The Affordable Care Act and
American Indians and Alaska Natives:
What Did We Expect, and What Did We Get?

Edward J. Fox, PhD

Policy Paper (Final) — Originally presented April 2016 | Updated 2025
March 2026

Carved mask, gift to the author from the Port Gamble S'Klallam Tribe

Executive Summary

The Affordable Care Act (ACA) of 2010 included specific provisions designed to reduce the historically high rates of uninsurance among American Indians and Alaska Natives (AI/ANs). Before implementation, analysis suggested that as many as 80% of AI/ANs would be eligible for free or subsidized coverage through Medicaid expansion or Exchange health plans.

The record is mixed. Medicaid expansion produced real and significant coverage gains — particularly in states that expanded early and had large reservation-based AI/AN populations. Exchange health plan (QHP) enrollment, by contrast, fell far short of projections. As of 2015, only approximately 50,000 AI/ANs — roughly 10% of eligible uninsured — had enrolled in QHPs through federal and state marketplaces. The reasons are structural, legal, and administrative, and several remain unresolved.

Pre-ACA (2011): ~1.1 million uninsured AI/ANs; by 2014, estimated ~950,000
Medicaid: Enrollment gains of 10–50%+ in early expansion states; blocked in opt-out states
QHP/Exchange: ~50,000 enrolled of ~500,000 eligible — approximately 10% take-up
Tribal sponsorship: A promising tool, but limited to ~150–175 sponsored in Washington (2016)
Primary barriers: Restrictive definition of "Indian," Supreme Court opt-out ruling, trust responsibility resistance

1. Background: The Pre-ACA Landscape

Before the ACA, AI/ANs had the highest uninsured rates of any racial or ethnic group in the United States. In 2011, an estimated 1.1 million AI/ANs lacked health insurance — a rate roughly twice that of the general U.S. population. The Indian Health Service (IHS) provided direct care to approximately 2 million of the 5 million AI/ANs nationally, at a total annual appropriation of roughly $4.5 billion. Critically, IHS is not health insurance: it functions as a provider of last resort, funded at levels that cover only a fraction of estimated need.

Table 1. Income Distribution of Uninsured AI/ANs, 2011 (Fox and Boerner Estimates)

Income Group	Estimated Population	Primary Coverage Pathway
Under 139% FPL	~517,000	Medicaid expansion (if state expanded)
139%–400% FPL	~500,000	Exchange QHPs with subsidies and cost-sharing

Over 400% FPL	Smaller share	Private/employer-sponsored insurance

2. What We Expected

2.1 Medicaid Expansion

The original legislation required all states to expand Medicaid to adults up to 139% of FPL, effective 2014. For AI/ANs — a population disproportionately concentrated at low incomes — this provision held the greatest promise. Expectations included coverage of all AI/ANs with income under 139% FPL in all 50 states, simplified enrollment procedures, and nationally the enrollment of the ~517,000 AI/ANs below 139% FPL, generating over $2 billion in new Medicaid-financed health care services for Indian health programs.

The 100% Federal Medical Assistance Percentage (FMAP) for services provided through IHS and Tribal facilities added a fiscal amplifier: every Medicaid dollar enrolled through Indian health programs would be fully federally funded, relieving states of their normal matching share.

2.2 Exchange / Qualified Health Plans

For AI/ANs with incomes between 139% and 400% of FPL, the Exchanges offered subsidized QHPs with special protections: no cost-sharing for AI/ANs at or below 300% of FPL; a special monthly enrollment period; and premium tax credits scaling with income. Approximately 44% of all AI/ANs were projected eligible for QHP subsidies and cost-sharing exemptions.

2.3 Tribal Sponsorship

Some tribes developed a third pathway: sponsorship, in which a tribe or tribal organization purchases QHP coverage on behalf of tribal members. Sponsorship was attractive because it allowed tribes to leverage the 100% FMAP provision — by enrolling members in QHPs whose premiums the tribe paid, claims for IHS and Tribal facility services could still be billed to Medicaid at the full federal match rate.

3. What We Got: Results Through 2016

3.1 Medicaid Expansion: Partial Success, Structurally Blocked

The Supreme Court's 2012 ruling in NFIB v. Sebelius transformed Medicaid expansion from a mandate into a state option. States with the largest and most reservation-concentrated AI/AN populations — Oklahoma, South Dakota, Wyoming — chose not to expand, leaving hundreds of thousands of AI/ANs in a coverage gap below QHP eligibility thresholds. Where states did expand, results were meaningful.

Table 2. Medicaid Expansion Status and AI/AN Impact, Selected States, 2016

State	Expansion Year	AI/AN Result (2016)	Notes
Washington	2014	Strong gains; +3,000 enrollees 2013–2014	Early expander; state-Tribal collaboration
Arizona	2014	Significant gains	Large reservation-based population
New Mexico	2014	Significant gains	High AI/AN % of Medicaid population
Alaska	2015	Gains; reduced sponsorship need	Reduced QHP sponsorship after expansion
Oklahoma	Non-expansion (2016)	Blocked; large coverage gap	Large AI/AN pop. excluded
South Dakota	Non-expansion (2016)	Blocked; large coverage gap	High % Medicaid pre-ACA; expansion pending

3.2 Exchange / QHP Enrollment: A Significant Shortfall

QHP enrollment among AI/ANs fell far short of projections. As of 2015, HHS reported approximately 29,000 AI/AN enrollees through the federal Healthcare.gov platform; state-based exchanges added an estimated 21,000 additional. Total estimated QHP enrollment: ~50,000 of approximately 500,000 eligible AI/ANs — a 10% take-up rate. In Washington State, approximately 17,000 AI/ANs were estimated eligible; actual 2015 enrollment was approximately 1,150 — about 7%.

Why QHP enrollment was so low:

1. Restrictive definition of "Indian": Federal exchanges required tribal enrollment to qualify for AI/AN cost-sharing protections — excluding IHS-eligible descendants not enrolled in a federally recognized tribe.

2. Family definition complexity: Split-plan enrollments forced on households with mixed Indian/non-Indian membership, raising costs and administrative burden.

3. The "family glitch": The ACA's affordability test applied to the employee's own coverage, not family coverage, making many family members ineligible for subsidies.

4. Trust responsibility resistance: Some AI/ANs objected to participating in a means-tested federal program on grounds that the trust responsibility means they should not have to qualify through income testing.

5. IHS as partial substitute: AI/ANs with IHS access face reduced urgency to enroll even when QHP enrollment would benefit the broader tribal program.

3.3 Tribal Sponsorship: Promising but Limited

Sponsorship programs demonstrated proof of concept but reached only a small fraction of eligible AI/ANs. In Washington State, approximately 150–175 AI/ANs were sponsored across 8 tribes — Port Gamble S'Klallam (22), Lower Elwha (25), and Jamestown S'Klallam (approximately 25) among the active sponsors. In Alaska, approximately 700 were sponsored in 2015, a number declining after Medicaid expansion reduced the urgency.

4. Structural Factors Explaining the Gap

4.1 The Supreme Court Decision

The single largest deviation from expectations was the Supreme Court's ruling that Medicaid expansion was optional. Projections assumed 50-state expansion. The opt-out states included some of the highest AI/AN-population states, effectively excluding their AI/AN populations from the single most accessible coverage pathway.

4.2 The Two Definitions of "Indian"

The ACA's Exchange provisions used a narrower definition of "Indian" than the Medicaid definition. The Medicaid statutory definition of "Indian" is broader than the IHS eligibility standard: it covers descendants of enrolled tribal members and, by statute (25 U.S.C. § 1603), members of terminated tribes. The Medicaid definition therefore includes individuals eligible for IHS services as well as some who are not. The Exchange definition required current enrollment in a federally recognized tribe — excluding a large share of IHS-eligible patients from the most attractive QHP provisions.

4.3 The 100% FMAP Rule Expansion (A Positive Development)

In February 2016, CMS issued a new rule extending 100% federal reimbursement to states for all AI/AN patients — enrolled tribal members and descendants alike — receiving services through IHS or Tribal health facilities. This expanded the fiscal incentive for state Medicaid programs to invest in AI/AN enrollment outreach.

5. Longer-Term Context: 2023 Update

The national AI/AN uninsured rate fell from approximately 29–32% pre-ACA to approximately 20% by 2022, a reduction of 10–12 percentage points. AI/ANs continue to have the highest uninsured rate of any racial or ethnic group. In states with early Medicaid expansion (2014), AI/AN uninsured rates fell substantially more than in non-expansion states. Late expansion states (Oklahoma 2021, South Dakota 2023) are beginning to show gains, validating the core expectation that Medicaid expansion is the primary driver of AI/AN coverage improvement.

QHP enrollment has grown modestly. During the 2023 open enrollment period, 66,016 AI/ANs enrolled through federal and state Marketplaces — up from approximately 50,000 in 2015, but still a small fraction of the eligible population. The fundamental structural issues — non-expansion states, definition of Indian, and IHS as a partial alternative to enrollment — remain the binding constraints on further AI/AN coverage gains.

6. What's Next: Remaining Policy Agenda

6.1 Medicaid Expansion in Remaining Non-Expansion States

States with large AI/AN populations that have not expanded Medicaid — including Wyoming and others — represent the largest remaining coverage gap.

6.2 Unified Definition of "Indian"

Aligning the Exchange definition of "Indian" with the Medicaid definition would extend cost-sharing protections and monthly enrollment periods to the full IHS-eligible population, including descendants of enrolled members.

6.3 Sustained Outreach Funding

QHP take-up at 10% is not a success. Sustained, tribally-led enrollment and outreach funding — including support for navigators embedded in Tribal health programs — is necessary until take-up reaches levels commensurate with eligibility.

6.4 Research and Monitoring

Systematic monitoring of AI/AN enrollment by state, income category, and program type remains inadequate. The NIHB CMS–IHS Data Match (2023) represents a significant advance in administrative data capacity, but annual reporting on QHP and Medicaid enrollment for AI/ANs at the state level remains incomplete.

Conclusion

The ACA produced real coverage gains for American Indians and Alaska Natives. Medicaid expansion, where it occurred, worked largely as expected, and the 100% FMAP provision created a fiscal structure that makes AI/AN Medicaid enrollment financially beneficial for states as well as beneficial for Indian health programs. But the law also fell short of its potential. The Supreme Court's opt-out ruling blocked coverage in states with some of the most AI/AN-dense populations. QHP enrollment reached only 10% of eligible AI/ANs — a result attributable to structural design flaws, operational failures, and the partial alternative that IHS provides.

The larger lesson is that general coverage expansions — even when they include AI/AN-specific provisions — do not automatically reach Indian Country. Coverage gains in AI/AN communities require sustained, tribally-led outreach; legal definitions that match the IHS-eligible population; and fiscal structures that give states and tribes a shared interest in enrollment.

Key Sources

Fox, E. (2016, April 6). The Affordable Care Act: What did we expect? What did we get? What's next? Presentation to the Skokomish Tribe, Region X HHS, Seattle, WA.

Fox, E., & Boerner, V. (2011–2014). State-level analyses of AI/AN insurance coverage and ACA eligibility [unpublished analyses]. Northwest Portland Area Indian Health Board.

Kaiser Family Foundation (KFF). (2022). Key data on health and health care for American Indian or Alaska Native people.

National Indian Health Board (NIHB). (2023). CMS–IHS Data Match: Medicaid enrollment and expenditures for AI/AN IHS-access population.

U.S. Department of Health and Human Services, ASPE. (2022). Coverage and access for American Indians and Alaska Natives: ACA impacts.

Centers for Medicare & Medicaid Services (CMS). (2016, February). Final rule: 100% federal medical assistance percentage for services to AI/ANs through Indian health programs.

NFIB v. Sebelius, 567 U.S. 519 (2012).