Community Catalyst

Curbing the Risk of Medical Debt Among American Indian and Alaskan Native (AI/AN) Communities

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In American Indian and Alaskan Native (AI/AN) communities across the United States, the issues of health care access and affordability pose significant challenges. While Indian Health Services (IHS) is tasked to provide health care services to the community, its facilities have endured longstanding criticism of inadequate funding, poor quality of care, and cultural insensitivity. Additionally, according to 2019 Census data, AI/AN populations continue to have the highest uninsured rates. Despite the presence of federal programs such as IHS and provisions from the Affordable Care Act (ACA), the current health care system fails to meet the complete medical needs of these communities and may leave many families with the burden of medical debt. Curbing the risk of medical debt in the AI/AN community involves improving access to quality, affordable, and culturally sensitive services.

Background

There is a common misconception that AI/AN communities have all their health care needs covered in full by the federal government as a result of treaties, laws, executive orders and court decisions. Although these legal agreements between the United States and tribal communities were meant to afford the AI/AN community a legal right to health services, the reality reveals a far less ideal scenario that many tribal leaders argue is in violation of their rights. Despite limited studies on the impacts of medical debt on AI/AN's health and economic stability, there are stark signs indicating that AI/AN communities are at a high risk for incurring medical debt.

AI/AN people belong to 574 federally recognized tribes in 37 states. Additionally, there are tribes located throughout the U.S. that do not have official recognition. IHS may provide service directly through IHS-operated facilities, Urban Indian Health Programs, or provide financial support to Tribally-run health care centers. The IHS has a long history of being underfunded and understaffed. Rural/remote reservations are particularly subject to staffing shortage issues. Due to the funding structure, IHS (unlike Medicare or Medicaid) operates on annual appropriations and the amount of IHS funding is subject to change on an annual basis with discretion from Congress. Many AI/ANs are forced to postpone services for the next fiscal year when funding is depleted. Congressional delegates often unfamiliar with the health care implications of this population are at the decision-making table deciding the fate of how many AI/ANs can receive care.

> The Government Accountability Office (GAO) finds that in 2017, IHS per capita spending was $4,078, as compared with $8,109 for Medicaid, $10,692 for the VHA, $13,185 for Medicare, and $8,600 for federal prisoners.

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This policy brief explores key drivers of medical debt that uniquely impact the AI/AN community and explores strategies to advocate for community-driven solutions.

Key Drivers of Medical Debt

Challenges due to Geographic Proximity to available IHS facilities and Lack of Certain Specialty Services

- The migration of AI/AN families moving away from reservations has created challenges to receiving care. Although the Urban Indian Program offers some care points, it still does not provide sufficient access to all. The probability that someone will incur medical debt increases as geographic distance from IHS facilities also increases. A 2022 study from John Hopkins University shows the number of unpaid medical debt increases with every 100-mile increase in distance from the closest IHS/Tribal care facility.

- IHS is unable to provide all medical services at its facilities, which often requires referrals to external specialists (such as mental health providers, MRI scans, and cardiac testing) that are often not covered by IHS through the Purchased/Referred Care (PRC) program. For instance, an IHS eligible patient who lives on or near an Indian reservation may utilize the PRC program to obtain a mental health service through a private (non-IHS) health care provider. However, a referral does not necessarily imply IHS will pay for the care. A patient must meet residency requirements, obtain advanced notification, document medical necessity, and exhaust alternate resources. In emergency situations, a patient must notify PRC within 72 hours and PRC must approve that the emergency care was medically necessary. Those who seek care outside of the IHS system are required to petition for reimbursement from IHS, but not all are able to receive reimbursement due to limited funding. At least two-thirds of these referral claims are rejected. The New York Times found that since 2016 – 2019, IHS has declined to pay medical bills for more than 500,000 patients, resulting in more than $2 billion in medical debt.

> "Appropriations for the IHS have never been adequate to meet basic patient needs, and health care is delivered in mostly third-world conditions."
>
> - National Congress of American Indians

- Retaining staff within IHS facilities is difficult and facilities often have high vacancy rates for nurses, physicians, and dentists. The rural location of IHS facilities and insufficient housing exacerbate the issue of understaffing. Additionally, the average IHS facility is more than 40 years old, but funding

has not allowed for maintenance and modernization of its infrastructure. Community members often have to wait more than a month to receive primary care and often wait two to six months for women's care, general physicals, and dental care.

***Recommendations**: Improving access to IHS facilities may be addressed through offering services such as telemedicine, mobile health clinics, and offering transportation services. Additionally, the lack of specialty services may be addressed through additional partnerships with local providers to ensure an expanded network for AI/AN patients living far away from IHS facilities. AI/AN community members may not be delaying care voluntarily, but due to limited capacity within IHS facilities. Strengthening IHS facilities through increased stable funding structures would allow these facilities to employ and retain providers.*

Lack of access to Medicaid or insurance coverage expanded under the Affordable Care Act

- The Affordable Care Act (ACA) opened up an opportunity for coverage options.[1] Nonetheless, 15 percent of AI/AN communities remain uninsured in comparison to 9 percent of the general public. In 2019, an estimated 164,000 uninsured AI/ANs were eligible for Tribal ACA plans. Health insurance plans have been a foreign concept in AI/AN communities that require working with tribal leaders and individuals to sign up. There are often multiple barriers the community faces to enroll in the marketplace such as lack of knowledge, lack of access to technology, language/literacy barriers, and geographic/transportation barriers. Many community members rely on IHS care without an understanding of their limited services, which may result in costly unexpected medical care and confusion on what services are actually covered.

- Medicaid remains an important coverage option for many within the AI/AN community. Because Congress underfunds IHS, the program often relies on reimbursement from third-party payors such as Medicaid to provide and pay for care to its patients. AI/AN families who are enrolled in Medicaid and need to access care outside of the IHS system may be less likely to incur medical debt than if they rely exclusively on the PRC program. However, while federal law provides AI/AN families with

[1] The Affordable Care Act (ACA) expanded coverage to Native Americans with household incomes between 100 percent to 400 percent of the Federal Poverty Level. Households below 300 percent FPL are eligible for $0 cost sharing, and households below 100 percent or between 300 – 400 percent FPL are eligible for limited cost sharing. Enrollment occurs year-round and is not limited to applying during open enrollment periods.

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stronger rights and protections under Medicaid (e.g., no premiums or cost-sharing), eligibility for the program is still income-based and may not be available to all AI/AN families.

Recommendations: *The promise of health care coverage should not encompass burdensome enrollment in public programs. Understanding the complexities of health care coverage is difficult for many communities. To help individuals navigate the various coverage options, IHS may be able to integrate consumer assistance programs to educate the community and help members enroll in coverage.*

Cultural Disconnect and Poor Health Outcomes Lead to High Health Care Needs

- While AI/ANs have been found to experience high risk of chronic illnesses such as obesity, heart disease, and diabetes, they are less likely to seek out care outside of reservations due to stigma from the perception of American society. AI/AN individuals have a life expectancy 4.4 years less than all race populations within United States. The community also sees higher rates of death than other Americans in many preventable illness categories. For example, mental health is a significant issue within the AI/AN community; it stems from a long history of multi-generational trauma rooted from political marginalization, education disparities, and racial discrimination. This deeply ingrained history of forced displacement and broken treaties have caused many to lose trust in the federal government. Additionally, many IHS facilities are severely outdated, lacking funding for critical updates and resulting in long wait times. These systemic barriers and lack of trust contribute to the high risk of chronic illnesses, which may lead to an unexpected increase in financial burden to manage conditions.

- A provider that is trustworthy and culturally competent is crucial in ensuring the health care needs of the individual are met. However, many providers within the IHS system often lack familiarity with the AI/AN community. While many tribes share similar cultural values, there are hundreds of tribes accounting for over 200 Indigenous languages upholding diverse cultures and histories. This becomes particularly difficult for AI/AN members to express their health needs to their providers when certain words do not exist in their native languages. This cultural disconnect affirms GAO's findings in 2016, that "found frequent gaps in diagnosing and treating non-emergency medical conditions that cause pain or some degree of disability." Cultural disconnect between the provider and patient can lead to missed detection of serious health issues. Unfortunately, failure to properly manage health issues may result in increased cost of care due to increased complications.

- Engaging in cost avoidance behavior and delaying care are often associated with financial concerns. An unexpected medical bill is likely to deter an individual from seeking further care, especially with the rise in health care costs over the years. However, delaying care may lead to serious implications to an individual's long-term health. It was found that AI/AN patients were more likely to skip filling medication prescriptions due to costs (Odds Ratio = 1.2647), which may further contribute to poor health outcomes and/or complications. Additionally, a history of structural discrimination, forced relocation, and underfunding may be contributing factors to the health disparities amongst the AI/AN community. Delaying care due to systemic barriers can often lead to missing early detection of a serious illness.

Recommendations: *Ongoing cultural competency training on these communities is essential to ensure patients feel comfortable and assured with their care. A closer partnership between tribal leaders and IHS may be able to help providers identify barriers and better understand the needs of the community. Additionally, integrating community partnerships with tribal leaders and community health workers would allow for AI/AN members to understand the health implications of delaying care as well as health coverage options.*

Additional Recommendations to Improve Access and Strengthen IHS

Despite limited medical debt in Native American communities, enough evidence shows the AI/AN community may be vulnerable to medical debt. The following recommendations provide opportunities to implement equitable policies to honor the longstanding promise of health care for the AI/AN community.

- ***Mandatory Funding for IHS Subject to Increases with Health Care Costs***. In March 2022, the Biden administration proposed a historic $9.1 billion in mandatory funding for IHS to guarantee 10 years of stable funding for the community that would increase annually. This was the result of numerous recommendations from the tribal communities, but the Tribal Budget Formulation Workgroup (TBFWG), a national workgroup that identifies annual tribal funding priorities, estimates the community needs over $49.8 billion to appropriately serve the AI/AN community. Ultimately, the Fiscal Year 2023 omnibus spending package provided $6.9 billion in funding to IHS, but included a historic provision to provide $5.1 billion in advance appropriations for IHS. This historic win no longer poses risks of delayed care for Fiscal Year 2024 due to the annual appropriations process in Congress. However, IHS continues to be the only major federal health care program that remains

vulnerable to government shutdowns and political divide as the inclusion of advance appropriations is not guaranteed in future years.

- ***Community Voice and Allyship.*** We must recognize that limited availability of medical debt data in the AI/AN community does not imply that the community does not share these burdens. Meaningful change is a result of a strong organized community voices. While tribal leaders continue to advocate to federal agencies on the critical health care gaps in the current system, allyship is needed to ensure members of Congress are making informed decisions of the fate of the AI/AN community's access to health care rights. Encourage advocates to invite tribal leaders to the decision-making tables and welcome input on recommendations to address intersectional issues.

- ***Consumer Assistance.*** While the ACA expanded health care coverage options to the AI/AN community, the burden of understanding coverage options falls on the individual and/or family. Expanding access to services such as Community Health Workers (CHWs) would help the community learn about health coverage options and educate the community on the gaps within the IHS system. In turn, community members are empowered to educate their own networks to ensure everyone in the AI/AN community is fully informed.

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