI/AN veterans enrolled in VA health care.

A recent estimate suggests that IHS appropriations fund approximately half of the total funding needed to address existing health care resource needs in AI/AN communities.[36] To remedy the longstanding underfunding for Indian health care, the Fiscal Year (FY) 2025 President's Budget proposes increased federal resources for the Indian health system through the annual appropriation for IHS, exempting all IHS funding from sequestration – and then beginning in FY 2026, would shift the agency's funding from discretionary to fully mandatory funding. This would provide critically needed support for health care delivery, behavioral health and public health programs, staffing, and operations improvements including Health Information Technology modernization.

## Access to Care

Many AI/ANs experience challenges accessing health care, not only those living in rural, remote, or isolated areas.[37] AI/AN Medicaid enrollees, compared to non-Latino White Medicaid enrollees, are much less likely to report they have *easy access obtaining needed medical care, tests, treatments, or behavioral health services*; and they are more likely to report *never being able to see a specialist as soon as needed*.[38]

Table 3 reports several measures of access and affordability from the NHIS. Along with an overall increase in health insurance coverage among AI/ANs after the implementation of ACA coverage expansions, the percentage of AI/ANs who reported *having no usual source of care* fell roughly in half between 2010 and 2022, from 10.4 percent to 5.1 percent. The percentage of AI/ANs reporting that they delayed seeking care or filling prescriptions because of cost fell by similar amounts. Among all racial and ethnic groups, the percentages of people reporting they *delayed care due to cost* decreased between 2010 and 2022, and the AI/AN population

experienced the largest decrease in delaying care due to cost (decrease of 7 percentage points among AI/ANs, 5 percentage points among Black Americans, 5 percentage points among Non-Latino Whites, 3 percentage points among Latinos, and 2 percentage points among Asian Americans/Pacific Islanders).[39]

**Table 3: Access to Care Trends for American Indian/Alaska Native Population (Ages 0-64), Select Years**

| | 2010 | 2015 | 2020 | 2022 |
|---|---|---|---|---|
| **No Usual Source of Care** | 10.4% | 13.6% | 10.1% | 5.1% |
| **Delayed Care Due to Cost** | 10.5% | 9.2% | 5.6% | 4.2% |
| **Worried About Medical Bills (18-64)*** | 55.0% | 48.0% | 45.0% | 48.5% |
| **Delayed Filling Prescriptions (18-64)*** | 9.3% | 6.3% | 9.3% | 4.5% |

Source: ASPE Analysis of NHIS Microdata.
Notes: 1) Respondents are classified as worried about paying medical bills if they reported being very worried or somewhat worried about paying medical bills. 2) Respondents were asked about delaying refilling prescription medications only if they reported using prescriptions in the past 12 months.
* Data on worrying about medical bills or delayed prescriptions are available from 2011 (the earliest year available), consistently asked only among respondents aged 18-64.

### Disparities in Health Outcomes

Despite increases in health coverage rates among AI/ANs, there are persistent disparities in health outcomes.[40, 41] The AI/AN population is disproportionately affected by certain health conditions such as diabetes and has higher mortality rates from liver disease, diabetes, chronic lower respiratory diseases, suicide, and accidents compared to other Americans.[42, 43] In addition to limited health care access, several other factors that affect health outcomes are more prevalent in many AI/AN communities compared to the U.S. general population, such as poor infrastructure, lack of adequate sanitation facilities, and lack of access to a safe drinking water supply.[44] Historical trauma – the long-term intergenerational effect of colonization and historical cultural suppression of Indigenous peoples – also contributes to health disparities in AI/AN communities.[45] Ongoing efforts to increase Medicaid, CHIP, and Marketplace enrollment among eligible AI/ANs can improve access to care and advance health equity.

Analyses of available data indicate that AI/ANs were disproportionately affected by COVID-19 in terms of incidence and risk for infection, hospitalization, and death during the pandemic.[46] New flexibilities that began during the COVID-19 pandemic allowed IHS to collect CMS reimbursement for previously non-billable services and made it possible for IHS to significantly increase the use of telehealth. Telehealth has helped IHS address barriers to care for AI/AN communities such as long distances to health care facilities in remote rural areas, lack of transportation, and cultural barriers.[47, 48] Spurred in part by the COVID-19 public health emergency, IHS continues to increase its utilization of telehealth, enhancing patient access to primary care, specialty care, and behavioral health care services. IHS significantly expanded the use of virtual care services from a pre-COVID average of less than 1,300 telehealth visits per month to an average of 11,000 per month in 2022.[49]

## CONCLUSION

Since coverage expansions under the ACA were implemented, rates of health coverage among AI/AN people have increased across all sources. However, AI/ANs continue to have the highest uninsurance rate (19.9 percent in 2022), compared to other racial and ethnic populations. Proposed investments included in the Biden-Harris Administration's FY 2025 budget request aim to further increase health coverage, which could help address persistent health disparities in the AI/AN population. For example, the FY 2025 President's Budget proposes making the enhanced premium tax credits for Marketplace enrollment permanent, creating Medicaid-like coverage for low-income individuals living in states that have not expanded Medicaid under the Affordable Care Act, and promoting continuity of coverage and care for children enrolled in Medicaid and

CHIP.[50] To increase access to care, it is also necessary to recruit and retain additional physicians, nurses, pharmacists, dentists, and other health professionals to ensure the Indian health care system has a strong capacity to deliver services in AI/AN communities. Additional resources to strengthen the Indian health care system would help improve access to care, which plays a significant role in health outcomes.

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