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Los Angeles American Indian and Alaska Native Project[1] Technical Memo 4: AIAN Health Insurance Coverage

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PART I: INTRODUCTION

This technical memo examines health insurance coverage of AIANs in Los Angeles. Previous studies have found that AIANs are significantly less likely to have access, particularly to private insurance (Kaiser Commission on Medicaid and the Uninsured, 2000; American Indians and Alaska Natives: Health Coverage and Access to Care, 2004; Urban Indian Health Institute, 2012). The gap is particularly noticeable when compared to non-Hispanic whites. An analysis of the 2009, 2010, and 2011 American Community Survey Public Use Micro Sample (ACS PUMS) data documents this disparity in the region, although there are variations between AIANs alone (those who self-reported being only AIAN) and multiracial AIANs (those who self-reported being AIAN and at least one other racial category), with the former faring worse. Demographic, socioeconomic, and health factors contribute to the gap in access to health insurance, but being AIAN is correlated with lower coverage beyond these factors. Although many AIANs are eligible for Indian Health Services (I.H.S.), participation is extremely low, a pattern shared by other urban AIANs. AIANs face a number of challenges and opportunities with the Patient Protection and Affordable Care Act (a.k.a. Obamacare) and the responses to the "fiscal cliff."

Health insurance coverage is particularly important for AIANs because they have relatively more medical problems.

[1]This technical memo is a product of a collaborative effort by UCLA American Indian Studies Center and the Los Angeles Urban Indian Roundtable. We would like to thank reviewers for their input, feedback, and comments. The authors are solely responsible for the contents of this report. Data are collected on hearing, vision, cognitive, ambulatory, self care, and independent living difficulty for disabilities.

Table 1: Percent Disabled by Age

	Total Population	AIAN Alone	Multiracial AIAN	NHW
Total	9.8%	15.3%	15.9%	13.0%
0–17	2.8%	7.0%	5.5%	2.3%
18–39	3.8%	9.0%	10.7%	3.8%
40–64	10.9%	17.9%	22.8%	11.3%
65+	40.8%	49.9%	48.1%	40.4%

Other people have noted this in terms of morbidity and mortality as well (Jones, 2006; Barnes, Adams, and Powell-Griner, 2010; Kaiser Commission on Medicaid and the Uninsured, 2000; UCLA Center for Health Disparity Research, 2012; Belluck, 2009; The Henry J. Kaiser Family Foundation, 2009). This can be seen in the ACS PUMS data for Los Angeles (see table 1). AIANs are more than one and a half times as likely to have a disability[2] than the total population. The bottom of the table reports disability rates by age categories. Not surprising, the disability rate varies significantly with age, with the rate climbing in each age bracket, in part because some disabilities are only counted for older age groups, but largely because of the increases in chronic disabilities as people age. Overall and within each category, AIANs experience significantly higher disability rates than non-Hispanic whites (NHW) and the total population.

Despite the greater health care needs of AIANs, they have less access to health care because of higher rates of being uninsured and less access to private insurance. Nearly one in four AIANs alone is uninsured compared to less than one in eight NHWs.

The next section covers how health insurance coverage varies by key demographic, economic, and health characteristics. Part III compares coverage by private insurance. Part IV examines coverage for AIANs compared to other groups when these factors are controlled for, and Part V examines usage of IHS. The conclusion contains recommendations for future research and comments on policy implications

PART II: UNINSURANCE RATES

Health care coverage varies by race, as well as by other characteristics such as age, gender, income level, and

[2]Data are collected on hearing, vision, cognitive, ambulatory, self care, and independent living difficulty for disabilities.

disability status. There are various types and sources of health coverage, which can be categorized into two broad categories, government-run public health care or insurance from a private health insurer. While public health care extends coverage to those who might not otherwise have health insurance, such as the poor or elderly, private health insurance tends to provide better health coverage. Even including public health care, more than one in five people in Los Angeles have no health insurance or coverage. AIANs are more likely to be uninsured than NHWs, less likely to have private coverage than NHWs, and more likely to have increased reliance on only public forms of health coverage. AIANs alone are more likely to be uninsured and less likely to have private coverage (either private only or private and public) than the total population; they had increased reliance on public-only insurance when compared to the total population. Multiracial AIANs had lower levels of uninsured compared to the total population, but also lower levels of insurance in each category than NHWs (see table 2).

Table 2: Type of Health Coverage

	Total Population	AIAN Alone	Multi-racial AIAN	NHW
Uninsured	22.8%	24.3%	18.4%	11.6%
Private and Public	6.1%	7.1%	7.2%	11.5%
Private Only	47.8%	40.1%	48.9%	62.2%
Public Only	23.3%	28.5%	25.6%	14.7%

The percentage of uninsured tends to be low for youths who are primarily covered by their parents or other sources of health care. However, as they leave the age bracket, they often lose health insurance from these sources. Over time they are more likely to obtain a job with health care benefits, and the elderly have access to Medicare. Within each age group, multiracial AIANs tend to be better insured than the total population, but are not as well covered as NHWs. AIANs alone are more comparable to the total population.

There are gender differences. Women tend to be better insured than men, but AIAN-alone men are more likely to be uninsured than other men and AIAN women were more likely to be insured than other women, although both genders were not as insured as NHWs of either gender. Multiracial AIANs of both genders were better off, but still not as insured as NHWs.

People with low incomes relative to the federal poverty level tend either not to have jobs with health coverage benefits or not to be able to purchase it. This is partially offset by programs such as Medicaid for people with low income and Medicare for the elderly. AIANs alone are less insured than the total population in all income brackets except the lowest, and fare worse than NHWs at all levels. AIANs in combination are between the levels for the total population and NHWs except at the highest bracket.

Insurance companies are often prohibitive when accepting people with preexisting conditions, meaning that at the time this data was collected, disabled people were less likely to be covered. One in four AIANs alone with a disability did not have coverage, compared to one in eight for NHWs. AIANs in combination fared better, with one in five with a disability having no coverage, which was better than the total population, but not near the level of NHWs (see table 3).

Table 3: Percent Uninsured

	Total Population	AIAN Alone	Multi-racial AIAN	NHW
Uninsured	23%	24%	18%	12%
Percent Uninsured by Age				
0–17	10%	8%	8%	5%
18–39	36%	35%	30%	20%
40–64	26%	29%	20%	13%
65+	3%	2%	2%	1%
Percent Uninsured by Gender				
Male	25%	29%	21%	14%
Female	20%	19%	16%	10%
Percent Uninsured by Income-to-Poverty Ratio				
Less than 125% of Poverty	32%	28%	24%	22%
125–249%	32%	36%	27%	21%
250–499%	20%	23%	16%	13%
Over 500%	7%	9%	8%	5%
Percent Uninsured by Disability Status				
With a Disability	24%	25%	20%	12%
Without a Disability	12%	21%	10%	7%

The type of coverage affects health care access, with private coverage being the most desirable. Medicaid is less accepted than private insurance. Medicare is mixed, less accepted than private for primary care, but more accepted for specialized care (Bishop, Federman, and Keyhani, 2011). Differences are likely due to different reimbursement rates. There is a form of private insurance that is less accepted, capitated reimbursement (Decker, 2012). The reimbursement rates for a medical procedure vary with the type of insurance. For example, Medicaid (MediCal in California) offers a lower reimbursement amount than private insurance for the same treatment. Table 4 reports the percent covered by private insurance. AIANs alone have substantially lower rates of private health insurance than the general population and especially NHWs. AIANs in combination fare only slightly better by this metric than the overall population, but still do not come near the levels of NHWs. While almost three out of four NHWs have some private coverage, the figure is much lower for AIANs, around one-half.

PART III: PRIVATE COVERAGE

Private insurance is usually provided by an employer or union as part of a benefits package or is purchased as an individual. There is a large drop in the insurance rates for the elderly, since most of them are out of the labor force and rely on Medicare, which is public health coverage. Minority youth who are not NHW have low rates of private coverage, most likely because their parents do not have access to employer-based health coverage (and people with Medicaid are not included). The pattern of AIANs alone being worse off than the rest of the population and NHWs remains constant, as does the pattern of AIANs in combination being mostly between the levels of the rest of the population and NHWs.

The gender gap is small for most groups, with one exception, but there remains a sizable difference between AIAN-alone men and women. AIANs alone still tend to be worse off than the rest of the population and AIANs in combination still tend to be worse off than NHWs.

As income relative to the federal poverty level increases, so does the level of private coverage, but NHWs have far higher levels of private coverage at every income bracket, AIANs in combination are similar to the rest of the population, and AIANs alone are worse off than the rest of the population.

Coverage for people with a disability also follows the same pattern: AIANs alone are more disadvantaged than the rest of the population and AIANs in combination are between the total population and NHWs.

Table 4: Percent without Private Coverage

	Total Population	AIAN Alone	Multi-racial AIAN	NHW
Without Private Coverage	46%	53%	44%	26%
Percent without Private Coverage by Age				
0–17	51%	64%	46%	19%
18–39	47%	51%	44%	25%
40–64	38%	45%	40%	22%
65+	57%	66%	52%	43%
Percent Without Private Coverage by Gender				
Male	46%	55%	44%	27%
Female	46%	50%	44%	26%
Percent Without Private Coverage by Income-to-Poverty Ratio				
Less than 125% of Poverty	80%	82%	79%	61%
125–249%	60%	69%	60%	48%
250–499%	33%	37%	26%	23%
Over 500%	13%	16%	13%	10%
Percent Without Private Coverage by Disability Status				
With a Disability	65%	68%	59%	54%
Without a Disability	44%	50%	41%	22%

PART IV: RESIDUAL AIAN EFFECT BEYOND OBSERVABLE FACTORS

The analysis in the previous section shows that health insurance rates vary significantly by age, gender, poverty status, and disability. These factors help explain the low coverage for AIANs. For example, because AIANs are more likely to be poor, they are more likely to have less access to private insurance. While the above analysis is useful, it does not tell us whether the observed factors working together explain the entire gap between AIANs and others, particularly the gap relative to NHWs. This section summarizes the results of a multivariate analysis that simultaneously accounts for the observed demographic, economic, and health characteristics. Details of the model are in Appendix A. Table 5 reports the unadjusted and adjusted gap between AIANs and non-AIANS, and between AIANs to NHWs.

Multiracial AIANs are less likely to have no insurance and less likely to have private coverage when compared to non-AIANs, but not when compared to NHWs, and an especially large difference when it comes to private coverage. The difference is even greater for AIANs alone who are worse off than non-AIANs and NHWs. Although adjusting reduces the differences in most cases, there is still a significant difference across racial lines especially when compared to NHWs. When adjusted for several variables, AIAN-alone insurance coverage is on par with the rest of the population; they still have less private coverage and maintain large disparities with NHWs.

Table 5: Estimated Difference in Insurance Status Between AIANs and NH Whites

	AIAN Alone minus non-AIAN	Multiracial AIAN minus non-AIAN	AIAN Alone minus NHW	Multiracial AIAN minus NHW
Uninsured				
Unadjusted	1.4%	-4.5%	12.6%	6.8%
Adjusted	0.0%	-3.8%	8.3%	4.3%
No Private Insurance				
Unadjusted	6.7%	-2.1%	26.4%	17.6%
Adjusted	5.4%	-3.3%	21.7%	14.0%

PART V: INDIAN HEALTH SERVICES

AIANs are unique because they potentially have access to Indian Health Services (IHS). This program is the result of treaties, laws, executive orders, and Supreme Court rulings resulting in agreements between the United States government and federally recognized tribes to provide essential services for the health of AIANs. IHS operates under a government-to-government relationship established in 1787 and is based on Article I, Section 8 of the US Constitution. It is federally funded and operates off a $4.3 billion annual budget as of 2011, but it is not considered an entitlement program.

IHS covers AIANs and partially extends to non-AIAN members of their households, either providing direct service through IHS facilities or select non-IHS facilities through Contract Health Services (CHS). However, the requirements for CHS are stricter, CHS facilities are situated near tribal lands, and the number of IHS facilities is limited, particularly in urban areas.

Despite being a checkbox in the ACS's health coverage question, IHS is tabulated as neither public nor private health insurance or coverage. People who only have access to IHS but no other form of insurance or coverage are counted as being uninsured. In Los Angeles, AIANs make up 41% of people with IHS. The rest consists of people of other races, including nearly one-fifth that is NHW. However, even among AIANs, IHS usage in Los Angeles County is rare. Less than 5% of AIANs alone and less than 1% of multiracial AIANs use it. This is extraordinarily low compared with the national levels: 40% of AIANs alone and 10% of multiracial AIANs are covered.[3]

[3] The IHS reports that it covers 59% of AIANs in 2011. There are discrepancies in total numbers as well, which may be due to the way the ACS collects and weights their data. The 59% figure is reported as those enrolled but not all of whom are active users. ACS is based on self-reported answers, but people who are counted by IHS may not identify as being covered by IHS because they may not frequently use it or lack access because they have moved or for other reasons.

PART VI: CONLUSION AND RECOMMENDATIONS

The analysis shows that AIANs have greater health care needs but less access because of higher rates of being uninsured and lower odds of having private coverage. AIANs alone tend to be worse off than the total population, and multiracial AIANs tend to be worse off than NHWs. Demographic, socioeconomic, and disability factors contribute to the disparity in insurance rates, but even after accounting for these factors, AIANs have lower levels of health coverage than NHWs.

The status of health care coverage will change dramatically in the coming years with the restructuring of health care, making new research in the future vital to our understanding, depending on how things play out under healthcare reform. This includes changes to health care both on a federal level and its implementation at a local one.

Part of the Affordable Care Act (aka Obamacare) calls for a mandate on individual health insurance requiring it for every person in Public Law 111-148. This law was passed, and despite legal challenges to the individual mandate, it was upheld by the Supreme Court. Consequently, in the near future people will have to find health coverage. Because AIANs have low insurance rates, mandatory health insurance raises the question of how people will afford insuring themselves and their families. Although some AIANs may be exempt, it is not clear how it will affect the AIAN population in Los Angeles.

Another source of potential dramatic change is the "fiscal cliff." It comes from the inability of the White House and Congress to pass a budget to address the deficit and national debt. This resulted in a temporary agreement to extend Bush tax cuts until the end of 2012, and if a budget could not be passed, beginning in 2013, the tax cuts would expire and there would be a series of automatic cuts to government spending, including entitlement programs such as Medicare and Medicaid. However, even if a budget is passed, in order to reduce national spending, some cuts will likely be made to the same entitlement programs. Either way it is likely that Medicare and Medicaid will see some restructuring and budget cuts. Because of AIANs' increased reliance on public health care of some sort, changes to the extent of coverage could have disproportionately large effects on them.

The findings also raise many questions requiring further and more detailed research. This includes the observed gender disparity for AIANs alone in private coverage, the low health coverage for working-age AIANs alone, and low numbers enrolled in IHS due to lack of funding or other barriers. While the census shows that AIANs are more likely to be disabled, more analysis with other sources is needed to expand knowledge and details of the nature, magnitude, and causes of the health problems facing AIANs and future policy implications.

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APPENDIX A

For this memo, logistic regressions are used to control for the independent effects of observed factors. We examine two outcomes, being uninsured and not having private coverage. The logistic functions are defined as:

$$\text{Probability (Being Uninsured)} = e^{\beta X}/(1+e^{\beta X})$$
$$\text{Where Being Uninsured} \subset (1,0)$$

$$\text{Probability (No Private Coverage)} = e^{\beta X}/(1+e^{\beta X})$$
$$\text{Where No Private Coverage} \subset (1,0)$$

X is the vector of independent variables, and β is a vector of coefficients. Maximum likelihood is used to estimate the parameters. The following is a list of the variables and their functional forms. Sex is designated by a dichotomous variable for being male (1=yes, 0=no), and having at least one disability is designated by another dichotomous variable. We include both a continuous linear and a second-order term (squared) for age and the income-to-poverty ratio because their effects are not linear, as observed in Part II. There is a dichotomous variable indicating when the poverty ratio is not reported by the Census Bureau, and another for those in households with a capped top value of 5.01 times the federal poverty level. We include dummy variables to capture any residual effects of being AIAN alone or being AIAN in combination. One set of regressions compares AIANs with non-AIANS, and another set compares AIANs to non-Hispanic whites. Table A1 reports the logit regression results.

Dependent Variables: Without Insurance (models 1 & 2); Without Private Insurance (models 3 & 4)

Relative to non-AIANs (models 1 & 3); Relative to NH Whites (models 2 & 4)

The primary results are the gap in coverage after controlling for the observed factors. These adjusted differences in the probability of not being covered (ΔPr) are calculated by using the following equation:

$$\Delta Pr = B(p(1-p))*\Delta x$$

B is the estimated coefficient for the variable of interest (i.e., being AIAN); p is the observed probability of not being covered; and Δx is the difference in the independent variable, which by definition is equal to one.

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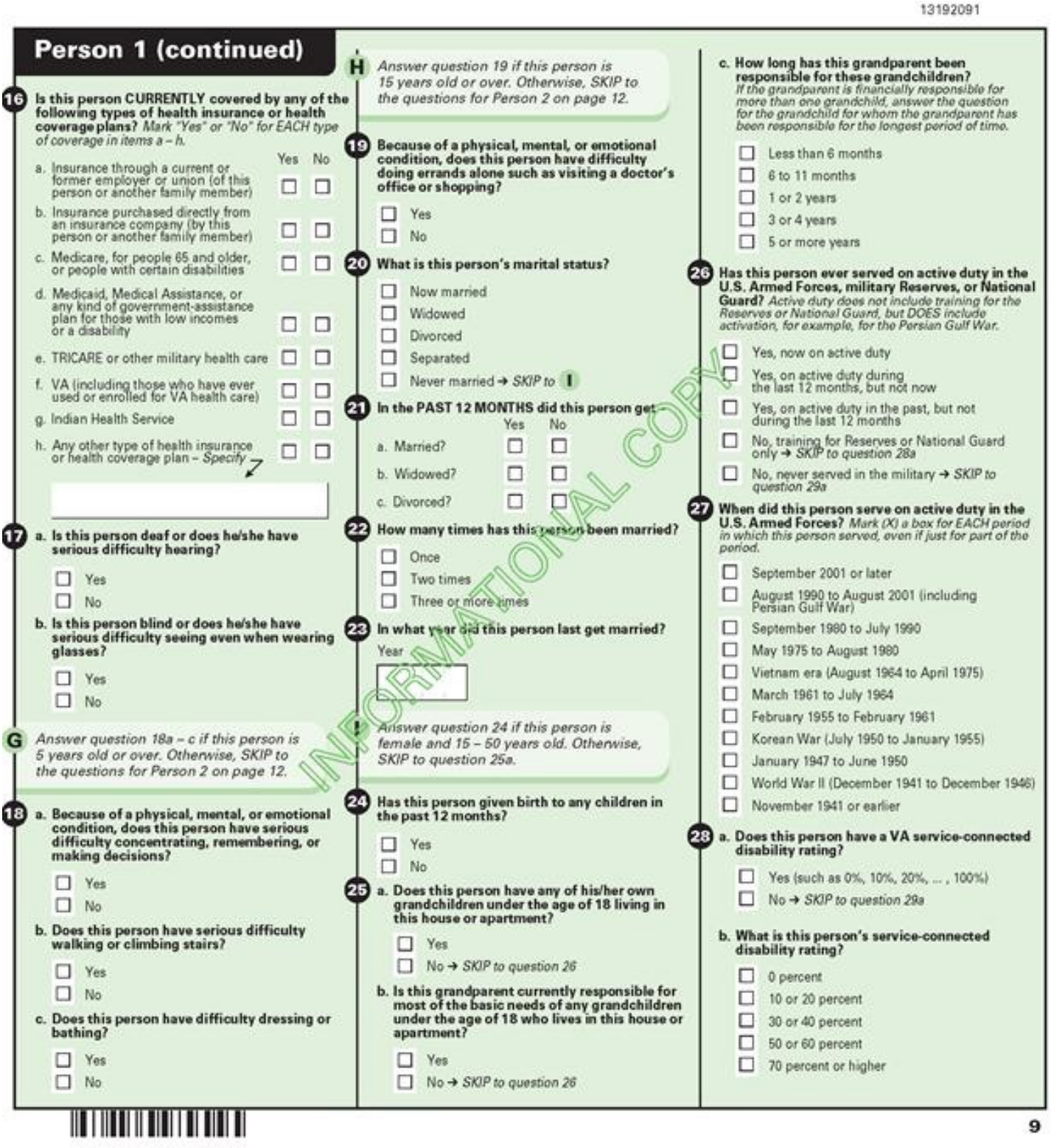
APPENDIX B



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Person 1 (continued)

16 **Is this person CURRENTLY covered by any of the following types of health insurance or health coverage plans?** *Mark "Yes" or "No" for EACH type of coverage in items a – h.*

	Yes	No
a. Insurance through a current or former employer or union (of this person or another family member)	☐	☐
b. Insurance purchased directly from an insurance company (by this person or another family member)	☐	☐
c. Medicare, for people 65 and older, or people with certain disabilities	☐	☐
d. Medicaid, Medical Assistance, or any kind of government-assistance plan for those with low incomes or a disability	☐	☐
e. TRICARE or other military health care	☐	☐
f. VA (including those who have ever used or enrolled for VA health care)	☐	☐
g. Indian Health Service	☐	☐
h. Any other type of health insurance or health coverage plan – *Specify*	☐	☐

17 **a. Is this person deaf or does he/she have serious difficulty hearing?**

☐ Yes
☐ No

b. Is this person blind or does he/she have serious difficulty seeing even when wearing glasses?

☐ Yes
☐ No

G *Answer question 18a – c if this person is 5 years old or over. Otherwise, SKIP to the questions for Person 2 on page 12.*

18 **a. Because of a physical, mental, or emotional condition, does this person have serious difficulty concentrating, remembering, or making decisions?**

☐ Yes
☐ No

b. Does this person have serious difficulty walking or climbing stairs?

☐ Yes
☐ No

c. Does this person have difficulty dressing or bathing?

☐ Yes
☐ No

H *Answer question 19 if this person is 15 years old or over. Otherwise, SKIP to the questions for Person 2 on page 12.*

19 **Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping?**

☐ Yes
☐ No

20 **What is this person's marital status?**

☐ Now married
☐ Widowed
☐ Divorced
☐ Separated
☐ Never married → *SKIP to* **I**

21 **In the PAST 12 MONTHS did this person get**

	Yes	No
a. Married?	☐	☐
b. Widowed?	☐	☐
c. Divorced?	☐	☐

22 **How many times has this person been married?**

☐ Once
☐ Two times
☐ Three or more times

23 **In what year did this person last get married?**

Year

I *Answer question 24 if this person is female and 15 – 50 years old. Otherwise, SKIP to question 25a.*

24 **Has this person given birth to any children in the past 12 months?**

☐ Yes
☐ No

25 **a. Does this person have any of his/her own grandchildren under the age of 18 living in this house or apartment?**

☐ Yes
☐ No → *SKIP to question 26*

b. Is this grandparent currently responsible for most of the basic needs of any grandchildren under the age of 18 who lives in this house or apartment?

☐ Yes
☐ No → *SKIP to question 26*

c. How long has this grandparent been responsible for these grandchildren? *If the grandparent is financially responsible for more than one grandchild, answer the question for the grandchild for whom the grandparent has been responsible for the longest period of time.*

☐ Less than 6 months
☐ 6 to 11 months
☐ 1 or 2 years
☐ 3 or 4 years
☐ 5 or more years

26 **Has this person ever served on active duty in the U.S. Armed Forces, military Reserves, or National Guard?** *Active duty does not include training for the Reserves or National Guard, but DOES include activation, for example, for the Persian Gulf War.*

☐ Yes, now on active duty
☐ Yes, on active duty during the last 12 months, but not now
☐ Yes, on active duty in the past, but not during the last 12 months
☐ No, training for Reserves or National Guard only → *SKIP to question 28a*
☐ No, never served in the military → *SKIP to question 29a*

27 **When did this person serve on active duty in the U.S. Armed Forces?** *Mark (X) a box for EACH period in which this person served, even if just for part of the period.*

☐ September 2001 or later
☐ August 1990 to August 2001 (including Persian Gulf War)
☐ September 1980 to July 1990
☐ May 1975 to August 1980
☐ Vietnam era (August 1964 to April 1975)
☐ March 1961 to July 1964
☐ February 1955 to February 1961
☐ Korean War (July 1950 to January 1955)
☐ January 1947 to June 1950
☐ World War II (December 1941 to December 1946)
☐ November 1941 or earlier

28 **a. Does this person have a VA service-connected disability rating?**

☐ Yes (such as 0%, 10%, 20%, ... , 100%)
☐ No → *SKIP to question 29a*

b. What is this person's service-connected disability rating?

☐ 0 percent
☐ 10 or 20 percent
☐ 30 or 40 percent
☐ 50 or 60 percent
☐ 70 percent or higher

9