United States Government Accountability Office

Report to Congressional Addressees

September 2013

INDIAN HEALTH SERVICE

Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment

GAO-13-553

GAO Highlights

Highlights of GAO-13-553, a report to congressional addressees

September 2013

INDIAN HEALTH SERVICE

Most American Indians and Alaska Natives Potentially Eligible for Expanded Health Coverage, but Action Needed to Increase Enrollment

Why GAO Did This Study

IHS provides care to American Indians and Alaska Natives through a system of health care facilities. PPACA provides states the option to expand their Medicaid programs and creates new health care coverage options, including for American Indians and Alaska Natives, beginning in 2014. PPACA also requires GAO to study IHS's coordination with public programs. In this report, GAO (1) estimated the number of American Indians and Alaska Natives potentially eligible for the expanded and new coverage options and (2) reviewed efforts by IHS, CMS, states, tribal organizations, and facilities to promote enrollment of American Indians and Alaska Natives in current programs and expanded and new coverage options, and any challenges associated with their enrollment.

To address the objectives, GAO (1) analyzed U.S. Census Bureau data and (2) interviewed IHS and CMS officials and state, facility, and tribal officials from three IHS areas with high levels of uninsured.

What GAO Recommends

GAO recommends that IHS and CMS coordinate to improve communication with facility staff and tribal leaders and increase outreach; that IHS realign its capacity to prepare for increased enrollment; and that CMS address issues related to sharing members' coverage status with their tribes.

HHS agreed with the recommendation to improve communication and outreach, but did not agree or disagree with the other two recommendations. GAO believes preparing for increased enrollment and addressing issues related to coverage status is important.

View GAO-13-553. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

GAO estimates, on the basis of recent U.S. Census Bureau data, that most American Indians and Alaska Natives will be potentially eligible for either expanded or new coverage options created by the Patient Protection and Affordable Care Act (PPACA). These options include expanded eligibility for Medicaid—the federal-state program for certain low-income individuals—and eligibility for the Health Insurance Exchanges (Exchanges), which are marketplaces where health insurance plans can be compared and purchased. While it is still unclear which states will opt to expand Medicaid, their decisions may affect a large proportion of American Indians and Alaska Natives, as GAO estimates that potential new enrollment could include about a quarter of this population. For example, in the Oklahoma City area—one of the Indian Health Service's (IHS) 12 federally designated service areas—tens of thousands of American Indians and Alaska Natives could be affected by the state of Oklahoma's decision not to expand its Medicaid program. For the Exchanges, GAO found that more than one-third of American Indians and Alaska Natives are potentially eligible for premium tax credits in the Exchanges—which help offset the cost of premiums for low-income individuals—and nearly one-third are below the income threshold for cost-sharing exemptions, which are limited to enrolled members of federally recognized tribes.

Some efforts have been made by IHS, the Centers for Medicare & Medicaid Services (CMS), and three states with high levels of uninsured to facilitate Medicaid enrollment through training of facility staff and conducting outreach for current public programs. However, uncertainty related to legal and policy decisions, lack of capacity building, unfamiliarity with expanded and new coverage options, and limited access to information present challenges to education and enrollment in expanded and new coverage options. While IHS and CMS have reported providing basic training on expanded Medicaid and the Exchanges, most of the facilities and tribes GAO interviewed said they received little or no information from IHS or CMS, as of February 2013. Many of the officials GAO interviewed—from federal agencies, state Medicaid programs, and facilities—said they delayed outreach and enrollment activities because of the uncertainty related to the Supreme Court decision about PPACA and states' subsequent decisions about expanding Medicaid that were both pending at the time of GAO's review. Although a Supreme Court decision had been issued and some state decisions had been made, IHS had not developed a plan to increase enrollment and billing capacity to accommodate the hundreds of thousands of American Indians and Alaska Natives potentially eligible for expanded and new coverage options. IHS officials told GAO, however, that the agency distributed a "business plan template" that directs IHS-operated facilities to plan for their community outreach and staff training needs in preparation for expanded Medicaid and the Exchanges. This plan was to be submitted in May 2013. Additionally, some tribes noted that their Medicaid outreach efforts could be more targeted and effective if they had information from states about their members' Medicaid coverage status.

Contents

Letter		1
	Background	9
	Most American Indians and Alaska Natives Will Be Potentially Eligible for Expanded Medicaid and New Coverage Options; States' Decisions Will Affect Coverage for Many	19
	Efforts Have Been Made to Enroll American Indians and Alaska Natives in Current Medicaid Programs, but Multiple Barriers May Hinder Enrollment in Expanded Medicaid and New Coverage Options	29
	Conclusions	38
	Recommendations for Executive Action	39
	Agency Comments and Our Evaluation	40
Appendix I	Methodology for Estimating Potential Eligibility for American Indians and Alaska Natives in Expanded Health Coverage	43
Appendix II	Estimates of Potential Medicaid Eligibility for American Indians and Alaska Natives, by Indian Health Service (IHS) Area	50
Appendix III	Potential Eligibility for Expanded Health Coverage in 2014, Nationally, by IHS Service Area, and by State	51
Appendix IV	Comments from the Department of Health and Human Services	64
Appendix V	GAO Contact and Staff Acknowledgments	68
Related GAO Products		69

Tables

Table 1: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid in 2014 21
Table 2: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for the Basic Health Program Option and for Cost-Sharing and Premium Tax Credits under the Health Insurance Exchanges 28
Table 3: Estimates of the Number and Percentage of All Races Potentially Eligible for Expanded Medicaid in 2014, by Indian Health Service (IHS) Service Area 52
Table 4: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid in 2014, by State 53
Table 5: Estimates of the Number and Percentage of All Races Potentially Eligible for Expanded Medicaid in 2014, by State 55
Table 6: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for the Basic Health Program Option in 2015, and Cost-Sharing Exemptions and Premium Tax Credits under the Health Insurance Exchanges in 2014, by Indian Health Service (IHS) Service Area 57
Table 7: Estimates of the Number and Percentage of All Races Potentially Eligible for the Basic Health Program Option in 2015 and Premium Tax Credits under the Health Insurance Exchanges in 2014, by Indian Health Service (IHS) Service Area 58
Table 8: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for the Basic Health Program Option in 2015, and Cost-Sharing Exemptions and Premium Tax Credits under the Health Insurance Exchanges in 2014, by State 59
Table 9: Estimates of the Number and Percentage of All Races Potentially Eligible for the Basic Health Program Option in 2015 and Premium Tax Credits under the Health Insurance Exchanges in 2014, by State 62

Figures

Figure 1: The 12 IHS Service Areas, Shown with Contract Health Service Delivery Area (CHSDA) Counties Included in Each Area 11
Figure 2: Relationship between American Indians and Alaska Natives as Self-Reported to the Census, for IHS Eligibility, and for Tribal Membership 13
Figure 3: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid in 2014, by IHS Service Area 23
Figure 4: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid in 2014 for IHS Service Areas and Non-IHS Service Areas 25

Abbreviations

ACS	American Community Survey
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHS	Contract Health Services
CHSDA	Contract Health Service Delivery Area
CMS	Centers for Medicare & Medicaid Services
FPL	federal poverty level
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IHS	Indian Health Service
IPUMS	Integrated Public Use Microdata Series
I/T/U	IHS facilities, tribal facilities, and urban Indian health programs
ISDEAA	Indian Self-Determination and Education Assistance Act
PPACA	Patient Protection and Affordable Care Act
PUMA	Public Use Microdata Areas

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

September 5, 2013

The Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS), is responsible for providing health care for approximately 2.1 million American Indians and Alaska Natives who are members or descendants of federally recognized tribes.[1] IHS provides this care through a system of health care facilities (facilities) managed by IHS, tribal organizations, or urban Indian health programs. However, American Indians and Alaska Natives have experienced long-standing problems accessing needed services, due in part to IHS funding constraints.[2] Many users of IHS services are also eligible for public insurance programs—Medicaid, the Children's Health Insurance Program (CHIP), and Medicare[3]—which are overseen by another HHS agency, the Centers for Medicare & Medicaid Services (CMS). Enrollment of eligible American Indians and Alaska Natives in these public programs can improve access to health care by providing them with benefits more comprehensive than available through IHS and can also reduce pressure on IHS's budget. In its 2014 budget justification, IHS stated that reimbursements from public and private insurance are a significant part of IHS and tribal budgets and provide increased access to health services for American Indians and Alaska Natives.[4] While both IHS and CMS have conducted outreach in the past to increase enrollment in public insurance

[1]IHS defines an Indian tribe as any Indian tribe, band, nation, group, Pueblo, or community, including any Alaska Native village or Native group, which is federally recognized as eligible for the programs and services provided by the United States to Indians because of their status as Indians.

Individuals are eligible for IHS services if they are considered American Indians and Alaska Natives by the community in which they live, as evidenced by factors such as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors. See 42 C.F.R. § 136.12.

[2]See GAO, *Indian Health Service: Health Care Services Are Not Always Available to Native Americans*, GAO-05-789 (Washington, D.C.: Aug. 31, 2005). See also the Related GAO Products page at the end of this report.

[3]Medicaid is a joint federal–state program that finances health insurance coverage for certain categories of low-income individuals. CHIP, also a joint federal–state insurance program, provides coverage to children whose family income is low, but too high for Medicaid. Medicare is the federal health insurance program for individuals age 65 and over and for individuals with certain disabilities or end-stage renal disease.

[4]Indian Health Service, "Justification of Estimates for Appropriations Committees, Fiscal Year 2014" (Rockville, Md., 2013).

programs, participation of American Indians and Alaska Natives in Medicaid and CHIP has been relatively low.[5]

The Patient Protection and Affordable Care Act (PPACA) expanded or created new health care coverage options that may benefit American Indians and Alaska Natives.[6]

- Medicaid eligibility will expand in 2014, in states opting to participate. This expansion will apply to Americans with incomes at or below 138 percent of the federal poverty level (FPL),[7] including previously ineligible categories such as childless adults.[8]

[5]For example, see Genevieve M. Kenney et al., "Who and Where are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" *Health Affairs*, vol. 29, no. 10 (2010).

HHS included in its Action Plan to Eliminate Racial and Ethnic Health Disparities the goal of increasing the health insurance coverage rate among racial and ethnic minorities as a means of eliminating health disparities.

[6]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. For purposes of this report, references to PPACA include the amendments made by the Health Care and Education Reconciliation Act of 2010. Unless otherwise noted, we use "expanded and new coverage options" to refer to expanded Medicaid and the new coverage options created by PPACA, specifically premium tax credits and exemptions from cost-sharing available for insurance obtained through Exchanges and the Basic Health Program.

[7]PPACA established 133 percent of the FPL as the income limit for expanded Medicaid eligibility; however, it also specifies that an income disregard in the amount of 5 percent of the FPL be deducted from an individual's income when determining Medicaid eligibility, which effectively raises the eligibility limit for newly eligible Medicaid recipients to 138 percent of the FPL. See Pub. L. No. 111-148, §§ 2001(a)(1), 2002, 124 Stat. 119, 271, 279 (2010); Pub. L. No. 111-152, § 1004, 124 Stat. 1029, 1034 (2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) and to be codified at 42 U.S.C. § 1396a(e)(14)(I)).

[8]The U.S. Supreme Court ruled in June 2012 that states choosing not to expand Medicaid coverage to individuals eligible under PPACA will forgo only the federal matching funds associated with such expanded coverage, rather than be subject to a termination of all Medicaid federal matching funds. See *Nat'l Fed'n of Indep. Bus. v Sebelius*,132 S.Ct. 2566 (2012).

- Health Insurance Exchanges (Exchanges)[9] will also be established in 2014, with enrollment beginning in October 2013. PPACA provides for a federal premium tax credit for eligible individuals obtaining insurance through the Exchanges with incomes between 100 and 400 percent of the FPL, and certain American Indians and Alaska Natives are also eligible for cost-sharing exemptions if they have incomes at or below 300 percent of the FPL.[10]

- In 2015, states will have the option of implementing the new "Basic Health Program," under which the federal government is to give states 95 percent of the premium tax credits and cost-sharing subsidies that would have been provided if the individuals had been enrolled through the Exchanges, to allow the states to provide coverage to certain low-income residents with incomes between 138 and 200 percent of the FPL, who—despite the expansion of Medicaid and establishment of Exchanges—might otherwise go uninsured.

---

[9]Exchanges are health insurance marketplaces in which individuals and small businesses will be able to compare, select, and purchase health coverage from among participating carriers. Exchanges are also referred to by HHS as Marketplaces. PPACA directed states to establish state-based Exchanges by January 1, 2014. In states electing not to establish and operate such an Exchange, PPACA requires the federal government to establish and operate an Exchange in the state, referred to as a Federally Facilitated Exchange. Pub. L. No. 111-148, §§ 1311(b)(1), 1321(c), 124 Stat. 119, 173, 186 (2010). CMS provided states in which a Federally Facilitated Exchange will operate the option to participate in a variation of a Federally Facilitated Exchange, called a Partnership Exchange, in which the state would assist CMS in carrying out certain Exchange activities.

[10]American Indians and Alaska Natives who obtain insurance through an Exchange are eligible for cost-sharing exemptions if they are members of federally recognized tribes and have a household income of not more than 300 percent of the FPL. Pub. L. No. 111-148, § 1402(d)(1), 124 Stat. 119, 222 (2010) (codified at 42 U.S.C. § 18071).

Although PPACA generally requires that individuals obtain health insurance or be subject to a federal tax—a requirement often referred to as the individual mandate—American Indians and Alaska Natives who are members of federally recognized tribes are statutorily exempt. See Pub. L. No. 111-148, §§ 1501(b),10106, 124 Stat. 119, 244, 909 (2010); Pub. L. No. 111-152, §§ 1002, 1004, 124 Stat. 1029, 1032, 1034 (2010) (codified at 26 U.S.C. § 5000A). Additionally, a final rule released June 26, 2013, established additional exemptions to the individual mandate under HHS's authority to establish hardship exemptions, including for individuals eligible for IHS services, who are not members of federally recognized tribes, and for individuals living in states that chose not to expand Medicaid eligibility but who would otherwise qualify for it. 78 Fed. Reg. 39,494 (July 1, 2013).

Although reimbursements from Medicaid or insurance obtained through an Exchange or Basic Health Program have the potential to alleviate some constraints on the IHS budget, eligible individuals must first be aware of and enroll in these programs and options, and choose to receive care through IHS.[11] PPACA required that GAO examine IHS's coordination of health care services provided through other public insurance programs.[12] This report specifically focuses on the expanded and new coverage options soon to be available to American Indians and Alaska Natives. This report

1. estimates the number of American Indians and Alaska Natives potentially eligible for the expanded and new coverage options and
2. reviews efforts by IHS, CMS, states, tribal organizations, and facilities to promote enrollment of American Indians and Alaska Natives in current programs and the expanded and new coverage options, and any challenges associated with their enrollment.

To estimate the number of American Indians and Alaska Natives potentially eligible for the expanded and new coverage options, we examined data from the American Community Survey (ACS)[13] of the U.S. Census Bureau, which contains information on race, age, income, and health insurance coverage, among other variables, for millions of households. In order to capture the appropriate family ties and income for

---

[11]The availability of more coverage options for American Indians and Alaska Natives could alleviate constraints on the IHS budget both by increasing reimbursements for services provided by IHS to enrolled individuals and by allowing American Indians and Alaska Natives more options for care, potentially resulting in fewer American Indians and Alaska Natives seeking care through Indian health facilities.

[12]See Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935 (2010) (enacting S. 1790, as reported by the Committee on Indian Affairs in the Senate in December 2009, into law with amendments); S. 1790, 111th Cong. § 199(a) (2009) (codified at 25 U.S.C. § 1680t(a)).

[13]Like other survey-based sources of health insurance coverage data, the ACS likely underestimates the population enrolled in Medicaid and CHIP compared to administrative data that includes information on enrollment. Researchers have attempted to estimate the magnitude of the underestimation—for example, see Victoria Lynch et al., "Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits" (Urban Institute Health Policy Center, 2011). Reporting errors can be due to several factors, including reluctance to report public coverage or confusion about what type of insurance respondents have. However, research by others shows that agency enrollment data may not accurately or consistently capture information on enrollees' race and ethnicity, particularly for American Indians and Alaska Natives.

determining program eligibility, we used an augmented version of the ACS data prepared by the University of Minnesota Population Center—the Integrated Public Use Microdata Series (IPUMS).[14] We used the most recent 3-year data available—2009 through 2011[15]—to provide estimates at the national, IHS area,[16] and state levels beginning in 2014. For expanded Medicaid,[17] we estimated the total number of American Indians and Alaska Natives who are

- potentially eligible, including: (1) all American Indians and Alaska Natives at or below 138 percent of the FPL,[18] (2) American Indians

---

[14]Because coverage options often consider family ties in determining program eligibility, we used the "health insurance unit," a variable included in the IPUMS data and considered the most accurate unit of analysis for estimating health insurance eligibility using survey data. The health insurance unit consists of all individuals residing in a sampled household, whose family ties determine them to be eligible for coverage, whereas the definition of a family or household in the Census's nonaugmented data typically includes all related members of a household, not all of whom would be eligible for coverage. See State Health Access Data Assistance Center, "Defining 'Family' for Studies of Health Insurance Coverage," Issue Brief #27 (Minneapolis: University of Minnesota).

Steven Ruggles et al., Integrated Public Use Microdata Series: Version 5.0, machine-readable database (Minneapolis: University of Minnesota, 2010).

[15]The 2009-2011 3-year estimates are averages over the pooled 2009-2011 period. At least 3 years of ACS data are needed for a reliable sample of most county populations. In this report, we do not conduct projections of eligibility on the basis of future income; instead, we estimate the number of American Indians and Alaska Natives who would be eligible for programs beginning in 2014 on the basis of the most recent data currently available. We also do not predict the take-up rate for these programs. As public programs generally do not have full take-up, it is likely that not all individuals who are eligible will enroll.

[16]The U.S. Census Bureau reports ACS data in Public Use Microdata Areas (PUMA), which aggregates smaller counties or breaks up larger counties into units of 100,000 individuals to protect anonymity. We created a crosswalk between the counties included in IHS areas and the counties included in PUMAs.

[17]The ACS data groups Medicaid and CHIP together when collecting information about Medicaid coverage status. As a result, some individuals eligible for CHIP are combined with Medicaid in our analysis.

We did not include estimates for Medicare in this report because eligibility for this program did not change as a result of PPACA.

[18]The ACS collects broader income data than will be used to determine eligibility for Medicaid, which will be based on Modified Adjusted Gross Income, a measure that excludes certain sources of income. See Pub. L. No. 111-148, § 2002, 124 Stat. 119, 279 (2010); Pub. L. No. 111-152, § 1004, 124 Stat. 1029, 1034 (2010) (to be codified at 42 U.S.C. § 1396a(e)(14)).

and Alaska Natives above 138 of the FPL who were eligible for Medicaid in each state,[19] (3) American Indians and Alaska Natives who received Supplemental Security Income,[20] and (4) American Indians and Alaska Natives who reported in the ACS as being enrolled in Medicaid;[21]

- currently enrolled in Medicaid, meaning individuals who reported in the ACS as being currently enrolled; and
- potential new Medicaid enrollees, including individuals who will be newly eligible for expanded Medicaid and some who are eligible now but did not report to ACS as being currently enrolled.

We also estimated the number of American Indians and Alaska Natives potentially eligible for the Basic Health Program option beginning in 2015, and income-based cost-sharing exemptions and premium tax credits in the Exchanges beginning in 2014.[22] Because the number of IHS eligible individuals is likely to be between the number identifying solely as American Indian and Alaska Native and the number identifying as American Indian and Alaska Native alone or in combination with another racial/ethnic group, we present results for both groups to show the range

[19]Some states offer Medicaid coverage to certain categories of individuals above 138 percent of the FPL, such as children and pregnant women.

[20]Individuals who qualify for Supplemental Security Income—certain low-income individuals who are aged, blind, or disabled—are generally eligible for Medicaid.

[21]A subset of those who identified as being currently enrolled in Medicaid did not otherwise meet our criteria, which could be due to a variety of factors. Considering that these individuals reported being enrolled, we included them in our estimates of the number potentially eligible.

[22]For both the income-based cost-sharing exemption and premium tax credit in the Exchanges, we estimated the number of American Indians and Alaska Natives between 138 percent of the FPL and 300 or 400 percent of the FPL, respectively. Although individuals at lower incomes may be eligible, for our analysis we excluded individuals from these categories who could be potentially eligible for expanded Medicaid. For the income-based cost-sharing protections, we estimated the number of American Indians and Alaska Natives within this income range; however, the subset of those who are also members of federally recognized tribes, and therefore eligible under PPACA, is unknown. Individuals who already have a minimum level of coverage, as specified by HHS, are ineligible for the premium tax credit. The ACS data did not contain a variable that would allow us to identify the subset of individuals who fall into the income range for premium tax credits but who already have minimum essential coverage.

within which the number who are IHS-eligible is likely to fall.[23] In the absence of information on IHS eligibility status of respondents, this approach allowed us to present a lower and upper bound for these estimates.

To assess the precision of ACS estimates, which are subject to some sampling error, we calculated a relative standard error for each estimate. Unless otherwise noted, we present estimates that have relative standard errors of less than 15 percent. We assessed the reliability of 2009-2011 ACS data by reviewing documentation and discussing the database with knowledgeable officials. After taking these steps we determined the data were sufficiently reliable for our purposes. See appendix I for more details about our methodology for estimating the number of American Indians and Alaska Natives potentially eligible for the expanded and new coverage options.

To review efforts to promote the enrollment—through training and outreach—of American Indians and Alaska Natives in both the current programs and expanded and new coverage options, and to identify any associated challenges, we examined actions taken by IHS, CMS, states, tribal organizations, and facilities. Specifically, we reviewed their recent and planned efforts to facilitate enrollment of American Indians and Alaska Natives into Medicaid under states' current Medicaid and CHIP programs. We also examined efforts to prepare for the increase in American Indians and Alaska Natives eligible for expanded Medicaid or the new coverage options, specifically the Exchanges.[24] We also consulted our prior work for descriptions of initial outreach initiatives that encouraged enrollment in other relatively recent federal programs, such as CHIP and the Medicare Part D prescription drug benefit. In addition, we examined whether efforts to promote enrollment included an emphasis on eligibility for expanded Medicaid and the new coverage options, the extent to which IHS has coordinated and communicated with other entities in its efforts, and the extent to which IHS has managed its

[23]We excluded from our analysis individuals identifying as American Indians and Alaska Natives who were foreign-born, as these individuals are generally unlikely to be eligible for IHS services.

[24]Our review of efforts to promote enrollment in the expanded and new coverage options focused on expanded Medicaid and the Exchanges rather than on the Basic Health Program.

personnel to prepare for increased enrollment.[25] We obtained this information through interviews with: IHS headquarters officials; CMS officials, including members of its Tribal Affairs Group, Center for Medicaid and CHIP Services, and Center for Consumer Information and Insurance Oversight; and national associations representing tribal and urban Indian health organizations. In addition, we selected a sample of three IHS service areas to obtain additional information—Aberdeen, Albuquerque, and Billings—on the basis of the percentage of American Indians and Alaska Natives in these areas who were uninsured.[26] Within each, we interviewed officials from the IHS area office, the Medicaid program of the state in which the area office is located, and, in the same state, an IHS-operated health facility, a tribally operated Indian health facility, an urban Indian health program, and a tribal outreach grantee who received funds appropriated by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).[27] We conducted these interviews from June through August 2012, and obtained updated information from these officials in February 2013. We asked officials a standard set of open-ended questions and did not independently validate their reported experiences. Given the small number of each type of entity included in the areas in our sample and our process for selecting them, the results from these interviews are not generalizable to all areas.

[25]Federal internal control standards specify that agency management should ensure that there are adequate means of timely and effective communication with, and obtaining information from, external stakeholders that have significant effect on the agency achieving its goals and that an agency should employ many and various means of communication, such as policy and procedure manuals and Internet web pages. Federal internal control standards also specify that agency management should ensure that proper personnel, with the right training, are in place to enable organizational success. See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999), and *Internal Control Management and Evaluation Tool,* GAO-01-1008G (Washington, D.C.: Aug. 1, 2001).

[26]Specifically, we selected the three areas with the highest level of uninsured American Indians and Alaska Natives, on the basis of ACS data, that also contained at least one entire state and each type of entity we sought to include. The Aberdeen, Albuquerque, and Billings area offices are located in South Dakota, New Mexico, and Montana, respectively.

[27]CHIPRA included funding for outreach to increase Medicaid and CHIP enrollment among American Indian and Alaska Native children. See Pub. L. No. 111-3, § 201, 123 Stat. 8, 35 (2009) (codified at 42 U.S.C. § 1397mm). We refer to recipients of these funds as CHIPRA tribal outreach grantees.

We conducted this performance audit from February 2012 to August 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The health care coverage options established by PPACA have implications for how American Indians and Alaska Natives may receive and pay for their future health care needs.

The IHS System

IHS was established as an HHS agency for the purpose of providing, or arranging for, health care to American Indians and Alaska Natives—a responsibility of the United States established in treaty and law. IHS has headquarters based in the Washington, D.C., area, but is organized into 12 federally designated geographic service areas that cover all or part of 35 states (see fig. 1).[28] IHS provides health care services directly through a system of facilities—hospitals, health clinics, and health stations—operated by IHS (for "direct service" tribes), by tribes or tribal organizations themselves,[29] or by urban Indian health programs. This system is often referred to collectively as "I/T/U." When health care services at IHS or tribally operated facilities, referred to as direct care services, are not available, care may be obtained from external providers and paid for through IHS's Contract Health Services (CHS) program. However, as we have noted in past reports, IHS is not able to pay for all eligible health care services—through direct care services and services obtained through the CHS program—leading to an unmet need for health

[28]The 12 areas are Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

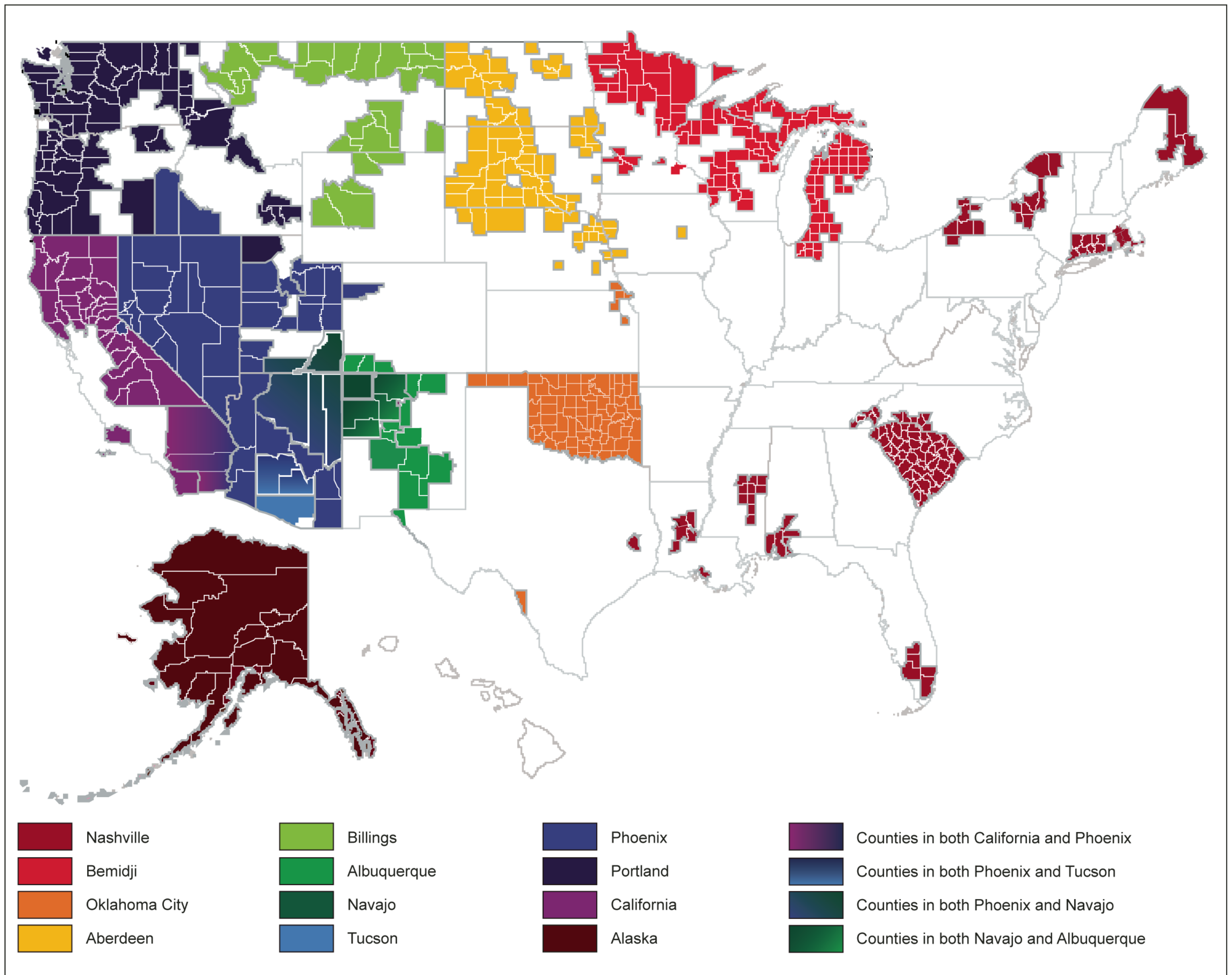
[29]Direct service tribes receive health care directly from IHS, instead of receiving services through IHS-funded facilities or programs operated by Indian tribes or tribal organizations. Under the Indian Self-Determination and Education Assistance Act, as amended, federally recognized Indian tribes can enter into self-determination contracts or self-governance compacts with the Secretary of Health and Human Services to take over administration of IHS programs for Indians previously administered by IHS. See 25 U.S.C. §§ 450f(a), 458 aaa-4(b)(1).

care services.[30] Additionally, services obtained through the CHS program are generally limited to individuals who live on a federally recognized Indian reservation or within a designated Contract Health Service Delivery Area (CHSDA).[31] American Indians and Alaska Natives living outside of these areas, which may include many urban Indians, therefore are unlikely to be eligible for CHS program services.

[30]See GAO-05-789 and GAO, *Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need*, GAO-11-767 (Washington, D.C.: Sept. 23, 2011).

[31]See 42 C.F.R. § 136.23. CHSDAs typically encompass reservation and trust lands—areas located on or off a reservation, for which the United States holds title in trust for the benefit of a tribe or individual Indian—and bordering counties. Patients must also meet other eligibility, administrative, and medical priority requirements to have their services paid for by the CHS program.

Figure 1: The 12 IHS Service Areas, Shown with Contract Health Service Delivery Area (CHSDA) Counties Included in Each Area



Source: GAO analysis of IHS information.

Note: While CHSDAs, which make up IHS service areas, are typically counties, the city of Elton, Louisiana, is also designated as a CHSDA in the Nashville area.

In addition to IHS funding, I/T/U facilities can use reimbursements from third-party payers for services they provide to patients as an additional source of funds, and IHS may not reduce funding to tribally operated facilities and urban Indian health programs because of such reimbursements.[32] For direct care services, I/T/Us are authorized to bill third-party payers, including public and private insurance, for care provided to enrolled patients. For both tribal and IHS-operated CHS programs, any alternate sources of coverage that may be available to a patient, including Medicare, Medicaid, CHIP, and private insurance, must pay for services before the CHS program, as I/T/Us are generally the payers of last resort.[33] Increased enrollment in alternative sources of coverage among American Indians and Alaska Natives could thus increase revenue for I/T/U facilities if these individuals choose to receive care through IHS, improving access to care and reducing the level of unmet need American Indians and Alaska Natives experience. Increased enrollment in alternative sources of coverage may allow American Indians and Alaska Natives more options for care, if options exist in their community outside the I/T/U system, potentially resulting in fewer American Indians and Alaska Natives seeking care through I/T/U facilities.

To be eligible for IHS services, an individual must be closely affiliated with an American Indian or Alaska Native community that is federally recognized, but not necessarily an official member of a tribe. IHS tracks the number of users treated at IHS operated facilities, although the number of American Indians and Alaska Natives potentially eligible for IHS services is unknown. The Census Bureau produces data on the number of individuals identifying as American Indian and Alaska Native

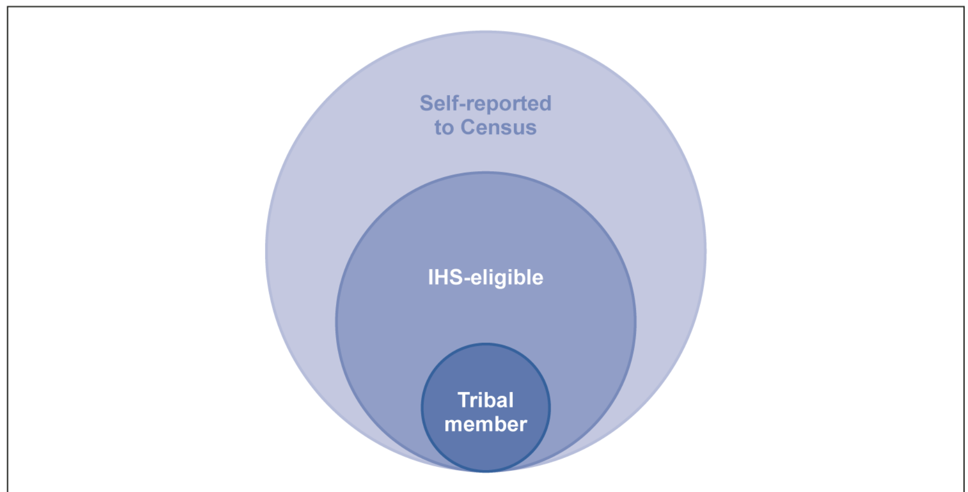
[32]The Indian Health Care Improvement Act authorizes IHS, tribes, and urban Indian organizations to collect reimbursement for services provided at I/T/U facilities from third-party payers, including Medicare, Medicaid, and private health insurers. See 25 U.S.C. §§ 1621e(a), 1621f. IHS is allowed to retain funds collected from these payers without a corresponding offset against its appropriations, so that all revenue collected by a facility remains with that facility, supplementing its funds. See 25 U.S.C. § 1621(b).

We previously reported that, in fiscal year 2008, IHS reported collecting about $795 million from all third-party payers. See GAO, *Indian Health Service: Updated Policies and Procedures and Increased Oversight Needed for Billings and Collections from Private Insurers*, GAO-10-42R (Washington, D.C.: Oct. 22, 2009).

[33]See 25 U.S.C. § 1623(b).

alone or in combination with another race.[34] In the 2010 Census, 5.2 million people identified as American Indian and Alaska Native alone or in combination with another race (2.9 million as American Indian and Alaska Native alone). IHS-eligible individuals are a subset of this population. (See fig. 2.)

Figure 2: Relationship between American Indians and Alaska Natives as Self-Reported to the Census, for IHS Eligibility, and for Tribal Membership



Source: GAO presentation of information from interviews with IHS officials.

Note: Figure reflects the general relationship, not actual size, of the populations.

[34]Prior to the 2000 Census, respondents could only select one race. Since the 2000 Census, the number of individuals identifying as American Indians and Alaska Natives, especially in combination with another race, has significantly increased.

PPACA Provisions Affecting American Indians and Alaska Natives

In 2014, in states opting to participate in Medicaid expansion, eligibility will expand to those with incomes at or below 138 percent of the federal poverty level (FPL).[35] Unlike current Medicaid eligibility rules that require an individual to meet both income and categorical requirements—such as children and pregnant women—eligibility under expanded Medicaid will apply to all individuals, including American Indians and Alaska Natives, at or below 138 percent of the FPL, including groups previously not eligible, such as childless adults. For those individuals obtaining insurance through the Exchanges beginning in 2014, PPACA includes a federal premium tax credit for eligible individuals whose incomes are between 100 and 400 percent of the FPL, and who do not have access to public insurance such as Medicaid or CHIP.[36] PPACA also includes a number of Exchange-related provisions specific to American Indians and Alaska Natives, including eliminating cost-sharing, such as deductibles and copays, for services provided to certain enrollees at or below 300 percent of the FPL, or for services provided by I/T/Us, regardless of the enrollee's income.[37] Additionally, expected to begin in 2015, states may implement the Basic Health Program option, under which the federal government is to give states 95 percent of the premium tax credits and cost-sharing subsidies that would have been provided if the individuals had been

[35]The U.S. Supreme Court ruled in June 2012 that states choosing not to expand Medicaid coverage to individuals eligible under PPACA will forgo only the federal matching funds associated with such expanded coverage, rather than a termination of all Medicaid federal matching funds. See *Nat'l Fed'n of Indep. Bus. v Sebelius*,132 S.Ct. 2566 (2012).

PPACA established 133 percent of the FPL as the income limit for Medicaid eligibility; however, it also specifies that an income disregard in the amount of 5 percent of the FPL be deducted from an individual's income when determining Medicaid eligibility, which effectively raises the eligibility limit for newly eligible Medicaid recipients to 138 percent of the FPL. See Pub. L. No. 111-148, §§ 2001(a), 2002, 124 Stat. 119, 271, 279 (2010); Pub. L. No. 111-152, § 1004, 124 Stat. 1029, 1034 (2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) and to be codified at 42 U.S.C. § 1396a(e)(14)(I)).

[36]See Pub. L. No. 111-148, §§1401, 10105(a)-(c), 10108(h), 124 Stat. 119, 213, 906, 914 (2010); Pub. L. No. 111-152, §§ 1011, 1004, 124 Stat. 1029, 1030, 1034 (2010) (codified at 26 U.S.C. § 36B); 26 C.F.R. § 1.36B-2(a)(1). In addition, PPACA provides cost-sharing subsidies to certain eligible individuals between 100 and 250 percent of the FPL to assist with such expenses as deductibles and copays, as well as limits on the percentage of income that health plans can charge enrollees for cost-sharing. See Pub. L. No. 111-148, § 1402(c), 124 Stat. 119, 221 (2010); Pub. L. No. 111-152, § 1001, 124 Stat. 1029, 1039 (2010) (codified at 42 U.S.C. § 18071).

[37]See Pub. L. No. 111-148, §1402(d), 124 Stat. 119, 222 (2010) (codified at 42 U.S.C. § 18071).

enrolled in the Exchanges to allow the states to provide coverage for individuals, including American Indians and Alaska Natives, with incomes between 138 and 200 percent of the FPL. Finally, although PPACA generally requires that individuals obtain health insurance or be subject to a federal tax—a requirement often referred to as the individual mandate—certain American Indians and Alaska Natives are statutorily exempt—specifically, those who are members of federally recognized tribes.[38] In June 2013, after our draft report was submitted to the agency for review and comment, HHS released a final rule establishing additional exemptions for specified individuals under its authority to establish hardship exemptions. The final rule included a hardship exemption for American Indians and Alaska Natives eligible for services from an Indian health care provider who are not members of federally recognized tribes.[39] Without this hardship exemption, American Indians and Alaska Natives who were not enrolled in a federally recognized tribe but who were still eligible for IHS services—for example, nonmember descendants—would have been subject to the individual mandate.

Because of the definitions used in PPACA to specify eligibility for certain benefits, some groups of American Indians and Alaska Natives participating in the Exchanges will not be eligible for certain benefits available beginning in 2014 compared to other American Indians and Alaska Natives. Specifically, exemption from cost-sharing such as deductibles and copays, as well as special monthly enrollment periods[40]—apply to "Indians," a term that is defined in PPACA provisions by reference to definitions found in other federal statutes that define

[38]See Pub. L. No. 111-148, §§ 1501(b),10106, 124 Stat. 119, 244, 909 (2010); Pub. L. No. 111-152, §§ 1002, 1004, 124 Stat. 1029, 1032, 1034 (2010) (codified at 26 U.S.C. § 5000A).

[39]HHS established hardship exemptions for individuals eligible for IHS services who are not members of federally recognized tribes and for individuals living in states that chose not to expand Medicaid eligibility but who would otherwise qualify for it. 78 Fed. Reg. 39,494 (July 1, 2013).

[40]Under PPACA, eligible American Indians and Alaska Natives may enroll in a different Exchange plan each month, in contrast to annual enrollment windows generally applicable to other participants. See Pub. L. No. 111-148, § 1311(c)(6)(D), 124 Stat. 119, 175 (2010) (codified at 42 U.S.C. § 18031(c)(6)(D)).

Indians as members of federally recognized tribes.[41] Consistent with the PPACA provisions, CMS's final rule for the establishment of the Exchanges provided that the benefits related to cost-sharing and special enrollment periods apply only to members of federally recognized tribes. CMS officials involved with the design of the single, streamlined application for health insurance—a PPACA requirement—told us that the application will include a section of questions specific to American Indians and Alaska Natives, including information about membership in a federally recognized tribe.[42] PPACA also requires establishment of application assistance programs,[43] which may help American Indians and Alaska Natives understand which provisions apply to them.

[41]Cost-sharing protections specific to American Indians and Alaska Natives incorporate the definition of Indian in section 4(d) of the Indian Self-Determination and Education Assistance Act, codified at 25 U.S.C. § 450b(d). The special enrollment period provision incorporates the definition of Indian in section 4 of the Indian Health Care Improvement Act, codified at 25 U.S.C. § 1603(13). CMS's final rule for the establishment of the Exchanges, published March 27, 2012, stated that the definitions contained in both the Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act are operationally equivalent and include only individuals who are members of federally recognized tribes. See 77 Fed. Reg. 18,310, 18,346. The United States recognized 566 tribes as of May 2013.

In contrast, in the American Recovery and Reinvestment Act in 2009, Congress established premium and cost-sharing protections for American Indians and Alaska Natives enrolled in Medicaid, without linking them to a specific definition of Indian. See Pub. L. No. 111-5, § 5006(a), 123 Stat. 115, 505 (2009) (codified at 42 U.S.C. § 1396o(j)). Consequently, CMS's regulation implementing these protections uses a broader definition that includes all American Indians and Alaska Natives who are eligible for IHS services. See 75 Fed. Reg. 30,244, 30,247 (May 28, 2010) (amending 42 C.F.R. § 447.50).

[42]PPACA requires the use of a single, streamlined application for health insurance that will include application pathways for Medicaid, CHIP, and the Exchanges. See Pub. L. No. 111-148, § 1413, 124 Stat. 119, 233 (2010) (codified at 42 U.S.C. § 18083). In April 2013, HHS released the model application to be used in federally operated Exchanges, which will also be used by state-operated Exchanges unless the Secretary of Health and Human Services grants permission to a state to use its own. The single, streamlined application is expected to be available for open enrollment beginning in October 2013 for coverage that begins in January 2014.

[43]See Pub. L. No. 111-148, §§ 1311(d)(4)(K),(i), 10104(h), 124 Stat. 119, 177, 180, 901 (2010) (codified at 42 U.S.C. § 18031). Application assistance programs are intended to help individuals submit the application, compare plans, and complete the enrollment process.

Consequently, these benefits may not apply to American Indians and Alaska Natives eligible for IHS services who

- live in urban locations and use urban Indian health programs, but who are not able to obtain tribal enrollment because they do not meet residency or other requirements, or are unable to document their descent,
- are affiliated with an Indian tribe but do not meet the tribe's minimum blood quantum requirements for enrollment, and
- would otherwise be eligible for tribal membership, except for certain requirements set by the tribe: for example, some tribes limit their membership to adults or base membership on matrilineal descent.[44]

We and others have noted in past reports that American Indians and Alaska Natives may face challenges in enrolling in Medicaid, CHIP, and Medicare.[45] According to a CMS-funded research paper, American Indians and Alaska Natives, and agencies seeking to enroll them in public programs, face unique challenges to enrollment, as well as other challenges common to rural populations.[46] Some challenges described relate to the relationship between the federal government and tribes and the treaty agreements and statutes that established a responsibility to provide health care—for example, the belief by some American Indians and Alaska Natives that such responsibility means that tribal members should not have to apply for assistance through public programs. This government-to-government relationship may also make some tribes hesitant to interact with state-run programs. Other challenges reported include lack of awareness about health care coverage programs generally; limited knowledge of benefits and eligibility criteria for programs; significant transportation challenges, and language and literacy

[44]Criteria for tribal membership vary by tribe and include such requirements as documented descent from an original member, residency on tribal lands, or minimum blood quantum levels—that is, the required degree of ancestry from a particular tribe.

[45]See GAO, *Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes*, GAO-08-724 (Washington, D.C.: July 11, 2008).

[46]See K. L. Langwell et al., "American Indian and Alaska Native Eligibility and Enrollment in Medicaid, SCHIP, and Medicare" (December 2003). This report, commissioned by CMS, included extensive analysis of common challenges affecting American Indian and Alaska Native participation in public programs.

barriers; the complexity of application and renewal processes for health care coverage programs; and cultural barriers. According to the same CMS-funded report, because a large proportion of American Indians and Alaska Natives reside in rural areas on reservations with high poverty rates and low educational levels, these challenges may be significant deterrents to enrollment.

Prior CMS Outreach and Enrollment Efforts

HHS has previously managed successful outreach and enrollment campaigns that may provide lessons learned, such as for the CHIP and the Medicare Part D prescription drug benefit programs. CHIP was established in August 1997 to reduce the number of low-income uninsured children in families with incomes too high to qualify for Medicaid. Medicare Part D was authorized in 2003 to provide an outpatient prescription drug benefit to millions of people already enrolled in Medicare.[47] As we and others have noted in previous reports,[48] both programs relied heavily on large-scale media campaigns to raise awareness among the general public. For CHIP, state outreach efforts encompassed multiple marketing approaches including multimedia campaigns, direct mailings, toll-free hotlines, widespread distribution of applications, and community- and school-based enrollment campaigns. In promoting Medicare Part D and the temporary drug discount card that preceded it, CMS employed a mass-media campaign comprised of large-scale advertising, direct mail, a dedicated website, and a toll-free hotline, as well as one-on-one counseling and partnerships with community organizations. Enrollment in both CHIP and Medicare Part D was high as the programs began, and increased steadily over time.[49]

[47]Medicare Part D took effect in 2006, although it was preceded by a temporary prescription drug discount card program beginning in 2004.

[48]See GAO, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May 14, 1999); *Medicare: CMS's Beneficiary Education and Outreach Efforts for the Medicare Prescription Drug Discount Card and Transitional Assistance Program*, GAO-06-139R (Washington, D.C.: Nov. 18, 2005).

[49]Enrollment in CHIP exceeded 700,000 in its first year—fiscal year 1998—and continued to grow steadily for more than a decade. By the final quarter of fiscal year 2000, all 50 states and the District of Columbia had implemented CHIP with a total enrollment of nearly 2.7 million. By fiscal year 2010, CMS reported CHIP enrollment had reached nearly 7.7 million. By 2010 nearly 30 million people had enrolled in Medicare Part D.

Despite the gains in CHIP enrollment over the last decade, in 2009 Congress recognized that some children eligible for CHIP, as well as Medicaid, were still not enrolled, and therefore included in CHIPRA funds for Medicaid and CHIP outreach targeted at enrollment. Of this funding, CHIPRA provided $10 million for the Secretary of Health and Human Services to award grants to I/T/Us to conduct outreach and enrollment efforts to increase Medicaid and CHIP coverage among American Indian and Alaska Native children.[50] Most of the funding, administered by CMS, was awarded in 2010 to 41 organizations in 19 states.

Most American Indians and Alaska Natives Will Be Potentially Eligible for Expanded Medicaid and New Coverage Options; States' Decisions Will Affect Coverage for Many

We estimate that, beginning in 2014, hundreds of thousands—more than half—of American Indians and Alaska Natives will be potentially eligible for health care coverage through Medicaid or the Basic Health Program, or for cost-sharing exemptions and premium tax credits for insurance obtained through the Exchanges. States' decisions whether to expand their Medicaid programs may affect coverage for many American Indians and Alaska Natives, however.

[50]See Pub. L. No. 111-3, § 201(a), 123 Stat. 8, 36 (2009) (codified at 42 U.S.C. § 1397mm(b)(2)).

More Than Half of American Indians and Alaska Natives Will Be Potentially Eligible for Coverage under Expanded Medicaid Depending on the Number of Participating States

If all states opt to expand their Medicaid programs, we estimate that more than half of all American Indians and Alaska Natives will be potentially eligible for Medicaid[51] in 2014. Excluding those already enrolled, potential new enrollment in Medicaid could exceed 650,000 out of 2.4 million (27 percent) for those identifying as American Indians and Alaska Natives alone, and almost 1.2 million out of 4.8 million (25 percent) for those identifying as American Indians and Alaska Natives alone or in combination with another race.[52] Compared to the general population, a significantly larger proportion of American Indians and Alaska Natives are potentially eligible for expanded Medicaid. Potential new enrollment among American Indians and Alaska Natives is also proportionally greater than among the general population. (See table 1.)

[51]We estimated the number of American Indians and Alaska Natives potentially eligible for Medicaid as individuals who met the criteria for Medicaid eligibility in 2014, which included individuals eligible for Medicaid at the expanded income levels in PPACA, as well as individuals currently eligible for Medicaid as reported in the ACS.

[52]Because the number of IHS eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range.

In the 2010 Census, 2.9 million individuals reported as American Indian and Alaska Native alone, and 5.2 million reported as American Indian or Alaska Native alone or in combination with another race. The ACS estimates are lower, in part, because we excluded foreign-born American Indians and Alaska Natives from our analysis of ACS data. We present the total population estimate from the ACS to represent the basis for the percentages in our analysis throughout this report. These estimates are not meant to represent the population in the United States for any year in that period. To obtain the population count, researchers should use counts from the most recent Census or population estimates from the U.S. Census Bureau's Population Estimates Program, which produces estimates of the population for the United States, its states, counties, cities, and towns, as well as for the Commonwealth of Puerto Rico.

Table 1: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid in 2014

Population group (Number)	Total potentially eligible number (percent)	Current enrollment[a] number (percent)	Potential new enrollment[b] number (percent)
American Indian and Alaska Native alone (2.4 million from ACS)	1,368,316 (58)	718,254 (30)	650,062 (27)
American Indian and Alaska Native alone or in combination with another race (4.8 million from ACS)	2,569,410 (54)	1,377,924 (29)	1,191,486 (25)
All races (309.2 million from ACS)	115,749,838 (37)	53,196,416 (17)	62,553,422 (20)

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Our estimates are based on the assumption of all states opting to expand Medicaid. While some states have indicated they do not intend to participate, they may opt to do so at a later date. We did not predict the number of people who will participate in this program, commonly referred to as the take-up rate.

Because the number of IHS-eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range. We excluded foreign-born American Indians and Alaska Natives from our analysis.

The estimates we present have relative standard errors of less than 15 percent.

[a]We use the term “current enrollment” to refer to estimated enrollment based on responses to the 2009-2011 ACS.

[b]We estimated potential new enrollment as those who will be newly eligible for expanded Medicaid and some who may be eligible now, but did not report to ACS as being currently enrolled. Percentages of current enrollment and potential new enrollment may not add up to the total of potentially eligible due to rounding.

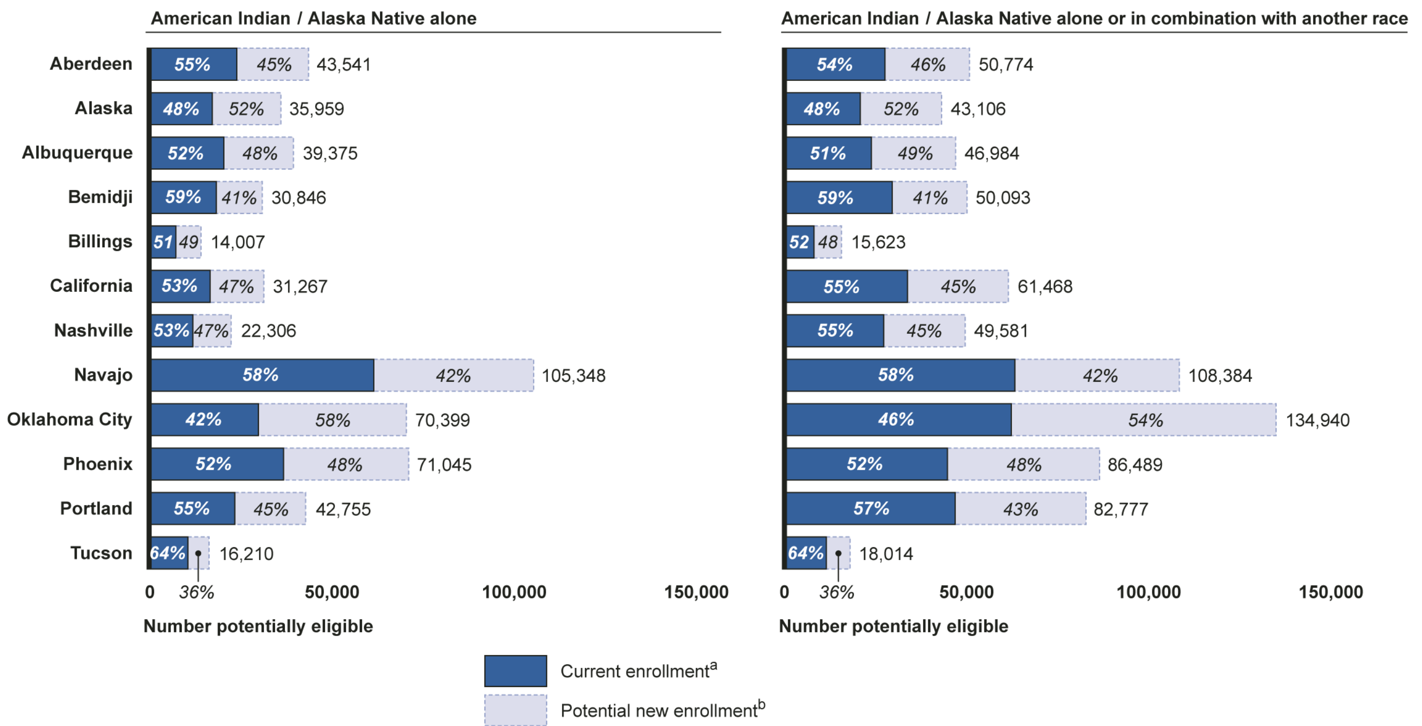
These estimates reflect all potential new enrollment, including both those who may be newly eligible under 2014 eligibility rules and not enrolled, as well as individuals currently eligible but not enrolled. Nationally, among those identifying as American Indians and Alaska Natives alone, about 16 percent will be newly eligible and about 11 percent are currently eligible but not enrolled.[53] Among those identifying as American Indians and Alaska Natives alone or in combination with another race, about 15 percent will be newly eligible and about 10 percent are currently eligible but not enrolled. While not all eligible individuals will enroll, the extent to which American Indians and Alaska Natives enroll in these programs is unknown.

[53]Unless otherwise specified, when referring to potential new enrollment we include both those who will be newly eligible in 2014 and those who are currently eligible, but not enrolled.

The 12 IHS service areas varied widely in the number and proportion of American Indians and Alaska Natives potentially eligible for Medicaid under 2014 rules and for potential new enrollment. The Oklahoma City area—the IHS service area with the largest population of American Indians and Alaska Natives—had large numbers and percentages of American Indians and Alaska Natives potentially eligible for Medicaid and of potential new enrollment.[54] The highest percentages of individuals potentially eligible for Medicaid were in the Aberdeen area for those identifying solely as American Indians and Alaska Natives (73 percent), and in the Navajo area for those identifying as American Indians and Alaska Natives alone or in combination with another race (71 percent). (See fig. 3).

[54]As with the national level, most of the potential new enrollment among American Indians and Alaska Natives in the Oklahoma City area consists of those who will be newly eligible for expanded Medicaid.

Figure 3: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid in 2014, by IHS Service Area



Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Our estimates are based on the assumption of all states opting to expand Medicaid. While some states have indicated they do not intend to participate, they may opt to do so at a later date. We did not predict the number of people who will participate in this program, commonly referred to as the take-up rate.

Because the number of IHS-eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range. We excluded foreign-born American Indians and Alaska Natives from our analysis.

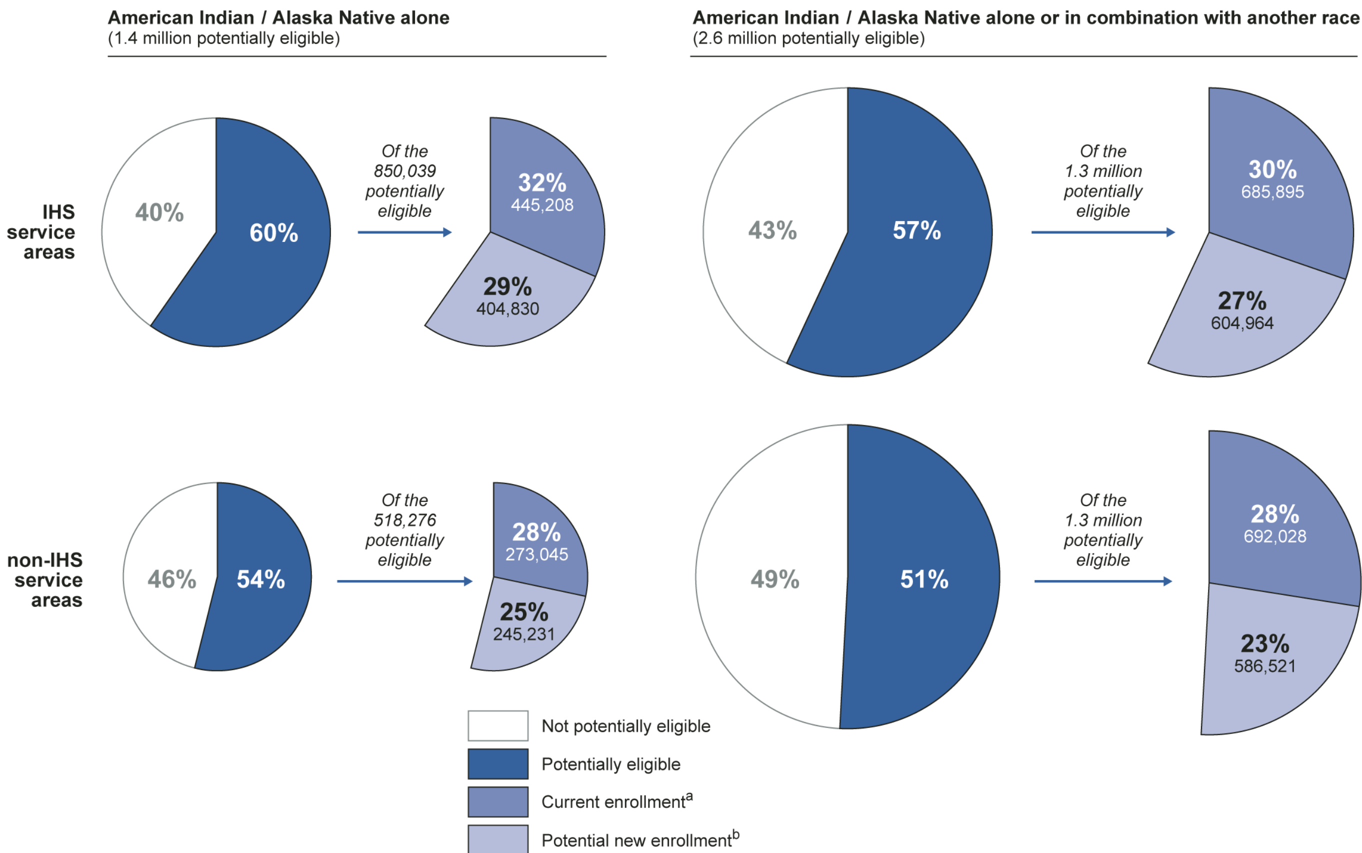
The estimates we present have relative standard errors of less than 15 percent.

[a]We use the term “current enrollment” to refer to estimated enrollment based on responses to the 2009-2011 ACS.

[b]We estimated potential new enrollment as those who will be newly eligible for expanded Medicaid and some who may be eligible now, but did not report to ACS as being currently enrolled. Percentages of current enrollment and potential new enrollment may not add up to the total of potentially eligible due to rounding.

While many American Indians and Alaska Natives in IHS service areas reflected potential new enrollment for Medicaid—we estimate about 405,000 for American Indian and Alaska Native alone, and about 605,000 for American Indian and Alaska Native alone or in combination with another race—a large number of American Indians and Alaska Natives living outside of IHS service areas are also potentially eligible, and reflected a large number of potential new enrollees—we estimate about 245,000 for American Indian and Alaska Native alone, and 587,000 for American Indian and Alaska Native alone or in combination with another race. (See fig. 4.) American Indians and Alaska Natives living outside IHS service areas were more likely to identify as American Indian or Alaska Native in combination with another race. Individuals living outside IHS service areas are less likely to have access to IHS or tribal health services. For American Indians and Alaska Natives not located in IHS service areas, states' decisions regarding Medicaid expansion could affect their coverage options and access to care, particularly if those American Indians and Alaska Natives living outside IHS service areas are not eligible for services at federally or tribally operated facilities, a group which may include many urban Indians. Appendix II provides more information on the estimated numbers and percentages of American Indians and Alaska Natives potentially eligible for expanded Medicaid, by IHS service area.

Figure 4: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid in 2014 for IHS Service Areas and Non-IHS Service Areas



Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Our estimates are based on the assumption of all states opting to expand Medicaid. While some states have indicated they do not intend to participate, they may opt to do so at a later date. We did not predict the number of people who will participate in this program, commonly referred to as the take-up rate.

Because the number of IHS-eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range. We excluded foreign-born American Indians and Alaska Natives from our analysis.

The estimates we present have relative standard errors of less than 15 percent.

[a]We use the term "current enrollment" to refer to estimated enrollment based on responses to the 2009-2011 ACS.

[b]We estimated potential new enrollment as those who will be newly eligible for expanded Medicaid and some who are eligible now, but did not report to ACS as being currently enrolled. Percentages of current enrollment and potential new enrollment may not add up to the total of potentially eligible due to rounding.

Our analysis assumed that all states would opt to participate in the expanded Medicaid program; however, some IHS service areas have large American Indian and Alaska Native populations located in states that may choose not to expand their Medicaid programs. This would limit access to Medicaid benefits for those who would be eligible for expanded Medicaid, as well as limit I/T/U facilities' ability to obtain Medicaid revenue for services provided to these individuals. For example, Oklahoma announced in November 2012 that the state would not pursue Medicaid expansion. In the state of Oklahoma alone, which comprises most of the Oklahoma City IHS service area, we estimate that potential new enrollment for Medicaid in 2014 would exceed 76,000 for individuals identifying as American Indians and Alaska Natives alone and more than 137,000 for those identifying as American Indians and Alaska Natives alone or in combination with another race.[55] According to CMS officials, states have not been given a deadline to declare their interest in expanding Medicaid. Some states have expressed intent to expand their programs, while others have indicated they will not participate.[56] See appendix III for state-level estimates of potential new Medicaid enrollment to understand the effect of each state's decision regarding Medicaid expansion.

[55]As with the national level, most of the potential new enrollment among American Indians and Alaska Natives in the Oklahoma City area consists of those who will be newly eligible for expanded Medicaid, but includes some who may be currently eligible but not enrolled.

[56]As of June 14, 2013, the Advisory Board Company's online Daily Briefing noted that the governors of 26 states and the District of Columbia announced they will participate in Medicaid expansion, 1 state is considering participating, 13 states announced they will not participate, 6 states are considering not participating, and 4 states are planning or proposing to increase coverage through other means. See http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap, downloaded August 19, 2013.

While some states have indicated they do not intend to participate, they may opt to do so at a later date.

About 35 Percent of American Indians and Alaska Natives Are Potentially Eligible for One or More Special Provisions under New Coverage Options

More than one-third of certain American Indians and Alaska Natives may also be potentially eligible for premium tax credits for insurance obtained through the Exchanges, many of whom would also be eligible for cost-sharing protections and, to a lesser extent, the Basic Health Program, on the basis of our estimates. Specifically, about 832,000 American Indians and Alaska Natives who identified as American Indians and Alaska Natives alone are potentially eligible for premium tax credits, as are 1.7 million who identified as American Indians and Alaska Natives alone or in combination with another race. More than 623,000 American Indians and Alaska Natives who identified as American Indians and Alaska Natives alone are within the income range for cost-sharing exemptions for insurance obtained through the Exchanges, as are almost 1.3 million who identified as American Indians and Alaska Natives alone or in combination with another race.[57] If all states decided to run a Basic Health Program,[58] we estimate that more than 292,000 American Indians and Alaska Natives who identified as American Indians and Alaska Natives alone could be covered, as well as about 593,000 American Indians and Alaska Natives who identified as American Indians and Alaska Natives alone or in combination with another race. Unlike potential eligibility for Medicaid, the percentages of American Indians and Alaska Natives potentially eligible for the Basic Health Program and cost-sharing exemptions and premium tax credits for insurance obtained through the Exchanges are comparable to the general population at the same income levels. (See table 2.) Appendix III provides more information on American Indians and Alaska Natives' potential eligibility for public programs.

[57]Some American Indians and Alaska Natives may not be members of federally recognized tribes, a requirement of eligibility for the cost-sharing exemptions.

[58]As of May 2013, HHS had not issued any rules regarding the Basic Health Program option, but announced in February 2013 that the program would begin in 2015, rather than 2014 as originally planned.

Table 2: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for the Basic Health Program Option and for Cost-Sharing and Premium Tax Credits under the Health Insurance Exchanges

Population group (Number)	Basic Health Program option[a] number (percent)	Exchange cost-sharing exemptions[b] number (percent)	Exchange premium tax credits[c] number (percent)
American Indian and Alaska Native alone (2.4 million from ACS)	292,599(12)	623,890(26)	831,985(35)
American Indian and Alaska Native alone or in combination with another race (4.8 million from ACS)	593,367(12)	1,290,362(27)	1,744,651(37)
All races (309.2 million from ACS)	35,432,727(11)	82,560,360(27)	118,632,279(38)

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Because the number of IHS-eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range. We excluded foreign-born American Indians and Alaska Natives from our analysis.

The estimates we present have relative standard errors of less than 15 percent.

We did not predict the number of people who will participate in these new coverage options, commonly referred to as the take-up rate.

Certain individuals who are eligible for the premium tax credits may also be eligible for cost-sharing exemptions.

[a]Beginning in 2015, states may opt to run a Basic Health Program for individuals between 138 and 200 percent of the federal poverty level (FPL). These estimates are if all states opt to run a Basic Health Program.

[b]Certain American Indians and Alaska Natives obtaining insurance through the Exchanges who are at or below 300 percent of the FPL are exempt from cost-sharing, such as deductibles and copays, although our estimates reflect only those above 138 percent of the FPL because individuals below this level would be potentially eligible for expanded Medicaid. While this provision applies only to certain American Indians and Alaska Natives and not the general population, we provide data here for all races at the same income level for comparison.

[c]Individuals obtaining insurance through the Exchanges who are between 100 and 400 percent of the FPL are eligible for premium tax credits on a sliding scale, although our estimates reflect only those above 138 percent of the FPL because individuals below this level would be potentially eligible for expanded Medicaid. Individuals with incomes above 138 percent of the FPL who may be eligible for Medicaid in a particular state are not eligible for premium tax credits.

Efforts Have Been Made to Enroll American Indians and Alaska Natives in Current Medicaid Programs, but Multiple Barriers May Hinder Enrollment in Expanded Medicaid and New Coverage Options

Although efforts have been made by the federal agencies and states we interviewed to facilitate Medicaid enrollment through training of I/T/U facility staff and conducting outreach for current public programs, uncertainty, lack of capacity-building, and limited awareness and information present challenges to enrollment in expanded Medicaid and new coverage options.[59]

Most Efforts to Promote Enrollment in Current Medicaid Programs Were Conducted by I/T/U Facilities and Tribes; Limited Efforts Have Been Made regarding Expanded and New Coverage Options

IHS, CMS, and the three states we interviewed reported taking some steps to train I/T/U facility staff on current program eligibility; however, most efforts to facilitate enrollment of individuals in these programs have taken place at the tribal or facility level.

IHS

According to IHS officials, the agency has collaborated with CMS to develop and disseminate information about program eligibility rules—mainly on current programs with some limited information on the expanded and new coverage options—to I/T/U facilities and tribes through letters to tribal leaders, the IHS Director's Blog, regional and national tribal consultation meetings, annual business office training, and a combined IHS and CMS national training for I/T/Us called the National Partnership Conference. However, officials from most of the nine facilities

[59]Our review of the efforts to promote enrollment in expanded and new coverage options focused on expanded Medicaid and the Exchanges rather than on the Basic Health Program.

and three tribes that we interviewed said that they received little or no guidance from IHS regarding expanded Medicaid or the Exchanges as of February 2013.[60] In contrast, federal internal control standards specify that agency management should ensure that there are adequate means for timely and effective communication with stakeholders that have a significant effect on the agency achieving its goals.

IHS officials told us that the agency does not conduct direct outreach to individual IHS users or to American Indian and Alaska Native communities at the headquarters level. Rather, direct outreach is generally conducted at the facility level by both tribally and federally operated facilities. The agency also contracts with other organizations to develop and disseminate outreach and educational materials. For PPACA-related outreach, the agency provided $1.8 million in funding to three national tribal organizations—the National Indian Health Board, National Congress of American Indians, and National Council of Urban Indian Health—over fiscal years 2011 through 2013 to develop and distribute materials for educating I/T/Us, tribes, and American Indian and Alaska Native communities about the expanded and new coverage options. These organizations have produced educational materials and tools designed to assist I/T/U administrators and tribal leaders in understanding PPACA-related changes, including Medicaid expansion and the Exchanges. They have also produced some training materials; however, additional direct outreach materials (such as mass media materials for general education, e.g., posters, videos, or mailers) for American Indians and Alaska Natives were still being developed and not widely disseminated as of April 2013. IHS also reported providing $3.7 million over fiscal years 2011 through 2013 to IHS area offices to educate tribes and organizations about PPACA, such as through briefing sessions for tribal leaders and facility staff. As the implementation of CHIP and Medicare Part D demonstrated, an effective outreach effort for building awareness of new programs and encouraging enrollment requires a large, multipronged effort, including the use of media, direct mail, one-on-one counseling, and partnerships with community

[60]IHS officials also noted that IHS collaborated with CMS to develop regulations on the expanded and new coverage options. Although some of these documents were not finalized until after our site visits, when we followed up with the facilities and tribes in February 2013, most confirmed at that time that they still had received little or no guidance from IHS.

organizations. IHS's efforts, however, do not match the large, multipronged efforts launched in advance of CHIP and Medicare Part D.

Additionally, IHS officials told us that the agency distributed a "business plan template" in April 2013. Using this template, IHS facilities were expected to submit a business plan to their respective area office director in May 2013. The business plan template, an initiative led by the IHS Deputy Director for Field Operations, is intended to help facilities identify and plan for their community outreach and staff training needs, among other things, in preparation for implementation of PPACA.[61] Although IHS officials said these templates were also shared with tribal facilities and urban Indian health programs, only IHS facilities have been directed to submit them. IHS headquarters officials told us in April that the area directors would be responsible for reviewing the plans and at this time IHS's headquarters would not conduct any additional review or analysis.

CMS

CMS has likewise reported disseminating information to I/T/U facilities about program eligibility rules under Medicaid and CHIP, and introductory material about the expanded and new coverage options, through regional and national training in collaboration with IHS, webinars, web-based videos, regular conference calls, and through the agency's regional Native American Contacts.[62] However, officials from most of the nine facilities and three tribes that we interviewed said that they received little or no guidance from CMS regarding expanded Medicaid or the Exchanges as of February 2013, similar to what they reported about a lack of information from IHS.[63] CMS officials indicated that additional, more-specific regional training on Medicaid expansion and the Exchanges would be planned after more states made decisions about whether to participate in expanded Medicaid or how Exchanges will operate. CMS officials also told us that they are planning nationwide training on PPACA-related changes, including expanded Medicaid and the Exchanges. The

[61]Additional components of the IHS business plan template include assessing the potential for growth in third-party billing and determining the effect on CHS programs, and other assessments to help prepare facilities for expanded and new coverage options.

[62]Native American Contacts are CMS staff based in the agency's 10 regional offices who serve as a resource to tribes and I/T/U facilities for questions about Medicaid, CHIP, and Medicare.

[63]According to HHS, travel restrictions and budget cuts in recent years have impeded CMS's ability to provide the typical level of in-person training for I/T/U facilities.

officials said this training is intended to include a broader audience than the past regional training and will include tribal and community leaders in addition to I/T/U facility staff.

CMS officials described a variety of direct outreach materials the agency has developed to educate American Indian and Alaska Native communities about current Medicaid and CHIP, including posters, brochures, and DVDs, for use by facilities in promoting enrollment in current programs. Officials told us that, as part of the agency's implementation of provisions regarding expanded Medicaid and the Exchanges, its Office of Communications is developing a general outreach strategy, which will include an American Indian and Alaska Native–specific component led by the CMS Tribal Affairs Group in collaboration with IHS. In March 2013, officials told us they planned to implement this outreach strategy in the coming months, noting that they did not want to launch outreach too early because the application to enroll would not be available until October 2013.[64] Officials also told us that they recently adapted materials developed for the general population by the Office of Communications with specific information on expanded Medicaid for American Indians and Alaska Natives, which were distributed in March 2013 to attendees of IHS regional tribal consultation meetings. In May 2013, CMS officials told us they recently launched a public website containing materials, including brochures, about the Exchanges for the general population, and were conducting a national awareness campaign about the Exchanges. As of May 2013, CMS was adapting the materials on the website for the American Indian and Alaska Native population, which were still under internal review.[65] In addition, CMS officials told us they plan to issue an announcement later this year to provide an additional $4 million in funding specifically for tribal outreach for Medicaid and CHIP, as authorized by PPACA. The $10 million in CHIPRA tribal outreach grants CMS administered to 41 organizations in 2010 resulted in nearly 20,000 American Indian and Alaska Native children enrolled in the

[64]A 6-month initial open enrollment period for the Exchanges is expected to begin October 2013 for the coverage that begins in January 2014.

[65]In May 2013, CMS officials told us that the website about the Exchanges, at marketplace.cms.gov, would be relaunched once the materials targeted to the American Indian and Alaska Native population had been approved.

first 2 years of funding.[66] Although the grants did not include an emphasis on the expanded and new coverage options, one CMS official noted that the lessons learned about effective tribal outreach through grantees' efforts can be applied to future years.

States

Two of the three states we interviewed conducted training for facility staff on their current Medicaid and CHIP programs and all three produced outreach materials, although none were engaged in training or outreach for expanded Medicaid or the Exchanges as of February 2013. Specifically, Montana and New Mexico reported conducting some training for I/T/U facilities regarding program eligibility and enrollment procedures under current Medicaid and CHIP, but not for expanded Medicaid or the Exchanges. These states distributed Medicaid and CHIP information to facilities through training, regular meetings with business managers and, in Montana, on-site training. Although officials in South Dakota indicated the state had not conducted any training of its own, the state has provided materials for the IHS area office to distribute to facility staff with information on eligibility and enrollment procedures. Direct outreach to American Indians and Alaska Natives by all three states we spoke with was limited and focused on current Medicaid and CHIP programs. Specifically, all three states produced and distributed print materials promoting their current Medicaid and CHIP programs, such as brochures and posters, and New Mexico also conducted radio advertising. Additionally, in Montana, the Medicaid program provided reimbursement for outreach activities conducted by two tribes.[67] None of the three states reported conducting any outreach regarding the expanded and new coverage options.

---

[66]CMS reported that grantees enrolled, or in some cases reenrolled, 19,602 American Indian and Alaska Native children through the second year of the 3-year grant period (April 16, 2010, to April 15, 2013); however, data were reported for only 35 of the 41 grantees. According to the CMS official we spoke with, certain data-reliability issues that prevented complete reporting in the first and second year were being addressed, and data for the third year would be available in 2014.

[67]Members of the Tribal Technical Advisory Group, a body that advises CMS on American Indian and Alaska Native issues, told us that the cost associated with Medicaid outreach is not affordable for many tribes and that few states provide reimbursement, although states' interest in the practice may be increasing. According to CMS officials, in addition to Montana, California's Medicaid program has also been approved to allow Medicaid matching for tribal outreach activities, plans for Washington and Alaska were pending, and three other states had expressed interest. Such reimbursement will assist those tribes for whom outreach activities may not otherwise be affordable.

Besides facility training and outreach as a means of facilitating enrollment of American Indians and Alaska Natives, officials in all three states reported more than one option available for individuals to enroll in Medicaid or CHIP. In addition to the option of enrolling at local enrollment offices and by mail, individuals could enroll online in Montana and by means of e-mail in New Mexico. Additionally, New Mexico installed electronic enrollment kiosks in select locations, and South Dakota was in the process of implementing kiosks with a native language audio format option. Although all the I/T/U facility staff we interviewed helped patients with submitting enrollment applications, eligibility was generally determined by the Medicaid program's local enrollment office; however, in Montana, the state entered into an agreement with one tribe to allow the tribe to complete the Medicaid determination process itself. Finally, two states—Montana and New Mexico—allowed for presumptive eligibility for children and pregnant women, in which individuals who appear to be eligible can receive covered services while their applications are being processed.

I/T/Us and Tribes

All the facilities we interviewed—three IHS-operated, three tribally operated, and three urban Indian health programs—reported that they routinely screen patients visiting their clinics for potential eligibility for Medicaid and CHIP.[68] The three tribal facilities, three urban Indian health programs, and three CHIPRA tribal outreach grantees were also involved in community outreach efforts outside of the clinic, including participation at community events, such as health fairs, pow wows, school events, and senior-center meetings. Several facilities and CHIPRA tribal outreach grantees reported that incentives, such as gift cards, baby supplies, and raffle tickets, were effective tools for generating interest. Several facilities and CHIPRA grantees also reported using other outreach methods, including radio, TV, newspapers, direct mail, and Facebook. Two of the CHIPRA grantees reported using home visits as their primary outreach method. In contrast, one of the three IHS-operated facilities we met with conducted community outreach; the other two said they rely on the tribes in their service area to conduct outreach. As of February 2013, none of the I/T/U facilities we spoke with reported conducting any early outreach

[68]In addition to community outreach, one tribal facility conducted targeted "cold calls" to tribal members turning 65 to set up a clinic visit, at which Medicare eligibility would be determined, and screened high-cost CHS users for eligibility for the state or federal high-risk insurance pool, private coverage through a spouse, or possible Medicaid or Medicare eligibility through disability status.

regarding the expanded and new coverage options. However, in June 2013 IHS officials told us that, as part of its business plan template, IHS facilities are expected to assess the need for, and describe, their planned outreach activities.

Multiple Barriers, Including Uncertainty and Lack of Capacity Building, Hinder Enrollment in Expanded Medicaid and New Coverage Options

We identified several issues that have presented and continue to present challenges to efforts to promote the enrollment of American Indians and Alaska Natives in the expanded and new coverage options, including legal and policy uncertainties, lack of capacity building, unfamiliarity with new and expanded coverage options, and tribes' limited access to coverage status information that could help target outreach efforts.

Uncertainty Related to Pending Legal and Policy Decisions

Officials we interviewed at federal agencies and I/T/U facilities told us when we spoke with them prior to, and immediately following, the Supreme Court's decision regarding PPACA that they were waiting for the court's decision, and subsequently their states' decisions about Medicaid expansion, before developing a plan to launch education and enrollment activities. Before the Supreme Court's decision, both IHS and CMS headquarters officials noted they were waiting for the decision before engaging in more widespread efforts to educate facilities and American Indians and Alaska Natives about the expanded and new coverage options. Similarly, officials in the Albuquerque area—from the area office, New Mexico Medicaid office, and two of the three facilities we spoke with in the area—cited the pending Supreme Court decision, later released in June 2012, as the reason for little or no action taken to that point. Following the Supreme Court's decision, we met with officials from the Aberdeen and Billings IHS service areas. Officials with the two IHS area offices, the South Dakota and Montana state Medicaid offices, and several facilities all cited uncertainty regarding their state's pending decision about Medicaid expansion as a reason for continued inaction as of the time we spoke with them. As of June 2013, New Mexico had opted to participate in Medicaid expansion, South Dakota decided not to participate, and Montana had not decided.[69]

[69]South Dakota announced in December 2012 that it would not participate in Medicaid expansion; New Mexico announced in January 2013 that it will participate; and, as of June 2013, Montana's Governor supported Medicaid expansion, but its legislature had not yet enacted a plan to expand it.

Lack of Capacity Building

I/T/U facilities will likely face increased workload related to enrollment in, and reimbursement from, Medicaid and the Exchange health plans with the estimated addition of hundreds of thousands of American Indians and Alaska Natives into expanded Medicaid and, to a lesser extent, the new coverage options under the Exchanges. IHS officials told us, however, that the agency has no national plan in place to adjust the number of patient benefit coordinators—I/T/U staff responsible for identifying program eligibility and assisting with enrollment—and billing staff to handle the large number of individuals who may seek to enroll in expanded Medicaid and the new coverage options. Officials said that increased collections through third-party billing from enrollments in public programs may provide additional funds to hire such staff, although they also acknowledged that such increased capacity would be needed prior to an increase in enrollment and collections. Officials told us that facility directors will need to maximize existing resources, adding that IHS's ability to manage the implementation process at tribally operated facilities and urban Indian health programs is limited. To help facility directors prepare for the implementation of expanded and new coverage options, officials told us in April 2013 that IHS developed a business plan template that calls for facilities to assess their current levels of public and private insurance, potential enrollment growth, effect on staffing levels, the workforce needed for enrollment activities, and marketing strategy. According to IHS Headquarters officials, all federally operated IHS facilities have been directed to use the business plan template to complete and submit their implementation plans by May 2013. The lack of a plan to shift staff to help facilitate increased enrollment in, and billing for, expanded Medicaid and new coverage options could result in some eligible American Indians and Alaska Natives remaining unenrolled or some facilities unable to bill for services. In contrast, federal internal control standards specify that agency management should ensure that proper personnel, with the right training, are in place to enable organizational success. Officials expressed doubt, however, that the demand for expanded Medicaid and the Exchanges would be high when enrollment begins.

Unfamiliarity with Expanded and New Coverage

Officials with two of the three CHIPRA tribal outreach grantees with whom we met were unaware of Medicaid expansion and creation of the Exchanges at the time we first spoke with them, in June through August 2012, more than 2 years after the enactment of PPACA. As direct service tribes, they relied on IHS-operated facilities for most of their health care services. The various training options cited by IHS and CMS, some of which included content on the expanded and new coverage options, were largely targeted to staff from IHS-operated and tribally operated facilities,

resulting in a potential gap in the level of awareness among direct service tribes, which generally do not operate their own health care facilities. Additionally, many of the officials from the I/T/U facilities we interviewed lacked awareness about eligibility for cost-sharing exemptions for insurance obtained through the Exchanges. CMS officials told us that they are including language in the brochures being developed for this population that will clarify which American Indians and Alaska Natives are eligible for cost-sharing exemptions and other provisions.

Limited Access to Information

At least one tribal facility or CHIPRA tribal outreach grantee in each of the three areas in which we focused our interviews reported a lack of information on tribal members' Medicaid enrollment status, which they said limits their ability to target outreach to nonenrollees and assist enrolled members with their annual Medicaid renewal applications. Specifically, they said that they had been unable to receive information on members' coverage status from their states because of restrictions on information sharing under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Privacy Rule promulgated under HIPAA permits individually identifiable health information to be shared in connection with providing or paying for health care but otherwise generally does not permit such information, including coverage status, to be shared without individuals' authorization.[70] Entities subject to the HIPAA Privacy Rule may, however, share such information without obtaining authorization in certain circumstances, such as in connection with government agencies providing public benefits.[71] The HIPAA Privacy Rule permits information sharing between health care providers and payers such as state Medicaid agencies and I/T/Us in connection with providing health care. Direct service tribes receive the majority of their

[70]See 45 C.F.R. § 164.502. The HIPAA Privacy Rule prescribes requirements and standards for protecting individually identifiable health information. An individual's insurance status is considered individually identifiable health information and is protected from unauthorized disclosure under the HIPAA Privacy Rule. See 45 C.F.R. § 160.103. Disclosure of protected health information for purposes of treatment, payment, or health care operations is generally permitted. See 45 C.F.R. § 164.506.

[71]Under the HIPAA Privacy Rule, a government agency administering a government program providing public benefits, such as a state Medicaid agency, may disclose individually identifiable health information relating to the program to another government agency administering a government program providing public benefits, such as IHS and tribal health facilities, if the programs serve the same or similar populations and the disclosure of the information is necessary to coordinate, or to improve the administration and management of, the programs. See 45 C.F.R. § 164.512(k)(6)(ii).

primary health care services from IHS. In some instances, direct service tribes choose to provide services or operate a portion of or a health program pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA). Direct service tribes are considered tribal health providers for those services or programs operated under an ISDEAA self-determination contract or self-governance compact. According to CMS officials, in the context of these services or programs, states are thus permitted to share information with these tribes on their members' coverage status without authorization. Confusion among states about whether they are allowed to share coverage status with tribes, particularly with direct service tribes, is an ongoing concern, they said, in part because the HHS guidance that clarified the permissibility of such sharing is nearly 30 years old and pre-dates HIPAA. This confusion limits tribes' ability to assist their members with enrollment. Officials with one direct service tribe told us their preferred method for Medicaid outreach is door-to-door home visits, although they said the tribe is not able to target those efforts due to a lack of information on members' coverage status, which reduces its effectiveness. All three CHIPRA tribal outreach grantees we interviewed said that they track the applications they submit as part of their outreach and enrollment efforts, although two noted that the applications submitted represent a small proportion of those eligible to enroll. One CHIPRA tribal grantee noted that keeping eligible members enrolled in Medicaid is also a challenge because many lack a permanent address or mailbox, and so do not receive renewal notices from the state. These challenges may affect HHS's ability to achieve its goal of increasing health insurance coverage among racial and ethnic minorities as a means to eliminate health disparities.

Conclusions

The expansion of Medicaid and new coverage options under PPACA may allow many American Indians and Alaska Natives to obtain additional health care benefits for which they were not previously eligible. If American Indians and Alaska Natives enroll in these programs and choose to receive care through IHS, the increase in reimbursements from third-party payers may free up resources and help alleviate some of the pressures on I/T/U facilities' and CHS budgets that contribute to unmet health care needs. Although some uncertainty remains regarding which states will opt to participate in Medicaid expansion, a significant share of the estimated hundreds of thousands of American Indians and Alaska Natives who could be eligible for expanded Medicaid are in states that plan to participate.

I/T/Us are leading current efforts to identify members who may be eligible for Medicaid and CHIP and assist with their enrollment process, and are poised to continue those efforts in the future. However, given the complexities of the eligibility requirements for different programs, these efforts can only be successful if facilities receive timely and important information from IHS and CMS, including specific information about new and expanding coverage options, such as eligibility rules, enrollment procedures, and other implementation details. The efforts to date to educate American Indians and Alaska Natives, and the facilities that serve them, about the coverage options available beginning in 2014 do not resemble the successful campaigns launched in advance of other recent programs. IHS and CMS have limited time to conduct a major outreach campaign before October 2013, when open enrollment in expanded Medicaid and the Exchanges begins. Increased enrollment will clearly lead to an increased workload for I/T/U facility staff; however, as of April 2013, IHS does not have an effective plan in place to ensure that a sufficient number of I/T/U staff are prepared to assist with enrollment and to process increased third-party payments. IHS officials told us their business plan template is intended to encourage facilities to plan for an increase in enrollment in expanded and new coverage options, although the effect of this step remains to be seen.

Recommendations for Executive Action

To help ensure successful outreach efforts resulting in significant new enrollment, we recommend that the Secretary of Health and Human Services direct

1. the Director of IHS and the Administrator of CMS to coordinate a plan to

    - improve their communication with facility staff and tribal leaders to ensure that information on Medicaid and the Exchanges, including detailed information on program eligibility rules and enrollment procedures, is being disseminated to all facilities and tribes and

    - increase direct outreach to American Indians and Alaska Natives who may be eligible for expanded Medicaid and the Exchanges;

2. the Director of IHS to prepare for the increase in eligibility for expanded Medicaid and new coverage options, and the need for enrollment assistance and billing capacity, by realigning current resources and personnel to increase capacity to assist with these efforts; and

3. the Administrator of CMS to develop a plan to educate state Medicaid agencies about when coverage status information may be shared between states and I/T/U facilities and tribes.

Agency Comments and Our Evaluation

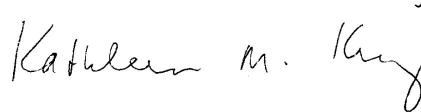
We provided a draft of this report for comment to HHS. HHS provided written comments, which we summarize below, in which HHS agreed with one recommendation and neither agreed nor disagreed with two recommendations. HHS's letter is reprinted in appendix IV. HHS also provided technical comments, which we incorporated as appropriate.

HHS agreed with our recommendation for CMS and IHS to coordinate a plan to improve communications with facility staff and tribal leaders and increase direct outreach to American Indians and Alaska Natives who may be eligible for expanded Medicaid and the Exchanges. The department noted that CMS is working closely with IHS to develop and review outreach materials and information dissemination and training strategies. HHS also cited a number of activities conducted in 2012 and 2013 intended to increase awareness among American Indians and Alaska Natives of expanded Medicaid and the Exchanges. In addition, in our draft report, we recommended the development of a strategy for educating American Indians and Alaska Natives about the effect of PPACA's definition of Indian on their coverage options and obligations. The issuance of HHS's final rule, which was released after our draft report had been submitted to HHS for review and comment, lessened the need for this strategy, and we deleted this recommendation accordingly.

HHS did not specify in its response whether it agreed or disagreed with our two remaining recommendations. In commenting on our recommendation for IHS to prepare for the increase in eligibility for expanded Medicaid and new coverage options and the need to increase its capacity for enrollment assistance and billing, HHS noted that the IHS business plan template is intended to serve this purpose. In light of the decentralized nature of this approach, we continue to believe that IHS should realign current resources and personnel to assist with these efforts. In commenting on our recommendation for CMS to develop a plan to educate states about sharing coverage information with I/T/Us and tribes, HHS noted that it plans to provide information to states as part of its technical assistance activities, but that it needed additional clarity about our recommendation to fully comment. We had subsequent discussions with HHS and CMS regarding this recommendation and revised our report and the recommendation to reflect those discussions.

We are sending copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http//www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of the report. GAO staff who made major contributions to this report are listed in appendix V.



Kathleen M. King
Director, Health Care

List of Addressees

The Honorable Maria Cantwell
Chairwoman
The Honorable John Barrasso
Vice Chairman
Committee on Indian Affairs
United States Senate

The Honorable Don Young
Chairman
The Honorable Colleen Hanabusa
Ranking Member
Subcommittee on Indian and Alaska Native Affairs
Committee on Natural Resources
House of Representatives

The Honorable Tim Johnson
United States Senate

The Honorable Lisa Murkowski
United States Senate

The Honorable John Thune
United States Senate

Appendix I: Methodology for Estimating Potential Eligibility for American Indians and Alaska Natives in Expanded Health Coverage

To estimate the number of American Indians and Alaska Natives potentially eligible for expanded Medicaid and new coverage options that will be available beginning in 2014, we examined data from the American Community Survey (ACS) of the U.S. Census Bureau, which contains nationwide information on race, age, income, and health insurance coverage, and other variables as described below. We used 3 years of ACS data to make reliable estimates at the state and Indian Health Service (IHS) service area levels.[1] In order to capture the appropriate family ties and income for determining program eligibility, we used an augmented version of the ACS data prepared by the University of Minnesota Population Center—the Integrated Public Use Microdata Series (IPUMS). We used the most recent data available—2009 through 2011—to provide estimates of American Indians and Alaska Natives eligible for coverage in expanded Medicaid,[2] the Basic Health Program, and income-based cost-sharing exemptions for American Indians and Alaska Natives and premium tax credits in the Exchanges—at the national, IHS service area, and state levels.

About the ACS

The ACS collects information about age, sex, race, family and relationships, income and benefits, health insurance, education, veteran status, disabilities, and geographic location, among other variables. The ACS initially samples about 3 million addresses each year, resulting in about 2 million final interviews for each year's survey. For the 2011 survey, a sample of 2.3 million households was selected from a sample frame of about 3.5 million. For the 2010 and 2009 surveys, a sample of 2.1 million households was selected from a sample frame of 3.1 million, for each year.[3]

[1]IHS coordinates care in 12 geographic areas in 35 states. The areas are Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

[2]The ACS data groups Medicaid and the Children's Health Insurance Program (CHIP) together when collecting information about Medicaid coverage status. As a result, some individuals eligible for CHIP are combined with Medicaid in our analysis.

[3]Information for the ACS was collected from housing units as well as group quarters, which include college dormitories, correctional facilities, and nursing facilities.

In general, ACS estimates are period estimates that describe the average characteristics of population and housing over a period of data collection. The 2009-2011 ACS 3-year estimates are averages over the period from January 1, 2009 to December 31, 2011, and reflect what the average value is over the full period. Because survey data are based on a sample of the population, the numbers in the report are not the same as those that would be obtained if everyone in the population were actually counted. For this reason, the ACS combines data from multiple years to produce reliable estimates for small areas—such as states—and population groups, such as American Indians and Alaska Natives. To produce data for small communities—between 20,000 and 65,000 individuals—3 years of data collection are pooled to produce reliable estimates.

Estimates from the ACS are subject to some sampling error. To assess the precision of these estimates, we calculated a relative standard error for each estimate. A relative standard error is calculated by dividing the standard error of the estimate by the estimate itself. For example, if an estimate has a mean of 100 and a standard error of 20, the relative standard error would be 20/100, which would be 20 percent. Estimates with small relative standard errors are considered more reliable than estimates with large relative standard errors. A small relative standard error is a more precise measurement since there is less variance around the mean. Unless otherwise noted, we present estimates that have relative standard errors of less than 15 percent. In addition to sampling errors, nonsampling errors may affect the data; however, the Census Bureau takes steps to minimize these errors.

The results of ACS data analysis are based on self-reported information. The Census Bureau applied some logical edits to the data to correct for obvious misunderstanding of the questions. All respondents to the survey are asked to identify their race, with the option to check one or more boxes indicating racial category.[4] We refer to respondents who marked

[4]Specifically, the ACS questionnaire asks respondents to indicate their race by marking one or more selections among a number of racial categories, including white, black/African American, American Indian or Alaska Native, several options for Asian American and Pacific Islander, or “some other race,” with the option to fill in the name of an unlisted race. The ACS asks respondents a separate question about their Hispanic origin. Because Hispanic origin is not treated as a racial category, some individuals who identify solely as American Indian and Alaska Native may also identify as being of Hispanic origin.

only the “American Indian or Alaska Native” response box as the “American Indian and Alaska Native alone” population. We refer to respondents who marked both the “American Indian and Alaska Native” response box and one or more other racial categories as the “American Indian and Alaska Native alone or in combination” population. Self-identification as an American Indian and Alaska Native in the ACS is not an indication of either being a member of a federally recognized tribe or eligibility for IHS services. In the absence of ACS data on IHS eligibility, we report our results separately for American Indians and Alaska Natives alone, and American Indians and Alaska Natives alone or in combination, allowing us to provide a lower and upper bound within which the number who are actually IHS-eligible is likely to fall. The range we report—of those identifying as American Indian and Alaska Native alone and those identifying as American Indian and Alaska Native alone or in combination with another race—include American Indians and Alaska Natives who are members of a federally recognized tribe. We excluded foreign-born American Indians and Alaska Natives from our analysis, as these individuals are generally unlikely to be eligible for IHS services.[5]

ACS data are reported in Public Use Microdata Areas (PUMA), which aggregates smaller counties or breaks up larger counties into units of 100,000 individuals to protect anonymity. We created a crosswalk between the counties included in PUMAs and the counties included in each of the 12 geographic areas the Indian Health Service has designated for service, called IHS service areas.

Like other survey-based sources of coverage data—such as the National Health Interview Survey—the estimates from ACS data of Medicaid coverage are lower than numbers found in program counts by the Centers for Medicare & Medicaid Services (CMS), even after logical edits have been applied by the Census Bureau. In order to account for a variety of scenarios that might contribute to the differences in these

[5]We included native-born American Indians and Alaska Natives if they reported being born in the United States or its territories, or if they were born abroad to a parent or parents who were U.S. citizens. We excluded foreign-born American Indians and Alaska Natives if they reported being a naturalized citizen, or not a citizen. While American nationality is not a criterion for receiving IHS services, and several American Indian and Alaska Native tribes straddle the Canadian and Mexican borders, we aimed to include tribes that would be eligible for IHS services rather than tribes from, for example, South or Central America. Individuals from these tribes may report being American Indian or Alaska Native on the ACS.

numbers, one group of researchers has developed an additional set of edits—for example, assigning to Medicaid a child for whom no coverage was reported when that child has a sibling enrolled in Medicaid.[6] We did not apply these edits because the publicly available data set was sufficient for the purpose of providing an approximate range in which the number of IHS-eligible American Indians and Alaska Natives could fall.

Augmented American Community Survey Dataset

In order to capture the appropriate family ties and income for determining program eligibility, we used an augmented version of the ACS data prepared by the University of Minnesota Population Center—the Integrated Public Use Microdata Series (IPUMS).[7] The IPUMS dataset constructs a health insurance unit variable that follows program eligibility definitions of family eligibility more closely than the ACS' household unit.

Estimating Eligibility for American Indians and Alaska Natives in Expanded Medicaid and New Coverage Options

The Patient Protection and Affordable Care Act (PPACA) expanded Medicaid and created new coverage options. For expanded Medicaid, assuming all states opt to participate, we estimated

- the total number of American Indians and Alaska Natives who are potentially eligible under the eligibility rules beginning in 2014, including: (1) all American Indians and Alaska Natives at or below 138 percent of the federal poverty level (FPL);[8] (2) American Indians and Alaska Natives above 138 of the FPL who were eligible in each state in 2011; (3) American Indians and Alaska Natives who received

[6]See Victoria Lynch et al., "Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits" (Urban Institute Health Policy Center: Sept. 27, 2011). The researchers developed 16 additional edits applied to responses from children and 6 additional edits applied to responses from nonelderly adults, which when applied, resulting in a 3.5 and 0.8 percent increase in their Medicaid/CHIP estimates, respectively.

[7]Steven Ruggles et al., Integrated Public Use Microdata Series: Version 5.0, machine-readable database (Minneapolis: University of Minnesota, 2010).

[8]The FPL is another name for the poverty guidelines issued annually in the Federal Register by the Department of Health and Human Services. The FPL is a simplified version of the national poverty thresholds used for counting the number of people in poverty, and is used mainly for administrative purposes, such as determining eligibility for program participation.

supplemental security income;[9] and (4) American Indians and Alaska Natives who reported in the ACS as being enrolled in Medicaid, but who did not meet the other three criteria;[10]

- the number of American Indians and Alaska Natives who reported in the 2009-2011 ACS as being currently enrolled; and
- the number of potential new enrollees, calculated by determining the number of individuals who will be potentially eligible for expanded Medicaid including some who may be eligible now, but did not report to the ACS as being currently enrolled.[11]

To examine the number of American Indians and Alaska Natives who would be eligible for other benefits if they were not eligible for Medicaid, we also estimated the number of American Indians and Alaska Natives potentially eligible for the

- Basic Health Program option, if their income was between 138 and 200 percent of the FPL;

[9]All states provide Medicaid eligibility based on disability status. In 39 states and the District of Columbia, recipients of supplemental security income are eligible for Medicaid, while 11 states apply their own eligibility criteria for Medicaid eligibility based on their own measures of disability status. Because these states allow Medicaid eligibility based on some measure of disability status, we did not exclude them.

[10]About 7.2 percent of those who identified as being currently enrolled in Medicaid did not otherwise meet our criteria—that is, they did not report income below the levels we used to estimate eligibility for Medicaid or report receiving supplemental security income. This could be due to a variety of factors, such as: a difference between state Medicaid eligibility rules during the survey response time frame (2009-2011) and the year reflected in the state-specific limits we applied to the data (2011); a difference in how income is defined in the ACS, in contrast to how income is applied for Medicaid eligibility, which excludes certain income sources; or a difference in how individuals reported income and family structure when applying for Medicaid compared to how they reported income and family structure to the ACS.

[11]We also estimated at the national level the proportion of potential new enrollees who were newly eligible under 2014 eligibility rules, which does not include those American Indians and Alaska Natives who are currently eligible but unenrolled.

- income-based cost-sharing exemptions for insurance obtained through the Exchanges,[12] if their income was between 138 and 300 percent of the FPL; and
- premium tax credits for insurance obtained through the Exchanges, if their income was between 138 and 400 percent of the FPL.

In this report, we do not conduct projections of eligibility based on future income; instead, we estimate the number of American Indians and Alaska Natives who would be eligible for programs and benefits beginning in 2014 based on the most recent data currently available. We did not predict the number of people who will participate in these programs and benefits, commonly referred to as the take-up rate. As public programs generally do not have full take-up, and take-up for Medicaid and the Children's Health Insurance Program (CHIP) generally tends to be lower for American Indians and Alaska Natives than the rest of the population,[13] it is likely not all who are eligible for Medicaid and new coverage options will enroll.

Program eligibility among our samples was determined by comparing total income of the health insurance unit to the FPL. In order to determine whether individuals were eligible for expanded Medicaid or new coverage options, we defined two factors needed to compare the income to the FPL: (1) the number of people in the family—defined by the health insurance unit in our analysis; and (2) the total family income, added for all individuals with the same health insurance unit identification code. Income was then adjusted to 2011 dollars across all 3 years of the survey, in order to determine the poverty level status for program eligibility.[14] We discussed our approach with a Census Bureau senior

[12]American Indians and Alaska Natives who are members of federally recognized tribes are also eligible for cost-sharing exemptions for services are obtained through Indian health facilities, regardless of income. Because the ACS data do not include a variable for tribal enrollment status, we were unable to estimate the number of individuals who may be eligible for these services.

[13]See Genevieve M. Kenney et al., "Who and Where are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?" *Health Affairs*, vol. 29, no. 10 (2010).

[14]For 2011, the FPL for a family of four was $22,350 in the lower 48 states and the District of Columbia, $27,940 in Alaska, and $25,710 in Hawaii.

official, who agreed that our approach regarding this analysis was reasonable.

In conducting our analysis, we considered several other data sources, including the Current Population Survey, the National Health Interview Survey, and the Medicaid Statistical Information System and the Medicaid Analytic Extract. After reviewing these sources, we determined that data from the ACS were the most appropriate for our analysis for determining the number of individuals potentially eligible for these expanded Medicaid and new coverage options based on family income and race, and reporting on areas smaller than the state level in some cases. This information is not complete or consistently collected in the other sources. For example, while data from the Medicaid Statistical Information System and the Medicaid Analytic Extract include a race variable to identify American Indians and Alaska Natives, the states do not consistently collect this information.

Appendix II: Estimates of Potential Medicaid Eligibility for American Indians and Alaska Natives, by Indian Health Service (IHS) Area

	American Indian and Alaska Native alone			American Indian and Alaska Native alone or in combination with another race		
IHS Service Area	Total potentially eligible number (percent)	Current enrollment[a] number (percent)	Potential new enrollment[b] number (percent)	Total potentially eligible number (percent)	Current enrollment[a] number (percent)	Potential new enrollment[b] number (percent)
Aberdeen	59,645 (73)	32,441 (40)	27,203 (33)	72,534 (70)	39,632 (38)	32,902 (32)
Alaska	57,078 (62)	27,276 (30)	29,802 (33)	74,320 (58)	35,562 (28)	38,758 (30)
Albuquerque	61,523 (64)	31,363 (33)	30,161 (31)	74,578 (63)	37,710 (32)	36,868 (31)
Bemidji	50,568 (61)	29,668 (36)	20,900 (25)	82,120 (60)	48,595 (36)	33,526 (25)
Billings	22,962 (61)	11,711 (31)	11,251 (30)	26,935 (58)	13,791 (30)	13,144 (28)
California	58,994 (53)	31,218 (28)	27,776 (25)	120,525 (51)	65,886 (28)	54,640 (23)
Nashville	42,087 (53)	22,155 (28)	19,932 (25)	97,217 (52)	53,347 (28)	43,870 (23)
Navajo	146,317 (72)	85,197 (42)	61,120 (30)	150,533 (71)	88,018 (42)	62,515 (30)
Oklahoma City	135,383 (52)	57,261 (22)	78,121 (30)	259,501 (53)	119,474 (24)	140,027 (28)
Phoenix	114,589 (62)	59,271 (32)	55,319 (30)	149,119 (58)	77,813 (30)	71,306 (28)
Portland	77,737 (55)	42,807 (30)	34,930 (25)	156,182 (53)	88,692 (30)	67,490 (23)
Tucson	23,157 (70)	14,841 (45)	8,316 (25)	27,294 (65)	17,375 (42)	9,919 (24)
IHS service area total	**850,039 (60)**	**445,208 (32)**	**404,830 (29)**	**1,290,859 (57)**	**685,895 (30)**	**604,964 (27)**
Non-IHS service areas	518,276 (54)	273,045 (28)	245,231 (25)	1,278,549 (51)	692,028 (28)	586,521 (23)

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Our estimates are based on the assumption of all states opting to expand Medicaid. While some states have indicated they do not intend to participate, they may opt to do so at a later date. We did not predict the number of people who will participate in this program, commonly referred to as the take-up rate.

Because the number of IHS-eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range. We excluded foreign-born American Indians and Alaska Natives from our analysis.

The estimates we present have relative standard errors of less than 15 percent.

[a]We use the term “current enrollment” to refer to estimated enrollment based on responses to the 2009-2011 ACS.

[b]We estimated potential new enrollment as those who will be newly eligible for expanded Medicaid and some who may be eligible now, but did not report to ACS as being currently enrolled. Percentages of current enrollment and potential new enrollment may not add up to the total of potentially eligible due to rounding.

Appendix III: Potential Eligibility for Expanded Health Coverage in 2014, Nationally, by IHS Service Area, and by State

We examined data to provide estimates of the number of American Indians and Alaska Natives potentially eligible for expanded Medicaid[1] and new coverage options that will be available beginning in 2014, including the Basic Health Program option and the premium tax credits and the exemption from cost-sharing for insurance obtained through the Exchanges. We used an augmented version of the U.S. Census Bureau's American Community Survey (ACS) 2009-2011 data, called the Integrated Public Use Microdata Series. For Medicaid, we estimated the total number of American Indians and Alaska Natives who are potentially eligible under provisions of PPACA applicable in 2014; the number of American Indians and Alaska Natives who reported being currently enrolled; and potential new enrollment, calculated by determining the number of individuals who will be newly eligible for expanded Medicaid and some who may be eligible now, but did not report to ACS as being currently enrolled. We also estimated the number of American Indian and Alaska Natives potentially eligible for coverage in a state that chooses the Basic Health Program option beginning in 2015, and income-based cost-sharing exemptions and premium tax credits for insurance obtained in the Exchanges beginning in 2014. Because the number of individuals eligible for services provided by the Indian Health Service (IHS) is likely to be between the number identifying as American Indian and Alaska Native alone, and the number identifying as American Indian and Alaska Native in combination with one or more other racial/ethnic groups, we present results for both groups as the range. In the absence of precise data, this approach allowed us to present a lower and upper bound.

Tables 3 through 9 present the results of our estimates by IHS service area or by state.

[1]The ACS data groups Medicaid and CHIP together when collecting information about Medicaid coverage status. As a result, some individuals eligible for CHIP are combined with Medicaid in our analysis.

Table 3: Estimates of the Number and Percentage of All Races Potentially Eligible for Expanded Medicaid in 2014, by Indian Health Service (IHS) Service Area

IHS Service Area	Total potentially eligible number (percent)	Current enrollment[a] number (percent)	Potential new enrollment[b] number (percent)
Aberdeen	656,204 (33)	282,311 (14)	373,893 (19)
Alaska	239,010 (34)	104,497 (15)	134,513 (19)
Albuquerque	1,041,685 (47)	481,496 (22)	560,189 (25)
Bemidji	2,408,969 (36)	1,154,241 (17)	1,254,728 (19)
Billings	200,454 (33)	80,061 (13)	120,393 (20)
California	4,302,079 (41)	2,056,411 (20)	2,245,668 (22)
Nashville	8,297,725 (39)	3,835,419 (18)	4,462,307 (21)
Navajo	268,851 (53)	140,960 (28)	127,892 (25)
Oklahoma City	1,621,849 (41)	669,412 (17)	952,438 (24)
Phoenix	3,362,161 (37)	1,471,219 (16)	1,890,942 (21)
Portland	3,597,807 (34)	1,631,993 (16)	1,965,814 (19)
Tucson	421,364 (42)	218,839 (22)	202,525 (20)
IHS service area total	**26,418,161 (38)**	**12,126,858 (18)**	**14,291,303 (21)**
Non-IHS service areas	89,331,678 (37)	41,069,559 (17)	48,262,119 (20)

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Our estimates are based on the assumption of all states opting to expand Medicaid. While some states have indicated they do not intend to participate, they may opt to do so at a later date. We did not predict the number of people who will participate in this program, commonly referred to as the take-up rate.

The estimates we present have relative standard errors of less than 15 percent.

[a]We use the term “current enrollment” to refer to estimated enrollment based on responses to the 2009-2011 ACS.

[b]We estimated potential new enrollment as those who will be newly eligible for expanded Medicaid and some who may be eligible now, but did not report to ACS as being currently enrolled. Percentages of current enrollment and potential new enrollment may not add up to the total of potentially eligible due to rounding.

Table 4: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid in 2014, by State

	American Indian and Alaska Native alone			American Indian and Alaska Native alone or in combination with another race		
State	Total potentially eligible number (percent)	Current enrollment[a] number (percent)	Potential new enrollment[b] number (percent)	Total potentially eligible number (percent)	Current enrollment[a] number (percent)	Potential new enrollment[b] number (percent)
Alabama	10,562 (43)	4,841 (20)	5,721 (24)	25,563 (46)	11,340 (21)	14,223 (26)
Alaska	63,281 (63)	30,665 (30)	32,616 (32)	80,988 (59)	39,162 (29)	41,826 (31)
Arizona	192,553 (68)	117,001 (42)	75,552 (27)	219,568 (66)	133,706 (40)	85,862 (26)
Arkansas	8,024 (45)	4,357 (24)	3,667 (20)	22,673 (50)	11,955 (26)	10,718 (23)
California	127,298 (52)	70,950 (29)	56,348 (23)	298,007 (49)	167,835 (28)	130,172 (22)
Colorado	24,904 (53)	12,783 (27)	12,121 (26)	51,212 (48)	27,597 (26)	23,615 (22)
Connecticut	3,046[c] (50)	2,075[c] (34)[c]	971[c] (16)[c]	12,563 (45)	8,081 (29)	4,482 (16)
Delaware	1,065[c] (50)[c]	— (—)	— (41)[c]	2,806 (36)	1,267[c] (16)[c]	1,539[c] (20)[c]
District of Columbia	701[c] (46)[c]	560[c] (37)[c]	— (—)	2,300 (49)	1,471[c] (31)	829[c] (18)[c]
Florida	25,170 (50)	11,915 (24)	13,255 (27)	66,478 (49)	33,322 (25)	33,156 (24)
Georgia	8,809 (44)	3,469 (17)	5,340 (27)	29,052 (44)	11,389 (17)	17,663 (27)
Hawaii	1,258[c] (36)[c]	— (25)[c]	— (—)	18,730 (57)	10,853 (33)	7,877 (24)
Idaho	11,835 (59)	5,448 (27)	6,387 (32)	19,517 (55)	9,266 (26)	10,251 (29)
Illinois	11,556 (54)	5,991 (28)	5,565 (26)	35,686 (50)	18,336 (26)	17,350 (24)
Indiana	6,659 (53)	2,218 (18)	4,441 (35)	26,360 (50)	12,298 (24)	14,062 (27)
Iowa	6,173 (61)	3,598[c] (35)	2,575[c] (25)	18,405 (63)	12,490 (43)	5,915 (20)
Kansas	13,150 (56)	4,956 (21)	8,194 (35)	35,850 (54)	16,712 (25)	19,138 (29)
Kentucky	4,453 (52)	2,528[c] (29)	1,925[c] (22)[c]	17,484 (57)	9,659 (31)	7,825 (25)
Louisiana	14,057 (57)	7,154 (29)	6,903 (28)	28,182 (56)	14,739 (29)	13,443 (27)
Maine	4,456 (64)	3,155 (45)	1,301[c] (19)[c]	11,681 (59)	8,752 (44)	2,929 (15)
Maryland	6,319 (47)	3,438 (26)	2,881 (21)	21,954 (46)	11,541 (24)	10,413 (22)
Massachusetts	5,961 (55)	4,419[c] (41)	1,542[c] (14)[c]	19,639 (49)	14,524 (36)	5,115 (13)
Michigan	27,643 (51)	15,941 (30)	11,702 (22)	70,867 (52)	43,228 (32)	27,639 (20)
Minnesota	40,838 (71)	25,330 (44)	15,508 (27)	69,556 (69)	40,987 (41)	28,569 (29)
Mississippi	7,570 (57)	3,445 (26)	4,125 (31)	15,594 (58)	7,215 (27)	8,379 (31)
Missouri	10,189 (48)	5,437 (26)	4,752 (22)	40,579 (53)	22,139 (29)	18,440 (24)
Montana	38,330 (61)	17,927 (28)	20,403 (32)	45,501 (59)	21,847 (28)	23,654 (31)
Nebraska	11,864 (72)	6,378 (39)	5,486 (33)	20,539 (66)	10,885 (35)	9,654 (31)
Nevada	13,587 (49)	5,467 (20)	8,120 (29)	22,848 (47)	8,951 (18)	13,897 (28)
New Hampshire	1,040[c] (42)[c]	710[c] (29)[c]	330[c] (13)[c]	3,799 (40)	2,144 (23)	1,655[c] (18)[c]
New Jersey	7,152 (47)	4,185[c] (27)	2,967[c] (19)[c]	19,392 (42)	11,120 (24)	8,272 (18)

State	American Indian and Alaska Native alone: Total potentially eligible number (percent)	American Indian and Alaska Native alone: Current enrollment[a] number (percent)	American Indian and Alaska Native alone: Potential new enrollment[b] number (percent)	American Indian and Alaska Native alone or in combination with another race: Total potentially eligible number (percent)	American Indian and Alaska Native alone or in combination with another race: Current enrollment[a] number (percent)	American Indian and Alaska Native alone or in combination with another race: Potential new enrollment[b] number (percent)
New Mexico	129,546 (67)	62,881 (33)	66,665 (35)	143,157 (66)	69,878 (32)	73,279 (34)
New York	28,462 (56)	18,170 (36)	10,292 (20)	70,009 (52)	43,578 (32)	26,431 (19)
North Carolina	62,131 (58)	32,570 (30)	29,561 (27)	101,065 (56)	53,637 (30)	47,428 (26)
North Dakota	23,270 (65)	10,269 (29)	13,001 (36)	26,426 (62)	12,213 (28)	14,213 (33)
Ohio	10,415 (51)	4,921 (24)	5,494 (27)	46,406 (53)	25,775 (29)	20,631 (24)
Oklahoma	133,291 (52)	56,588 (22)	76,703 (30)	255,555 (53)	117,602 (24)	137,953 (28)
Oregon	25,305 (53)	13,486 (28)	11,819 (25)	56,373 (53)	30,574 (29)	25,799 (24)
Pennsylvania	8,150 (54)	5,145[c] (34)	3,005 (20)	34,372 (52)	21,047 (32)	13,325 (20)
Rhode Island	2,935 (70)	1,511[c] (36)[c]	1,424[c] (34)[c]	7,548 (65)	4,673 (40)	2,875[c] (25)[c]
South Carolina	7,677 (56)	3,982 (29)	3,695 (27)	21,109 (55)	10,362 (27)	10,747 (28)
South Dakota	53,691 (75)	30,352 (43)	23,339 (33)	62,654 (74)	35,476 (42)	27,178 (32)
Tennessee	6,172 (50)	3,449[c] (28)	2,723 (22)[c]	29,278 (54)	16,306 (30)	12,972 (24)
Texas	51,889 (47)	25,328 (23)	26,561 (24)	111,459 (43)	53,347 (20)	58,112 (22)
Utah	19,053 (62)	8,922 (29)	10,131 (33)	27,043 (57)	12,910 (27)	14,133 (30)
Vermont	855[c] (44)[c]	518[c] (27)[c]	— (—)	3,973 (53)	2,528 (34)	1,445[c] (19)[c]
Virginia	7,561 (35)	2,744[c] (13)[c]	4,817 (22)	25,690 (37)	10,690 (15)	15,000 (22)
Washington	51,029 (56)	29,268 (32)	21,761 (24)	99,622 (53)	58,926 (31)	40,696 (21)
West Virginia	1,839 (56)	1,064[c] (33)[c]	775[c] (24)[c]	12,569 (58)	7,376 (34)	5,193 (24)
Wisconsin	27,041 (56)	14,412 (30)	12,629 (26)	49,675 (58)	29,046 (34)	20,629 (24)
Wyoming	8,501 (63)	5,268 (39)	3,233 (24)	12,054 (55)	7,169 (33)	4,885 (22)
Total	**1,368,316 (58)**	**718,254 (30)**	**650,062 (27)**	**2,569,410 (54)**	**1,377,924 (29)**	**1,191,486 (25)**

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Our estimates are based on the assumption of all states opting to expand Medicaid. While some states have indicated they do not intend to participate, they may opt to do so at a later date. We did not predict the number of people who will participate in this program, commonly referred to as the take-up rate.

Because the number of IHS-eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range. We excluded foreign-born American Indians and Alaska Natives from our analysis.

Unless otherwise noted, the estimates we present have relative standard errors of less than 15 percent. Estimates with relative standard errors greater than 30 percent are omitted.

[a]We use the term "current enrollment" to refer to estimated enrollment based on responses to the 2009-2011 ACS.

[b]We estimated potential new enrollment as those who will be newly eligible for expanded Medicaid and some who may be eligible now, but did not report to ACS as being currently enrolled.

Percentages of current enrollment and potential new enrollment may not add up to the total of potentially eligible due to rounding.

[c]Relative standard error of the estimate is between 15 and 30 percent.

Table 5: Estimates of the Number and Percentage of All Races Potentially Eligible for Expanded Medicaid in 2014, by State

State	Total potentially eligible number (percent)	Current enrollment[a] number (percent)	Potential new enrollment[b] number (percent)
Alabama	1,955,265 (41)	870,108 (18)	1,085,157 (23)
Alaska	247,597 (35)	108,671 (15)	138,926 (20)
Arizona	2,544,027 (40)	1,286,480 (20)	1,257,547 (20)
Arkansas	1,312,714 (45)	611,947 (21)	700,767 (24)
California	15,036,282 (40)	7,134,352 (19)	7,901,930 (21)
Colorado	1,577,788 (31)	672,433 (13)	905,355 (18)
Connecticut	1,129,058 (32)	563,149 (16)	565,909 (16)
Delaware	309,172 (34)	169,972 (19)	139,200 (15)
District of Columbia	292,339 (48)	155,687 (26)	136,652 (23)
Florida	7,362,867 (39)	2,958,596 (16)	4,404,271 (23)
Georgia	3,885,976 (40)	1,545,237 (16)	2,340,739 (24)
Hawaii	564,190 (41)	203,263 (15)	360,927 (27)
Idaho	560,947 (36)	224,590 (14)	336,357 (21)
Illinois	4,624,033 (36)	2,265,211 (18)	2,358,822 (18)
Indiana	2,320,838 (36)	983,983 (15)	1,336,855 (21)
Iowa	957,367 (31)	472,285 (15)	485,082 (16)
Kansas	911,862 (32)	364,552 (13)	547,310 (19)
Kentucky	1,762,366 (41)	823,531 (19)	938,835 (22)
Louisiana	2,052,868 (45)	957,560 (21)	1,095,308 (24)
Maine	482,639 (36)	305,920 (23)	176,719 (13)
Maryland	1,946,646 (34)	811,217 (14)	1,135,429 (20)
Massachusetts	2,192,026 (33)	1,366,120 (21)	825,906 (13)
Michigan	3,721,250 (38)	1,901,559 (19)	1,819,691 (18)
Minnesota	1,899,738 (36)	768,063 (14)	1,131,675 (21)
Mississippi	1,408,772 (47)	693,677 (23)	715,095 (24)
Missouri	2,130,573 (36)	909,635 (15)	1,220,938 (20)
Montana	328,487 (33)	125,629 (13)	202,858 (20)
Nebraska	609,581 (33)	242,969 (13)	366,612 (20)
Nevada	924,095 (34)	299,079 (11)	625,016 (23)
New Hampshire	355,591 (27)	149,418 (11)	206,173 (16)

State	Total potentially eligible number (percent)	Current enrollment[a] number (percent)	Potential new enrollment[b] number (percent)
New Jersey	2,606,674 (30)	1,183,299 (13)	1,423,375 (16)
New Mexico	983,222 (48)	472,629 (23)	510,593 (25)
New York	7,393,719 (38)	4,200,350 (22)	3,193,369 (16)
North Carolina	3,703,744 (39)	1,628,400 (17)	2,075,344 (22)
North Dakota	184,646 (27)	66,878 (10)	117,768 (17)
Ohio	4,314,151 (37)	1,924,763 (17)	2,389,388 (21)
Oklahoma	1,540,881 (41)	641,202 (17)	899,679 (24)
Oregon	1,349,809 (35)	579,746 (15)	770,063 (20)
Pennsylvania	4,311,622 (34)	2,151,585 (17)	2,160,037 (17)
Rhode Island	416,093 (40)	181,819 (17)	234,274 (22)
South Carolina	1,966,415 (42)	808,541 (17)	1,157,874 (25)
South Dakota	265,053 (32)	117,475 (14)	147,578 (18)
Tennessee	2,518,761 (40)	1,208,562 (19)	1,310,199 (21)
Texas	10,189,074 (40)	4,221,763 (17)	5,967,311 (24)
Utah	871,846 (31)	315,030 (11)	556,816 (20)
Vermont	237,942 (38)	146,507 (23)	91,435 (15)
Virginia	2,350,901 (30)	879,536 (23)	1,471,365 (18)
Washington	2,301,507 (34)	1,093,373 (16)	1,208,134 (18)
West Virginia	753,274 (41)	360,572 (19)	392,702 (21)
Wisconsin	1,924,191 (34)	998,648 (18)	925,543 (16)
Wyoming	159,359 (28)	70,845 (13)	88,514 (16)
Total	**115,749,838 (37)**	**53,196,416 (17)**	**62,553,422 (20)**

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Our estimates are based on the assumption of all states opting to expand Medicaid. While some states have indicated they do not intend to participate, they may opt to do so at a later date. We did not predict the number of people who will participate in this program, commonly referred to as the take-up rate.

Unless otherwise noted, the estimates we present have relative standard errors of less than 15 percent.

[a]We use the term "current enrollment" to refer to estimated enrollment based on responses to the 2009-2011 ACS.

[b]We estimated potential new enrollment as those who will be newly eligible for expanded Medicaid and some who may be eligible now, but did not report to ACS as being currently enrolled. Percentages of current enrollment and potential new enrollment may not add up to the total of potentially eligible due to rounding.

Table 6: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for the Basic Health Program Option in 2015, and Cost-Sharing Exemptions and Premium Tax Credits under the Health Insurance Exchanges in 2014, by Indian Health Service (IHS) Service Area

	Basic Health Program option[a] number (percent)		Exchange cost-sharing exemptions[b] number (percent)		Exchange premium tax credits[c] number (percent)	
IHS Service Area	**American Indian and Alaska Native alone**	**American Indian and Alaska Native alone or in combination with another race**	**American Indian and Alaska Native alone**	**American Indian and Alaska Native alone or in combination with another race**	**American Indian and Alaska Native alone**	**American Indian and Alaska Native alone or in combination with another race**
Aberdeen	9,014 (11)	11,397 (11)	17,605 (21)	22,868 (22)	22,006 (27)	29,288 (28)
Alaska	11,722 (13)	16,056 (13)	26,142 (29)	37,133 (29)	33,459 (37)	49,537 (39)
Albuquerque	12,022 (12)	14,339 (12)	25,975 (27)	31,265 (26)	35,627 (37)	43,109 (36)
Bemidji	9,871 (12)	17,268 (13)	21,413 (26)	36,729 (27)	29,294 (35)	49,225 (36)
Billings	4,904 (13)	6,341 (14)	9,521 (25)	12,196 (26)	12,633 (33)	16,334 (35)
California	13,926 (12)	30,048 (13)	31,109 (28)	63,679 (27)	40,303 (36)	84,676 (36)
Nashville	9,405 (12)	22,296 (12)	21,458 (27)	51,233 (27)	28,619 (36)	70,964 (38)
Navajo	22,347 (11)	23,436 (11)	46,410 (23)	48,303 (23)	61,006 (30)	63,905 (30)
Oklahoma City	37,934 (15)	73,282 (15)	79,608 (31)	153,691 (31)	106,030 (41)	204,569 (42)
Phoenix	23,604 (13)	32,573 (13)	46,115 (25)	66,217 (26)	60,931 (33)	88,675 (35)
Portland	17,347 (12)	36,989 (12)	39,952 (28)	80,905 (27)	52,950 (37)	108,541 (37)
Tucson	3,863[d] (12)	4,992 (12)	7,078 (21)	9,968 (24)	8,895 (27)	12,245 (29)
IHS service area total	**175,959 (13)**	**289,018 (13)**	**372,386 (27)**	**614,187 (27)**	**491,753 (35)**	**821,067 (36)**
Non-IHS service areas	116,640 (12)	304,349 (12)	251,504 (26)	676,174 (27)	340,231 (35)	923,583 (37)

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Because the number of IHS-eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range. We excluded foreign-born American Indians and Alaska Natives from our analysis.

Unless otherwise noted, the estimates we present have relative standard errors of less than 15 percent.

We did not predict the number of people who will participate in these new coverage options, commonly referred to as the take-up rate.

Certain individuals who are eligible for the premium tax credits may also be eligible for cost-sharing exemptions.

[a]Beginning in 2015, states may opt to run a Basic Health Program for individuals between 138 and 200 percent of the federal poverty level (FPL). These estimates are if all states opt to run a Basic Health Program.

[b]Certain American Indians and Alaska Natives obtaining insurance through the Exchanges who are at or below 300 percent of the FPL are exempt from cost-sharing, such as deductibles and copays, although our estimates reflect only those above 138 percent of the FPL because individuals below this level would be potentially eligible for expanded Medicaid.

[c]Individuals obtaining insurance through the Exchanges who are between 100 and 400 percent of the FPL are eligible for premium tax credits on a sliding scale, although our estimates reflect only those above 138 percent of the FPL because individuals below this level would be potentially eligible for expanded Medicaid. Individuals with incomes above 138 percent of the FPL who may be eligible for Medicaid in a particular state are not eligible for premium tax credits.

[d]Relative standard error of the estimate is between 15 and 30 percent.

Table 7: Estimates of the Number and Percentage of All Races Potentially Eligible for the Basic Health Program Option in 2015 and Premium Tax Credits under the Health Insurance Exchanges in 2014, by Indian Health Service (IHS) Service Area

IHS Service Area	Basic Health Program option[a] number (percent)	Exchange premium tax credits[b] number (percent)
Aberdeen	226,433 (11)	850,311 (43)
Alaska	83,373 (12)	311,310 (45)
Albuquerque	286,561 (13)	836,492 (38)
Bemidji	825,085 (12)	2,906,786 (44)
Billings	83,541 (14)	275,478 (45)
California	1,256,696 (12)	3,852,121 (37)
Nashville	2,430,650 (11)	8,049,301 (38)
Navajo	56,095 (11)	184,299 (36)
Oklahoma City	521,131 (13)	1,656,550 (42)
Phoenix	1,137,368 (13)	3,719,458 (41)
Portland	1,173,223 (11)	4,138,184 (39)
Tucson	124,460 (12)	393,027 (39)
IHS service area total	**8,204,617 (12)**	**27,173,316 (39)**
Non-IHS service areas	27,228,110 (11)	91,458,963 (38)

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

The estimates we present have relative standard errors of less than 15 percent.

We did not predict the number of people who will participate in these new coverage options, commonly referred to as the take-up rate.

[a]Beginning in 2015, states may opt to run a Basic Health Program for individuals between 138 and 200 percent of the federal poverty level (FPL). These estimates are if all states opt to run a Basic Health Program.

[b]Individuals obtaining insurance through the Exchanges who are between 100 and 400 percent of the FPL are eligible for premium tax credits on a sliding scale, although our estimates reflect only those above 138 percent of the FPL because individuals below this level would be potentially eligible for expanded Medicaid. Individuals with incomes above 138 percent of the FPL who may be eligible for Medicaid in a particular state are not eligible for premium tax credits.

Table 8: Estimates of the Number and Percentage of American Indians and Alaska Natives Potentially Eligible for the Basic Health Program Option in 2015, and Cost-Sharing Exemptions and Premium Tax Credits under the Health Insurance Exchanges in 2014, by State

	Basic Health Program option[a] number (percent)		Exchange cost-sharing exemptions[b] number (percent)		Exchange premium tax credits[c] number (percent)	
State	American Indian and Alaska Native alone	American Indian and Alaska Native alone or in combination with another race	American Indian and Alaska Native alone	American Indian and Alaska Native alone or in combination with another race	American Indian and Alaska Native alone	American Indian and Alaska Native alone or in combination with another race
Alabama	2,660 (11)	6,491 (12)	7,733 (32)	16,240 (29)	10,025 (41)	22,539 (41)
Alaska	12,890 (13)	17,401 (13)	28,612 (28)	39,968 (29)	36,480 (36)	52,978 (39)
Arizona	31,967 (11)	38,615 (12)	64,703 (23)	79,670 (24)	84,816 (30)	104,834 (31)
Arkansas	2,604 (15)	6,805 (15)	6,184 (34)	15,250 (33)	7,870 (44)	19,068 (42)
California	29,093 (12)	69,195 (11)	64,034 (26)	151,102 (25)	86,182 (35)	208,511 (34)
Colorado	6,418 (14)	13,374 (13)	13,266 (28)	29,498 (28)	18,978 (40)	41,349 (39)
Connecticut	— (—)	4,259[d] (15)	1,373[d] (22)[d]	7,963 (29)	2,038[d] (33)[d]	11,271 (41)
Delaware	— (—)	1,391[d] (18)[d]	— (20)[d]	2,494[d] (32)[d]	605[d] (28)[d]	3,191 (41)
District of Columbia	— (—)	— (—)	— (—)	— (—)	— (—)	964[d] (21)[d]
Florida	5,786 (12)	17,745 (13)	12,287 (25)	38,037 (28)	16,664 (33)	50,996 (38)
Georgia	2,137[d] (11)[d]	7,607 (12)	5,704 (29)	17,977 (27)	7,647 (39)	24,816 (38)
Hawaii	851[d] (24)[d]	4,217[d] (13)[d]	1,167[d] (34)[d]	9,967 (30)	1,596[d] (46)	13,774 (42)
Idaho	2,408[d] (12)[d]	4,636 (13)	5,286 (26)	10,694 (30)	6,851 (34)	13,603 (38)
Illinois	1,859[d] (9)[d]	7,215 (10)	5,380 (25)	19,759 (28)	7,335 (35)	26,862 (37)
Indiana	1,304[d] (10)[d]	7,428 (14)	3,724 (29)	16,472 (31)	5,018 (40)	21,028 (40)
Iowa	1,733[d] (17)[d]	4,271[d] (15)[d]	3,293[d] (32)	7,974 (27)	3,725[d] (37)	9,836 (34)
Kansas	2,854 (12)	7,416 (11)	5,957 (25)	18,181 (27)	7,924 (34)	25,523 (38)
Kentucky	1,147[d] (13)[d]	3,812 (12)	2,558 (30)	8,170 (27)	2,969 (35)	10,320 (34)
Louisiana	3,330[d] (13)	6,610 (13)	6,424 (26)	13,692 (27)	8,939 (36)	19,354 (38)
Maine	— (—)	2,597[d] (13)[d]	1,327[d] (19)[d]	5,448 (28)	2,031[d] (29)	7,297 (37)
Maryland	943[d] (7)[d]	4,580 (10)	2,248[d] (17)[d]	10,000 (21)	3,582 (27)	14,486 (30)
Massachusetts	— (9)[d]	4,381 (11)	2,091[d] (19)[d]	9,781 (25)	3,075[d] (28)	13,954 (35)
Michigan	7,595 (14)	19,374 (14)	14,984 (28)	38,984 (29)	20,838 (39)	52,479 (39)
Minnesota	6,173 (11)	12,230 (12)	13,024 (23)	24,822 (25)	17,356 (30)	33,454 (33)
Mississippi	1,519[d] (11)[d]	3,048[d] (11)[d]	4,196 (31)	7,774 (29)	5,224 (39)	10,399 (38)
Missouri	2,232[d] (11)	9,588 (13)	6,095 (29)	21,371 (28)	8,952 (42)	29,171 (38)
Montana	7,685 (12)	9,935 (13)	15,395 (24)	19,590 (25)	20,548 (33)	26,278 (34)
Nebraska	2,127[d] (13)[d]	3,871 (13)	3,787 (23)	6,806 (22)	4,879 (30)	9,914 (32)
Nevada	4,007 (14)	7,051 (14)	8,045 (29)	14,652 (30)	10,258 (37)	19,521 (40)

State	Basic Health Program option[a] number (percent)		Exchange cost-sharing exemptions[b] number (percent)		Exchange premium tax credits[c] number (percent)	
	American Indian and Alaska Native alone	American Indian and Alaska Native alone or in combination with another race	American Indian and Alaska Native alone	American Indian and Alaska Native alone or in combination with another race	American Indian and Alaska Native alone	American Indian and Alaska Native alone or in combination with another race
New Hampshire	— (—)	1,126[d] (12)[d]	744[d] (30)[d]	2,433 (26)	1,167[d] (47)	3,843 (41)
New Jersey	1,743[d] (11)[d]	4,659 (10)	3,467 (23)	10,298 (22)	5,003 (33)	15,864 (34)
New Mexico	23,430 (12)	26,135 (12)	49,010 (25)	54,552 (25)	66,114 (34)	74,152 (34)
New York	5,287 (10)	12,582 (9)	11,791 (23)	32,257 (24)	16,310 (33)	45,518 (33)
North Carolina	14,652 (14)	24,716 (14)	31,077 (29)	53,298 (29)	38,279 (36)	67,203 (37)
North Dakota	2,280[d] (6)[d]	2,844[d] (7)[d]	6,919 (19)	8,887 (21)	9,220 (26)	11,949 (28)
Ohio	3,143[d] (15)	12,599 (14)	5,917 (29)	26,947 (31)	7,889 (38)	35,040 (40)
Oklahoma	37,664 (15)	72,715 (15)	79,010 (31)	152,144 (31)	105,343 (41)	202,414 (42)
Oregon	6,793 (14)	14,042 (13)	14,429 (30)	29,427 (28)	18,543 (39)	38,517 (36)
Pennsylvania	1,385[d] (9)[d]	8,044 (12)	2,982 (20)	16,712 (25)	4,848 (32)	23,976 (36)
Rhode Island	— (—)	1,374[d] (12)[d]	994[d] (24)[d]	2,207[d] (19)[d]	1,356[d] (32)[d]	3,254 (28)
South Carolina	1,622[d] (12)[d]	4,306 (11)	3,914 (29)	10,014 (26)	5,354 (39)	14,325 (37)
South Dakota	7,711 (11)	9,054 (11)	13,695 (19)	18,354 (22)	17,285 (24)	22,592 (27)
Tennessee	1,628[d] (13)[d]	6,851 (13)	3,447 (28)	14,646 (27)	4,916 (40)	19,758 (36)
Texas	14,177 (13)	32,923 (13)	28,932 (26)	74,637 (29)	39,332 (36)	102,385 (39)
Utah	3,688[d] (12)[d]	5,941 (12)	7,384 (24)	12,101 (25)	9,633 (31)	16,360 (34)
Vermont	— (—)	1,074[d] (14)[d]	— (—)	2,414 (32)	948[d] (49)[d]	4,182 (56)
Virginia	3,126[d] (15)[d]	8,353 (12)	6,845 (32)	20,087 (29)	8,835 (41)	27,738 (40)
Washington	10,314 (11)	22,530 (12)	24,751 (27)	50,392 (27)	33,322 (36)	68,825 (36)
West Virginia	505[d] (15)[d]	2,555 (12)	1,114[d] (34)[d]	5,801 (27)	1,187[d] (36)[d]	7,705 (36)
Wisconsin	6,180 (13)	10,337 (12)	13,703 (28)	23,254 (27)	19,231 (40)	32,550 (38)
Wyoming	2,272[d] (17)[d]	3,329 (15)	3,959[d] (29)[d]	6,701 (31)	5,075 (38)	8,731 (40)
Total	**292,599 (12)**	**593,367 (12)**	**623,890 (26)**	**1,290,362 (27)**	**831,985 (35)**	**1,744,651 (37)**

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

Because the number of IHS-eligible individuals is likely to be between the number of individuals who self-identify as American Indians and Alaska Natives alone and American Indians and Alaska Natives alone or in combination, we presented results for both groups as the range. We excluded foreign-born American Indians and Alaska Natives from our analysis.

Unless otherwise noted, the estimates we present have relative standard errors of less than 15 percent. Estimates with relative standard errors greater than 30 percent are omitted.

We did not predict the number of people who will participate in these new coverage options, commonly referred to as the take-up rate.

Certain individuals who are eligible for the premium tax credits may also be eligible for cost-sharing exemptions.

[a]Beginning in 2015, states may opt to run a Basic Health Program for individuals between 138 and 200 percent of the federal poverty level (FPL). These estimates are if all states opt to run a Basic Health Program.

[b]Certain American Indians and Alaska Natives obtaining insurance through the Exchanges who are at or below 300 percent of the FPL are exempt from cost-sharing, such as deductibles and copays, although our estimates reflect only those above 138 percent of the FPL because individuals below this level would be potentially eligible for expanded Medicaid.

[c]Individuals obtaining insurance through the Exchanges who are between 100 and 400 percent of the FPL are eligible for premium tax credits on a sliding scale, although our estimates reflect only those above 138 percent of the FPL because individuals below this level would be potentially eligible for expanded Medicaid. Individuals with incomes above 138 percent of the FPL who may be eligible for Medicaid in a particular state are not eligible for premium tax credits.

[d]Relative standard error of the estimate is between 15 and 30 percent.

Table 9: Estimates of the Number and Percentage of All Races Potentially Eligible for the Basic Health Program Option in 2015 and Premium Tax Credits under the Health Insurance Exchanges in 2014, by State

State	Basic Health Program option[a] number (percent)	Exchange premium tax credits[b] number (percent)
Alabama	584,905 (12)	1,854,582 (39)
Alaska	85,706 (12)	317,908 (45)
Arizona	778,325 (12)	2,521,814 (39)
Arkansas	401,989 (14)	1,216,079 (42)
California	4,216,442 (11)	12,863,653 (34)
Colorado	533,713 (11)	1,916,497 (38)
Connecticut	321,598 (9)	1,199,422 (34)
Delaware	98,089 (11)	341,818 (38)
District of Columbia	46,282 (8)	158,258 (26)
Florida	2,392,563 (13)	7,531,421 (40)
Georgia	1,121,198 (12)	3,667,884 (38)
Hawaii	177,223 (13)	592,985 (44)
Idaho	226,044 (14)	719,097 (46)
Illinois	1,404,723 (11)	4,802,739 (37)
Indiana	813,117 (13)	2,800,941 (43)
Iowa	351,300 (12)	1,360,465 (45)
Kansas	350,367 (12)	1,212,107 (42)
Kentucky	546,772 (13)	1,776,393 (41)
Louisiana	524,484 (12)	1,710,480 (38)
Maine	171,101 (13)	585,878 (44)
Maryland	529,201 (9)	1,929,703 (33)
Massachusetts	589,495 (9)	2,204,596 (34)
Michigan	1,136,069 (11)	3,974,626 (40)
Minnesota	546,341 (10)	2,135,973 (40)
Mississippi	367,880 (12)	1,137,216 (38)
Missouri	732,846 (12)	2,518,872 (42)
Montana	132,167 (13)	444,635 (45)
Nebraska	215,875 (12)	807,154 (44)
Nevada	350,437 (13)	1,131,112 (42)
New Hampshire	132,249 (10)	518,179 (39)
New Jersey	807,361 (9)	2,907,472 (33)
New Mexico	252,790 (12)	791,781 (38)
New York	1,991,643 (10)	6,789,077 (35)

State	Basic Health Program option[a] number (percent)	Exchange premium tax credits[b] number (percent)
North Carolina	1,176,315 (12)	3,799,848 (40)
North Dakota	76,515 (11)	295,907 (44)
Ohio	1,359,034 (12)	4,752,273 (41)
Oklahoma	497,346 (13)	1,576,455 (42)
Oregon	476,007 (12)	1,569,424 (41)
Pennsylvania	1,453,820 (11)	5,178,832 (41)
Rhode Island	115,361 (11)	383,823 (36)
South Carolina	566,467 (12)	1,840,598 (40)
South Dakota	95,792 (12)	367,951 (45)
Tennessee	790,484 (12)	2,599,340 (41)
Texas	3,006,362 (12)	9,324,879 (37)
Utah	361,150 (13)	1,292,879 (47)
Vermont	71,796 (11)	271,785 (43)
Virginia	799,384 (10)	2,921,457 (36)
Washington	696,422 (10)	2,561,712 (38)
West Virginia	235,843 (13)	775,393 (42)
Wisconsin	657,266 (12)	2,434,021 (43)
Wyoming	67,068 (12)	244,885 (43)
Total	**35,432,727 (11)**	**118,632,279 (38)**

Source: GAO analysis of U.S. Census Bureau data.

Notes: Data are from 2009-2011 American Community Survey (ACS) 3-year estimates.

The estimates we present have relative standard errors of less than 15 percent.

We did not predict the number of people who will participate in these new coverage options, commonly referred to as the take-up rate.

[a]Beginning in 2015, states may opt to run a Basic Health Program for individuals between 138 and 200 percent of the federal poverty level (FPL). These estimates are if all states opt to run a Basic Health Program.

[b]Individuals obtaining insurance through the Exchanges who are between 100 and 400 percent of the FPL are eligible for premium tax credits on a sliding scale, although our estimates reflect only those above 138 percent of the FPL because individuals below this level would be potentially eligible for expanded Medicaid. Individuals with incomes above 138 percent of the FPL who may be eligible for Medicaid in a particular state are not eligible for premium tax credits.

Appendix IV: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

JUL 26 2013

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "INDIAN HEALTH SERVICE: Most American Indians and Alaska Natives Potentially Eligible for Expanded Medicaid and New Coverage Options, but Action Needed to Increase Enrollment" (GAO-13-553).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: MOST AMERICAN INDIANS AND ALASKA NATIVES POTENTIALLY ELIGIBLE FOR EXPANDED MEDICAID AND NEW COVERAGE OPTIONS, BUT ACTION NEEDED TO INCREASE ENROLLMENT" (GAO-13-553)

The Department appreciates the opportunity to review and comment on this draft report.

Recommendation

To help ensure successful outreach efforts resulting in significant new enrollment, GAO recommends that the Secretary of Health and Human Services (HHS) direct the Director of IHS and the Administrator of CMS coordinate a plan to:

- Improve their communications with facility staff and tribal leaders to ensure that information on Medicaid and the Marketplace, including detailed information on program eligibility rules and enrollment procedures, is being disseminated to all facilities and tribes; and,
- Increase direct outreach to American Indians and Alaska Natives who may be eligible for expanded Medicaid and the Marketplace, including strategy for educating American Indians and Alaska Natives about the effect of Patient Protection & Affordable Care Act's (PPACA) definition of Indian on their coverage options and obligations.

HHS Response

HHS concurs with this recommendation. CMS' Center for Medicaid and CHIP Services, Tribal Affairs, and Center for Consumer Information and Insurance Oversight staff are currently working closely with IHS and HHS Intergovernmental & External Affairs staff to develop and review outreach, education and enrollment materials and information dissemination/training strategies.

HHS is actively engaged in a number of outreach and education activities to ensure active participation of American Indian/American Native (AI/AN) in the expanded and new coverage options available through the Affordable Care Act. CMS has organized a number of All Tribes Calls and webinars to disseminate information about the Marketplace and the Medicaid expansion. In addition, CMS has issued guidance directly to tribal leaders and health directors and has participated in a number or tribal consultations. CMS conducted six (three in 2012 and three in 2013) face-to-face national tribal consultations and 18 regional consultations (11 in 2012 and 7 in 2013) to discuss the Marketplace and the Medicaid expansion. Further, as part of our ongoing outreach and education efforts, CMS has developed AI/AN training materials and fact sheets on Medicare, Medicaid and CHIP. Building off these existing outreach materials, CMS has developed AI/AN specific outreach materials on the Marketplace and Medicaid expansion. These outreach and education activities are necessary to ensure the active participation of AI/AN in the new and expanded coverage options and ensures that CMS develops culturally appropriate policies that consider tribal views.

As described above, within HHS, CMS's Center for Medicaid and CHIP Services, Tribal Affairs, and Center for Consumer Information and Insurance Oversight staff is currently working closely with IHS and HHS Intergovernmental & External Affairs staff to develop and review outreach,

1

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: MOST AMERICAN INDIANS AND ALASKA NATIVES POTENTIALLY ELIGIBLE FOR EXPANDED MEDICAID AND NEW COVERAGE OPTIONS, BUT ACTION NEEDED TO INCREASE ENROLLMENT" (GAO-13-553)

education and enrollment materials and information dissemination/training strategies, including educating tribal communities about the hardship exemption for Indians from the shared responsibility payment.

IHS will continue to work with CMS to move forward to improve communication with Area Offices, facility staff and tribal leaders to ensure information on Medicaid and exchanges are addressed including detailing program eligibility rules and enrollment procedures. IHS will increase direct outreach to AI/ANs who may be eligible for expanded Medicaid and the exchanges, including a strategy for educating American Indians and Alaska Natives about the effect of the Affordable Care Act's definition of Indian on their coverage options and obligations. IHS continues to work closely with CMS to review rules and regulations related to Affordable Care Act ensuring AI/AN coverage options and obligations are addressed.

Recommendation

The Director of IHS to prepare for the increase in eligibility for expanded Medicaid and new coverage options, and the need for enrollment assistance and billing capacity, but realigning current resources and personnel to increase capacity to assist with these efforts.

HHS Response

IHS developed the Business Plan Template to ensure that capacity building and enrollment activities are maximized at the local level in coordination with Headquarters and Area Offices. Local facilities are required to develop and implement local implementation plans that focus on capacity building activities including staffing needs. Leadership at the local level is required to implement these plans and to increase resources to support staff and expand duties, as necessary. This is a priority for IHS, and Headquarters and the respective Areas will monitor the overall implementation process. Each IHS operated facility is directed to maximize the full benefit of the Affordable Care Act. IHS Headquarters and Areas will continue to work with the local levels and move forward on both enrollment activities and capacity building at the local facility level. Monitoring this process will take place through the performance plan evaluations of local leadership by their respective Area Director, with monitoring of the Areas by the IHS Deputy Director for Field Operations.

Recommendation

GAO recommends the Administrator of CMS develop a plan to:

- Educate state Medicaid agencies about when coverage status information may be shared between states and I/T/U facilities; and,
- Provide a means for members of direct service tribes to authorize disclosure of information about their coverage status with their tribes, such as through the single, streamlined application for health insurance, or through application assistance personnel.

2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "INDIAN HEALTH SERVICE: MOST AMERICAN INDIANS AND ALASKA NATIVES POTENTIALLY ELIGIBLE FOR EXPANDED MEDICAID AND NEW COVERAGE OPTIONS, BUT ACTION NEEDED TO INCREASE ENROLLMENT" (GAO-13-553)

HHS Response

The CMS' Center for Medicaid and CHIP Services will include this education as part of their State Operations and Technical Assistance (SOTA) and other technical assistance calls with states.

Based on our reading of the report, it appears that the issue of directing service tribes to authorize disclosure of information about their coverage status with their tribes might be addressed on pages 31 and 32 of the report, but we would need further clarification of what GAO is recommending to fully comment. Otherwise, we suggest the recommendation be deleted in its entirety.

3

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114 or kingk@gao.gov

Staff Acknowledgments

In addition to the contact named above, Catina Bradley, Assistant Director; Lisa Motley; Giao N. Nguyen; Laurie Pachter; Dae Park; Perry Parsons; and Monique Williams made key contributions to this report.

Related GAO Products

Indian Health Service: Capping Payment Rates for Nonhospital Services Could Save Millions of Dollars for Contract Health Services. GAO-13-272. Washington, D.C.: April 11, 2013.

Medicaid Expansion: States' Implementation of the Patient Protection and Affordable Care Act. GAO-12-821. Washington, D.C.: August 1, 2012.

Indian Health Service: Action Needed to Ensure Equitable Allocation of Resources for the Contract Health Service Program. GAO-12-446. Washington, D.C.: June 15, 2012.

Indian Health Service: Increased Oversight Needed to Ensure Accuracy of Data Used for Estimating Contract Health Service Need. GAO-11-767. Washington, D.C.: September 23, 2011.

Indian Health Service: Updated Policies and Procedures and Increased Oversight Needed for Billings and Collections from Private Insurers. GAO-10-42R. Washington, D.C.: October 22, 2009.

Medicare and Medicaid: CMS and State Efforts to Interact with the Indian Health Service and Indian Tribes. GAO-08-724. Washington, D.C.: July 11, 2008.

Indian Health Service: Health Care Services Are Not Always Available to Native Americans. GAO-05-789. Washington, D.C.: August 31, 2005.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (http://www.gao.gov). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to http://www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, http://www.gao.gov/ordering.htm.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on Facebook, Flickr, Twitter, and YouTube. Subscribe to our RSS Feeds or E-mail Updates. Listen to our Podcasts. Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: http://www.gao.gov/fraudnet/fraudnet.htm
E-mail: fraudnet@gao.gov
Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548

Please Print on Recycled Paper.