

LOS ANGELES URBAN INDIAN ROUNDTABLE



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Los Angeles American Indian and Alaska Native Project

Access to Care Among American Indians and Alaska Natives in Los Angeles

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INTRODUCTION

Los Angeles continues to be one of the largest and most diverse metropolitan areas in the country. Correspondingly, Los Angeles is also home to the nation's largest population of American Indians and Alaska Natives (roughly 222,000 according to a US Census Bureau report released in June 2015).¹ A little known fact is that nearly 70% of the nation's 5.2 million American Indians and Alaska Natives (AIAN) live in urban areas.² Sometimes referred to as "Invisible Tribes," these urban-dwelling AIANs face unique and complex challenges when trying to access health care. This policy brief describes the current landscape of health care coverage for AIANs residing in Los Angeles. It highlights some of the misperceptions about access in this special population; identifies their current barriers to care; and formulates recommendations to optimize the health and well-being of this vulnerable yet resilient population.

Assumption #1: All American Indians and Alaska Natives, including those residing in Los Angeles, are eligible for free health care through the Indian Health Service (IHS).

FALSE. In exchange for land and natural resources, the US government is legally obligated to provide health care for American Indians and Alaska Natives. This obligation is codified in legislation, treaties, and intergovernmental policies over centuries, and is also part of the Federal Trust Responsibility.³ However, IHS is not a health insurance program, and does not provide minimum essential health benefits.

Numerous federal policies have interfered with this health care obligation. First, Termination Era policies resulted in countless tribes being stripped of their sovereignty, land base, and federal recognition, making the perception of eligibility for IHS services of non-federally recognized tribes complicated. In reality, there is no tribal or ethnic requirements to use urban Indian clinics, but this may vary for tribal clinics. For instance, of those AIANs in California who identify as being from a California tribe, only 45% reported having access to IHS services.⁴ This may be due to the fact that many California tribes continue legal battles to gain or regain recognition by the federal government.⁵ Tribes indigenous to Los Angeles County do not have a land base, or federal recognition, and there is no specific data on their access to care.

Second, the Relocation Era resulted in a large demographic shift of AIANs from their tribal lands to urban areas. If one does not live on or near the reservation of the tribe in which the individual is enrolled, it may be difficult to access certain services out of that service delivery area. This is true of AIANs residing in California who are not from a California tribe; only 9% reported having access to IHS. AIANs from non-California tribes represent 50.9% of all AIANs in California.⁶

Third, the IHS budget is only funded at 56% of need, with the lowest per capita spending compared to all other Department of Health and Human Services (DHHS) agencies.⁷ Despite the fact that more than 70% of AIANs reside in ur-

ban areas, only 1% of the total IHS budget is allocated for Urban Indian Health Organizations.⁸ Even if urban AIANs do have access to IHS, often the services are limited to primary care. Hence, urban AIANs cannot solely rely on the IHS as a usual source of care, or for specialty care. This point is particularly salient in Los Angeles, where there is currently only one Urban Indian Health Organization for the entire county.

Assumption #2: Since a large proportion of AIANs live at or below the federal poverty level (FPL), the level of uninsured should be low due to coverage by public insurance programs such as Medi-Cal, Medicare, or the State Children’s Health Insurance Program (CHIP).

FALSE. Nearly one-fifth of AIANs in Los Angeles are uninsured, despite their overrepresentation in public insurance programs compared to non-Hispanic Whites (NHW) (table 1). Overrepresentation in public insurance programs is in part explained by high unemployment and poverty rates.⁹ AIANs who are between the ages of 18–64, male, greater than 125% of the FPL, and with a disability are more likely to be uninsured (appendix, table 2).^{*} Even after controlling for these factors simultaneously in a statistical model, AIANs are still more likely to be uninsured and without private insurance compared to NHWs (fig. 1).^{*} One potential reason for this is historical mistrust. AIANs, as well as other communities of color, have reasons to distrust government programs, researchers, and clinicians due to past experiences including involuntary sterilization, mishandling of research specimens, and withholding of information.^{10,11} Cultural barriers such as language differences between provider and patient, fear, intimidation, and preference of traditional beliefs may also contribute to disinterest in seeking out Western medicine.^{12,13}

Table 1. Type of Health Coverage by Race

	Total Population	AIAN Alone	Multiracial AIAN	Non-Hispanic White
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%

AIANs alone are those who report AIAN only, and no other races. Multiracial AIANs are those who report AIAN in combination with another race. Roughly half of all AIANs in Los Angeles report AIAN in combination with another race. *Source: ACS PUMS, 2009–2011.*

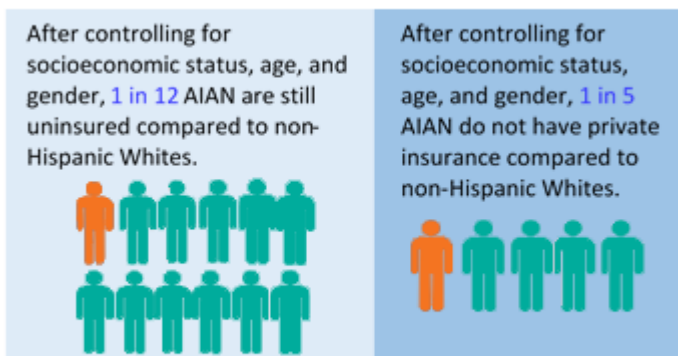
Assumption #3: With the passage of the Patient Protection and Affordable Care Act (ACA), and the reauthorization of the Indian Health Care Improvement Act (IHCA), AIANs are receiving better access to health care.

Unfortunately, there is limited data on AIAN access to care after the passage of the ACA. Between October 2013 and April 2014, roughly 4,000 AIANs in California enrolled in a subsidized insurance plan (excluding Medi-Cal).¹⁴ Under the ACA, every American is guaranteed subsidies for health insurance if they fall within certain income levels. In addition, federally recognized AIANs are eligible for special provisions:¹⁵

- AIANs do not have to wait for special enrollment periods. They can enroll in an insurance plan at virtually any time.
- AIANs with a family of four who earn less than 300% of the FPL do not have to pay certain out-of-pocket expenses, such as copays or deductibles, if they enroll through Covered California.
- There is no cost sharing for covered services provided by an AIAN health provider or clinic, regardless of income.
- AIANs are exempt from the individual mandate and the associated penalty if they fail to maintain minimum essential coverage.

While these special provisions take into consideration the federal Indian trust responsibility, there are unintended consequences associated with them. For example, these provisions are limited to those AIANs enrolled in federally recognized tribes (or who otherwise qualify for IHS). Exemption from the penalty of the individual mandate may have the unintended consequence of disincentivizing AIAN individuals from enrolling in an insurance plan at all. Further, enrollment in IHS alone does not meet the minimum essential coverage requirement.¹⁶

Figure 1: Logistic Regression Model Results for Uninsured and Privately Insured According to Demographic Characteristics*



**Model controls for socioeconomic status, age, gender and reports adjusted results for AIAN alone compared to non-Hispanic Whites. More detailed results available upon request.*

Recommendations to Improve Access to Health Care for American Indians and Alaska Natives Who Reside in Los Angeles County:

Data

1. Disaggregated data on AIAN tribal affiliation is critical and has important implications on access to resources.
2. Garnering resources to conduct a periodic independent health assessment of AIANs using culturally congruent methods and sampling, with additional triangulation of multiple data sources and with oversight from a community advisory board, would be useful for tracking the needs of this vulnerable population.

Best Practices in a Culturally Sensitive Medical Home

3. Given excess morbidity and mortality, higher burdens of psychiatric and substance abuse diagnoses, and historical trauma, access to a culturally sensitive medical home is a best practice in promoting health equity among AIANs. For example, while Los Angeles has the highest number of AIANs in the nation, there is only one Urban Indian Health Organization in the county that meets this definition.
4. Current literature details how community-informed and traditional practices can be complementary to conventional therapies in addressing mental health and substance abuse disparities, particularly here in Los Angeles.^{17,18,19} Consideration should be given to how these complementary practices can be made available to the community (e.g., expansion, reimbursement, etc.).
5. Creating partnerships between local AIAN organizations, county stakeholders, local government, private interests, and academic institutions can help:
 - a. increase the AIAN health professional workforce by building pipeline training programs in Los Angeles;
 - b. increase AIAN access to quality health professionals, and increase non-AIAN cultural sensitivity by having the only AIAN clinic in Los Angeles serve as a training site;
 - c. increase AIAN cultural sensitivity by implementing an interdisciplinary curriculum in partnering with nursing, medical, and public health schools;
 - d. increase AIAN access to specialty and tertiary care by building partnerships with county and academic facilities.

Determinants of Health Equity

6. Meaningful policies adopted by institutions such as LA County, the Board of Supervisors, the new Health Agency, and other local stakeholders can lay the foundation for continued commitment to increasing the health and wellness of AIANs in Los Angeles County. Given an impending building lease expiration of the only AIAN clinic in Los Angeles, perhaps now is a good time to amass partners and resources to build a sustainable AIAN Wellness Center in Los Angeles.

Similar dedication to a vulnerable community is not unprecedented, as illustrated by the joint efforts of former Governor Pat Brown, District Supervisor Mark Ridley-Thomas, Los Angeles County, and the University of California. Together they recognized the needs of the South LA community and committed to the cosponsoring of an Assembly bill, funding, opening, and reopening the Martin Luther King, Jr. Community Hospital.²⁰ On the heels of other meaningful efforts such as the Native Lives Matter and the School-to-Prison Pipeline/Restorative Justice movements, the time is ripe for considering innovations for improving Los Angeles AIAN health, wellness, and access to health care.

“Indian people still lag behind the American people as a whole in achieving and maintaining good health. I am signing this bill because of my own conviction that our first Americans should not be last in opportunity.”

—Gerald R. Ford on signing the Indian Health Care Improvement Act in 1976

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- American Indian Chamber of Commerce
- American Indian Community Council
- American Indian Healing Center
- Fernandeño Tataviam Band of Mission Indians
- Los Angeles City/County Native American Indian Commission
- Pukúu Cultural Community Services
- Red Circle Project
- Southern California Indian Center
- Title VII at Los Angeles Unified School District
- Torres Martinez Tribal Temporary Assistance for Needy Families
- UCLA American Indian Studies Center
- United American Indian Involvement

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Appendix Table 2: Percent Uninsured According to Demographic Characteristics

	Total Population	AIAN Alone	Multi-racial AIAN	Non-Hispanic White
Uninsured	22.8%	24.3%	18.4%	11.6%
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%

AIAN Alone are those who report AIAN only, and no other races. Multi-racial AIAN are those who report AIAN in combination with another race. Roughly half of all AIAN in Los Angeles report AIAN in combination with another race. *Source: ACS PUMS, 2009-2011.*

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Contributions

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