Health Care Reform in Indian Country
Self-Governance Communication & Education
Self-Governance Tribes Striving Towards Excellence in Health Care

American Indian and Alaska Native (AI/AN) Marketplace Enrollment, Including Access to Cost-Sharing Protections, and Medicaid Enrollment[1]

December 20, 2019

This brief provides data to Tribes on: 1) the number of AI/ANs enrolled in health insurance coverage through the Marketplace in 2019; 2) trends in AI/AN Marketplace enrollment and access to cost-sharing protections over the past five years; and 3) ongoing efforts by Tribes and Tribal organizations (T/TOs) to ensure that eligible AI/ANs receive the comprehensive cost-sharing protections to which they are entitled. Finally, this brief examines trends in AI/AN Medicaid enrollment during the 2010-2018 period.

KEY FINDINGS

An analysis of data from the Centers for Medicare and Medicaid Services (CMS)[2] and from the annual American Community Survey conducted by the Census Bureau indicates that:

- For Tribal citizens, enrollment in the Federally-Facilitated Marketplace (FFM) increased by 14.2% from 2018 to 2019;
  - Enrollment of other Indian Health Service (IHS)-eligible individuals declined by 11.7%;
  - When combining the two populations, FFM enrollment of AI/ANs increased by about 2,300, or 3.5%, from 2018 to 2019.
  - In contrast, among the general population, FFM enrollment *decreased* by 2.6% from 2018 to 2019.
- Enrollment gains varied by state, with two states (Nebraska and Oklahoma) showing a greater than 20% increase of Tribal members and other states showing more modest gains, holding flat, or declining (measured by *enrollment levels on the report run date*).
- In each of 2018 and 2019, the total number of Tribal members and other IHS-eligible individuals enrolled in (FFM and SBM) Marketplace coverage *at some point during the year* neared 100,000.
- The Marketplace continues to provide substantial federal resources to AI/AN Marketplace enrollees in the form of premium tax credits and cost-sharing reductions.
- T/TOs have proven successful in assisting AI/ANs to enroll in the most beneficial health plan options, and by working with CMS and health plans, in ensuring that AI/AN enrollees receive the cost-sharing protections to which they are entitled, although continued efforts are needed.

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Doneg McDonough, TSGAC Technical Advisor, at DonegMcD@Outlook.com.

[2] For the CCIIO Marketplace data, enrollment counts are gathered in two ways: (1) the number of individuals enrolled on the report date (*e.g.*, November 4, 2019) and (2) the number of individuals enrolled at any time during 2019.

- With regard to Medicaid, across the 24 states with a federally-recognized Tribe that have expanded Medicaid eligibility since 2010, AI/AN Medicaid enrollment jumped by 135,827, or 47.9%, from 2010 to 2018.
    - In contrast, during the same period, AI/AN Medicaid enrollment increased by 24.3% (34,213) *in non-expansion states* with at least one federally-recognized Tribe.
- About 50,000 additional uninsured AI/ANs potentially could qualify for Medicaid if the 11 current non-expansion states with at least one federally-recognized Tribe adopted the expansion, and 79% of these uninsured AI/ANs reside in just two states (Oklahoma and South Dakota).

BACKGROUND

The Health Insurance Marketplace, established by the Affordable Care Act (ACA), allows consumers to compare available health plans, determine eligibility for federal financial assistance (such as premium tax credits), and enroll in comprehensive health insurance coverage. To assist AI/ANs in accessing health care services when enrolled in Marketplace coverage, the ACA established Indian-specific cost-sharing protections, under which AI/ANs who meet the ACA definition of Indian (*i.e.*, Tribal members)[3] pay no deductibles, coinsurance, or copayments when receiving essential health benefits.[4] Tribal members can enroll in either a zero or limited cost-sharing plan, depending on their income level.[5] Other AI/ANs who are eligible for services through the IHS (other IHS-eligible individuals) and have a household income at or less than 250% of the federal poverty level (FPL) can obtain general (partial) cost-sharing protections if they enroll in a silver plan.[6]

AI/AN MARKETPLACE ENROLLMENT

Attachment A below provides data on AI/AN Marketplace enrollment in the 39 states with an FFM.[7] The table shows, by state, the number of Tribal members, as well as the number of other IHS-eligible individuals,[8] in 2018 and 2019 who were enrolled in Marketplace coverage on the report run dates in states with an FFM.[9] In 2019, FFM enrollment of AI/ANs (*i.e.*, Tribal citizens and other IHS-eligible individuals)

[3] The ACA defines "Indian" as a member of an Indian tribe or shareholder in an Alaska Native regional or village corporation (Tribal member).

[4] The ACA also prohibits health insurers from reducing payments to Indian health care providers (IHCPs) by the amount of any cost-sharing that Tribal citizens would have owed without these protections.

[5] Tribal members who have a household income between 100% and 300% of the federal poverty level (FPL) and qualify for premium tax credits are eligible for the "zero" cost-sharing protections. All other Tribal members who enroll in coverage through a Marketplace are eligible for the "limited" cost-sharing protections. Both cost-sharing variations provide comprehensive cost-sharing protections.

[6] These general protections require Marketplace plan issuers to reduce cost-sharing in their standard silver plans, which have an AV of 70%, to meet a higher AV, based on the household income of enrollees: 94% for individuals at or less than 150% FPL, 87% for those from 151-200% FPL, and 73% for those from 201-250% FPL.

[7] The data in Attachments A and B include figures for states with an FFM, State-Based Marketplace on the Federal Platform, or State Partnership Marketplace (all states using the HealthCare.gov platform).

[8] These AI/ANs do not meet the ACA definition of Indian and thus do not qualify for Indian-specific cost-sharing protections.

[9] Figures represent FFM enrollment of AI/ANs on October 9, 2018, and November 4, 2019, respectively (not the total number of AI/ANs enrolled in Marketplace coverage at any point during the year).

totaled more than 68,000 on the report run date (*i.e.*, November 4, 2019). The table also shows the change in FFM enrollment of AI/ANs, by state, from 2018 to 2019.

Findings: Enrollment of Tribal citizens—for whom enrollment in the Marketplace provides the greatest financial benefits, including comprehensive cost-sharing protections—increased by 14.2% from 2018 to 2019. In contrast, for others voluntarily indicating "IHS eligibility" on the Marketplace application, where no documentation is required but also no additional benefits are provided, enrollment of other IHS-eligible individuals registered a significant decline in enrollment (-11.7%). Net enrollment across the two categories of AI/ANs was reported to increase by 3.5%.

Some potential reasons for the differing enrollment trajectories of Tribal citizens as compared with other IHS-eligible individuals are:

- The awareness of the availability of health insurance premium subsidies, as well as no out-of-pocket costs (which is provided to Tribal citizens but not other IHS-eligible individuals) under Marketplace coverage is increasing across Tribal communities, leading to greater interest and enrollment of Tribal citizens in Marketplace coverage;
- Some individuals might have been identified as "IHS eligible" (and not enrolled Tribal members) in prior years but have since successfully secured and provided documentation of Tribal citizenship to the Marketplace, increasing enrollment of "Tribal members" and decreasing enrollment of "other IHS eligible individuals"; and
- The realization that indicating "IHS eligibility" on the application does not result in additional benefits might be leading to declining responses to this voluntary question. (Likewise, the number of applicants indicating "AI/AN" in response to race/ethnicity questions is very low and is only a fraction of the number of applicants indicating, and documenting, Tribal citizenship.) If this dynamic is in fact occurring, the decline in reporting of "IHS eligible" status might not necessarily indicate a decrease in the number of other IHS-eligible individuals with health insurance coverage through a Marketplace.

Overall, FFM enrollment of Tribal citizens continues to strengthen, whether measured by the 14.2% increase of Tribal citizens with Marketplace coverage, or by the 3.5% net gain in enrollment of Tribal citizens and other IHS-eligible individuals, or in comparison with the 2.6% decline in *total* FFM enrollment nationally from 2018 to 2019.

Attachment B below includes a graph on AI/AN Marketplace enrollment in states with an FFM for 2015, 2016, 2017, 2018, and 2019.

In **Attachment C**, data are presented on AI/AN Marketplace enrollment in the 12 states with a State-Based Marketplace (SBM). The table shows, by state, the number of Tribal members who enrolled in a health plan through the Marketplace in states with an SBM in 2018 and 2019.[10]

[10] Data are not available on the number of other IHS-eligible individuals who enrolled in a plan through the Marketplace in states with an SBM.

Findings: SBM enrollment of Tribal members increased from almost 6,900 to more than 7,500, or by 10.1%, from 2018 to 2019. (No data were provided by CMS on enrollment of other IHS-eligible individuals through SBMs.)

The graph in **Attachment D** below illustrates a second data set that shows AI/AN Marketplace enrollment *at any point during the year*, rather than at a specific point in time. In each of 2018 and 2019, the total number of Tribal members and other IHS-eligible individuals enrolled in (FFM and SBM) Marketplace coverage at some point during the year neared 100,000.

ENROLLMENT TRENDS

- ***Enrollment of Tribal Members vs. Other IHS-eligible individuals***: The change in overall enrollment of AI/ANs in Marketplace coverage in states with an FFM masks significant differences in the reported year-to-year enrollment between Tribal members and other IHS-eligible individuals.[11] For example, at the state level, Alaska registered a 14.8% increase in enrollment of Tribal members but a 17.2% *decrease* in enrollment of other IHS-eligible individuals, resulting in a 10.6% net gain in enrollment among all AI/ANs in the state.

- ***Differences in Enrollment Among States***: Enrollment of AI/ANs in Marketplace coverage in states with an FFM varies substantially by state. Among FFM states with a relatively large AI/AN population, Oklahoma showed the most significant increase in Marketplace enrollment of AI/ANs from 2018 to 2019 (a 26% increase, representing more than 4,800 additional enrollees).[12] Meanwhile, among the other 38 states with an FFM, enrollment of AI/ANs in Marketplace coverage *declined* by about 2,500, or 5.4%, from 2018 to 2019. It is important to note, however, that the decrease in overall FFM enrollment of AI/ANs outside of Oklahoma resulted from a significant (12.1%) decline in enrollment of other IHS-eligible individuals; among Tribal citizens, enrollment in these states increased by 2.9%.

- ***Enrollment by Metal Level***: Among AI/AN FFM enrollees, the preferred "metal level" of the selected Marketplace plan varies for Tribal members versus other IHS-eligible individuals. Most Tribal members enroll in bronze plans (78% in 2019), while other IHS-eligible individuals tend to enroll in silver plans (58% in 2019). This difference among AI/ANs in the selection of plans by metal level largely results from varying eligibility for cost-sharing protections. Tribal members qualify for comprehensive cost-sharing protections, regardless of the metal level of the plan in which they enroll, and generally receive the greatest value by enrolling in bronze plans, where the premiums are the lowest and the federal government covers the greatest share of health care costs. In contrast, lower-income other IHS-eligible individuals in most cases should enroll in silver plans to

[11] Due to the processes used for determining Indian status, there is more certainty about the accuracy of the "Tribal member" designation versus the "other IHS-eligible" designation. To be identified as a Tribal member, documentation is required; whereas, to be identified as "other IHS-eligible," a self-declaration is made by the enrollee.

[12] Expanded FFM enrollment of Tribal members in Oklahoma accounted for the vast majority of this growth, as enrollment of other IHS-eligible individuals decreased slightly (from 937 to 933) from 2018 to 2019.

gain access to the general cost-sharing protections.[13] As indicated by the graph in **Attachment E** below, the percentage of AI/ANs—particularly Tribal members—who enroll in plans at the "correct" metal level has increased over time.

ACCESS TO COST-SHARING PROTECTIONS

As noted earlier, among AI/AN enrollees, the type of cost-sharing protections for which they qualify depends on whether they meet the ACA definition of Indian and their income level. The graph in **Attachment F** below shows the percentage breakdown of the type of cost-sharing protections received by AI/AN FFM enrollees over time.

Findings: As Figure 4 indicates, the percentage of Tribal member FFM enrollees receiving the comprehensive Indian-specific cost-sharing protections (through either a zero or limited cost-sharing plan) *has increased* over time (from 85% in 2015 to 89% in 2019). The percentage of Tribal member enrollees receiving no cost-sharing protections *has continued to decline* (from 12% in 2015 to 7% in 2019), although those receiving the less-comprehensive "general" cost-sharing protections has increased by 2 percentage points over this period (from 2% to 4%).

This increased access to cost-sharing protections for AI/ANs was a result, in part, of efforts since 2014 by T/TOs and the federal CMS to ensure that eligible Tribal members receive the comprehensive cost-sharing protections to which they are entitled. Still, in 2019, 4,838 eligible Tribal members did not receive comprehensive cost-sharing protections; among these individuals, 3,231 received no cost-sharing protections, and 1,607 received only the general cost-sharing protections.

One potential cause for the loss of comprehensive cost-sharing protections is that some eligible Tribal members enrolled in Marketplace coverage were not aware that they need to enroll in a different plan than their family members who do not qualify for these protections. To address this concern, the TSGAC and the Tribal Technical Advisory Group (TTAG) to CMS in April 2018 recommended that CMS make modifications to on-screen notices that appear during the Marketplace (HealthCare.gov) application process to ensure AI/ANs understand fully the implications of enrolling family members in the same or different plans with respect to their eligibility for cost-sharing protections.[14] Further, the TSGAC asked CMS to encourage Marketplaces that do not use the HealthCare.gov platform to include a similar notice in their application process. With adoption of this change in online information on HealthCare.gov (or SBM equivalents), Tribal representatives anticipated that an even greater percentage of Tribal members would secure one of the two comprehensive cost-sharing variations (zero or limited) and fewer would end up with the cost-sharing reductions available to the general population or no cost-sharing reductions at all.

[13] For other IHS-eligible individuals who have a household income above 250% FPL, and therefore are not eligible for the general cost-sharing protections, enrollment in a gold plan is sometimes the preferred option, as premiums for gold plans can be lower than premiums for silver plans due to the practice of "silver loading."

[14] Specifically, CMS could add pop-up notices to explain the rationale for providing AI/AN Marketplace applicants with the option to enroll family members in the same or different plans and to indicate clearly the impact of enrolling family members who have different eligibility for cost-sharing protections in the same plan (*i.e.*, the loss of eligibility for the comprehensive cost-sharing protections for all AI/AN family members).

In response to these recommendations from the TSGAC and the TTAG, in the summer of 2019, CMS indicated an FAQ in the Learn Tab on HealthCare.gov contains a question specific to a family with both AI/AN and non-AI/AN family members enrolling through the Marketplace. It is reported to indicate the following:

Q. "My household consists of both AI/ANs and non-AI/ANs family members. Can we all enroll in the same Marketplace plan?"

A. "Yes, but you may get less cost sharing reductions than you qualify for. We recommend that AI/ANs and non-AI/ANs enroll in separate plans to take advantage of all potential savings."

A search of HealthCare.gov was not successful in identifying the FAQ. Tribal representatives will continue to engage with CMS to implement the TSGAC / TTAG recommendations.

SUMMARY OF BENEFITS AND COVERAGE (SBC) FOR ZERO AND LIMITED COST-SHARING PLANS

The TSGAC also has continued efforts to ensure that the SBCs prepared by Marketplace plan issuers accurately reflect the comprehensive cost-sharing protections. A TSGAC review in 2018 of SBCs prepared for zero and limited cost-sharing plans offered by eight issuers in four states found a number of inaccuracies, which have the effect of depressing Marketplace enrollment and resulting in eligible Tribal members not securing the comprehensive cost-sharing protections to which they are entitled.[15] After the TSGAC reported the results of this review to CMS, the agency offered trainings to Marketplace plan issuers and state regulators regarding SBCs prepared for zero and limited cost-sharing plans. Continued work on this issue is needed, however; a subsequent review of the same SBCs found that many of the inaccuracies identified in 2018 persisted in 2019. And in at least one state, SBCs for the zero and limited cost-sharing plans were not available at all to potential plan enrollees in 2019.

AI/AN MEDICAID ENROLLMENT

The ACA provided states with the option, beginning in 2014,[16] of expanding their Medicaid programs to cover all residents with a household income at or less than 138% FPL, including many AI/ANs, with the federal government covering 90% of program expenditures on health care services beginning in 2020 and an even greater percentage in the initial years.[17] As of November 5, 2019, 36 states, including 24 with at least one federally-recognized Tribe, and the District of Columbia have adopted the Medicaid expansion.

Attachment G provides data on the number of AI/ANs enrolled in Medicaid in each state. Data were taken from the 2010-2018 American Community Survey (ACS), 1-Year Estimates.[18] For each state, the table shows the number of AI/ANs enrolled in Medicaid coverage annually during the 2010-2018 period, the gain in

[15] The TSGAC report on SBCs is available at https://www.tribalselfgov.org/health-reform/2019-health-actions/.

[16] Under the ACA, states could expand Medicaid prior to 2014 through a State Plan Amendment (SPA), a section 1115 waiver, or a combination of the two. Four states with substantial AI/AN populations—California, Connecticut, Colorado, and Minnesota—expanded their Medicaid programs prior to 2014.

[17] For health services furnished by IHS and Tribal providers to IHS-eligible individuals, the federal government will continue to cover 100% of health service expenditures (100% FMAP).

[18] Data are for "individuals with IHS access," defined as individuals who responded "Yes" to part g of the following question in the 2016 American Community Survey questionnaire: "16. Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans? ... g. Indian Health Service."

Medicaid enrollment during this period, and the estimated remaining number of uninsured AI/ANs who have an income at or less than 138% FPL. It is important to note that the Census ACS data should be viewed as rough estimates of the Medicaid enrollment status of IHS Active Users, as there are discrepancies in the state-by-state counts in the Census data for those identified as "individuals with IHS access" versus the state-by-state counts of IHS Active Users in the IHS National Data Warehouse data set. The IHS is in the process of reviewing the IHS Active User data set to ensure consistent reporting of Active User insurance status across Tribal programs. Once the review is complete, relying on the IHS Active User data set will improve the accuracy of the reported data on Medicaid enrollment status.

Findings:

- Among states with at least one federally-recognized Tribe, AI/AN Medicaid enrollment in expansion states jumped by 135,827, or 47.9%, from 2010 to 2018.
- During the same period, AI/AN Medicaid enrollment increased by 34,213, or only 24.3%, in non-expansion states with at least one federally-recognized Tribe.
- As of 2017, about 50,000 uninsured AI/ANs potentially could qualify for Medicaid if the current non-expansion states with at least one federally-recognized Tribe adopted the expansion; 79% of these uninsured AI/ANs reside in just two states (Oklahoma and South Dakota).
- And, according to Census Bureau data, in expansion states, there are approximately 68,000 uninsured AI/ANs who might be eligible for, but not enrolled in, Medicaid coverage.

Attachment A

Table 1: Enrolled Tribal Members[1] and Other IHS Eligibles with Coverage Through the Federally-Facilitated Marketplace (FFM), by State; 2018 and 2019[2, 3]

State	Enrolled Tribal Members[4]			Other IHS Eligibles[4]			All	
	2018	2019	% Change	2018	2019	% Change	2019 vs. 2018	% Change
Alabama	616	608	-1.3%	1,249	1,076	-13.9%	-181	-9.7%
Alaska	795	913	14.8%	122	101	-17.2%	97	10.6%
Arizona	944	883	-6.5%	624	554	-11.2%	-131	-8.4%
Arkansas	611	621	1.6%	284	255	-10.2%	-19	-2.1%
Delaware	27	23	-14.8%	85	83	-2.4%	-6	-5.4%
Florida	1,230	1,305	6.1%	2,953	2,662	-9.9%	-216	-5.2%
Georgia	361	362	0.3%	1,243	1,177	-5.3%	-65	-4.1%
Hawaii	46	45	-2.2%	162	188	16.0%	25	12.0%
Illinois	319	316	-0.9%	825	695	-15.8%	-133	-11.6%
Indiana	152	159	4.6%	384	322	-16.1%	-55	-10.3%
Iowa	90	83	-7.8%	111	110	-0.9%	-8	-4.0%
Kansas	887	877	-1.1%	469	385	-17.9%	-94	-6.9%
Kentucky	71	80	12.7%	188	180	-4.3%	1	0.4%
Louisiana	225	227	0.9%	440	415	-5.7%	-23	-3.5%
Maine	193	186	-3.6%	253	198	-21.7%	-62	-13.9%
Michigan	1,035	1,049	1.4%	807	717	-11.2%	-76	-4.1%
Mississippi	81	70	-13.6%	141	139	-1.4%	-13	-5.9%
Missouri	751	763	1.6%	954	759	-20.4%	-183	-10.7%
Montana	1,128	1,178	4.4%	219	229	4.6%	60	4.5%
Nebraska	485	583	20.2%	246	253	2.8%	105	14.4%
Nevada	331	338	2.1%	370	302	-18.4%	-61	-8.7%
New Hampshire	33	35	6.1%	137	107	-21.9%	-28	-16.5%
New Jersey	64	66	3.1%	669	591	-11.7%	-76	-10.4%
New Mexico	657	550	-16.3%	207	178	-14.0%	-136	-15.7%
North Carolina	782	854	9.2%	3,034	2,739	-9.7%	-223	-5.8%
North Dakota	586	627	7.0%	96	98	2.1%	43	6.3%
Ohio	146	126	-13.7%	649	524	-19.3%	-145	-18.2%
Oklahoma	17,781	22,666	27.5%	937	933	-0.4%	4,881	26.1%
Oregon	921	993	7.8%	705	670	-5.0%	37	2.3%
Pennsylvania	169	152	-10.1%	1,022	722	-29.4%	-317	-26.6%
South Carolina	245	261	6.5%	635	583	-8.2%	-36	-4.1%
South Dakota	815	786	-3.6%	113	123	8.8%	-19	-2.0%
Tennessee	360	347	-3.6%	865	665	-23.1%	-213	-17.4%
Texas	3,206	3,384	5.6%	3,431	3,272	-4.6%	19	0.3%
Utah	1,066	1,240	16.3%	482	428	-11.2%	120	7.8%
Virginia	353	297	-15.9%	1,380	931	-32.5%	-505	-29.1%
West Virginia	31	24	-22.6%	75	56	-25.3%	-26	-24.5%
Wisconsin	1,027	1,052	2.4%	449	411	-8.5%	-13	-0.9%
Wyoming	247	240	-2.8%	134	134	0.0%	-7	-1.8%
All States	**38,867**	**44,369**	**14.2%**	**27,149**	**23,965**	**-11.7%**	**2,318**	**3.5%**

Source

CMS, "Table 1: American Indian and Alaska Native Applicants and Enrollees in the Federally-Facilitated Marketplace," coverage year 2018-2019 data.

Notes

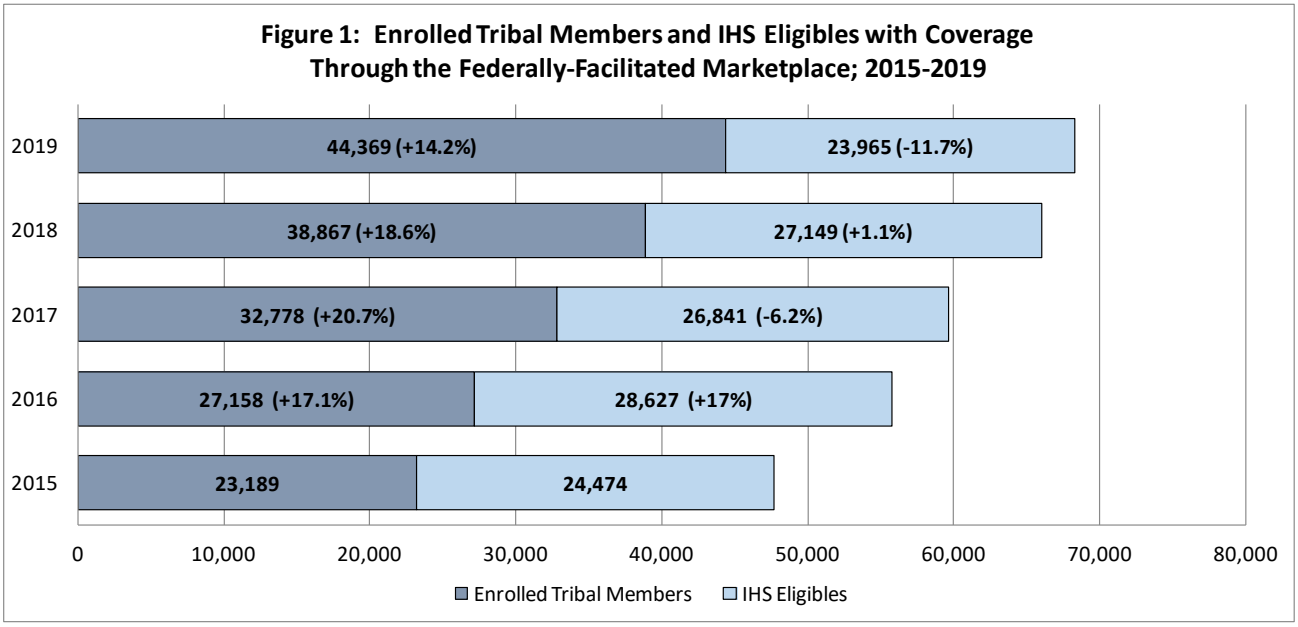
[1] An enrolled Tribal member is an individual who meets the definition of Indian under the Affordable Care Act as a member of an Indian Tribe or shareholder in an Alaska Native regional or village corporation.

[2] Figures are for enrollment on the report run dates in October 2018 and November 2019. Totals include values in suppressed cells.

[3] The FFM includes State-Based Marketplaces on the Federal Platform and State-Partnership Marketplaces.

[4] Enrolled Tribal members are eligible for comprehensive Indian-specific cost-sharing protections; "other IHS eligibles" are not.

Attachment B



Attachment C

Table 2: Enrolled Tribal Members[1] with Zero or Limited Cost-Sharing Reductions (CSRs) in State-Based Marketplaces, 2018-2019[2]
(Suppress Cells <=11)

State	Tribal Members with Zero CSRs			Tribal Members with Limited CSRs			All	
	2018	2019	% Change	2018	2019	% Change	2019 vs. 2018	% Change
California	3,208	3,557	10.9%	997	1,154	15.7%	506	12.0%
Colorado	354	417	17.8%	100	80	-19.8%	43	9.5%
Connecticut	84	77	-8.1%	23	37	61.2%	7	6.8%
District of Columbia	--	**	--	--	**	--	--	--
Idaho	265	321	21.4%	35	46	30.0%	67	22.4%
Maryland	88	45	-49.2%	14	**	--	--	--
Massachusetts	190	204	7.5%	79	90	13.5%	25	9.2%
Minnesota	189	197	3.8%	87	104	19.2%	24	8.6%
New York	130	161	23.7%	64	67	3.9%	33	17.1%
Rhode Island	25	25	-0.7%	**	**	--	--	--
Vermont	**	14	--	**	**	--	--	--
Washington	677	742	9.5%	264	230	-12.7%	31	3.3%
Totals	5,211	5,759	10.5%	1,663	1,807	8.6%	692	10.1%

Source

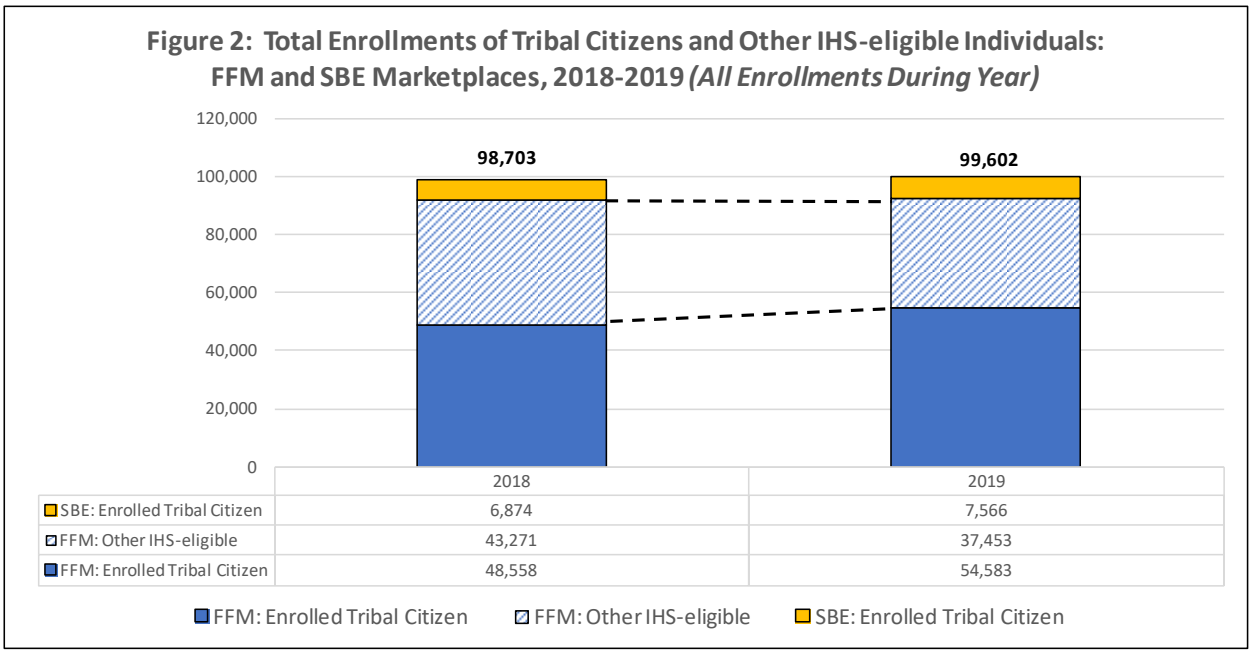
CMS, "Average Effectuated Enrollment (as of October 2018)" (data for State-Based Marketplaces); CMS, "State-Based Marketplace Enrollment of Enrolled Tribal Members, 2019: Average Effectuated Enrollment (as of October 2019)"

Notes

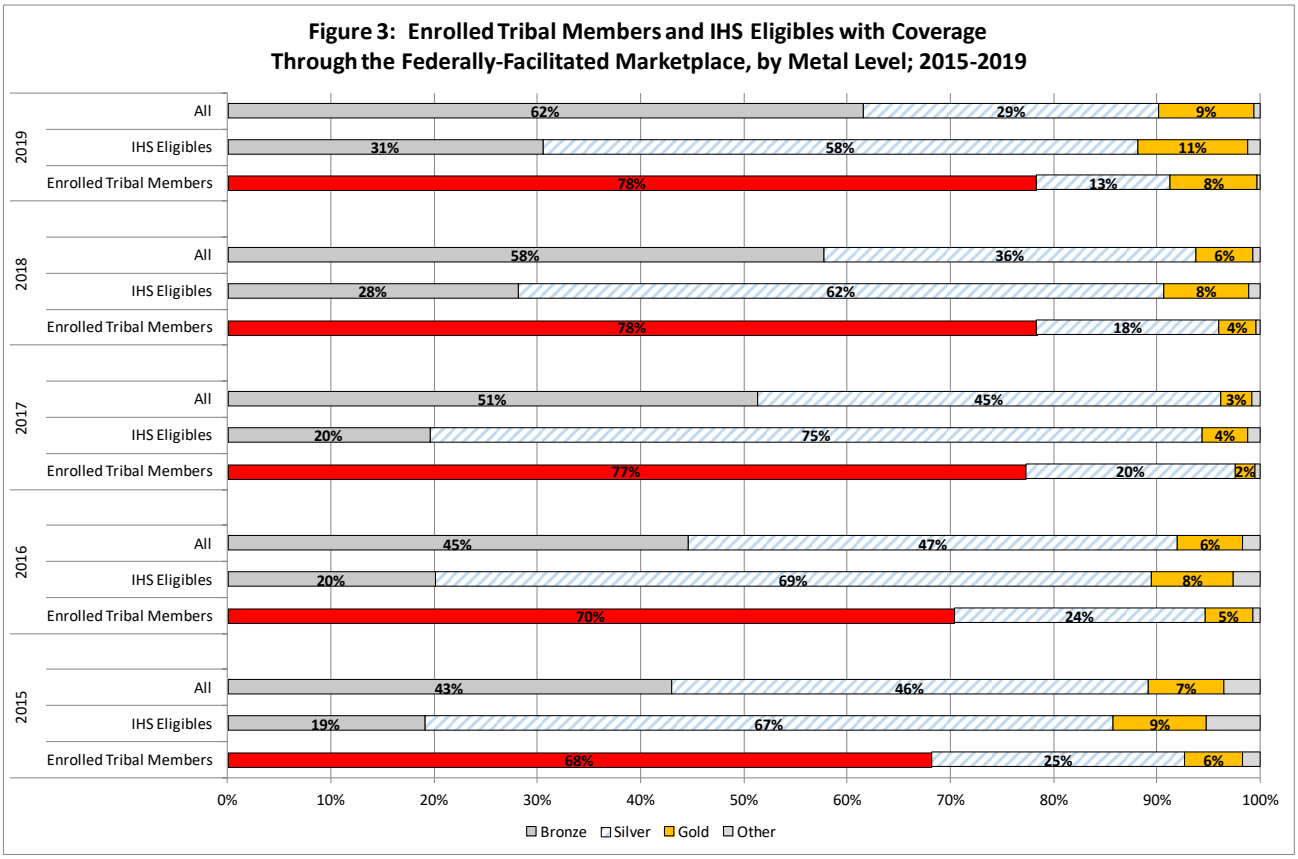
[1] An enrolled Tribal member is an individual who meets the definition of Indian under the Affordable Care Act as a member of an Indian Tribe or shareholder in an Alaska Native regional or village corporation.

[2] Figures are for October 2018 and October 2019.

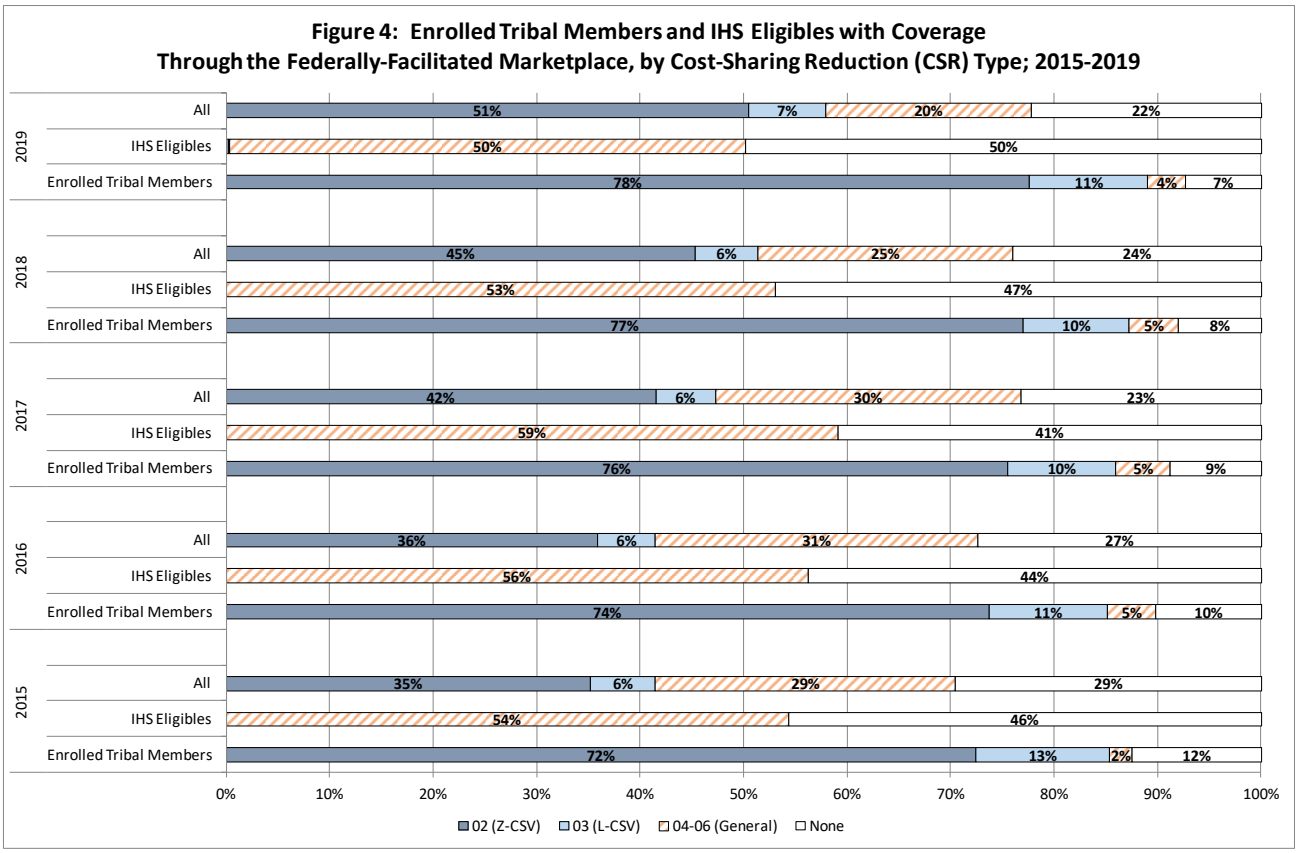
Attachment D



Attachment E



Attachment F



Attachment G

Table 3: Medicaid Enrollment of Individuals with IHS Access, by State; 2010-2018													
State	Federally Recognized Tribe	Medicaid Expansion Status[3]	Medicaid Enrollment of Individuals with IHS Access, by Year[1] (Shading Indicates Year Medicaid Expansion Took Effect, if Implemented)									Change (2010-2018)	Remaining Uninsured[2] (0-138% FPL)
			2010	2011	2012	2013	2014	2015	2016	2017	2018		
Alabama	Yes	No	1,094	1,071	1,370	832	1,858	519	976	761	1,166	72	23
Alaska	Yes	Yes	37,725	31,019	41,335	38,139	39,593	41,605	49,701	44,813	46,584	8,859	4,388
Arizona	Yes	Yes	79,799	63,936	69,972	75,247	92,462	82,234	80,140	91,986	87,262	7,463	22,255
Arkansas	No	Yes	2,379	5,653	2,539	2,254	3,134	2,896	5,966	4,622	2,385	6	626
California	Yes	Yes	26,326	33,002	25,364	33,867	31,416	39,075	40,433	42,422	44,354	18,028	5,352
Colorado	Yes	Yes	3,262	1,407	1,536	2,630	4,074	3,428	4,138	3,655	5,938	2,676	584
Connecticut	Yes	Yes	279	530	1,042	778	98	296	743	192	971	692	0
Delaware	No	Yes	0	0	31	0	165	0	345	0	0	0	0
District of Columbia	No	Yes	161	129	0	95	450	100	0	697	373	212	0
Florida	Yes	No	4,070	3,547	3,632	4,267	4,347	4,505	5,168	5,936	3,068	-1,002	203
Georgia	No	No	2,242	3,224	2,318	1,127	1,131	1,662	2,597	2,922	2,274	32	336
Hawaii	No	Yes	161	832	437	775	296	935	61	355	272	111	0
Idaho	Yes	Authorized	2,636	4,648	3,150	2,667	3,518	4,446	4,412	4,473	4,403	1,767	723
Illinois	No	Yes	3,303	2,450	2,185	1,970	1,886	1,592	2,203	2,229	2,282	-1,021	0
Indiana	Yes	Yes	5,284	5,691	6,085	5,739	7,320	8,440	11,126	10,672	9,892	4,608	2,884
Iowa	Yes	Yes	1,610	651	780	1,681	937	3,015	1,742	1,243	1,953	343	0
Kansas	Yes	No	2,644	3,121	2,594	1,782	3,266	2,191	2,250	4,851	4,431	1,787	621
Kentucky	No	Yes	1,224	347	220	1,140	268	788	1,763	2,351	1,963	739	0
Louisiana	Yes	Yes	782	746	1,418	1,019	1,611	1,291	2,077	1,363	1,319	537	199
Maine	Yes	Yes	2,166	3,021	2,760	2,502	1,476	2,383	1,891	1,624	1,511	-655	125
Maryland	No	Yes	1,030	648	1,478	594	431	1,349	704	730	1,532	502	0
Massachusetts	Yes	Yes	1,830	1,598	1,693	2,341	1,851	1,825	2,854	833	1,579	-251	0
Michigan	Yes	Yes	9,966	6,915	8,611	8,844	8,954	9,779	11,601	11,455	13,678	3,712	2,087
Minnesota	Yes	Yes	12,825	14,222	12,945	15,459	14,772	15,006	18,043	17,231	19,226	6,401	4,290
Mississippi	Yes	No	2,690	3,524	2,681	4,146	2,342	3,289	3,731	3,794	5,065	2,375	1,444
Missouri	No	No	1,502	474	1,485	3,171	3,002	1,512	1,092	2,891	2,027	525	923
Montana	Yes	Yes	18,139	14,288	17,996	18,748	17,945	17,773	22,302	20,713	23,795	5,656	4,496
Nebraska	Yes	Authorized	3,038	2,692	2,789	3,532	2,510	3,007	3,571	4,734	4,942	1,904	392
Nevada	Yes	Yes	4,120	6,494	4,923	4,368	5,690	5,875	5,968	7,442	8,150	4,030	805
New Hampshire	No	Yes	515	92	98	209	0	0	816	0	233	-282	47
New Jersey	No	Yes	2,164	1,407	522	696	794	2,207	1,907	398	2,061	-103	801
New Mexico	Yes	Yes	38,991	47,152	47,417	54,807	60,674	75,784	70,802	87,899	95,884	56,893	12,641
New York	Yes	Yes	6,601	10,210	8,410	8,025	7,852	7,609	8,989	10,299	8,023	1,422	1,108
North Carolina	Yes	No	3,925	3,876	3,955	3,986	5,543	5,203	3,557	4,209	3,444	-481	486
North Dakota	Yes	Yes	7,542	8,119	7,741	12,293	10,324	12,962	12,981	10,172	8,511	969	2,042
Ohio	No	Yes	1,786	1,583	2,311	1,832	1,794	2,546	2,423	1,422	1,857	71	0
Oklahoma	Yes	No	70,818	70,000	77,084	82,333	71,713	74,865	84,544	79,125	84,617	13,799	30,259
Oregon	Yes	Yes	6,657	10,594	11,964	10,473	11,340	10,156	13,214	10,389	10,582	3,925	966
Pennsylvania	No	Yes	3,408	1,649	1,561	4,003	2,908	2,852	3,431	2,627	3,355	-53	0
Rhode Island	Yes	Yes	862	69	50	64	203	938	0	584	228	-634	0
South Carolina	Yes	No	1,399	997	3,194	2,058	621	2,338	1,102	1,200	1,499	100	125
South Dakota	Yes	No	23,824	31,067	29,797	28,875	25,617	26,575	30,798	32,275	36,375	12,551	9,135
Tennessee	No	No	694	857	1,141	505	843	1,291	1,537	930	2,208	1,514	0
Texas	Yes	No	7,726	8,051	5,967	8,060	4,200	6,058	9,803	8,272	10,383	2,657	1,700
Utah	Yes	Authorized	4,168	2,639	2,451	4,209	2,313	4,828	3,955	3,231	2,953	-1,215	917
Vermont	No	Yes	311	298	144	27	0	0	0	882	0	-311	0
Virginia	Yes	Yes	779	1,828	1,170	2,611	1,016	1,466	2,924	985	1,954	1,175	0
Washington	Yes	Yes	17,925	21,171	19,669	19,469	21,990	24,782	26,331	23,004	27,903	9,978	3,692
West Virginia	No	Yes	421	378	187	360	97	719	394	382	359	-62	0
Wisconsin	Yes	No	9,231	9,463	7,849	9,390	10,556	8,975	10,676	12,902	9,119	-112	3,528
Wyoming	Yes	No	3,301	4,471	3,064	2,876	2,487	1,495	4,410	3,463	3,312	11	388
TOTAL (Expansion States)			**300,333**	**298,129**	**304,594**	**333,059**	**353,821**	**381,706**	**408,013**	**415,671**	**435,969**	**135,636**	**69,388**
Expansion States with Tribe			283,470	282,663	292,881	319,104	341,598	365,722	388,000	398,976	419,297	135,827	67,914
Expansion States with no Tribe			16,863	15,466	11,713	13,955	12,223	15,984	20,013	16,695	16,672	-191	1,474
TOTAL (Non-Expansion)			**145,002**	**153,722**	**154,521**	**163,816**	**145,867**	**152,759**	**174,179**	**175,969**	**181,286**	**36,284**	**51,203**
Non-Expansion States with Tribe			140,564	149,167	149,577	159,013	140,891	148,294	168,953	169,226	174,777	34,213	49,944
Non-Expansion States with no Tribe			4,438	4,555	4,944	4,803	4,976	4,465	5,226	6,743	6,509	2,071	1,259
GRAND TOTAL			**445,335**	**451,851**	**459,115**	**496,875**	**499,688**	**534,465**	**582,192**	**591,640**	**617,255**	**171,920**	**120,591**

Notes:

[1] Census Bureau, 2010-2018 American Community Survey, 1-Year Estimates. Montana and Louisiana implemented the Medicaid expansion in January 2016 and July 2016, respectively. Maine approved the Medicaid expansion through a ballot initiative in November 2017 but the then-governor did not set a date for implementation; the newly elected governor on January 3, 2019, signed an executive order directing the state Department of Health and Human Services to begin implementation of the expansion and provide coverage to eligible residents retroactive to July 2018. Virginia approved the Medicaid expansion as part of its FY 2019-2020 budget in June 2018, with implementation planned for January 1, 2019. Shading indicates the year the Medicaid expansion went into effect, if any.

[2] Analysis of Census Bureau, 2018 American Community Survey, 1-Year Estimates. Figures assume that all individuals live in a 3-person household.

[3] In November 2018, Idaho, Nebraska, and Utah authorized the Medicaid expansion (shown in green) through ballot initiatives. These states are identified as "Authorized" and counted among non-Medicaid expansion states. In addition, lawmakers in Kansas and Wisconsin have indicated a likelihood of authorizing Medicaid expansion.