sharing can illuminate a path to substantial improvements in community health.

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Study concept and design: Alpern, Sharfstein.

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4. Afzal S. First, we assessed overall national coverage changes. Then we used a differences-in-differences approach to compare pre-ACA (2012-2013) and post-ACA (2014) changes in outcomes between Medicaid expansion and nonexpansion states. The outcome was primary health insurance, in 4 mutually exclusive categories: Medicaid with IHS, Medicaid without IHS, private coverage, and uninsured. We also assessed overall rates of IHS coverage.

Abbreviations: AI/AN, American Indian or Alaska Native; FPL, federal poverty level.

* Includes Fond du Lac (Minnesota, Wisconsin), Goshute (Nevada, Utah), Duck Valley (Idaho, Nevada), Lake Traverse (North Dakota, South Dakota), Navajo Nation (Arizona, New Mexico, Utah), Standing Rock (North Dakota, South Dakota), and Ute Mountain (Colorado, New Mexico, Utah).

** Among individuals 16 years or older.
Models adjusted for demographics and employment. We used national survey weights and robust standard errors clustered by state. Two-sided \( P < .05 \) was considered significant. The study used publicly available data, and institutional review board approval was waived by Harvard University.

### Results

Our national and reservation samples included 168,654 and 24,575 nonelderly Native Americans, respectively (Table 1). The reservation sample was poorer, younger, and less likely to be employed.

Nationally, the Native American uninsured rate dropped from 24.8% to 20.6% (\( P < .001 \)). The national differences-in-differences estimate for Medicaid expansion was a 2.9 percentage-point decline in the uninsured rate (95% CI, −4.4 to −1.5; \( P < .001 \)), and a decline of 8.6 percentage points (95% CI, −15.6 to −1.7; \( P = .02 \)) in the reservation sample (Table 2). Medicaid coverage (with or without IHS) increased nationally, with coverage gains roughly equally divided between those with and without concurrent IHS. On reservations, however, most Medicaid coverage gains occurred among those also reporting IHS. Reductions in private coverage were nonsignificant, with estimates ranging from −1.5 (95% CI, −3.3 to 0.4; \( P = .12 \)) to −2.0 (95% CI, −12.4 to 8.4; \( P = .68 \)) percentage points. Overall changes in IHS were also nonsignificant.

We tested whether coverage was differentially changing in expansion vs nonexpansion states in 2013 (pre-ACA). Nationally, we detected 2 significant changes for expansion vs nonexpansion states: 0.8 percentage points in Medicaid with IHS (95% CI, 0.1 to 1.6; \( P = .03 \)) and −1.8 percentage points in private coverage (95% CI, −3.3 to −0.2; \( P = .02 \)). Uninsured and IHS rates were stable (−0.1; 95% CI, −1.9 to 1.7; \( P = .91 \)); and 0.4; 95% CI, −2.0 to 2.8; \( P = .74 \), respectively), and there were no significant differential changes in the reservation sample. Repeating the Table 2 regressions for the national sample adjusting for differential linear time trends for expansion vs nonexpansion states produced results similar to our main findings, except that the 2014 change in Medicaid with IHS became nonsignificant (−0.1; 95% CI, −1.2 to 1.0; \( P = .82 \)).

**Discussion**

The ACA was associated with significant coverage increases for Native Americans, primarily in Medicaid expansion states, consistent with national trends for all racial/ethnic groups.\(^4,5\) Nationally, much of the coverage increase occurred among Native Americans without connections to IHS. Among those living on or near reservations, Medicaid gains were concentrated among those also reporting IHS coverage, whose health care costs at IHS facilities can now be reimbursed by Medicaid. Meanwhile, there was no net change in IHS rates, suggesting that Medicaid expansion is supplementing rather than replacing IHS. Moreover, this finding suggests that the law may bring additional resources from Medicaid into IHS, which has struggled with budget shortfalls.\(^6\)

Study limitations include only 1 year of post-ACA data, imprecise measurement of income and insurance in survey data, and the absence of health care utilization data in the ACS. Finally, factors besides the ACA may have differentially affected coverage in expansion and nonexpansion states.

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Invited Commentary

Medicaid Coverage and Access to Care for American Indians and Alaska Natives Under the Affordable Care Act

In this issue of JAMA Internal Medicine, Frean and colleagues1 find Medicaid coverage gains among American Indians and Alaska Natives (AIANs) in states that expanded Medicaid under the Affordable Care Act (ACA) Medicaid expansion. They also find that, among AIANs living near reservations, most gaining Medicaid utilize Indian Health Services (IHS) for care. These findings suggest important strides forward for the 5 million individuals who self-identify as AIAN. American Indians and Alaska Natives confront persistent disparities in health and health care. They have a high uninsured rate, face significant barriers to obtaining care, and have substantial health needs, including high rates of obesity, diabetes, and suicide.2 Medicaid coverage gains will increase their access to care and enhance capacity among IHS and Tribal health care providers.

Treaties and laws establish the federal government’s responsibility to provide certain rights, protections, and services to AIANs, including health care. The IHS is the primary vehicle through which the federal government provides health services to AIANs. Indian Health Services-funded health services are provided through hospitals, clinics, and health stations that are managed directly by IHS, Tribes, and Urban Indian Health Programs. Services provided through IHS and Tribal facilities are limited to members or descendants of members of federally recognized Tribes living on or near reservations and consist largely of primary care. Congress funds IHS through an annual fixed appropriation, but it has historically been underfunded to meet AIAN needs.3-5 Moreover, many AIANs do not live on or near reservations, limiting their ability to access IHS or Tribal facilities.

Given these limitations and the low incomes of AIANs, Medicaid is an important source of health coverage for AIANs that provides access to a broader array of services and clinicians, including specialty care, than often is available through IHS. Medicaid is also a key source of financing for IHS and Tribal health care providers. While IHS funds are limited at a fixed amount per year, Medicaid funds are provided on an open-ended basis for covered services throughout the year, helping IHS and Tribal facilities cover operational costs and meet demands for care.

The ACA Medicaid expansion to adults with incomes up to 138% of the federal poverty level provides a significant opportunity to increase coverage among AIANs in the 32 states that have adopted the expansion to date. Nationwide, 41% of AIANs who were uninsured as of 2015 are estimated to be eligible for Medicaid based on household income and states’ current Medicaid eligibility limits.2 This share includes newly eligible adults in expansion states and adults and children who were previously uninsured but not enrolled in expansion and nonexpansion states. Coverage gains will not only increase AIANs’ access to services and clinicians but will also increase Medicaid revenues flowing to IHS and Tribal facilities, which may enhance their capacity to meet health care needs.

In states that have not expanded Medicaid, 65,000 uninsured poor adult AIANs are left without an affordable coverage option.2 These adults earn too much to qualify for Medicaid but not enough to qualify for Marketplace premium tax credits, which begin at 100% of the federal poverty level. Although several states that include a large share of AIANs have expanded Medicaid, such as Alaska, Arizona, California, and New Mexico, other states that are home to many AIANs have not, such as Oklahoma, South Dakota, and Texas. In states that do not expand, many poor adults will likely remain uninsured and IHS and Tribal health care providers will not realize gains in Medicaid revenue. Medicaid expansion decisions also create unique equity issues for AIANs because some Tribal nations extend across states that have made differing expansion decisions. For example, a Navajo Nation member living in Arizona may be eligible for Medicaid, while a Navajo member with the same income living in Utah would not.

Separate from the Medicaid expansion, the Centers for Medicare and Medicaid Services released new guidance in

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February 2016 intended to improve delivery systems for AIANs. The guidance is designed to encourage new care coordination agreements between IHS and Tribal facilities and other health care providers that would provide AIANs access to a wider array of services and clinicians.\(^6\)

Looking ahead, targeted outreach and enrollment efforts will be key for continued coverage gains and overcoming enrollment barriers faced by AIANs, including mistrust of governments, certain cultural beliefs, and a preference for using IHS services and the belief among some AIANs that the federal government should fund all AIAN care through IHS.\(^7\) The Department of Health and Human Services provided grants for AIAN communities to develop strategies to enroll eligible children in Medicaid and the Children’s Health Insurance Program; additional funds will be awarded to continue this effort.\(^8\) In the face of substantial health needs, Medicaid can provide immediate benefits to AIANs and leverage federal dollars to improve capacity at IHS and Tribal facilities, enhancing access to a broader set of services to meet their needs.

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In Defense of Off-label Prescribing

To the Editor The study by Eguale and colleagues\(^1\) demonstrates that off-label use of prescription drugs is associated with increased ADEs (adverse drug events) only when such use lacks strong scientific evidence. Specifically, off-label uses of drugs with strong scientific evidence had the same risk of ADEs as on-label use. This finding implies that the extreme expense and delay caused by the process of US Food and Drug Administration (FDA) approval of an already-approved drug for a new indication may not be necessary if strong scientific evidence supports such use. The take-home message of this study is not that we need to crack down on off-label prescribing but that we need to crack down on unscientific prescribing.\(^2\) Electronic health records should be programmed to discourage unscientific prescribing, not off-label prescribing. Because off-label prescriptions backed by strong evidence are just as safe as prescriptions for FDA-approved indications, the FDA ban on promotion of the former denies patients the benefits of safe and scientifically proven medications. The focus should shift to suppression of off-label prescribing only when it is not backed by strong evidence.

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In Reply Unscientific prescribing constitutes 4 of 5 off-label uses,\(^1,\(^3\) and this unscientific prescribing has resulted in a 54% increased risk of adverse drug events compared with on-label uses.\(^4\) To crack down on unscientific prescribing, drug regulatory bodies need to demand strong scientific evidence from pharmaceutical companies to safeguard the public.

Scientific evidence for off-label use takes years to develop. Older drugs have more off-label use compared with recently introduced drugs,\(^3\) and these same drugs have more off-label use backed with strong scientific evidence. Drugs approved before 1996 have more off-label use compared with drugs approved after 1996, and as many as 25% of these off-label uses of older drugs (before 1996) have strong scientific evidence compared with only 7.5% of drugs approved after 1996. We need to be cautious in the use of recently introduced drugs for off-label uses owing to a lack of strong scientific evidence.

We\(^1\) have also shown that, with the aid of electronic health records, accurate documentation of treatment indications is possible and can answer important patient safety questions. Documentation of treatment indication is 1 value-added feature for physicians and facilitated the creation of a problem list of active and current diagnoses, as