HEALTH CARE REFORM:
Tracking Tribal, Federal, and State Implementation

◆ Submitted on: May 20, 2011 ◆

Submitted to:
Tribal Affairs Group (TAG)
Office of External Affairs
Central Office M/S: S1-20-21
7500 Security Blvd
Baltimore, MD 21244
Contact: Rodger Goodacre
Phone: 410-786-3209
Email: rodger.goodacre@cms.hhs.gov

Submitted by:
Kauffman & Associates, Inc.
South 165 Howard St., Suite 200
Spokane, WA 99201
Phone: 509-747-4994
Email: michael.meyer@kauffmaninc.com

Prepared by:
Ed Fox, PhD
Director of Health Policy Research

CMS CENTERS for MEDICARE & MEDICAID SERVICES

KAi

Executive Summary

This report analyzes the impact of national health care reform on American Indian and Alaska Native (AI/AN) people. Twenty states are included in a systematic study of the most significant aspects of health care reform. The report identifies which elements of national health care reform are most likely to affect health care access for AI/ANs. It also projects the extent of these changes in health care access in the 20 study states under various scenarios. To provide this analysis, the report accesses data on Medicaid expenditures for AI/ANs provided by a series of studies sponsored by the Centers for Medicare & Medicaid Services (CMS) and conducted by the California Rural Indian Health Board (CRIHB), as well as health, demographic, and other data from the American Community Survey (ACS).[1]

Two elements of the Affordable Care Act of 2010 will likely have a substantial effect on AI/ANs: Medicaid expansion and health insurance exchanges, including exchange subsidies. As this report describes, Medicaid expansion will likely increase the number of AI/ANs enrolled in Medicaid in the 20 study states by an estimated 286,000 if aggressive outreach and enrollment practices are funded. Predicting participation in health insurance exchanges is more difficult, but an estimated 364,000 AI/ANs in the study states are likely eligible for exchange subsidies. Medicaid expansion, not without its own challenges, will be far easier to achieve than AI/AN participation in the health insurance exchanges.

This report examines variations between the 20 study states along a number of salient indicators including measures described in the following table.

Measures for 20 Study States	Lowest State	Mode	Highest
Percentage Uninsured, AI/AN Alone	15.1 %	30%	42.9%
AI/AN Uninsured, 18 to 64 years	17.9%	30%	56.7%
AI/AN Percentage of State Medicaid Population	0.2%	2%	35.6%
Projected Percentage Increase with Medicaid Expansion	5.2%	61%	88.6%
Number of AI/ANs Eligible for Subsidies	2,490	22,000	80,716

By highlighting differences and similarities in AI/AN populations between states, this paper provides some of the information that will be needed by states and tribes as they seek to implement the Affordable Care Act. The analysis in this report focuses on round one of national health care reform, health insurance expansion, but notes that Indian health programs must also pay attention now to how payment reform, the second aspect of national health care reform, may affect their program in the years to come.

[1] Centers for Medicare and Medicaid, Tribal Technical Advisory Group. American Indian and Alaska Native Medicaid Program and Policy Data, March 2010, Medicaid & CHIP Enrollment Service Use & Payments. Sacramento, CA California Rural Indian Health Board: James Crouch, Chi Kao, Juan Korenbrot, & Carol Korenbrot.

Table of Contents

Executive Summary **1**

Introduction: U.S. Health Care Reform and Reducing the Number of Uninsured **4**

Background: [About Indian Health Programs] **5**

Indian Health Service is not an insurance program *5*

Indian Country and Indian People *6*

Rates of Uninsurance for American Indians and Alaska Natives *8*

Methodology and Research Design: A close examination of 20 states **9**

Medicaid Baseline 13

Medicare Baseline 20

Projected Impacts of Expansion of Medicaid, Community Health Centers, and Health Insurance Exchanges for AI/AN Populations in 20 Study States **21**

Medicaid Expansion *21*

How income factors into estimating the impact of health care reform *24*

Health Insurance Exchanges *25*

Special provisions for AI/ANs in Health Exchanges *27*

Estimated Exchange Enrollment of AI/ANs for 20 Study States *27*

Outreach and Enrollment for Medicaid and the New Health Insurance Exchanges *30*

Simplified Eligibility Determination and Enrollment in a more Complex System *30*

Community Health Centers *31*

Employer-Sponsored Health Insurance *33*

Conclusion **33**

Introduction: U.S. Health Care Reform and Reducing the Number of Uninsured

The debate over health care reform in the United States is framed by the question of who has health insurance and who does not, and the primary goal of recent health care reforms has been to increase Americans' access to health insurance. Thus, national health care reform has become fundamentally about health insurance reform to ensure greater access to health insurance coverage for more Americans.

The goals of health care reform are not clearly expressed in a vision statement or list of objectives, but policy changes of the Affordable Care Act (ACA) of 2010 indicate certain priorities. Health care reform aims to control costs and to expand health insurance coverage through Medicaid expansion and health insurance exchanges, along with implementing insurance reforms intended to keep more people covered under private insurance plans. Health care reform also expands safety net clinics, increases the health care workforce, and develops public health through health care research and health promotion and disease prevention programs. Significantly, particularly for a discussion of Indian health programs, health care reform also includes a specific goal to reduce the recognized health disparities between racial and ethnic minorities and the general population.

The path to sustainable health care reform includes controlling costs. Since employer-based and public health insurance is still the mainstay of the health care system, insurance payment mechanisms are the foundation of current attempts to control costs. In the current system, you get what you pay for, and most experts express dissatisfaction with what the current system produces—a strong financial incentive to deliver high-cost treatments with little regard for their impact on actual health outcomes. Unfortunately, the ACA does little to address the current system of incentives. The goal is good health, but the vast majority of the new funding supports increasing access to acute health care services with a smaller percentage assigned to public health activities including health promotion and disease prevention.[2] Some health care experts identify the expansion of health insurance coverage as Round One of necessary health care reforms, and payment for performance as Round Two—an aspect of the current system that will ultimately need to be addressed for sustainable health outcomes. There is little awareness in the general public that most health care "insiders" believe the current system requires significant changes in existing funding mechanisms in order to maintain the current levels of care, much less support universal health insurance coverage. The analysis in this report focuses on Round One, insurance expansion, and how it will affect AI/ANs, but it also advises Indian health programs to pay close attention now to how payment reforms may affect their program in the years to come.

[2]Health is broadly defined in most health care legislation, but it stops far short of addressing the most important social determinants of health. For further discussion, see A New Way to Talk about the Social Determinants of Health, Robert Wood Johnson website, accessed December 21, 2010.

Background: How Indian Health Programs Differ from National Health Insurance Reform

The current "health insurance access" paradigm of health care reform does not fit Indian health programs. The Indian Health Service (IHS), the primary federal agency responsible for the provision of health services to American Indian and Alaska Native (AI/AN) people, is not an insurance system. Instead, it provides health services to members of federally recognized tribes (or contracts with other organizations to provide services) based on treaty obligations between the U.S. government and AI/AN tribes and corporations.

How, then, will implementation of the ACA affect AI/AN people and their health care needs? National health care reform as it exists under the ACA was not designed with AI/AN people or Indian health programs in mind. If it were, funding increases for the IHS would have been an explicit part of health care reform. Most members of federally recognized tribes define their health care problem as the chronic underfunding of the IHS, a separate issue from the 50 million Americans without health insurance coverage that the ACA works to address. Nonetheless, health care in Indian Country will undergo significant change over the next 10 years, with comprehensive reforms already underway due to recent federal and state legislation. There is little in health care that is not affected by the new authorities, funding, and regulations that make up health care reform.

The most notable changes for AI/AN health programs will occur in the areas where Indian health programs intersect with other elements of U.S. health care systems, including Medicaid eligibility and expansion and health insurance exchanges and subsidies. Despite these areas of overlap, however, it is important to note that Indian health care still retains unique status, set part from the rest of the health care debate. Included in the ACA was the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), originally enacted in 1976. The unique political status of tribes, and the existence of treaties and legislation such as the IHCIA, commits the federal government to the provision of health care services for Indian people. Thus, the political status of Indian tribes and American Indian/Alaska Native (AI/AN) people underlies special aspects of U.S. health care reform generally, and the ACA specifically.

Indian Health Service Is Not an Insurance Program

For most legal residents of the U.S., health care reform is about health insurance. AI/ANs stand apart from much of the discussion of expanding health insurance. If they are a descendent of a federally recognized tribe (or of equivalent status in California or Alaska), they have the right to health care services from programs funded by the IHS. The IHS annually provides health care services through federal, tribal, and urban programs for about 1.5 million AI/ANs, with at least 1.9 million active IHS registrants.[3] But it is not an insurance program: there are no application forms once an AI/AN verifies their eligibility, there are no premium payments, and there is little

[3] IHS estimates a 1.9 million service population eligible for care in the service areas of current IHS-funded tribal and IHS programs, and these are included in IHS planning; 1.5 million AI/ANs are considered, "active users" who have received a service in an IHS or Tribal (but also not including Urban) Health Program in the previous 3 years.

immediate recourse when services are inadequate to meet demand. In fact, the rationing of care under the IHS is a defining characteristic of the current IHS program. The IHS budget is only sufficient to provide about half the necessary health care services required. In response to this ongoing shortfall, tribes have advocated for full access to other public health care programs such as Medicare and Medicaid. The IHCIA, the Children's Health Insurance Program Reauthorization Act (CHIPRA), the American Recovery and Reinvestment Act (ARRA), and the ACA have all reaffirmed, with specific provisions, that Native Americans and Indian health programs (IHS, Tribal, and Urban) can access these federal programs without diminishing the federal treaty obligations and related legislative responsibilities.

IHS funded health services for about 1.5 million AI/ANs in 2009. The IHS user population includes all eligible AI/ANs who have received care from an Indian health program in the previous three years. The Indian health system is not a health insurance system like Medicare, Medicaid, or private insurance. The $4.2 billion appropriation (FY 2010) for IHS is distributed to Indian health programs as a global budget that these programs accept as their annual budget. If service demands exceed funds, a system of priorities—that is, a framework for the rationing of health care—guides the process for denials of provider-recommended services. Of the total IHS budget, $3.6 billion is for health care services and the balance, $400 million, is for facilities budget expenditures including sanitation, drinking water, new facilities construction, maintenance, and improvement.[4] The 2011 IHS appropriation is expected to increase modestly, if at all, and is awaiting final action by the 112th Congress in spring 2011.

Indian Country and Indian People

The definitions of Indian Country and AI/ANs are imprecise. Indian Country certainly includes Indian reservations and ceded reservation lands, but no definition can capture the connotation of "Indian Country" and what it means to Native people. In a nation that was at one time all Native American, historical principles are overtaken by political realities. In the present day, at its broadest, it includes locations where Indian people live and where they engage in cultural activities. Most AI/ANs would reject any definition of Indian Country that is narrowly drawn. The term is still widely used despite its variable definitions. It is not essential to a good understanding of Indian health to have a precise definition of Indian Country. AI/ANs live in every state, and many have legal rights that are not waived by residing "outside" reservation lands or even outside a broader definition of Indian Country. Since IHS only funds health programs in 37 states (including urban programs in Chicago, IL, and Baltimore, MD, which are in states with no federally recognized tribes), access to these services is obviously a function of both eligibility (is the person AI/AN?) and proximity (can that person get to the services?). Thirty-five states where there are both federally recognized tribes and IHS-funded programs are called reservation states, and they retain significance from that aspect alone: they are states where sovereign Indian nations are located. Some Indian nations have boundaries that extend

[4] Congressional Justification of Estimates for Appropriations Committee. Fiscal Year 2011, Indian Health service. Page CJ-10.

beyond a single state (e.g., Navajo Nation is in three different states and is larger than several states).

Who is an AI/AN? Tribes define who is eligible for tribal citizenship. The Bureau of Indian Affairs (BIA) estimates that in 2005 there were approximately 2 million tribal members.[5] The IHS currently follows a policy of "unrestricted descendency," for direct service programs which means that anyone who is a descendent of a member of a federally recognized tribe (or its equivalent in California and Alaska) is eligible for IHS-funded services.[6] Urban Indian programs have a more expansive definition of eligibility that includes state-recognized tribes and other Indians without a direct and substantiated link to federally recognized tribes. Tribes are advocating for a uniform definition of Indian for the purposes of enrollment in Medicaid, CHIP, or the health exchange plans.[7]

An AI/AN population of nearly 5 million (see Table 3) is a good working estimate to use when considering the impact of health care reform on Indian people. Still, one has to recognize that there are various definitions of AI/AN. Recent legislation and regulations promulgated by the Centers for Medicare and Medicaid Services (CMS) have standardized the definition that is used for determination of eligibility for CMS exemptions from cost sharing for Medicaid.[8] Tribes have indicated their support for a uniform definition of AI/AN in the unified application process for Medicaid and Exchange plan offerings in 2014.[9]

Data in this report from the American Community Survey (ACS) uses the self-reported race of survey respondents. Respondents reporting their race as AI/AN had the opportunity to identify as "AI/AN alone" (only American Indian and/or Alaska Native ancestry) or "AI/AN in combination" (American Indian and/or Alaska Native ancestry, plus one or more other races or ethnicities) on the ACS survey. When the terms "alone" and "in combination" are used in reference to race or ethnicity, they refer to the self-identification of respondents in ACS reports. In addition, it is important to note that demographic data identified in this report as "AI/AN alone or in combination" combines the two categories of ACS data for a single number that includes the individuals identified in ACS figures as AI/AN alone *and* AI/AN in combination.

---

5 In the BIA's 2005 American Indian Population and Labor Force Report, the latest available, the total number of enrolled members of the (then) 561 federally recognized tribes was shown to be less than half the Census number, or 1,978,099.

6 Dear Tribal Leader Letter, January 10, 2000, Dr. Michael Trujillo.

7 The Definition of "Indian" Under the Affordable Care Act: Approved by the Tribal Technical Advisory Group, October 13, 2010.

8 See discussion of this issue and relevant citations in the October 4, 2010, National Indian Health Board (NIHB) letter to Office of Consumer Information and Insurance Oversight (OCIIO) in response to 45 CFR Part 1970 Request for Comments Regarding Exchange-Related Provisions in Title I of the ACA.

9 NIHB letter to OCIIO dated December 17, 2010. The May 28, 2010, Federal Register Vo. 75, No. 103 contains the revised final rule for Medicaid Program and Cost Sharing to reflect statutory changes contained in the American Recovery and Reinvestment Act, section 5006(a).

Rates of Uninsurance for American Indians and Alaska Natives

Health care reform seeks to reduce the number of uninsured, but reliable estimates of the number of uninsured AI/ANs are just now being made available. The 2009 rate of uninsurance for AI/ANs alone is 29.20%, nearly double the national all-races rate of 15.1%.[10] Table 1 shows the rates of uninsurance for various population groups, based on ACS data from 2009. Numbers in this table do not include institutionalized persons.

Table 1. 2009 Rate of Uninsurance for Various Population Groups

	Total Number	Number Uninsured	Percent Uninsured
Total civilian non-institutionalized population	301,472,074	45,664,741	15.10%
Race & Hispanic or Latino Origin			
White alone	226,131,614	30,109,971	13.30%
Black or African American alone	36,724,621	6,664,427	18.10%
American Indian and Alaska Native alone	2,393,821	698,681	29.20%
Asian alone	13,682,874	2,028,044	14.80%
Native Hawaiian and Other Pacific Islander alone	439,918	75,991	17.30%

Source: United States S2701: Health Insurance Coverage Status. Data Set: 2009. American Community Survey 1-Year Estimates.

Table 2 provides more detail, comparing AI/AN insurance rates to U.S. all-races rates for various types of insurance coverage. The rate of uninsurance for the AI/AN population alone and in combination is 24.3%. This table also highlights the glaring difference in the rate of private insurance for AI/ANs, with just 48% of AI/ANs having private health insurance coverage, compared to 67.4% of U.S. all races who have private insurance.

[10] One-year estimates from the American Community Survey are available now for 2009, and in November 2011, three-year estimates will provide statistically significant estimates with smaller confidence intervals than the one-year estimates are capable of producing for smaller geographies such as metropolitan areas and cities of 20,000+.

Table 2. 2009 Health Insurance Coverage Rates, AI/AN Alone Compared to All Races

Health Insurance Coverage	U.S. All Races	AI/AN Alone or In Combination
Total civilian non-institutionalized population	301,472,074	3,697,232
With private health insurance coverage	67.4%	48.0%
With public health coverage	28.5%	35.6%
No health insurance coverage	15.1%	24.3%
Total AI/AN alone or in combination uninsured		898,427

Source: United States S0201: Selected Population Profile in the United States. Data Set: 2009. American Community Survey, 1-Year Estimates.

A Kaiser Family Foundation analysis of uninsurance rates for AI/AN children demonstrates equally high rates of uninsured children. Over 137,000 AI/AN children have neither health insurance nor access to IHS services (120,000 reside in the study states).[11] These national averages highlight the basic fact that AI/ANs have high uninsurance rates. However, aggregate data like this also mask important information that informs the variable impact health care reform will have on individual states. Some states have much higher rates of uninsured than others. Likewise, some states have the potential for far greater expansion of Medicaid than others. In order to explore those differences, this report examines the variation among states 20 study states in greater detail.

Methodology and Research Design: A Close Examination of 20 States

IHS-funded hospitals and clinics are located in 36 states.[12] For the purposes of this review of the impact of health care reform on AI/ANs, 20 states are included in a systematic study of the most salient aspects of health care reform. Subsequent reports will expand this field of analysis, first to the 35 states where there are Indian health programs (and federally recognized tribes) and then potentially to all 50 states.

Table 3 shows the AI/AN population of the 20 selected study states. The 20 states, listed below, include all U.S. states with large Indian populations. They contain 70% of the AI/AN alone population and 64% of the AI/AN alone or in combination population.

[11] James, Cara. A Profile of American Indians and Alaska Natives and Their Health Coverage, Kaiser Family Foundation, 2009.

[12] This includes the State of Illinois, the one state without a federally recognized tribe, but with an IHS-funded Title V Urban Indian Health Program.

Table 3. Population Estimates for AI/ANs in 20 Study States, from Current Population Survey 2009

State	AI/AN Alone	AI/AN In Combination	Alone as % of Alone and In Combination
Alaska	106,398	126,999	84%
Arizona	320,587	366,954	87%
California	447,424	739,964	60%
Colorado	62,231	102,451	61%
Idaho	23,986	36,464	66%
Massachusetts	20,812	45,653	46%
Michigan	62,485	128,335	49%
Minnesota	66,640	95,130	70%
Montana	62,873	74,399	85%
Nevada	39,588	60,283	66%
New Mexico	195,403	215,605	91%
New York	110,304	194,714	57%
North Dakota	36,258	40,740	89%
Oklahoma	296,182	415,371	71%
Oregon	59,665	104,143	57%
South Dakota	68,976	76,205	91%
Utah	39,289	53,679	73%
Washington	117,121	188,071	62%
Wisconsin	57,060	82,335	69%
Wyoming	14,118	18,692	76%
20 State Total	2,207,400	3,166,187	
U.S. Total	3,151,284	4,960,643	

Although the states contain just 64% of the nation's AI/AN population, they include 87% of the IHS user population and over 85% of the nation's Medicaid population that is identified as AI/AN.

Alaska, Arizona, New Mexico, Oklahoma, Montana, North Dakota, and South Dakota have AI/AN populations so large that their inclusion in Medicaid (and health insurance exchange) policymaking is more likely. In some states, however, tribes may be viewed by a state as an inconvenient complication as they grapple with implementation of the Affordable Care Act. In the seven states noted above, tribes are such an important component of the Medicaid program that, in most cases, state Medicaid policymakers will work with tribes to implement health care reform. The converse is also true; in some states, tribes and Indian people are in danger of being ignored. With only a small negative impact on the state's overall Medicaid program, but with significant impacts to Indian health programs, some states have already moved forward without meaningful input from tribes. California and Massachusetts, for example, have already passed significant health insurance exchange legislation that fails to mention tribes or Indian people. In California, apparently, this was done despite the fact that

1.9% of the state's population is Indian. Ironically, California has the largest Indian population in the United States, with a 2010 AI/AN population of 723,225 (alone and in combination).

Table 4 highlights the significance of these 20 states in an analysis of the overall impact of health care reform on AI/ANs. Although the 20 states represent just 64% of the total U.S. AI/AN population, they represent well over 80% of the nation's AI/AN Medicaid population.

Table 4. 20 Study States AI/AN Populations, Medicaid Enrollment, and Medicaid Spending

	Sum of 20 Study States	% of Total U.S.
AI/AN Alone Population, 2009	2,207,400	70.05%
AI/AN In Combination Population, 2009	3,166,187	63.83%
IHS User Population, 2009	1,314,464	87.74%
AI/AN Medicaid Population, 2008 Annual Eligibles	615,254	76.29%
AI/AN Medicaid Population as Percentage of Total U.S. Medicaid Population, 2008	.02% to 36%	
AI/AN Medicaid Beneficiaries, August 2007, final Medicaid Statistical Information System (MSIS)	537,831	85.84%
AI/AN Medicaid Beneficiaries, August 2008, final MSIS	562,643	87.45%
Medicaid Payments for AI/ANs, 2007	$2,927,670,477	86.44%
Medicaid Payments for AI/ANs, 2008	$3,350,877,299	86.94%

As Table 4 demonstrates, the funding from Medicaid is significant, with over $3 billion in Medicaid payments in the 20 study states. The ACA holds the promise of increasing these payments significantly in 2014-2019 and beyond. All 20 of the study states have at least one Indian health program. In nearly every state, these programs rely heavily on funding from the Medicaid program.

The utility of breaking out national figures down to the state level is demonstrated in Table 5, which examines the variation in rates of insurance for the non-institutionalized population between the ages of 18 and 64. Table 6 is based on national data from the 2009 American Community Survey described earlier, and the table depicts a range in uninsurance rates from a best in the nation low of 18% in Massachusetts to a highest in the nation 56.6% in Montana. These figures make it clear that there is great variation in rates of uninsurance between states. Some states of the Midwest have uninsurance rates for AI/ANs below 30%, and many of the states in the West have rates over 40%. Tables 5 and 6 disaggregate the national AI/AN rate of uninsurance by the 20 study states.

Table 5. AI/AN Percentage Uninsured in 20 Study States, 2009

State	% Uninsured*
Montana	42.9%
New Mexico	38.7%
Idaho	37.8%
South Dakota	37.8%
Alaska	37.5%
Wyoming	35.0%
Utah	33.5%
Arizona	30.6%
Oregon	30.5%
Oklahoma	30.2%
Nevada	30.1%
Colorado	29.4%
North Dakota	27.7%
Washington	27.1%
New York	25.6%
Minnesota	23.9%
California	23.6%
Michigan	20.8%
Wisconsin	16.8%
Massachusetts	15.1%

*All ages; IHS is not considered insurance coverage

Source: United States S2701: Health Insurance Coverage Status. Data Set: 2009. American Community Survey 1-Year Estimates.

Table 6 is useful in estimating the potential Medicaid expansion for AI/ANs, since most of the Medicaid expansion population will be between ages 18 and 64. This table ranks the 20 study states according to the uninsurance rate of the state's non-institutionalized adult AI/AN alone population that is under the age of Medicare eligibility.

Table 6. Number and Rate of Uninsured 18- to 64-year-old AI/AN Adults in 20 Study States, 2009

State	AI/AN Alone Population	AI/AN 18 to 64 Population	AI/AN 18 to 64 Without Insurance	% Uninsured of Total AI/AN 18 to 64 Population
Montana	64,053	37,224	21,087	56.65%
South Dakota	65,745	36,912	18,992	51.45%
New Mexico	185,714	113,154	56,275	49.73%
Alaska	90,233	55,690	26,387	47.38%
Utah	30,404	17,507	7,740	44.21%
Wyoming	13,751	8,760	3,847	43.92%
Idaho	22,368	13,905	5,770	41.50%
Oregon	47,311	29,308	11,578	39.50%
Oklahoma	218,483	134,715	52,362	38.87%
Nevada	30,682	18,708	6,941	37.10%
Arizona	289,547	172,001	63,696	37.03%
North Dakota	32,282	21,453	7,411	34.55%
Colorado	46,661	33,605	10,991	32.71%
New York	62,464	43,055	13,202	30.66%
California	287,138	190,448	57,997	30.45%
Washington	85,643	55,547	16,892	30.41%
Minnesota	53,242	33,947	10,002	29.46%
Michigan	48,636	31,496	8,653	27.47%
Wisconsin	46,535	28,069	6,068	21.62%
Massachusetts	9,635	6,678	1,196	17.91%
Totals for 20 Study States	1,730,527	1,082,182	407,087	37.62%

Source: United States C27001C: Health Insurance Coverage Status by Age (American Indian and Alaska Native Alone) - Civilian Non-Institutionalized Population. Data Set: 2009. American Community Survey 1-Year Estimates.

Medicaid Baseline

Before examining the proposed expansion of Medicaid under health care reform, it is essential to consider the current program as the baseline to measure the success of expansion for AI/ANs. In 2008, there were 45 million enrollees in Medicaid; 800,000 were AI/ANs, equaling 1% of total Medicaid eligibles.[13] Approximately 736,000 lived in one of the 35 IHS states, and less than half were also at least one-time users of IHS programs. CMS reports indicate that only

[13] Medicaid defines someone who is enrolled in Medicaid as an "eligible" (as in "eligible for paid services") and Medicaid defines a beneficiary as someone who has had a paid claim. Typically, eligibles are the subject of broader reviews of Medicaid. It is also important to note the difference between the number of eligibles in a given year versus a given month. The average monthly enrollment of eligibles is substantially less than the annual total of eligibles, and typically the monthly total is more important for analysis.

279,712 of these eligibles had paid claims in 2004 (i.e., only 279,712 were Medicaid beneficiaries).[14]

Table 7 ranks the 20 study states by percentage AI/AN in the state's Medicaid population.

Table 7. Study States Ranked by AI/AN Percentage of Total Medicaid Population

State	AI/AN % of Medicaid Population
Alaska	35.61%
South Dakota	33.09%
Montana	21.72%
North Dakota	21.29%
New Mexico	13.09%
Oklahoma	12.35%
Arizona	10.62%
Wyoming	6.14%
Minnesota	3.48%
Utah	2.76%
Washington	2.51%
Idaho	2.23%
Oregon	2.19%
Wisconsin	1.57%
Nevada	1.41%
Colorado	0.84%
Michigan	0.50%
New York	0.45%
California	0.38%
Massachusetts	0.20%

AI/ANs in Alaska, South Dakota, Montana, and North Dakota make up an extremely large percentage of the poor in their states and, thus, a large percentage of the Medicaid population. Not surprisingly, New Mexico, Oklahoma, and Arizona—states which have a very large Indian population—have a large share as well.

[14] CRIHB, 2010. Medicaid Program and Policy Data. March 2010.

Table 8. 2008 AI/AN Medicaid Eligibles and Beneficiaries, and Payments to Indian Health Programs for AI/ANs in 20 Study States

	AI/AN Medicaid Eligibles	AI/AN Medicaid Beneficiaries	Payments for AI/ANs
Arizona	80,945	80,861	$366,767,605
New Mexico	57,779	56,952	$78,433,397
Alaska	18,387	18,191	$48,041,436
South Dakota	21,509	21,507	$34,687,828
Oklahoma	33,948	33,940	$30,902,973
Montana	13,715	13,626	$29,922,300
Washington	14,514	14,510	$25,373,420
Minnesota	10,316	10,234	$22,214,646
California	10,693	10,693	$11,460,883
North Dakota	5,234	5,186	$5,984,073
Wyoming	3,483	3,483	$5,746,418
Mississippi	1,957	1,956	$5,114,240
Oregon	2,809	2,778	$4,832,818
Nevada	1,471	1,470	$2,371,104
Idaho	1,800	1,800	$1,905,247
Colorado	458	458	$478,130
Michigan	690	674	$62,003
Massachusetts	4	4	$1,203
Totals for 20 Study States	279,712	278,323	$681,706,607

Source: CMS MSIS, MAX Database, accessed November 2010.

Most Medicaid payments for AI/ANs go to hospitals and specialists. As Table 8 indicates for our study, only $681 million of this amount was paid to Indian health programs. Even in Alaska, where Alaska Natives operate a tertiary care hospital, the majority of payments go to non-Indian providers of Medicaid services. In a 2010 report, the state of Alaska indicated that the Medicaid program paid $346 million in services for Alaska Natives.[15] Of this amount, one-third was paid to Native programs and two-thirds were paid to non-Native providers for services to Alaska Natives (and a small number of American Indians). States do not receive the 100% Federal Medical Assistance Percentage (FMAP) for services offered by non-Indian health providers. Some states, like Arizona, have protested this shifting of federal responsibility to the states. However, court rulings have established that the federal government has the right to determine the FMAP, not the states.

It is not known precisely how many of the AI/ANs whose medical bills are paid by Medicaid are also users of IHS-funded health care programs. The California Rural Indian Health Board (CRIHB) has produced reports based on a methodology that matches Indian health program patients

[15] Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2009-2029, January 2010.

(not including urban Indian health program patients) with Medicaid eligibles.[16] CRIHB reports that in 2004 there were 278,852 AI/ANs who were registered as IHS users (not necessarily "active users") who received Medicaid services. Services to these beneficiaries resulted in payments to Indian health programs (not including urban Indian programs) of $536 million in 2004. As expected, payments to non-Indian health providers totaled far more, at $992 million. Table 9 takes the data from the CRIHB reports and compares Medicaid expenditures to IHS expenditures in the 12 IHS Areas to put the degree of relative funding in perspective. Table 9 makes two things clear: Medicaid is an important source of funding for health care for Indian people, and Medicaid is an important source of revenue for both Indian and non-Indian providers.

The CRIHB research is the first attempt to develop precise measurements of the financial impact of CMS programs using the individual level of analysis. The data are for "person files" and could someday provide great detail about the scope and volume of services provided to individuals and individuals of desired categories using available indicators of services and basic demographics such as age and gender. A second report is forthcoming in 2011 that will update the 2004 data through the year 2009.[17]

Table 9. 2004 Medicaid Payments for IHS Users to IHS/Tribal Programs and Non-IHS Providers

IHS Area*	Number of IHS Users	Payments to IHS/Tribal Programs	Payments to Non-IHS Providers	Total Medicaid Payments
Navajo	78,292	$171,017,000	$248,848,000	$419,865,000
Alaska	27,737	$94,216,000	$185,828,000	$280,044,000
Phoenix	27,331	$80,648,000	$128,618,000	$209,266,000
Albuquerque	24,892	$27,102,000	$80,471,000	$107,573,000
Aberdeen	27,873	$37,880,000	$62,287,000	$100,167,000
Oklahoma	31,883	$25,567,000	$69,324,000	$94,891,000
Portland	17,643	$22,925,000	$58,968,000	$81,893,000
Billings	17,703	$29,263,000	$41,105,000	$70,368,000
Tucson	6,155	$18,991,000	$41,045,000	$60,036,000
Bemidji	8,140	$14,018,000	$44,358,000	$58,376,000
California	7,642	$8,324,000	$23,871,000	$32,195,000
Nashville	3,561	$6,898,000	$7,439,000	$14,337,000
Totals All Areas	278,852	$536,849,000	$992,162,000	$1,529,011,000

*12 IHS Areas are treated as aggregates of counties in Data File.

Source: James Crouch, Chi Kao, Juan Korenbrot, Carol Korenbrot. American Indian and Alaska Native Medicaid Program and Policy Data, California Rural Indian Health Board, March 2010, compiled by Kauffman & Associates, Inc.

[16] CRIHB, 2010. Medicaid Program and Policy Data. March 2010.
[17] Personal communication, February 2010.

One way to put Medicaid expenditure data into perspective is to compare Medicaid payments for patients to IHS funding for the same-size population of users. The CRIHB research makes it possible to compare Medicaid spending by Area with the more familiar Area-level IHS allowances for health care services (not including facilities). Table 10 highlights the relative importance of Medicaid expenditures for health funding in IHS Areas. Three states stand out as having very large Medicaid payments relative to their IHS allocations: Arizona, New Mexico, and Alaska. AI/ANs who are enrolled in Medicaid not only receive an excellent benefit package, but also (unlike private insurance), these benefit packages include the cost of non-emergency medical transportation, a benefit critical to ensuring access to medical care in Alaska and other rural states. Enrollment in Medicaid results in payments for health care services to AI/ANs that are nearly equal to IHS funding for the Area offices in some states, and are significant percentages of total spending for most study states. These payments take the form of direct payments to IHS and tribal programs and payments to specialists and hospitals, thereby extending the available funds of the always-insufficient contract health services budgets of health programs.

Table 10. 2004 Comparisons of IHS Allowances for Health Care Services to Medicaid Payments for IHS Users by IHS Area

IHS Area	Medicaid Payments for IHS Users	IHS Allowances for Health Care Services	Medicaid as a Percentage of IHS Allowance
Tucson	$60,036,000	$38,427,217	156.23%
Navajo	$419,865,000	$307,030,302	136.75%
Phoenix	$209,266,000	$221,540,291	94.46%
Alaska	$365,359,945	$400,809,060	91.16%
Albuquerque	$107,573,000	$121,532,318	88.51%
Billings	$70,368,000	$134,210,770	52.43%
Aberdeen	$100,167,000	$219,714,752	45.59%
Portland	$81,893,000	$181,449,609	45.13%
Bemidji	$58,376,000	$131,962,298	44.24%
Oklahoma	$94,891,000	$344,864,621	27.52%
Nashville	$14,337,000	$93,643,964	15.31%
California	$8,324,000	$121,669,195	6.84%
Totals	$1,590,455,945	$2,316,854,397	

Source: American Indian and Alaska Native Data Symposium Proceedings, July 30, 2010.

Thanks to research conducted for the CMS Tribal Affairs Group by CRIHB, it will be possible to update these figures for 2009. This will allow studies of changes over time that may help inform health care reform implementation.

Not all AI/ANs have access to IHS-funded programs. A review of how access varies across the study states is depicted in Table 11. The table includes the results of the 2009 ACS survey of those families whose income is between 139 and 400% of the federal poverty level. The table provides a novel analysis of the degree of difference in access to IHS health programs across

states; many incorrectly assume access to services is uniform across the Indian health system. The American Community Survey provides important information about this variation. Over the course of one year, 30,000 AI/AN survey respondents indicate whether or not they feel they have access to IHS-funded services. On average, approximately 25% nationally feel they do have access, and about 37% of respondents in the study states report having access to IHS health services. However, this average masks great variation. In Alaska, over 80% of AI/ANs in this income category responding to the survey feel they have access to IHS services; in South Dakota, Montana, New Mexico, and North Dakota, over 60% feel they do; in Washington, Minnesota, Wisconsin, and Nevada, the percentage ranges from 29-34%. At the extreme end, fewer than 20% in Michigan, Oregon, California, or Utah feel they have access to IHS services. The reasons are varied and complex, but it is important to recognize that there is great variation in the perceived access to IHS services by AI/ANs in the study states. It is important to keep in mind that the respondents in any given state are not saying they have access to a full set of comprehensive primary, secondary, or tertiary care. They are simply saying they have access to IHS-funded programs—many of which face chronic underfunding and rationing of care that includes denials for provider-recommended referrals due to funding constraints.

Table 11. Perceived Access to IHS Coverage by Uninsured AI/ANs Between 139-400% FPL

	AI/ANs between 139-400% poverty	Number Reporting Perceived Access to IHS Coverage	Percentage with Perceived Access to IHS coverage
Alaska	60,193	48,676	80.9%
South Dakota	26,228	20,131	76.8%
Montana	25,055	17,112	68.3%
Oklahoma	212,969	131,031	61.5%
North Dakota	17,809	10,877	61.1%
New Mexico	94,840	56,755	59.8%
Arizona	145,841	74,758	51.3%
Wyoming	10,882	5,497	50.5%
Idaho	16,345	7,261	44.4%
Washington	71,595	24,385	34.1%
Minnesota	35,969	10,526	29.3%
Nevada	23,241	6,733	29.0%
Wisconsin	29,536	7,166	24.3%
Michigan	52,253	10,921	20.9%
Oregon	41,556	7,807	18.8%
Utah	19,947	3,022	15.2%
California	269,485	26,389	9.8%
Colorado	47,036	4,199	8.9%
New York	62,884	4,625	7.4%
Massachusetts	15,748 (Not in total)	N/A	N/A
Total for Study States	1,263,664	477,871	37.8%
U.S. Total	2,037,119	512,224	25.1%

Source: American Community Survey 2009, compiled from CRIHB dataset.[18]

As noted above, it is very likely that AI/ANs in states where access to IHS coverage is greater will have lower participation rates for health insurance exchange plans for three reasons: first, because they have access to IHS programs; second, they are not subject to individual mandate penalties;[19] and third, because Indian health programs typically do not invoke the alternative resource rule and require application for an insurance plan if a patient incurs any of the cost of such insurance. It is possible that tribes may consider requiring enrollment in exchange plans, but it is not clear if IHS has this authority.[20] Section 402 of the Indian Health Care Improvement Act gives tribes, tribal organizations, and urban Indian organizations the authority to purchase

[18] Centers for Medicare and Medicaid Services, Tribal Technical Advisory Group. Uninsured American Indians and Alaska Natives with Incomes 133% to 400% of Poverty: Data for Health Insurance Exchange Outreach. December 2010. Sacramento, CA: Carol Korenbrot and James Crouch, Appendix B.

[19] See the discussion of how the take up rate for health insurance exchanges would decline in the absence of a mandate in "Why the Individual Mandate Matters" by John Holahan, Mathew Buettgens, and Garrett Bowne. Urban Institute/Robert Wood Johnson Foundation. December 2010.

[20] IHS training of staff emphasizes that the alternative resource rule only applies to CHS eligibility. Some Tribes do require application for alternative resources for direct services.

health care.[21] It may be necessary for direct service tribes to develop a financing mechanism with IHS if they intend to sponsor their tribal members (or other AI/ANs) with IHS funds. The uninsured AI/ANs who are most likely to enroll in exchange plans are (and most likely it will be a combination of the following):

- those with no (or very low) premium or cost sharing (those under 300% of FPL);
- those who have no reasonable access to IHS services; or
- those whose Indian health program has developed a sponsorship mechanism using IHS funds, a combination of IHS and tribal funds, or other funding sources.

Participation in the health exchanges is likely to be less than desired for AI/ANs without regulations that seek to overcome some of the barriers to enrollment. Without favorable regulations that require states to work with tribes, and include their recommendations, the goal of reducing uninsurance rates for AI/ANs in the states where rates of uninsurance are highest is threatened. Ironically, in those states where most AI/ANs have access to IHS-funded services, albeit with funding levels inadequate to provide comprehensive services to all eligible AI/ANs, the challenge may be the greatest. It is clear that more attention needs to be paid to this possible weakness in health care reform for AI/ANs. The challenge is how to make the exchanges work for AI/ANs, given their unique circumstances.

Medicare Baseline

The CMS reports that there were 280,419 AI/AN enrollees in Medicare in 2006.[22] The ACA will not have a large or immediate impact on the AI/AN Medicare population for several reasons. Improving the solvency of the program is, of course, a positive reform since over 90% of all AI/ANs over 65 are enrolled in the program. Since proportionally few AI/ANs participate in Medicare Advantage (Medicare Part C) plans, the planned savings (reductions in payments to those plans) will not impact many AI/ANs. Medicare Part D has worked well for tribes and AI/ANs, thanks to CMS implementation of an Indian Addendum that makes it easy for Indian health programs to participate. CMS regulation also makes it easy for tribes to sponsor and pay premiums for their tribal members. These innovations for Part D (the addendum and sponsorship) continue under health care reform and represent a model innovation for the health insurance exchanges as well.

The AI/AN Medicare-aged population is an important area of population growth, however, and an aging Indian population is an extremely important consideration in terms of future health care expenditures. The ACA has important provisions for dual eligibles (beneficiaries enrolled in both Medicare and Medicaid), and a higher percentage of AI/ANs enrolled in Medicare are eligible for full benefits paid by the Medicaid program, including Medicare premiums, and, in most cases, deductible and coinsurance amounts. In addition, Medicaid also provides benefits not covered by Medicare. The ACA establishes the Coordinated Care Center that focuses on

[21] U. S. Code, Title 25, Chapter 18 section § 1642. Purchasing health care coverage
[22] Medicare 2006., Crouch, James, Chi Kao, Rebecca Garrow, and Carol Korenbrot. 2010.

dual eligibles, and its Centers for Medicare and Medicaid Innovation are interested in new systems for health care delivery that focus on chronic care innovations. There is some concern that there may not be sufficient support in the new CMS centers for smaller health care programs that are common to most IHS and tribally operated programs. Accountable care organizations and other innovative delivery systems, while smaller than health maintenance organizations, are still larger than most Indian health programs.

Projected Impacts of Medicaid Expansion, Community Health Centers, and Health Insurance Exchanges for AI/AN Populations in 20 Study States

The following analysis looks at Medicaid expansion, exchange subsidies available under the new health insurance exchanges, and the potential increase in services to AI/ANs in Community Health Centers in the 20 study states.

Medicaid Expansion

Medicaid is a key component in health care reform's goal of reducing the number of uninsured Americans. Medicaid expansion will increase the number of Medicaid enrollees by an estimated 16 to 22.8 million people by 2019.[23] The expansion includes the "newly eligible," including childless adults up to 139% of the federal poverty level,[24] and those who are currently eligible but not enrolled in Medicaid.[25] John Holohan and Irene Headen of the Urban Institute have produced estimates based on the Urban Institute's sophisticated modeling of the Medicaid program, which takes into account the current characteristics of a state's Medicaid program and estimates how the ACA will affect Medicaid enrollment. They estimate the number newly eligible and the likelihood they will participate. Holohan and Headen give high and low estimates for enrollment in Medicaid. The low or "standard" estimate, originally developed by the Congressional Budget Office, is for a take-up rate of 57%, which approximates the current Medicaid take-up rate. The high estimate is for a 75% take-up rate, based on enhanced outreach and the continued existence of the individual mandate.[26] CMS has aggressively targeted Indian communities for enhanced outreach and enrollment activities, and it is possible that this higher rate may be achieved.

According to Holohan and Headen, increases will vary widely between the states. States with currently low eligibility standards will see the greatest increases. These variations are displayed in Table 12. The Urban Institute has not specified how it established the baseline from which these figures were estimated, but this suggests that their estimates are calculated as if full implementation takes place in 2014.

---

[23] Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. John Holohan and Iren Headen, Urban Institute. May 2010.

[24] The new national standard for Medicaid is 133% plus a 5% income disregard equaling a maximum of 138%.

[25] Very few Medicaid eligibles will be subject to the individual mandate, but it is thought that the mandate and the new culture of coverage will, despite its non-application, act as an incentive to many more to enroll in Medicaid.

[26] Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. John Holohan and Iren Headen, Urban Institute. May 2010, p. 8.

Estimates presented here explicitly take this approach. The baseline over time should be what enrollment would be without the ACA; however, in the analysis here, the baseline is, first, the level of enrollment in 2008 and, second, the level of enrollment in 2009. This should result in a reasonable but perhaps conservative estimate. In the event that states cut Medicaid rolls in the next 3 years, the starting point for future increases could actually be lower than those in 2008 or 2009. One should keep the issue of baseline in mind and where necessary make revisions in these estimates based on expected eligibility and benefit reductions in 2011-2012. Arizona, to take a current example, has proposed dropping its coverage of childless adults on September 30, 2011, resulting in the loss of coverage for up to 27,360 AI/ANs. Many states are also reducing their funding for outreach workers and reducing their efforts to enroll more in Medicaid and CHIP. Such reductions would decrease Medicaid enrollment and also lower the baselines for projected expansion due to health care reform.

As results shown in Table 12 demonstrate, the projected increase in Medicaid enrollees under health care reform show high base sensitivity; that is, estimates can vary greatly depending on the initial baseline, making Medicaid enrollment and eligibility at the time Medicaid expansion is initiated critical for accurately predicting health insurance outcomes for AI/ANs.

Table 12. Estimated Medicaid Expansion for AI/ANs Under Three Scenarios: Limited Outreach and Enhanced Outreach with 2008 Baseline, and Enhanced Outreach with 2009 Baseline

State	AI/AN Percentage of State Medicaid Population	Percentage Increase with Limited Outreach*	Increase in AI/AN Enrollees, 2008 Baseline, Limited Outreach†	Percentage Increase with Enhanced Outreach*	Increase in AI/AN Enrollees, 2008 Baseline, Enhanced Outreach†	Increase in AI/AN Enrollees, 2009 Baseline, Enhanced Outreach†
Alaska	35.61%	38.50%	16,561	53.90%	23,186	26,911
Arizona	10.62%	7.70%	11,904	22.40%	34,631	34,631
California	0.38%	20.10%	8,085	29.90%	12,027	12,628
Colorado	0.84%	47.70%	2,218	60.60%	2,817	2,958
Idaho	2.23%	39.40%	1,867	53.10%	2,516	2,556
Massachusetts	0.20%	2.00%	55	5.20%	144	151
Michigan	0.50%	30.20%	2,805	40.16%	3,730	3,917
Minnesota	3.48%	32.90%	8,987	45.60%	12,456	13,955
Montana	21.72%	54.50%	13,119	75.00%	18,053	19,547
Nevada	1.41%	61.70%	2,145	88.60%	3,080	3,234
New Mexico	13.09%	28.30%	18,566	39.40%	25,848	40,256
New York	.045%	6.00%	1,350	16.00%	3,601	3,781
North Dakota	21.29%	44.00%	6,500	61.00%	9,012	9,462
Oklahoma	12.35%	51.20%	45,487	67.40%	59,879	65,082
Oregon	2.19%	60.60%	6,814	79.60%	8,950	8,955
South Dakota	33.09%	25.90%	10,515	34.60%	14,048	14,231
Utah	2.76%	56.10%	4,509	72.80%	5,851	6,143
Washington	2.51%	25.20%	7,357	33.60%	9,810	10,300
Wisconsin	1.57%	20.80%	3,228	28.00%	4,345	4,562
Wyoming	6.14%	40.00%	1,918	53.60%	2,570	3,416
Totals			173,989		256,552	286,677

*Percentage increases in Medicaid enrollment for "limited" and "enhanced" outreach scenarios calculated by John Holohan and Irene Headen, Kaiser Family Foundation, 2010.

†Projected increases in AI/AN enrollees calculated by KAI based on percentages supplied by Holohan and Headen. Calculations start from enrollment numbers in a base year, either 2008 or 2009 as specified.

The methodology used here for AI/ANs is to take the "limited outreach" and "enhanced outreach" estimates for Medicaid expansion given by Holohan and Headen and multiply their

estimates by the percentage of the overall state AI/AN Medicaid population.[27] The estimates give the best current estimate of expected growth in the AI/AN Medicaid population in these states. It is clear that Medicaid, already a significant source of income for Indian health programs and a significant source of payment for services provided to AI/ANs by specialists and hospitals outside Indian health programs, will grow significantly by 2019. It is a very positive development that CMS has recently reaffirmed that there will be no cost sharing (no premiums, copays, deductibles, or cost sharing of any kind) for AI/ANs. It is also of extreme significance that the definition of Indian is expansive and inclusive of any person who has been deemed an AI/AN for the purposes of receiving any federal benefit from the Department of the Interior or the Department of Health and Human Services. Because of these positive factors, it makes sense to utilize the high estimate, 286,677, as the goal for health care reform for AI/ANs.

There is surprisingly wide variation in the degree of Medicaid expansion between states. The potential Medicaid expansion for each state varies from just 2% in Massachusetts to 88% in Nevada. Oklahoma could increase from 51% to 67.4%, while Arizona's predicted increase ranges from 7.7% to 22%. (As discussed above, the estimate for Arizona will need revision if proposed Medicaid cuts occur.) Using estimates for each of the states' results in a total increase in Medicaid enrollees ('eligibles') ranging from 173,989 under the limited outreach scenario to 286,677 under the enhanced scenario. This variation needs to be considered for policy and program planning, not only for outreach efforts, but for workforce, services, and facilities planning.

How Income Influences the Projected Impact of Health Care Reform

National income estimates obscure the variation between states for the AI/AN population. Since both Medicaid and health insurance exchange subsidies are means-tested, the income distribution of AI/AN populations deserves greater attention in research and policy analysis. Table 13 depicts the extreme variation between states if one compares the within-state difference between the AI/AN population and the general population. Table 13 notes that more than half the states (11) have AI/AN median incomes that are over 70% of the all races income, but eight states have incomes that range from just 55% to 65% of the states' all races median income. It is reasonable, then, to expect that eligibility for subsidies will be greater for AI/ANs than the general population, and health exchange subsidy estimates for AI/ANs should take this income distribution into account.

One aspect of Medicaid expansion that could hurt AI/ANs is that after 2014, when Maintenance of Effort requirements end, many states may reduce their current Medicaid eligibility for adults to 138% of poverty level. That is, states may decide to lower their existing threshold to move enrollees to the health exchanges in order to save states' own-source funds. Many believe it is unlikely that states would continue to cover at a higher income level since these individuals would likely be eligible for subsidies in health insurance exchanges; in addition, these

[27] Estimates are from *Medicaid and Indian Health Programs*, Edward Fox, PhD, and Verne Boerner, 2009, updated where current information is available.

individuals would be paying for part of their coverage and, in effect, federal and personal funds would substitute for current state expenditures. This would have a negative impact on AI/ANs, and indirectly on Indian health programs, since AI/AN participation in the exchanges will very likely be far less than those who are subject to the individual mandate, especially if they have access to some services from an Indian health program. Unfortunately, many AI/ANs would not have access to referral services or hospital care unless they present themselves at hospital emergency rooms, as many AI/ANs do now.

Table 13. Study States Ranked by AI/AN Income as Percentage of State's All Races 2009 Median Income

	AI/AN Income as Percentage of All Races Median Income	AI/AN Income 2009	All Races Income 2009
South Dakota	54.97%	$24,640	$44,828
Minnesota	57.31%	$32,669	$57,007
North Dakota	58.55%	$26,429	$45,140
Massachusetts	60.17%	$38,808	$64,496
Montana	61.93%	$26,685	$43,089
Arizona	62.70%	$31,537	$50,296
Utah	63.45%	$35,306	$55,642
Alaska	63.93%	$41,322	$64,635
New York	68.64%	$37,911	$55,233
Washington	70.04%	$39,493	$56,384
Oregon	70.13%	$34,385	$49,033
Wisconsin	70.88%	$36,552	$51,569
Colorado	72.35%	$40,675	$56,222
New Mexico	74.01%	$31,634	$42,742
Michigan	74.96%	$36,505	$48,700
Idaho	75.21%	$34,733	$46,183
Wyoming	75.86%	$39,440	$51,990
California	77.68%	$46,912	$60,392
Nevada	80.25%	$44,608	$55,585
Oklahoma	83.01%	$34,748	$41,861

Source: 2005-2009 American Community Survey, 5-Year Estimates.

Health Insurance Exchanges

The second critical component of health care reform is the establishment of health insurance exchanges and the provision of advanceable and refundable tax credits through exchanges. In these cases, payment would go from the treasury to the health plan in nearly every case; however, some states may allow the choice of monthly payments and the taxpayer would receive a credit after tax filing. Health insurance exchanges begin in January 2014, although

some states have indicated enrollment will start in July 2013. On January 1, 2014, any uninsured person of any income level who does not have a viable offer of insurance from their employer will be able to purchase health insurance from health insurance exchanges. If they are below 400% of poverty, they will be eligible for subsidies in the exchange or for Medicaid, CHIP, or a state basic health plan (section 1330 plan). The subsidies, including exemptions from cost sharing for those below 250% of poverty, are especially generous, with the bulk of all public expenditures being made for this group. In addition, reduced maximum out-of-pocket limits are provided to those with incomes below 400% of the federal poverty level.

Exchanges will vary from state to state, and until federal regulations are issued and states pass enabling legislation, it is not clear the extent of the state health exchange authorities or requirements. In every state, anyone eligible for the exchange will have a choice of a health care plan, and within those carriers, they will have a choice of four or more levels of benefits and costs. States will decide if they will operate their own exchanges or if they will adopt, by agreement, the federal exchange.

An Urban Institute study estimates 43.8 million people will be insured in the exchanges; 23.1 million people will be through individually purchased (non-group market) plans that are not employer related; and the balance of 20.7 million people will be covered by a health plan purchased by their employer.[28] In addition, it is expected that 9 million will purchase health insurance in the non-group market outside the exchange.[29] In a Lewin Group study prepared for Families USA, it was found that the number eligible for subsidies is estimated at 28.6 million.[30] The actual number taking advantage of these subsidies will be less. The Congressional Budget Office estimates 19 million people will take advantage of subsidies in 2014 and enroll through the health insurance exchanges by 2019, with 14 million enrolling in the first year.[31]

Health insurance exchanges are complementary to the Medicaid expansion effort. Health insurance subsidies and limits on cost sharing will be offered to households with income above the Medicaid threshold of 138% of poverty up to 400% of poverty. These two measures combined are expected to reduce the number of uninsured by 30 to 32 million in 2014. The estimated reduction in the uninsured for each component is remarkably similar, with estimates of 15 to 16 million each for Medicaid expansion and newly insured through the health insurance exchanges.

The eligibility and enrollment process of the exchanges requires them to integrate the Medicaid program with the offerings of health insurance exchanges. There will be one application

[28] Holohan, John and Irene Headen. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. Kaiser Family Foundation/Urban Institute, May 2010.
[29] CBO
[30] Families USA, "Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit." September 2010. See also Familis USA "Implementing Health Insurance Exchanges: A Guide to State Activities and Choices."
[31] Congressional Budget Office, "Effects of Eliminating the Individual Mandate to Obtain Health Insurance." June 16, 2010.

process for both, with the exception of disabled and dual eligibles. The law requires that states operating exchanges develop online applications using electronic signatures and to implement the coordination between Medicaid, CHIP, exchange, and subsidy programs.

Special provisions for AI/ANs in Health Exchanges

There are several special provisions for AI/ANs who participate in health insurance exhanges. AI/ANs are exempt from cost sharing up to 300% of poverty. No final decision has been made on the question of whether or not premiums will be considered part of the cost sharing exemption. AI/ANs will not be required to enroll during a once-a-year enrollment period (i.e., they will also be able to enroll in any month). Since AI/ANs are not subject to the individual mandate penalty, there is a reduced incentive to obtain insurance. In addition, a provision of the IHCIA will play a role in the exchanges. Tribes have a new incentive to pay premiums under the ACA and the IHCIA since they are now able to pay for premiums for AI/ANs and those payments will not be considered taxable income by the IRS (i.e., these payments are exempt from income tax). Put in a different way, a disincentive to pay premiums has been removed. If premiums are assessed for AI/ANs in the exchanges, tribes may have an option to group-pay and, if given the opportunity, to sponsor and directly pay for an AI/AN. It is expected that tribes will exercise this option. The type of sponsorship has been used in Washington State since 1995 for the states' Basic Health insurance program.

Estimated Exchange Enrollment of AI/ANs for 20 Study States

It is more difficult to estimate AI/AN exchange enrollment than it is Medicaid expansion enrollment. It does seem that AI/ANs are less likely to take advantage of the exchanges than they will be of taking advantage of Medicaid. The exemption from cost sharing for those up to 300% FPL is certainly an attractive incentive to enroll, but the lack of a mandate (i.e., AI/ANs' exemption from the individual mandate penalty) and the availability of IHS-funded services may dampen enrollment in the exchanges unless there is an aggressive outreach and enrollment campaign. The greatest disincentive of all would be a ruling that AI/ANs under 300% of poverty will be required to pay premiums. An analysis, completed by Lewin and Associates, includes estimates for only eight of the study states. It does not provide estimates for the states of Oklahoma, Arizona, and Alaska, all of which have very large Indian populations.[32] Since the Lewin/Families USA data are incomplete for the group of 20 study states, an alternative estimate is given here. It is important to remember that this is an estimate of ***eligibility*** for subsidies, not participation in the exchanges nor enrollment in exchange health plans.

Table 14 provides three estimates. The first estimate multiplies the estimated total for each state developed by Lewin and Associates by Families USA by that state's 2009 percentage of AI/AN population (alone and in combination). AI/AN families, in most but not all states, have a larger percentage of their population in the income range that would make them eligible for subsidies, and this suggests the need for a revision to the basic estimate by population.[33]

[32] Lower Taxes, Lower Premiums, The New Health Insurance Tax Credits. FamiliesUSA, 2010.

[33] A November 2009 Kaiser Family Foundation report, Health Reform and Communities of Color, reports that only 21% of AI/AN families (alone or in combination) have incomes over 400% of poverty compared to 43% for whites.

The second estimate includes one income factor developed that is specific to each state. The difference between the percentage of the states' population between 139% and 400% of poverty and the AI/AN median income can be expressed as the ratio between the two. Multiplying the basic estimate by this ratio produces a second estimate. The reason this adjustment results in a lower estimate in some states, such as South Dakota, is because so many of the state's AI/AN population is in the under 139% income distribution, and in others because they have more AI/ANs in the 400% and above category than the all races population. A final adjustment is made to account for the higher rate of AI/ANs who are uninsured by multiply the second estimate by 10%, the difference between the national rate of uninsured and the AI/AN rate, resulting in a third adjusted estimate.

Table 14. Estimate of AI/ANs Eligible for Exchange Subsidies in 20 Study States

State	Families USA Estimate of Total Number Eligible for Subsidies	AI/AN Percentage of State Population, 2009	Families USA Estimate by % AI/AN of Population	Ratio of All Races to AI/AN 139-400% FPL	Number of AI/ANs Between 139-400% FPL	Factor (10%) for higher rate of un-insurance among AI/ANs	Adjusted Estimate of AI/AN Eligible
Alaska	72,000	17.30%	12,456	112.8%	14,046	1,405	15,451
Arizona	597,100	5.50%	32,841	117.7%	38,657	3,866	42,522
California	3,473,000	1.90%	65,987	115.6%	76,303	7,630	83,933
Colorado	493,900	2.00%	9,878	120.9%	11,940	1,194	13,134
Idaho	201,400	2.30%	4,632	98.7%	4,572	457	5,030
Mass.	416000	0.68%	2,835	128.2%	3,635	364	3,999
Michigan	468,200	1.27%	5,927	116.6%	6,910	691	7,601
Minnesota	117,500	1.80%	2,115	107.6%	2,276	228	2,503
Montana	287,400	7.50%	21,555	82.6%	17,794	1,779	19,574
Nevada	211,200	2.20%	4,646	88.1%	4,095	409	4,504
New Mexico	211200	10.50%	22,176	128.7%	28,541	2,854	31,396
New York	1,600,000	0.98%	15,666	118.2%	18,516	1,852	20,367
North Dakota	74,300	6.20%	4,607	101.8%	4,690	469	5,159
Oklahoma	381,500	10.80%	41,202	123.9%	51,059	5,106	56,165
Oregon	444,400	2.60%	11,554	89.6%	10,354	1,035	11,390
South Dakota	92,800	9.20%	8,538	87.7%	7,488	749	8,237
Utah	321,700	1.90%	6,112	98.2%	6,001	600	6,601
Washington	597,100	2.70%	16,122	96.1%	15,499	1,550	17,049
Wisconsin	476,900	1.40%	6,677	91.9%	6,133	613	6,746
Wyoming	59,000	3.40%	2,006	115.5%	2,316	232	2,548
Total			297,532		330,825		363,907

The data are based on the one 2009 American Community Survey, the best measure of income and insurance available to make an income-based estimate. This estimate will be revised in November 2011 when the American Community Survey releases its 3-year estimate for health insurance coverage. The 3-year estimate will allow the public release of data for much smaller levels of analysis (20,000 persons) with a lower rate of error and smaller confidence intervals.

If uninsured tribal members and other AI/ANs feel they already have access to health care, are not subject to a mandate, or do not belong to a tribe that is willing or financially able to pay their premium, the estimates for available subsidies will misrepresent and overestimate the actual number of AI/ANs who will participate as individuals or as families in the health insurance exchanges. This conclusion can also be restated in its converse: if an uninsured AI/AN does not have access to IHS-paid services, if she or he feels a social obligation from the mandate that applies to others, or if he/she belongs to a financially successful tribe that is willing to pay for premiums, then he/she is more likely to take advantage of the subsidies. The question may result in very different answers for each of the states. It is likely that those who are on or near reservations will be far less likely to enroll in the health exchanges than those who do not regularly interact with a reservation-based health care system.

As noted above, there is an exemption from the penalty ($95 in 2014 and rising thereafter to a percentage of income, with the maximum set at 9.5% in 2016). Therefore, enrollment will rely far more on incentives (subsidies) than penalties. In addition to an exemption from any penalties for AI/ANs, many tribes and IHS-operated programs will not invoke the alternative resource rule (if premiums or copays are charged for their patients) and require enrollment in a health exchange-offered plan—despite the fact that the coverage is subsidized and no cost sharing is assessed for many (those up to 300% of poverty). It is expected, however, that some tribes will be willing to "sponsor" their eligible patients and pay the premiums, if premiums are required. AI/AN enrollment in exchanges will be lower than for other populations without enhanced outreach and the removal of barriers to enrollment.

It is essential for the success of exchanges' enrollment of AI/ANs that they require health plans to include Indian Health Service, tribal, and urban Indian health programs (I/T/U) providers as essential community providers in their networks. Likewise, they should allow AI/ANs the option to seek care at these programs—even if they have chosen a managed care health plan. Enrollment in exchange-offered health plans will be greater to the extent such provisions are included, and it will be less if AI/ANs are not able to receive care at their Indian health programs.

Simply put, there is currently no firm estimate for the number of AI/ANs who will enroll in health exchange plans. Only experience will tell how many will take advantage of the subsidies available for the health insurance exchanges. It is tempting to simply use the estimates for the non-Indian population and adjust those by the percentage of the AI/AN population as Table 14 does; however, more fine-grained estimates are required since the special provisions available to AI/ANs and the well-known differences in take-up rates in the Medicaid program suggest

their enrollment experience will not be the same. The estimate in Table 14 of 297,532 to 363,907 eligible for subsidies in the health exchanges is similar to the estimated number of newly enrolled in Medicaid: 256,552 to 286,677. Thus, these estimates closely align with estimates for the non-Indian population that also estimate similar numbers for expansions of health insurance through the exchanges and Medicaid/CHIP (roughly 15 to 16 million Medicaid and "net newly insured" of 15 to 16 million through the exchanges).

Outreach and Enrollment for Medicaid and the New Health Insurance Exchanges

The goal of health care reform is to enroll everyone in one of the options for health insurance. For Medicaid, the goal for AI/ANs should be no less than full participation. In the case of the 20 states examined here, the goal under Medicaid expansion should be at least 286,777 newly enrolled. The goal for health exchanges should be 363,000 newly enrolled, but that estimate awaits further clarification and review of expected health insurance exchange regulations. The key to increasing health insurance coverage for AI/ANs is effective outreach and removal of barriers to enrollment. As noted above, the number of AI/ANs eligible for Medicaid will increase by over 50% in 2014, but the take-up rate is very likely to reduce the projected increase to 25 or 35%, unless concentrated outreach efforts to increase enrollment are initiated.

Fortunately, the ACA includes many features that are expected to increase the rate of enrollment of those eligible for Medicaid, CHIP, or the health plans offered by the health insurance exchanges. One view of the new "culture of coverage" in 2014 is the notion that the key eligibility question will not be, "Are you eligible?" Rather, the question will be, "For which form of coverage are you eligible?" AI/ANs are unique in the answer to that question as they are eligible for Medicaid (and CHIP) and for subsidies to purchase health insurance exchange-offered health plans, but they are also eligible for IHS-funded services. This eligibility has a profound impact on outreach and enrollment activities. Only time will tell if the additional option of IHS services dampens enrollment and frustrates attempts to reduce the rate of uninsured AI/ANs— many of whom have only very limited access to an underfunded Indian Health System. It is imperative that outreach, enrollment, and eligibility determination systems understand and integrate positive accommodations to the unique choices that AI/ANs have when they make their decisions about which program to access for their health care needs.

Simplified Eligibility Determination and Enrollment in a More Complex System

Health care reform legislation recognized and addressed the well-known research finding that a complex application process impedes enrollment in health care programs. The ACA requires certain elements in the application, eligibility determination, and enrollment process to simplify the inherently complex process of deciding who is eligible for which type of coverage and at what cost to the enrollee. Thankfully, there are examples from Massachusetts and other states that a complex set of decisions impacting the finances of individuals and governments can be simplified and still maintain financial integrity. The success of the system will be judged, in part, by whether or not people participate and get access to health insurance and whether the financial supports reach the intended recipients.

The following are some of the main simplification elements.

- Single application for Medicaid, CHIP, and the plans offered by the health exchange
- Online application as well as paper and telephone applications
- Online eligibility determination
- Online enrollment and updating of status
- Use of Modified Adjusted Gross Income (MAGI) to determine eligibility at 133% of poverty with an additional 5% to further adjust for the prohibition against income disregards and exemptions
- Navigator system of outreach and enrollment assistance using community groups, non-profits, tribes, brokers, and others including Indian health organizations
- Express-lane enrollment, including tribes, at state option
- Presumptive eligibility authority for hospitals
- Retroactive eligibility for up to 3 months
- Option for 1-year eligibility for change in status
- Health insurance exchange determination of exemption from penalties

Tribes, IHS, urban Indian health programs, and other Indian organizations are expected to play a key role in the outreach and enrollment effort. In addition to grant funding for outreach, many will likely become navigators under the state health insurance exchanges. This means states will have to work closely with tribes to tap their access to AI/ANs and knowledge of how to encourage enrollment in Medicaid and exchange-offered health insurance. It is important that explicit "goals for enrollment" be set along the lines of the estimates provided here to determine if the level of effort is sufficient to meet specified performance measures. Medicaid outreach efforts have already been stepped up with the CHIPRA grants to tribes, IHS, and urban programs, but this effort will have to be redoubled with the advent of enrollment in health exchanges in 2013 (6 months prior to initiation of the exchange coverage). It is very possible that states, with mixed motives, wanting to both expand health insurance and control costs, will vary in the degree of effort they expend on enrollment activities if they do not have specific requirements and performance measures, including explicit goals for the enrollment of AI/ANs.

Community Health Centers

Health care reform includes $11 billion in new, dedicated funding for Community Health Centers (CHCs) and rural and migrant health centers. According to the National Association of Community Health Centers (NACHC), CHC patients will increase from 20 million in 2010 to an estimated 40 million in 2015.[34] Approximately 200,000 (2%) of CHC patients in the NACHC data base are AI/AN. It is likely that the definition of Indian varies from that used by Indian health programs, but it is expected that reporting will improve with the adoption of a uniform definition of Indian and the incentive for AI/ANs to declare their Indian status in order to claim their exemption from cost sharing. Approximately 124,000 (or perhaps 150,000 given the large

[34] Community Health Centers and Health Care Reform: Summary of Key Health Center Provisions. National Association of Community Health Centers 2010.

numbers who do not declare ethnicity or racial identification when accessing CHC services), or about 75%, of all AI/AN Community Health Center patients are in the 20 study states.

CHC expansion is not separate from the Medicaid and health exchange expansion. Rather, it is complimentary; in fact, they overlap, and one should not add CHC expansion numbers in the manner one can for Medicaid and the exchange enrollees. Medicaid patients constitute 36% of the patient load at CHCs nationwide. They will also be providers for health exchange enrollees. The health plans offered by the exchanges will include plans that have "safety net" providers such as CHCs. Since those who remain without health insurance coverage (and many AI/ANs will be among the estimated 20 to 22 million uninsured in 2019), they will be eligible for services at CHCs.

Table 15. Reported Numbers of Patients At Community Health Centers, 2008

	Total Patients All Races	AI/AN Patients	AI/AN %
Alaska	81,109	29,311	36.14%
Arizona	356,094	18,712	5.25%
California	2,521,822	24,412	0.97%
Colorado	419,514	2,967	0.71%
Idaho	108,756	3,420	3.14%
Minnesota	154,030	8,064	5.24%
Montana	84,760	4,744	5.60%
Nevada	No data	n/a	n/a
New Mexico	259,073	14,354	5.54%
North Dakota	26,144	1,249	4.78%
Oklahoma	101,954	3,676	3.61%
Oregon	240,486	4,811	2.00%
South Dakota	55,526	10,056	18.11%
Utah	105,551	10,647	10.09%
Washington	664,795	14,538	2.19%
Wisconsin	196,227	2,445	1.25%
Wyoming	20,207	438	2.17%
Totals	5,396,048	124,533	2.31%

The goal of health care reform is to double the capacity of CHCs, but it is not clear that this would mean the AI/AN patient population of CHCs would double to 250,000 in 2015. The other expansions of Medicaid and the exchanges are likely to expand the capacity of Indian health programs, making the impact on AI/ANs use of CHCs unclear. One might expect fewer to need CHCs, since they are likely to choose an Indian health program if they have insurance. If fewer than expected obtain insurance for reasons discussed in this analysis, perhaps more will access CHCs. It is also possible that hybrid CHC/urban or CHC/tribal programs might expand in response to CHC's planned expansion in order to meet the increased demand for services from

newly insured AI/ANs. Seven IHS Title V Urban Indian Health Programs (UIHPs) are currently CHCs, and a growing number of tribal programs also receive CHC funding. If AI/ANs fail to take advantage of the health exchange subsidies or decline to participate in a means-tested Medicaid program, they will continue to depend on IHS or other safety net providers like CHCs and hospital emergency rooms.[35]

Employer-Sponsored Health Insurance

It is important to learn more about employer-sponsored insurance (ESI) for AI/ANs. Health care reform provides many new protections for enrollees in ESI plans relating to lifetime limits (prohibited), pre-existing conditions (prohibited after 2014 and now for children), rescissions (prohibited in 2014), and percentage of premiums that have to be spent on benefits (benefit-loss ratios in 2014). Since rates of insurance coverage of AI/ANs vary greatly across the states examined here, it follows that these protections will have variable benefits for Indian people in those states. Tribes who are both employers of and advocates for tribal members are currently unsure if health care reform will be a net benefit or an additional cost as their employees come under ACA requirements in 2014. Tribes and tribal organizations are best suited to develop the needed information for analyzing ESI and its impact on ACA implementation.

Conclusion

The main thrust of health care reform is to reduce the number of uninsured. Indian health is in some ways incompatible with health insurance reform. Tribal members who believe treaty obligations guarantee health care services are particularly troubled by the uncertainties that remain concerning the expansion of health insurance through Medicaid expansion and health insurance exchanges. Medicaid expansion is likely to be well received by tribes and Indian people since it provides protection against cost sharing and a simplified definition of Indian for the purpose of determining eligibility. Unfortunately, it is less likely that the health exchanges and the subsidies to purchase health plans will play their expected role in reducing the uninsurance rate for AI/ANs, especially if regulations determine that premiums are not part of the cost sharing exemption provisions of the ACA. Instead, AI/ANs will depend on IHS to provide care instead of enrolling in health exchange plans, unless their tribe is able to sponsor their enrollment and pay for their premiums. Since recent changes in the Indian Health Care Improvement Act allow IHS funding to be applied to such sponsorship of insurance, it is likely that many tribes will want to sponsor their patients. However, the actual availability of sufficient funds and the mechanisms to apply them to insurance payments and reconciliations, particularly for direct service tribes, will require careful attention and positive action.

This analysis documents the level of the uninsurance for AI/ANs and describes in detail how poverty rates and income levels, Medicaid coverage, other insurance coverage, and uninsurance rates vary across the 20 states selected for detailed study. AI/ANs have the highest

[35] The ACA will also result in new regulations concerning, charity care, or the 'community benefits,' that non-profit hospitals must provide and these regulations could include special provisions for AI/ANs who are more likely to remain uninsured than other populations who are eligible for the full range of ACA health insurance expansions.

rate of uninsurance in the nation and in every state studied here. Likewise, the overall impact of health care reform on Indian Country will vary a great deal by state. States play a critical role in implementation, and attention to how states vary is important to understanding and influencing state action. The importance of outreach and enrollment is emphasized here in order to maximize the potential participation in the newly expanded Medicaid program and the newly offered health plans available through health insurance exchanges. A companion report provides a tracking tool to chart the state-level implementation of health care reform in Indian Country.

Bibliography

A New Way to Talk About the Social Determinants of Health. Retrieved December 21, 2010, from Robert Wood Johnson website, http://www.rwjf.org/vulnerablepopulations/product.jsp?id=66428.

Bureau of Indian Affairs. (2005). *2005 American Indian Population and Labor Force Report.* Washington, DC: Government Printing Office.

Centers for Medicare and Medicaid, Tribal Technical Advisory Group. *American Indian and Alaska Native Data Symposium: Developing Medicaid and Medicare Data.* Summary of the Proceedings July 30, 2010. Sacramento, CA California Rural Indian Health Board.

Centers for Medicare and Medicaid, Tribal Technical Advisory Group. American Indian and Alaska Native Medicaid Program and Policy Data, March 2010, Medicaid & CHIP Enrollment Service Use & Payments. Sacramento, CA California Rural Indian Health Board: James Crouch, Chi Kao, Juan Korenbrot, & Carol Korenbrot. Retrieved from http://crihb.org/files/0_Medicaid_Report_6_2_2010.pdf.

Centers for Medicare & Medicaid Services, Tribal Technical Advisory Group. American Indian and Alaska Native Medicare Program and Policy Statistics: Summary Report December 2009. Medicare 2006 Enrollment and Utilization. Sacramento, CA California Rural Indian Health Board: James Crouch, Chi Kao, Rebecca Garrow, & Carol Korenbrot. Retrieved from http://crihb.org/files/3_AIAN_Medicare_Statistics_2009.pdf.

Centers for Medicare & Medicaid Services, Tribal Technical Advisory Group. Uninsured American Indians and Alaska Natives with Incomes 133% to 400% of Poverty: Data for Health Insurance Exchange Outreach. December 2010. Sacramento, CA California Rural Indian Health Board: Carol Korenbrot & James Crouch.

Centers for Medicare & Medicaid Services, Tribal Technical Advisory Group. *American Indians and Alaska Natives: Medicaid State Data Collection*. December 2010. Sacramento, CA California Rural Indian Health Board: Carol Korenbrot & James Crouch.

Families USA Foundation. (2010). *Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit.* Washington, DC: Jennifer Sullivan and Kathleen Stoll.

Fox, E., & Börner, V. (2009, March). Medicaid and Indian Health Programs: Financing Indian Health Programs in the United States. Paper presented at the annual meeting of the WPSA Annual Meeting, "Ideas, Interests and Institutions," Hyatt Regency Vancouver, BC Canada, Vancouver, BC, Canada.

Franklin, R.K. (2010, December 17). *National Indian Health Board Letter to Office of Consumer Information and Insurance Oversight (OCIIO).* Retrieved from http://www.tribalhealthcare.org/documentlibrary/2010/12/NIHB%20response%20to%20OCIIO%20on%20Exchange%20DearTribalLeaderLtr%20FINAL%202010%2012%2017b.pdf.

Indian Health Service. (2011). Indian Health Service 2011 Justification of Estimates for Appropriations Committees. Washington, DC. Government Printing Office.

Kaiser Family Foundation. (2009). *A Profile of American Indians and Alaska Natives and Their Health Coverage*. (Pub. No. 7977). Washington, DC: .Cara James, Karyn Schwartz, and Julia Berndt.

Kaiser Family Foundation. (2010). Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL. (Pub. No. 8076). Washington, DC: John Holohan and Iren Headen.

Medicaid Budget Group, Department of Human Services. (2010). Long Term Forecast of Medicaid Enrollment and Spending in Alaska: 2009-2029. Juneau, AK.

National Indian Health Board (NIHB) Letter to Office of Consumer Information and Insurance Oversight (OCIIO) in response to 45 CFR Part 1970 Request for Comments Regarding Exchange-Related Provisions in Title I of the ACA. October 4, 2010.

Trujillo, M. (Dear Tribal Leader Letter, January 10, 2000).

Urban Institute. (2010). *Why the Individual Mandate Matters: Timely Analysis of Immediate Health Policy Issues.* (Pub. No. 412280). Washington, DC: John Holahan, Mathew Buettgens, and Bowne Garrett.

Urban Institute. (2010). *America under the Affordable Care Act.* (Pub. No. 412267). Washington, DC: Matthew Buettgens, Bowen Garrett, and John Holahan.

Urban Institute. (2011). Health Care Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid. Matthew Buettgens, John Holahan and Caitlin Carroll.

Washington State Office of Financial Management. (2008). 2008 Washington State Population Survey, Health Insurance by Race/Ethnicity, 2008, Research Brief No. 52. Retrieved from http://www.ofm.wa.gov/researchbriefs/2008/brief052.pdf.