

# **Lifelong Disparities among Older American Indians and Alaska Natives**

R. Turner Goins, PhD  
Western Carolina University

Marc B. Schure, PhD; Jolie Crowder, RN, MSN, CCM; Dave Baldrige; and William Benson  
International Association for Indigenous Aging

Nancy Aldrich  
Health Benefits ABCs, LLC



**Public Policy  
Institute**

AARP's Public Policy Institute (PPI) informs and stimulates public debate on the issues we face as we age. Through research, analysis, and dialogue with the nation's leading experts, PPI promotes development of sound, creative policies to address our common need for economic security, health care, and quality of life.

The views expressed herein are for information, debate, and discussion and do not necessarily represent official policies of AARP.

Research Report 2015-08

November 2015

©2015, AARP

Reprinting with permission only

# **Lifelong Disparities among Older American Indians and Alaska Natives**

R. Turner Goins, PhD  
Western Carolina University

Marc B. Schure, PhD; Jolie Crowder, RN, MSN, CCM; Dave Baldrige; and William Benson  
International Association for Indigenous Aging

Nancy Aldrich  
Health Benefits ABCs, LLC





# Table of Contents

Introduction	7
Who Is an American Indian?	8
How Do Older AI/ANs Compare with the General US Population?	8
How Does AI/AN Health Coverage Compare with That of the General US Population?	11
Where Do AI/ANs Live?	14
Recommendations	16
Adviser Acknowledgments	19
Appendix A. Data and Methodology	21
Appendix B. Limitations	23
Appendix C. Master Table of Socioeconomic and Health Coverage Variables	25

## Box

Box 1. Effects of the Affordable Care Act on Health Care Provision for AI/ANs	13
---	----

## Figures

Figure 1. Age Distribution of 50+ AI/ANs Compared with the US General Population	9
Figure 2. Racial Breakdown of AI/ANs Ages 50+	9
Figure 3. Females by Age Distribution of AI/ANs Ages 50+ Compared with the US General Population	10
Figure 4. Marital Status of AI/ANs Ages 50+	10
Figure 5. Multigenerational Households of AI/ANs Ages 50+	10
Figure 6. Educational Attainment of AI/ANs Ages 50+	11
Figure 7. Employment Status Comparison of AI/ANs and the US General Population, Ages 50–64	11
Figure 8. Mean Annual Income: Comparison of AI/ANs with the US General Population, Ages 50+, by Income Source	11
Figure 9. Health Coverage: Comparison of AI/ANs with the US General Population, Ages 50+	12
Figure 10. Health Coverage: Comparison of AI/ANs Ages 50–64 and 65+	12
Figure 11. Percentage of AI/ANs Living on Tribal Lands, by Age: AI/AN Alone Compared with All AI/AN (Alone and Multiple Races)	14
Figure 12. Nonmetropolitan Location of Americans Ages 50+: All AI/AN and AI/AN Alone Compared with the US General Population	14
Figure 13. Geographic Location of Americans Ages 50+: AI/ANs Compared with the US General Population	15
Figure 14. States with the Highest Proportion of AI/ANs Ages 50+ as a Share of State Population	15
Figure 15. States with the Largest Number of AI/ANs Ages 50+	15

## Table

Table 1. Comparison of Characteristics of Older AI/ANs in States with the Highest Proportion of AI/ANs Ages 50+: Alaska, Oklahoma, New Mexico, South Dakota, and Montana	16
--	----

# Lifelong Disparities among Older American Indians and Alaska Natives

*Older American Indians and Alaska Natives (AI/ANs) constitute a population that will grow substantially over the next 30 years. Such growth follows an increase over the previous decade that is nearly three times more than other races. Numbers of AI/ANs ages 65 and over will triple, and the oldest cohort (ages 85 and over) is projected to increase more than sevenfold by 2050. The socioeconomic and health coverage disparities that have historically characterized their lives remain, to a large extent, unresolved. This report outlines the demographics of this growing cohort and concludes with recommendations for coordinating programmatic resources to better serve it.*

## Introduction

More than 5.2 million people in the United States are American Indian or Alaska Native (AI/AN), either alone or in combination with one or more other races. From 2000 to 2010, the AI/AN population grew 27 percent, increasing nearly three times faster than did the total population.<sup>1</sup> The number of AI/ANs ages 65 and older is projected to more than triple from 464,000 in 2012 to 1,624,000 in 2050.<sup>2</sup> The number of AI/ANs 85 years of age and older is projected to increase from 42,000 in 2012 to 300,000 in 2050—a more than sevenfold increase.<sup>3</sup>

This report uses American Community Survey (ACS) data from the US Census to provide a national overview of demographic and social char-

acteristics of those AI/ANs ages 50 years or older. Population-based data contribute to informing policy, establishing funding priorities, and anticipating service needs. Although information is available about the AI/AN population as a whole, relatively little is known about older AI/ANs.

This report uses ACS estimates of those who identify their race as AI/AN alone or in combination with one or more races.<sup>4</sup> Researchers note variations in demographic and social characteristics between those who report their race as AI/AN alone and those who report as AI/AN combined with other races. American Indians who identify as AI/AN alone and who live on or near reservations have been found to experience the greatest socioeconomic disparities within the AI/AN population.<sup>5</sup>

1 Tina Norris, Paula L. Vines, and Elizabeth M. Hoefel, “The American Indian and Alaska Native Population: 2010.” 2010 Census Briefs (C2010BR-10), US Census Bureau, Washington, DC, January 2012.

2 Jennifer M. Ortman, Victoria A. Velkoff, and Howard Hogan, “An Aging Nation: The Older Population in the United States,” Document P25-1140, US Census Bureau, Washington, DC, May 2014.

3 Ibid.

4 Race, like all other US Census data, is self-reported. Starting in 2000, the US Census allowed people to indicate more than one race. Those who marked “American Indian or Alaska Native” along with one or more additional races are classified as “American Indian or Alaska Native in combination.”

5 Norm DeWeaver, “Who Counts as American Indian in the Census: The Multiracial Difference,” Arizona State University American Indian Policy Institute, Tempe, AZ, 2013, <http://aipi.clas.asu.edu/MultiRacePaper>.

## Who Is an American Indian?

An *American Indian* is generally understood to be someone enrolled or eligible to be enrolled in a federally or state-recognized tribe or a member of an Alaska Native entity.<sup>6</sup> Individual tribes or Alaska Native entities ultimately determine who is eligible for membership. Tribes usually require a minimum blood quantum or proof of tribal ancestry; the membership criteria differ from tribe to tribe. Thus, a universally accepted definition of American Indian does not exist, and cultural, social, political, and administrative definitions vary. The US Census Bureau defines an AI/AN as a person who has origins in any of the aboriginal peoples of North and South America and who maintains tribal affiliations or community attachments. All US Census data are self-reported, including race.<sup>7</sup>

The United States has 566 federally recognized tribes. Alaska has 229 tribes—the most of any state.<sup>8</sup> State governments have recognized 67 tribes as of 2015.<sup>9</sup> Of the total population of AI/ANs ages 50 and over, 23.8 percent come from the 10 federally recognized tribes with the largest number of AI/ANs in that age group.<sup>10</sup>

6 Bureau of Indian Affairs, “Frequently Asked Questions: Who is an American Indian or Alaska Native,” <http://www.bia.gov/FAQs>.

7 It is important to note that AI/ANs are demographically, socially, culturally, and linguistically diverse. Census data are useful in obtaining a general picture of this population, although the data do not adequately illustrate this diversity. When national data are used to inform policy and service provision, for example, it is preferable to complement the statistics with tribal- or region-specific information.

8 Bureau of Indian Affairs, “Indian Entities Recognized and Eligible to Receive Services from the United States Bureau of Indian Affairs,” *Federal Register* 79, no. 19 (2014): 4748–53, <http://www.bia.gov/cs/groups/public/documents/text/idc006989.pdf>.

9 National Conference of State Legislatures, federal and state recognized tribes, <http://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx>. Other nonrecognized tribes and a number of state-recognized tribes have tried to seek federal recognition; however, the application and approval process is complex and can take decades. For more information, see National Congress of American Indians, “Federal Recognition,” <http://www.ncai.org/policy-issues/tribal-governance/federal-recognition>.

10 Authors’ analysis for this study.

As sovereign nations, federally recognized tribes have a unique government-to-government relationship with the United States.<sup>11</sup> One of the most important principles of federal AI/AN law is known as the *trust responsibility* that the federal government has to Native American and Alaska Native people—a result of previous treaty language and forcibly imposed limitations on tribal sovereignty.<sup>12</sup> The trust responsibility is a legal obligation of the federal government. It includes an obligation to protect tribal treaty rights, lands, assets, and resources, as well as the duty to carry out the mandates of federal law to AI/AN communities.

## How Do Older AI/ANs Compare with the General US Population?

### The 50+ Cohort Is Younger

As shown in figure 1, 68.3 percent of AI/ANs ages 50 and older are between 50 and 64 years, 25.4 percent are 65 to 79 years, and 6.3 percent are ages 80 and older. The same-age general US population includes a smaller percentage (59 percent) of individuals between ages 50 and 64 years, with larger percentages in both the 65 to 79 and the 80 and older age groupings.

### Half Identify Themselves as Multiracial

Fifty percent of AI/ANs ages 50 and over identify their race as AI/AN alone (figure 2). The next-largest racial group of AI/ANs in the 50+ cohort (41.7 percent) report themselves as AI/AN and white. The third-largest group (9.9 percent) report themselves as AI/AN and African American. Of those who are ages 80 and over, 45.7 percent identify as AI/AN alone.

11 *Tribal sovereignty* in the United States is the inherent authority of indigenous tribes to govern themselves within the borders of the United States. The federal government recognizes tribal nations as domestic dependent nations and has established a number of laws attempting to clarify the relationships between federal, state, and tribal governments.

12 “Trust Responsibility,” in American Indian Policy Review Commission, *Final Report*, submitted to Congress May 7, 1977, vol. 1, 121–38, <https://archive.org/details/finalreport01unit>; Brett Lee Shelton, “Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States,” Issue Brief 7021, Henry J. Kaiser Family Foundation, Menlo Park, CA, 2004.



Figure 1

**Age Distribution of 50+ AI/ANs Compared with the US General Population**

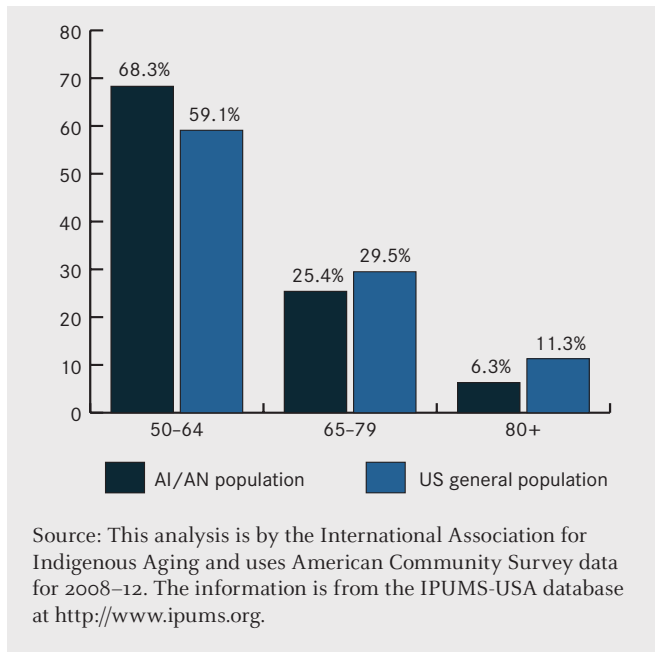
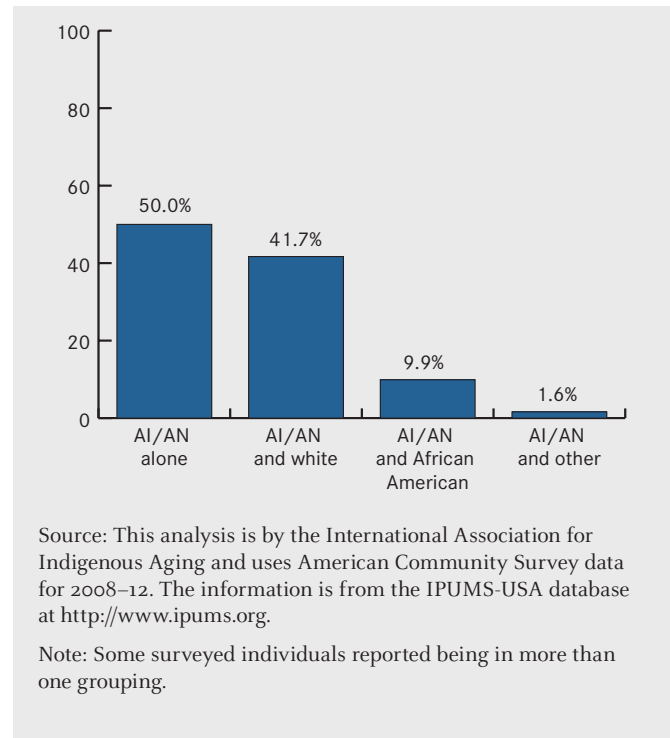


Figure 2

**Racial Breakdown of AI/ANs Ages 50+**



**Their Gender Breakdown Is Comparable**

Slightly more than half (53.8 percent) of AI/ANs ages 50 and over are female, which is comparable to the same-age group in the US population. The percentage of females increases with age, which is consistent with a trend seen in the general US population (see figure 3).

**They Are Less Likely to Be Married**

Approximately half (50.3 percent) of AI/ANs ages 50 and over are married, compared with 60.9 percent of the same-age US population (figure 4). Twenty-six percent of AI/ANs ages 50 and older are divorced or separated, compared with 17.1 percent of the same-age US population. The percentage of AI/ANs ages 50 and older who are widowed is comparable to the same-age group in the US population (13.6 percent versus 14.2 percent, respectively).

**They Are More Likely to Live in Multigenerational Households and Raise Grandchildren**

Close to 10 percent of AI/ANs ages 50 and older reside in households with three or more gener-

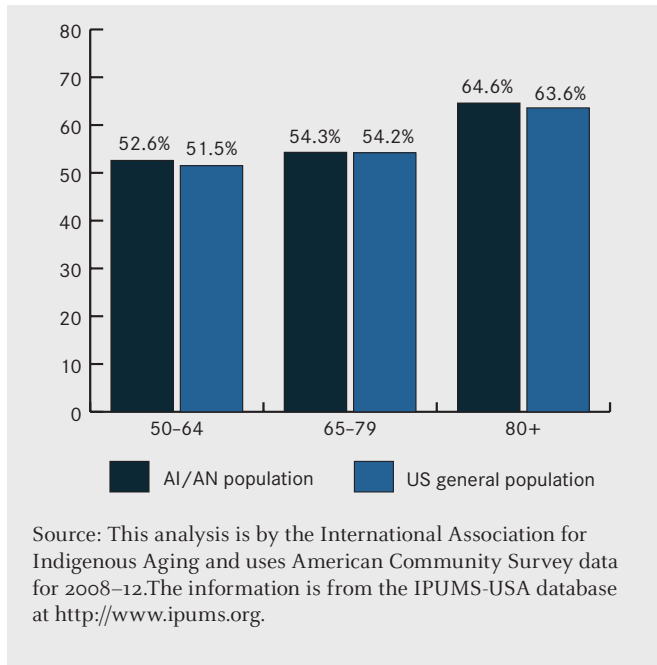
ations, compared with 6.5 percent of people in that age cohort in the general population (figure 5). Nearly 10 percent of AI/ANs ages 50 and older have grandchildren in the household, and 4.8 percent are responsible for most of the basic needs of their grandchildren, compared with 5.4 percent and 2.0 percent, respectively, of the same-age general US population.

The average household size for AI/ANs ages 50 and over is 2.3, compared with 2.2 persons in the same-age US population. A slightly greater percentage of AI/ANs ages 50 and older live alone compared with the same-age group in the US population (32.4 percent versus 27.6 percent, respectively).

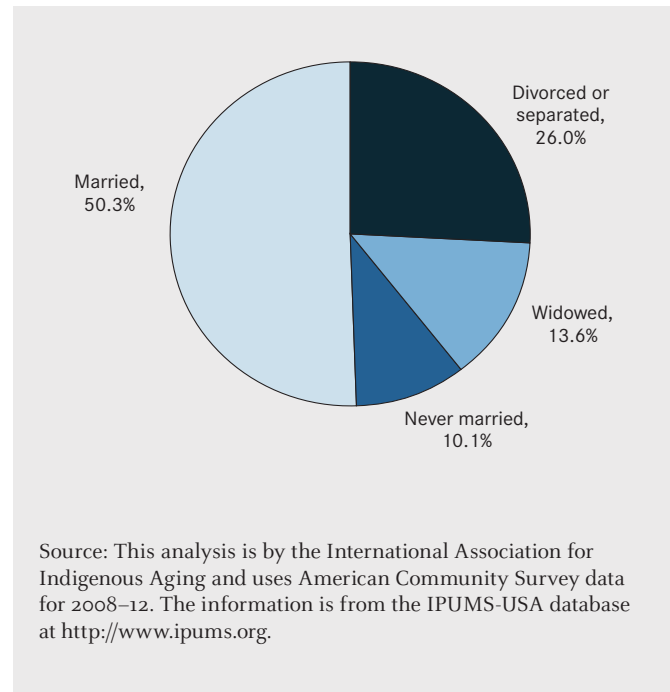
**They Are Less Likely to Have a College Degree**

Nearly 22 percent of AI/ANs ages 50 and over have less than a high school diploma, compared with 16 percent of the same-age US population. A larger percentage of AI/ANs in the 50+ cohort have completed some college compared with people of the same age in the general population (25.6 percent versus 20.3 percent, respectively). Only about a quarter (24.8 percent) of AI/ANs

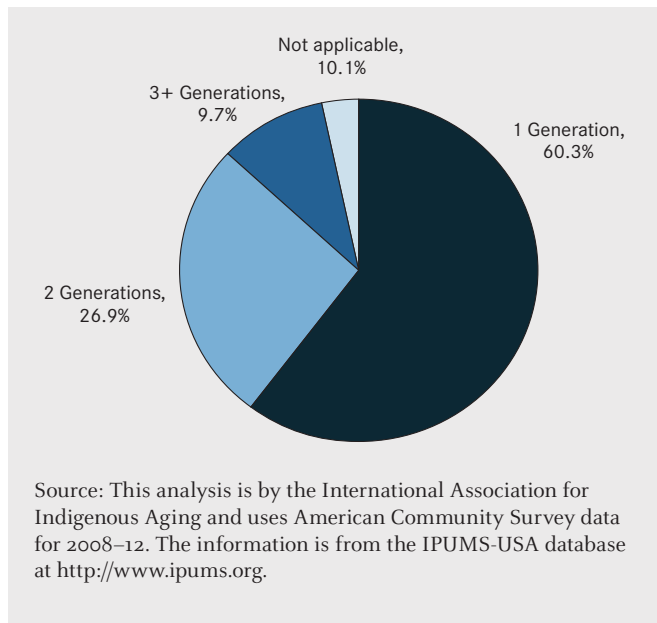
**Figure 3**  
**Females by Age Distribution of AI/ANs Ages 50+ Compared with the US General Population**



**Figure 4**  
**Marital Status of AI/ANs Ages 50+**



**Figure 5**  
**Multigenerational Households of AI/ANs Ages 50+**



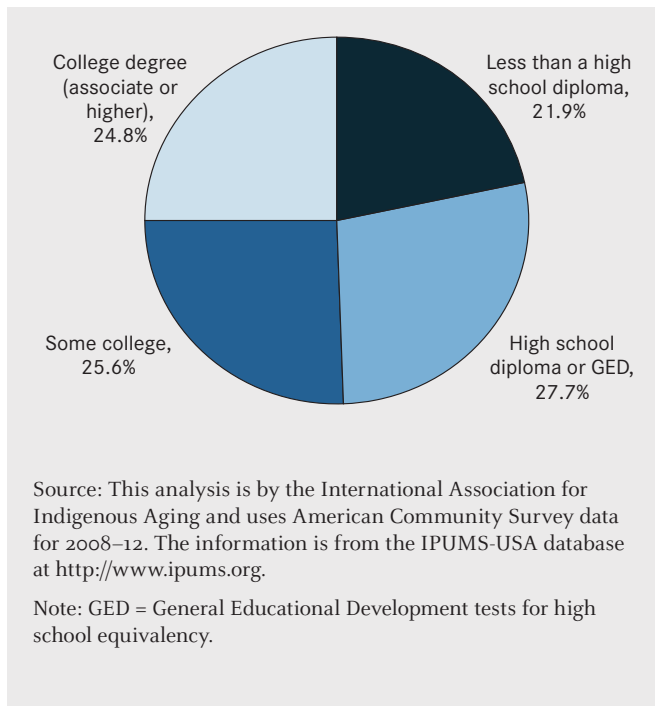
ages 50 and over have a college degree or more, compared with 32.7 percent of the same-age US population (figure 6).

**They Experience Significant Income Disparities**

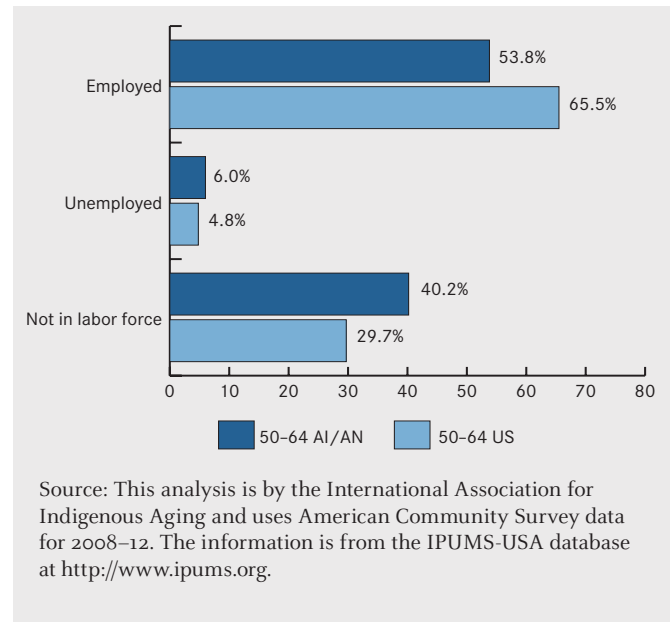
In both the 50 and over age group and the 50–64 age group of AI/ANs, a smaller percentage of AI/ANs are employed, a greater percentage are unemployed, and a larger percentage are not in the labor force compared with the same-age US populations. The differences are most significant in the 50–64 age group. Among AI/ANs ages 50–64, 53.8 percent are employed, compared with 65.5 percent of the same-age group in the US population, and 40.2 percent are not in the labor force, compared with 29.7 percent in the same-age US population (figure 7).

The mean total personal annual income for AI/ANs ages 50 and over is approximately \$10,000 less than that of the same-age US population; the mean annual Social Security income for AI/ANs ages 50 and over is about \$1,000 lower (figure 8). Compared with the same-age group in the US population, AI/ANs ages 50 and older

**Figure 6**  
**Educational Attainment of AI/ANs Ages 50+**



**Figure 7**  
**Employment Status Comparison of AI/ANs and the US General Population, Ages 50–64**



receive higher levels of Supplemental Security Income (\$605 versus \$313), and a larger percentage receive food stamps (17.1 percent versus 8.2 percent). The percentage of AI/ANs ages 50 and over whose personal income falls below the poverty level (17.5 percent) is nearly double that of the same-age group in the US population (9.5 percent).

## How Does AI/AN Health Coverage Compare with That of the General US Population?

Almost twice as many AI/ANs ages 50 and over are uninsured as are people of the same age in the US population. More of the uninsured AI/ANs (39.7 percent versus 35.8 percent) fall under 138 percent of the federal poverty level (figure 9). A much larger percentage of AI/ANs ages 50–64 are uninsured than are those ages 65 and over, with a large majority of AI/ANs ages 65 and over using Medicare (figure 10).

**Figure 8**  
**Mean Annual Income: Comparison of AI/ANs with the US General Population, Ages 50+, by Income Source**

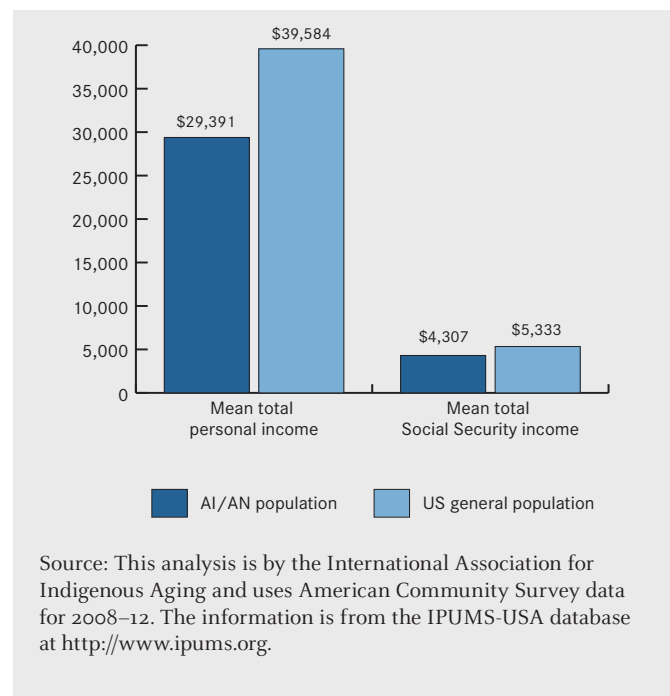


Figure 9

**Health Coverage: Comparison of AI/ANs with the US General Population, Ages 50+**

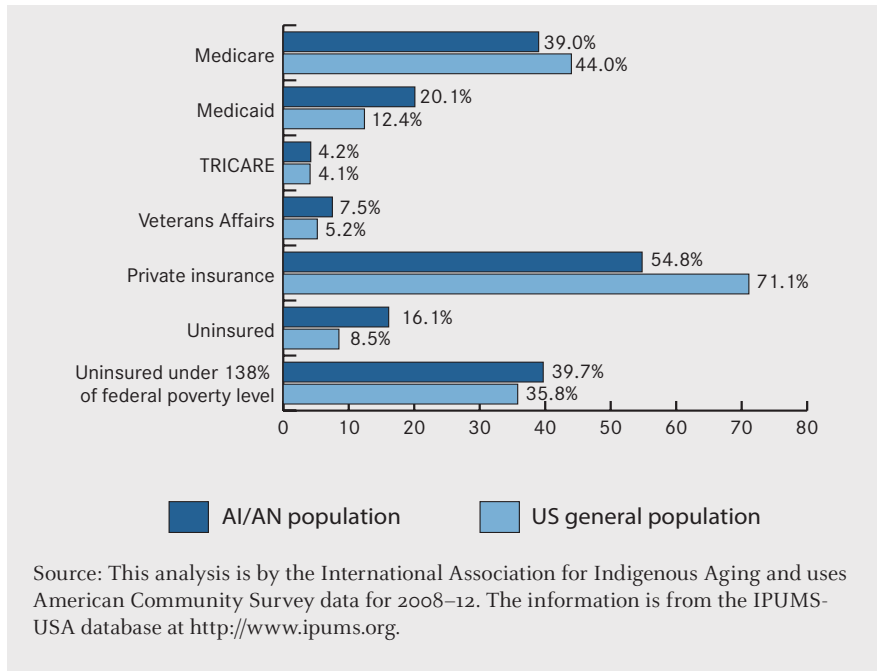
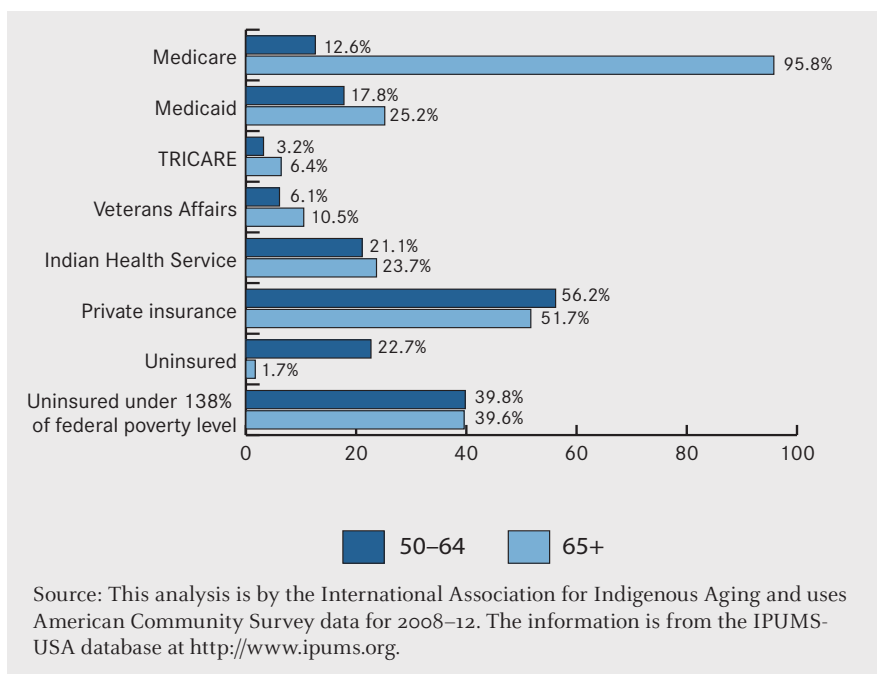


Figure 10

**Health Coverage: Comparison of AI/ANs Ages 50–64 and 65+**



A larger percentage of AI/ANs ages 50 and over receive Medicaid or related benefits<sup>13</sup> and use Veterans Affairs coverage than does the same-age group in the US population. A smaller percentage receives Medicare benefits or has private insurance. Close to 22 percent of AI/ANs ages 50 and over receive care from the Indian Health Service (IHS) (figure 10). Note that the ACS data that were analyzed predate implementation of the Affordable Care Act (ACA) Health Insurance Marketplace coverage options.

IHS, an agency within the US Department of Health and Human Services, has carried out the federal trust responsibility for AI/AN health care since 1955, following implementation of the Transfer Act of 1954 (Pub. L. No. 83-568). IHS provides primary and public health care and facility construction and maintenance through a system of providers in 12 geographic service areas. Annual IHS appropriations from Congress for FY2015 were \$4.64 billion.<sup>14</sup> Previous analysis supports the long-held view that IHS funding meets just 50 percent of need.<sup>15</sup>

13 The ACS question on Medicaid refers to Medicaid, medical assistance, or any kind of government-assistance plan for those with low incomes or a disability.

14 Indian Health Service, “Fiscal Year 2016: Justification of Estimates for Appropriations Committees,” <http://www.ihs.gov/budgetformulation/includes/themes/newihstheme/documents/FY2016CongressionalJustification.pdf>.

15 Northwest Portland Area Indian Health Board, “The FY 2010 Indian Health Service Budget: Analysis and Recommendations,” Portland, OR, 2009, [http://www.npaihb.org/images/policy\\_docs/IHS/2009/FY%202010%20Budget%20Analysis%20-%20Final\\_June%2010,%202009.pdf](http://www.npaihb.org/images/policy_docs/IHS/2009/FY%202010%20Budget%20Analysis%20-%20Final_June%2010,%202009.pdf).

Box 1

**Effects of the Affordable Care Act on Health Care Provision for AI/ANs**

The ACA provides health coverage protections and several provisions that directly affect AI/ANs who have private insurance or are receiving services through Medicare and Medicaid. Those services include the following:

- Certain AI/ANs can take advantage of special enrollment periods and exemptions in the new Health Insurance Marketplace.<sup>a</sup>
- Specified AI/AN entities have the authority to make their own determinations of Medicaid and Children’s Health Insurance Program eligibility to facilitate AI/AN enrollment.<sup>b</sup>

The ACA also reauthorized and made permanent the Indian Health Care Improvement Act, which gives IHS authorization for many programs and services.<sup>c</sup>

When the ACA’s Marketplace launched in 2013, the US Department of Health and Human Services predicted 579,000 uninsured AI/ANs would have new opportunities for coverage. Many would qualify for financial assistance or cost-sharing reductions, and still more would be covered under Medicaid expansions.<sup>d</sup>

It is difficult to determine how many AI/ANs are actually benefiting from those program changes. For example, as of April 2014, the US Department of Health and Human Services noted that only 48,103 marketplace applicants had indicated eligibility for the special protections specific to AI/ANs. Moreover, in a separate question about race on the same application, only 13,061 individuals self-identified as AI/AN.<sup>e</sup>

a. Elayne J. Heisler, “Indian Health Care: Impact of the Affordable Care Act (ACA),” Congressional Research Service, Washington, DC, December 2012, [http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/R41152\\_12142012.pdf](http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/R41152_12142012.pdf).

b. Ibid.

c. Ibid.

d. US Department of Health and Human Services, “Fact Sheet: The Affordable Care Act and American Indian and Alaska Native People,” <http://www.hhs.gov/healthcare/facts/factsheets/2011/03/americanindianhealth03212011a.html>.

e. Office of the Assistant Secretary for Planning and Evaluation, “Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period,” ASPE Issue Brief, US Department of Health and Human Services, Washington, DC, May 2014, [http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib\\_2014Apr\\_enrollment.pdf](http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf).

IHS estimates it receives only 22 percent of the funding needed for the Urban Indian Health Program.<sup>16</sup> The shortfall results in limited access to health care and rationing of services among AI/ANs.

IHS is designated as a “payer of last resort,” meaning that Medicare, Medicaid, and private insurance companies are billed before IHS is required to pay for medical costs. Funding from the Centers for Medicare & Medicaid Services’ programs helps supplement IHS programs, which increases access to care for older AI/ANs. Medicare and Medicaid payments can be used to offset IHS and tribal health care expenses without a reduction in appropriated funding. Medi-

care payments across the 12 IHS areas<sup>17</sup> vary from 11 percent to 19 percent of IHS active user costs.<sup>18</sup> Roughly 13 percent of total IHS funding comes from Medicaid.<sup>19</sup>

Many AI/ANs are eligible for benefits under the ACA (box 1). However, half of low-income unin-

17 Those areas are Alaska, Albuquerque, Bemidji, Billings, California, Great Plains, Navajo, Nashville, Oklahoma, Phoenix, Portland, and Tucson. Many areas encompass multiple states. More information is available at <http://www.ihs.gov/locations>.

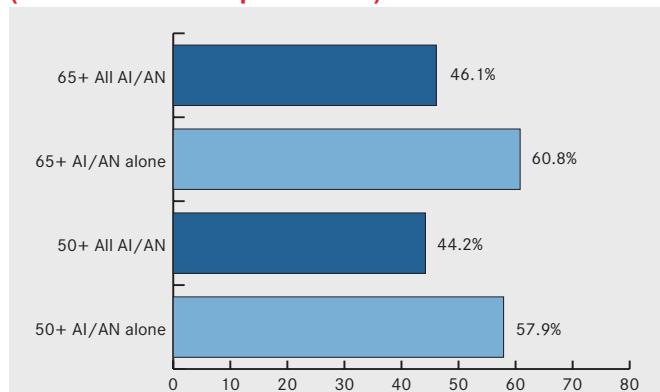
18 James Crouch, Juan Korenbrot, and Carol Korenbrot, *Medicare Statistics for American Indians and Alaska Natives* (Sacramento: California Rural Indian Health Board, 2012). *IHS active users* are users who have had a medical or dental visit with an IHS provider within three years.

19 Samantha Artiga, Rachel Arguello, and Philethea Duckett, “Health Coverage and Care for American Indians and Alaska Natives,” Henry J. Kaiser Family Foundation, Menlo Park, CA, 2013. <http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-american-indians-and-alaska-natives>.

16 Indian Health Service, “Office of Urban Indian Health Programs: Program Information,” 2014, [http://www.ihs.gov/urban/index.cfm?module=dsp\\_urban\\_programs](http://www.ihs.gov/urban/index.cfm?module=dsp_urban_programs).

Figure 11

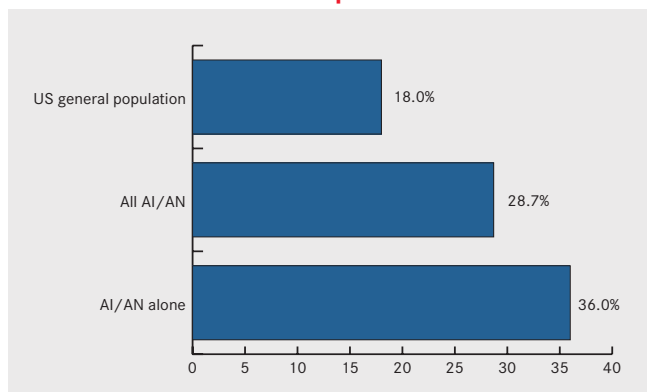
**Percentage of AI/ANs Living on Tribal Lands, by Age: AI/AN Alone Compared with All AI/AN (Alone and Multiple Races)**



Source: This analysis is by the International Association for Indigenous Aging and uses American Community Survey data for 2008–12. The information is from the IPUMS-USA database at <http://www.ipums.org>.

Figure 12

**Nonmetropolitan Location of Americans Ages 50+: All AI/AN and AI/AN Alone Compared with the US General Population**



Source: This analysis is by the International Association for Indigenous Aging and uses American Community Survey data for 2008–12. The information is from the IPUMS-USA database at <http://www.ipums.org>.

sured adult AI/ANs live in states that did not plan to move forward with Medicaid expansion as envisioned in the ACA.<sup>20</sup> Significant gaps in coverage exist because of the failure of many states to expand Medicaid and the lackluster enrollment among AI/ANs in the ACA’s Health Insurance Marketplace. Research finds that AI/ANs may experience lower benefit enrollment rates in Medicare and Medicaid because of costs associated with premiums,<sup>21</sup> their lack of awareness or knowledge, their mistrust of federal and state programs, their belief in the federal trust responsibility, a perceived “welfare stigma” associated with Medicare and Medicaid, and language or literacy barriers.<sup>22</sup>

**Where Do AI/ANs Live?**

The number and proportion of AI/ANs of all ages who reside in urban areas has increased over the

past four decades. A 2008 examination of US Census data by the National Urban Indian Family Coalition found a 23 percent increase between 1970 and 2000 in AI/ANs of all ages who did not reside on tribal lands.<sup>23</sup> A more recent analysis of US Census data by the Urban Indian Health Institute found that the number of AI/ANs residing in urban areas increased by 34 percent from 2000 to 2010.<sup>24</sup>

Forty-four percent of AI/ANs ages 50 and older reside on tribal lands. Furthermore, the percentage of AI/ANs ages 50 and older who live on tribal lands increases for those who are AI/AN alone and for those who are ages 65 and over regardless of whether they are of single or multiple races (figure 11).

The share of AI/ANs ages 50 and over who live in a nonmetropolitan area is higher for those who are AI/AN alone than for all AI/ANs in that age cohort, whether AI/AN alone or in combination with other races (figure 12). Moreover, a higher share of

20 Ibid.

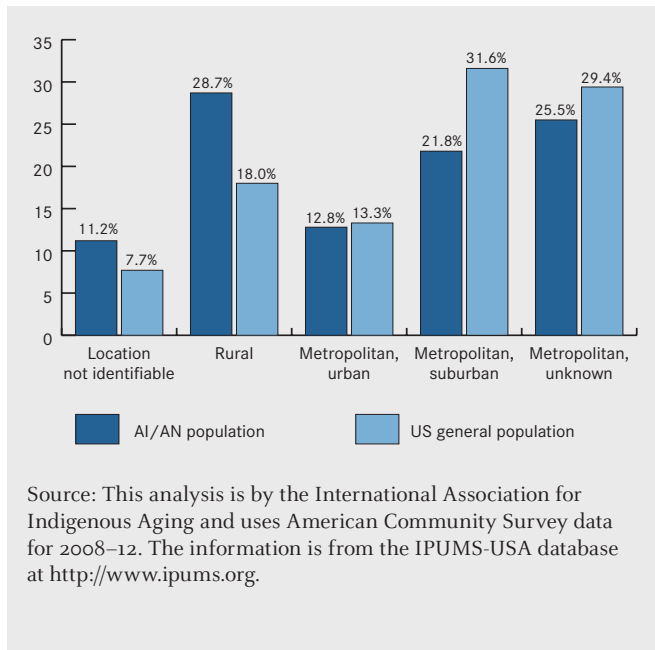
21 Kathryn Langwell, Mary Laschober, Erika Melman, and Sally Creliia, “American Indian and Alaska Native Eligibility and Enrollment in Medicaid, SCHIP, and Medicare: Individual Case Studies for 10 States,” Centers for Medicare & Medicaid Services, December 2003, [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/langwell\\_2003\\_5.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/langwell_2003_5.pdf).

22 R. Turner Goins, Andy Bogart, and Yvette Roubideaux, “Service Provider Perceptions of Long-Term Care Access in American Indian and Alaska Native Communities,” *Journal of Health Care for the Poor and Underserved* 21, no. 4 (2010): 1340–53.

23 National Urban Indian Family Coalition, “Urban Indian America: The Status of American Indian and Alaska Natives Children and Families Today,” Seattle, January 2008, <http://www.aecf.org/m/resourcedoc/AECF-UrbanIndianAmerica-2008-Full.pdf>.

24 Urban Indian Health Institute, “US Census Marks Increase in Urban American Indians and Alaska Natives,” Broadcast, February 2013, [http://www.uihi.org/wp-content/uploads/2013/09/Broadcast\\_Census-Number\\_FINAL\\_v2.pdf](http://www.uihi.org/wp-content/uploads/2013/09/Broadcast_Census-Number_FINAL_v2.pdf).

**Figure 13**  
**Geographic Location of Americans Ages 50+: AI/ANs Compared with the US General Population**

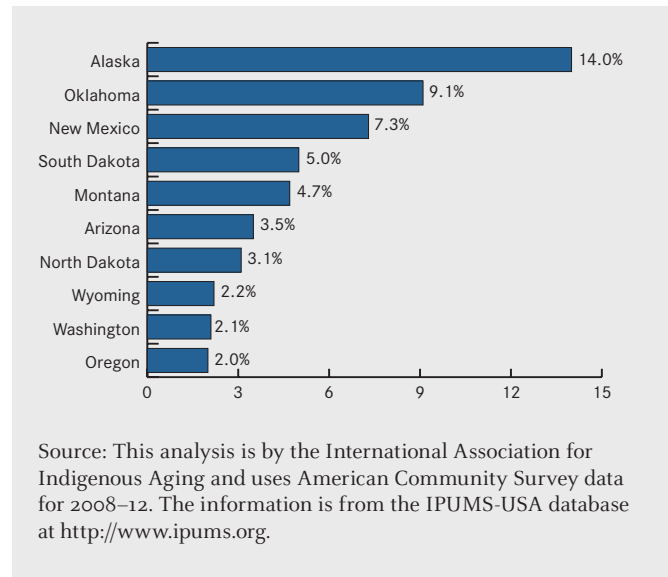


AI/ANs ages 50 and over live in nonmetropolitan areas than do people of the same age in the US population. Among AI/ANs ages 50 and over, 12.8 percent reside in urban areas and 21.8 percent reside in suburban areas, compared with 13.3 percent and 31.6 percent for the same-age population, respectively (figure 13).

Alaska has a higher proportion of AI/ANs ages 50 and over than any other state, with 14.0 percent, or 27,596, of the state’s population identifying as an AI/AN in that age group. Oklahoma has the second-highest proportion, followed by New Mexico. Figure 14 shows the states with the highest proportion of AI/AN residents ages 50 and over as a share of the overall state population, whereas figure 15 shows that California, Oklahoma, Texas, and Arizona actually have the largest number of AI/ANs ages 50 and over. Note that Arizona, New Mexico, Oklahoma, and Washington appear on both lists.

The five states with the highest proportion of AI/ANs ages 50 and over—Alaska, Oklahoma, New Mexico, South Dakota, and Montana—show

**Figure 14**  
**States with the Highest Proportion of AI/ANs Ages 50+ as a Share of State Population**



**Figure 15**  
**States with the Largest Number of AI/ANs Ages 50+**

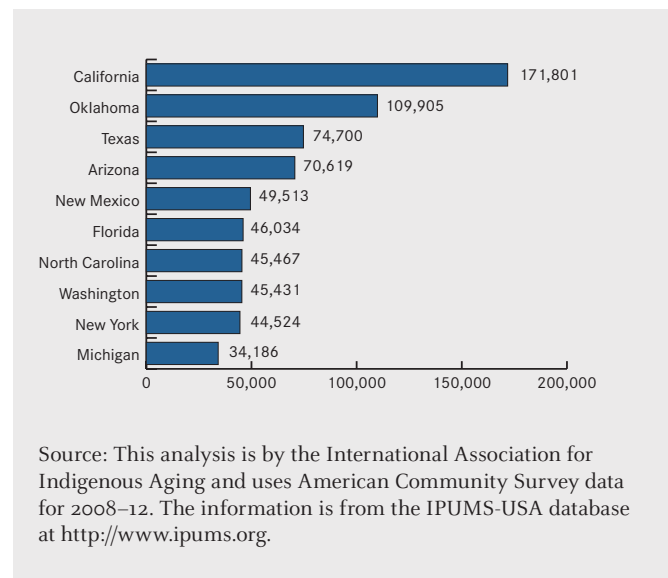


Table 1

### Comparison of Characteristics of Older AI/ANs in States with the Highest Proportion of AI/ANs Ages 50+: Alaska, Oklahoma, New Mexico, South Dakota, and Montana

	Proportion of AI/ANs (%)				
	AK	OK	NM	SD	MT
<b>Population</b>					
50+ in state	14.0	9.1	7.3	5.0	4.7
<b>Age</b>					
50–64	70.4	65.1	66.0	67.2	70.5
65–79	23.9	27.9	27.3	26.8	25.4
80+	5.7	7.0	6.7	6.0	4.1
<b>Education, 50+</b>					
Less than a high school diploma	24.9	18.8	31.4	23.7	20.9
High school diploma/GED	33.6	32.6	28.1	25.4	28.6
Some college	27.1	24.5	20.6	25.0	25.7
College degree or more	14.4	24.0	19.8	25.8	24.8
<b>Race, 50+</b>					
AI/AN alone	81.0	55.7	88.2	58.2	82.2
AI/AN in combination with other races	19.0	44.3	11.8	41.8	17.8
<b>Employment, 50+</b>					
Employed	42.8	43.6	39.9	43.8	44.6
Unemployed	6.2	2.3	3.0	6.1	4.5
Not in labor force	51.1	54.0	57.1	50.2	50.9
<b>Income, 50+</b>					
Living below poverty level	11.5	17.6	25.7	32.2	24.9
<b>Family, 50+</b>					
Grandparents raising grandchildren	9.1	3.9	8.0	14.7	12.3
<b>Health coverage, 50+</b>					
Indian Health Services	81.1	55.5	62.7	78.0	67.5
Medicaid and other government assistance	20.6	14.4	20.5	23.6	21.7
Medicare	32.9	41.9	38.6	38.9	35.8
Private health insurance	38.9	54.2	34.9	33.9	37.3

Source: This analysis is by the International Association for Indigenous Aging and uses American Community Survey data for 2008–12. The information is from the IPUMS-USA database at <http://www.ipums.org>.

Note: GED = General Educational Development tests for high school equivalency.

significant variation among selected characteristics (table 1). Multiracial status, access to IHS services, and income below the poverty line are the three variables with the greatest differences. For example, in New Mexico, 11.8 percent of AI/ANs ages 50 and over report race as AI/AN in combination with other races, compared with 44.3 percent of AI/ANs ages 50 and over in Oklahoma. In Alaska, 11.5 percent of AI/ANs ages 50 and over report income below the poverty level, as opposed to 32.2 percent in South Dakota.

## Recommendations

The United States will experience a substantial increase in the racial and ethnic diversity of older adults by 2050.<sup>25</sup> To prepare, the public and private sector should develop culturally sensitive strategies to effectively meet the needs of all aging adults, especially American Indians and Alaska Natives—all of whom face unique and shared challenges.

<sup>25</sup> Ortman, Velkoff, and Hogan, “An Aging Nation.”



The AI/AN culture has long valued elders for their wisdom, experience, knowledge, and contributions to their communities. Older AI/ANs provide a connection to the past as keepers of language, history, and traditions. Yet Native American elders suffer disproportionately compared with the general population in terms of social and economic conditions that affect health and well-being. The exceptionally rapid growth of the older AI/AN population warrants the attention of researchers, policy makers, and service providers. This report begins to illuminate the current and emerging needs of the often overlooked and underresourced population of AI/ANs ages 50 and over.

### **More In-Depth, National, Regional, and Community-Based Research about 50+ AI/ANs Is Needed to Guide Policy Development**

Scant research exists on the health and well-being of older AI/ANs. As a result, policy makers have little data to guide them in implementing or revising strategies to improve this population's well-being.

Large cross-sectional studies fail to yield reliable estimates or, because of small sample size, merge AI/AN statistics with those of other small minority groups.<sup>26</sup> Studies that include AI/ANs tend to focus on specific conditions such as diabetes, alcoholism, and depression rather than taking a comprehensive perspective. More information about older AI/ANs will help policy makers and service providers develop programs to meet unmet needs.

### **Successful Programs Should Be Supported and Shared**

Many successful AI/AN programs exist, including the Southcentral (Alaska) Foundation's integrated care teams and the IHS Special Diabetes Program for Indians (SDPI). Southcentral won a 2011 Malcolm Baldrige National Quality Award. The SDPI reduced the incidence of end-stage renal disease

by 27.7 percent in one 5-year period—the greatest decline of any racial or ethnic group in the nation.<sup>27</sup> Future program development and research for older AI/ANs should take an assets-based approach, in which solutions are built on the values of and strengths in Native communities.

### **Broader Strategies for Helping AI/ANs Should Be Considered**

A growing number of AI/ANs live beyond rural reservations and tribal lands,<sup>28</sup> and services need to reach AI/AN elders wherever they may live, including in urban and metropolitan areas across the nation. Strategies designed to reach this population should reflect that changing reality.

Correspondingly, the authors offer the following recommendations:

1. Increase interagency cooperation within the federal government and states to ensure that agencies coordinate efforts to meet the health, economic, social, and physical needs of aging AI/ANs.
2. Design programs that take into account unique cultural differences, health and socioeconomic disparities, and geographic diversity associated with different AI/AN populations.
3. Improve efforts to communicate with older AI/ANs about opportunities and services available to them, recognizing that those cohorts—and their communities—often lack the necessary resources to learn about and apply for services.
4. Improve current health, housing, and long-term services and support systems to be more responsive to the full spectrum of family and living conditions experienced by aging AI/ANs (e.g., multigenerational households, grandparents raising grandchildren, elders living alone).
5. Ensure greater accessibility to and enrollment in health coverage options for older AI/ANs in every state.

26 Linda Burhansstipanov and Delight E. Satter, "Office of Management and Budget Racial Categories and Implications for American Indian and Alaska Natives," *American Journal of Public Health* 90, no. 11 (2000): 1720–23. See also Jan Gryczynski and Jeannette L. Johnson, "Challenges in Public Health Research with American Indians and Other Small Ethnocultural Minority Populations," *Substance Use and Misuse* 46, no. 11 (2011): 1363–71; Dorothy A. Rhoades, "Commentary: Disparities in Data for American Indians and Alaska Natives," *American Indian and Alaska Native Mental Health Research* 13, no. 1 (2006): 70–74; and Dorothy A. Rhoades, "National Health Data and Older American Indians and Alaska Natives," *Journal of Applied Gerontology* 25, no. 1 (2006): 9S–26S.

27 Indian Health Service, "Special Diabetes Program for Indians," US Department of Health and Human Services, Washington, DC, March 2012.

28 National Urban Indian Family Coalition, "Urban Indian America."



# Adviser Acknowledgments

AARP would like to thank the following panel of advisers, who volunteered their time and expertise to the development and review of this report:

- Tom Anderson, acting executive director, Oklahoma City Area Inter-Tribal Health Board; director, Oklahoma City Area Tribal Epidemiology Center
- Michael Bird, member, AARP National Policy Council
- Cristina Boccuti, MA, MPP, senior associate, Program on Medicare Policy, Kaiser Family Foundation
- Curtis Cook, member and volunteer, AARP Arizona
- Dee Ann DeRoin, MD, MPH, family physician, health educator, Lawrence, Kansas
- Mim Dixon, Albuquerque, New Mexico
- Carlos Figueiredo, senior methods adviser, AARP
- Bruce Finke, MD, elder health consultant, Indian Health Service
- Lynda Flowers, senior strategic policy adviser, AARP
- Ralph Forquera, MPH, executive director, Seattle Indian Health Board; director, Urban Indian Health Institute
- Renee Gamino, associate state director for outreach, AARP Wyoming and member, National Partnership for Action/Regional Health Equity Council VIII
- Elizabeth Knaster, epidemiologist, Urban Indian Health Institute, Seattle Indian Health Board
- Sandra Littlejohn, executive director of hospital operations, Gunderson Health System
- Greg Macias, director, regional and state support, AARP
- Spero M. Manson, PhD, distinguished professor of public health and psychiatry, Centers for American Indian and Alaska Native Health; associate dean for research, Colorado School of Public Health, University of Colorado Denver
- Kelly Moore, MD, FAAP, associate professor, Centers for American Indian and Alaska Native Health, Colorado School of Public Health, University of Colorado Denver
- Ken Osterkamp, state director, AARP Alaska
- Leigh Purvis, director, health services research, AARP
- Diane Renzulli, senior policy advisor, AARP
- Daryl Royce, associate state director for community outreach, AARP Alaska
- Shira Rutman, epidemiologist, Urban Indian Health Institute, Seattle Indian Health Board
- Dorothy Siemon, vice president, AARP Office of Policy Integration
- Mashell Sourjohn, associate state director for community outreach, AARP Oklahoma
- Marisol Thomer, multicultural integration manager, AARP
- Eugene Varela, state director, AARP New Mexico
- Al Ward, member and volunteer, AARP Montana
- Ralph Yaniz, regional vice president, AARP Mountain Region



# Data and Methodology

The report used the Integrated Public Use Microdata Series, a subsample of the ACS. The ACS is a nationwide survey conducted throughout the year using mailed questionnaires, telephone interviews, and visits from US Census Bureau field representatives to about 3.5 million household addresses. It is designed to collect information such as individual demographic, socioeconomic, and housing characteristics. The Census Bureau produces those data to enable custom tables that are not available through pretabulated ACS products.<sup>29</sup> The Census Bureau discontinued use of the decennial long-form sample in the 2010 US Census. Instead, it implemented the ACS as a different kind of survey, using continuous measurement approaches and a rolling sample.<sup>30</sup> The ACS produces one-, three-, and five-year estimates annually. It is a mandatory survey, and responses are required by law.

The report used the online data analysis system from IPUMS-USA to obtain frequencies, percentages, and means derived from the five-year ACS samples for 2008 to 2012.<sup>31</sup> For estimates about AI/ANs residing on tribal lands and metropolitan status, the researchers used ACS samples from 2007 to 2011 because they provided the most recent five-year data available for those variables. The five-year data provide a 5 percent sample density that is representative of the entire US

population. The ACS-published margins of error are based on a 90 percent confidence interval. The researchers calculated direct estimates of the standard errors for all estimates in this report. They calculated standard errors using a replicate-based methodology that took sampling design and estimation procedures into account. Excluding the base weight, the researchers allowed replicate weights to be negative to avoid underestimating the standard error.

According to ACS, weights included with the ACS IPUMS for household- and person-level data adjust for the mixed geographic sampling rates, nonresponse adjustments, and individual sampling probabilities. Estimates from the ACS IPUMS samples may not be consistent with summary table ACS estimates because of the additional sampling error.

The US Census Bureau calculates race estimates on the basis of race data for the first five persons listed in the household. Specifically, it classifies those persons who marked only the “American Indian or Alaska Native” response option or who wrote in one or more tribes as “American Indian and Alaska Native alone.” It classifies those who marked the “American Indian or Alaska Native” response option in addition to another race option as “American Indian and Alaska Native in Combination with Other Races.”

The ACS data set includes individuals who identify as AI/AN in combination but may have origins with a tribe from south of the US border or whose race is unknown. Fifty percent of responses to the question regarding tribal affiliation were “blank/not applicable.” When asked separately about Hispanic origin, 12.2 percent

29 US Census Bureau, *A Compass for Understanding and Using American Community Survey Data: What PUMS Data Users Need to Know* (Washington, DC: US Government Printing Office, 2009).

30 Ibid.

31 The report used the University of Minnesota’s 2014 IPUMS-USA database, which is found at <http://www.ipums.org>.

of AI/AN ages 50 and over selected “Mexican,” “Puerto Rican,” “Cuban,” or “Other.” Those individuals were not excluded from this analysis. Hispanic origin is a separate and distinct concept and is not exclusive to self-identification of AI/AN or any other race.

The researchers calculated tribal land estimates using the “Homeland” variable from the ACS. *Homeland* indicates whether the household is in a Public Use Microdata Area (PUMA) that includes any Census block that was designated as an American Indian, Alaska Native, or Native Hawaiian homeland area. PUMAs are statistical

geographic areas developed for use with IPUMS data.

The researchers derived metropolitan status estimates from IPUMS-USA’s “metro” variable. The US Census Bureau grants metropolitan urban status to cities with 50,000 or more inhabitants. Suburban status refers to inhabited districts located either inside a town or city’s outer rim or just outside its official limits. Places outside of metropolitan areas include urban clusters (at least 2,500 and less than 50,000 people) and rural areas (all populations, housing, and territory not included within an urban area).

# Limitations

The ACS, conducted every year, provides current information about the social and economic needs of communities, whereas the US Census is taken every 10 years to provide an official count of the entire US population. To generate reliable estimates for small areas or populations, the US Census Bureau advises researchers to combine data from multiple years. Hence, this report uses five-year estimates from 2008 to 2012.<sup>32</sup> Using a five-year data set aggregates information over time to increase the reliability of findings. That approach is especially important when considering smaller populations. However, the result is an estimate over a period of time rather than a snapshot of a single point in time. Thus, there are implications for items such as economic variables, which can be affected by inflation and other factors.

Research acknowledges issues of over- and undercounting AI/ANs in US Census data.<sup>33</sup> All data are self-reported—including racial classifications—a situation that has inherent limitations.<sup>34</sup>

Some researchers have questioned whether respondents know if they are eligible for IHS or other health services. Research has compared the ACS data regarding the reported IHS eligibility to IHS active-user count data in 33 states and has concluded that the ACS estimate for a total population with access to IHS services corresponds well with actual figures from IHS.<sup>35</sup>

The AI/AN alone category is different from the AI/AN in combination racial category, whose population is significantly larger in representation and has greater heterogeneity than does the AI/AN alone population. Furthermore, differences exist in demographic and socioeconomic factors between those groups, a situation that may make them meaningful to examine and compare separately. Jordan and Beaghen found that AI/AN alone and in combination was a more “robust measure for AI/AN persons than was AI/AN alone” in ACS data.<sup>36</sup> The ACS data are relatively new, and more research is warranted to determine its accuracy, particularly for the AI/AN population.

32 US Census Bureau, *A Compass for Understanding and Using American Community Survey Data*.

33 DeWeaver, “Who Counts as American Indian in the Census.” See also Jonathan Ong and Paul Ong, “AIAN Underrepresentation in the ACS,” Technical Memo 5, Los Angeles American Indian and Alaska Native Project, University of California, Los Angeles, November 2012, [http://www.aisc.ucla.edu/research/pb1\\_memo3.aspx](http://www.aisc.ucla.edu/research/pb1_memo3.aspx).

34 DeWeaver, “Who Counts as American Indian in the Census.” See also Jill Fleury DeVoe, Kristen E. Darling-Churchill, and Thomas D. Snyder, *Status and Trends in the Education of American Indians and Alaska Natives: 2008* (Washington, DC: US Department of Education, 2008).

35 Edward Fox and Verné Boerner, “Health Care Coverage and Income of American Indians and Alaska Natives: A Comparative Analysis of 33 States with Indian Health Service Funded Programs,” Centers for Medicare and Medicaid Tribal Affairs Group, Baltimore, MD, 2012, <http://tribalhealthcare.org/wp-content/uploads/2013/09/Health-Care-Coverage-and-Income-of-AIANS.pdf>.

36 John M. Jordan and Michael Beaghen, “Coverage of American Indian and Alaska Native Persons and of the Population in American Indian and Alaska Native Areas in the American Community Survey,” in *Proceedings of the Survey Research Methods Section*, ASA (Alexandria, VA: American Statistical Association, 2013), 1316.





## Appendix C

# Master Table of Socioeconomic and Health Coverage Variables

### American Indians and Alaska Natives: Selected Socioeconomic Characteristics, 2008–12, ACS Five-Year Estimates

Indicators	AI/AN population 50+			US general population 50+		
	Number	Percent	SE	Number	Percent	SE
<b>Marital status</b>						
Married	617,981	50.3	0.19	60,570,964	60.9	0.02
Divorced or separated	318,214	26.0	0.16	17,050,754	17.1	0.01
Widowed	167,391	13.6	0.12	14,102,852	14.2	0.01
Never married	123,358	10.1	0.11	7,770,689	7.8	0.01
Average household size (mean + SE)	2.34	–	0.01	2.23	–	0.01
<b>Living arrangements</b>						
Alone	397,870	32.4	0.17	27,477,643	27.6	0.01
With other family members	829,074	67.6	0.17	72,017,616	72.4	0.01
<b>Multigenerational households</b>						
Not applicable	37,317	3.1	0.06	2,315,089	2.3	0.01
1 generation	725,674	60.3	0.17	65,497,446	65.8	0.02
2 generations	324,373	26.9	0.16	25,221,781	25.3	0.02
3 or more generations	116,604	9.7	0.10	6,460,943	6.5	0.01
<b>Grandchildren in household</b>						
Yes	117,405	9.6	0.10	5,407,452	5.4	0.01
No	1,109,539	90.4	0.10	94,087,807	94.6	0.01
<b>Grandparents responsible for grandchildren</b>						
Not applicable	1,109,539	90.4	0.10	94,087,807	94.6	0.01
No	58,611	4.8	0.08	3,430,801	3.4	0.01
Yes	58,794	4.8	0.08	1,976,651	2.0	0.01
<b>Education</b>						
Less than high school diploma	268,575	21.9	0.04	16,094,101	16.0	0.01
High school diploma or GED	339,970	27.7	0.12	30,830,500	31.0	0.01
Some college	313,771	25.6	0.10	20,216,309	20.3	0.01
College: associate degree or higher	304,628	24.8	0.07	32,354,349	32.7	0.01

Indicators	AI/AN population 50+			US general population 50+		
	Number	Percent	SE	Number	Percent	SE
Mean total personal income over 12 months	\$29,391	—	\$135.51	\$39,584	—	\$22.63
Income below poverty level	214,550	17.5	0.01	9,409,387	9.5	0.01
Employment status						
Employed	509,436	41.5	0.17	44,593,707	44.8	0.02
Not employed	56,320	4.6	0.07	3,240,270	3.3	0.01
Not in labor force	661,188	53.9	0.18	51,661,282	51.9	0.02
Mean total Social Security income over 12 months	\$4,307	—	\$23.03	\$5,333	—	\$3.07
Mean total Supplemental Security Income over 12 months	\$605	—	\$8.37	\$313	—	\$0.76
Receiving food stamps	205,398	17.1	0.13	8,014,204	8.2	0.01
Health coverage	AI/AN population 50+			US general population 50+		
	Number	Percent	SE	Number	Percent	SE
Medicare	478,679	39.0	0.17	43,753,929	44.0	0.02
Medicaid	246,890	20.1	0.14	12,301,770	12.4	0.01
TRICARE	52,108	4.2	0.07	4,086,471	4.1	0.01
Veterans Affairs	91,753	7.5	0.09	5,205,764	5.2	0.01
Indian Health Service	269,250	21.9	0.15	346,709	0.3	0.01
Private insurance	672,013	54.8	0.18	70,738,475	71.1	0.02
Uninsured	197,160	16.1	0.13	8,459,109	8.5	0.01
Uninsured under 138% federal poverty level	78,379	39.7	0.29	3,036,472	35.8	0.04
Health coverage	AI/AN population 50–64 years			AI/AN population 65+		
	Number	Percent	SE	Number	Percent	SE
Medicare	105,840	12.6	0.15	372,839	95.8	0.12
Medicaid	148,976	17.8	0.17	97,914	25.2	0.26
TRICARE	27,092	3.2	0.08	25,016	6.4	0.15
Veterans Affairs	50,827	6.1	0.10	40,926	10.5	0.18
Indian Health Service	177,127	21.1	0.18	92,123	23.7	0.25
Private insurance	470,710	56.2	0.22	201,303	51.7	0.30
Uninsured	190,450	22.7	0.18	6,710	1.7	0.08
Uninsured under 138% federal poverty level	75,722	39.8	0.40	2,657	39.6	0.18

Source: This analysis is by the International Association for Indigenous Aging and uses American Community Survey data for 2008–12. The information is from the IPUMS-USA database at <http://www.ipums.org>.

Note: SE = standard error; GED = General Educational Development tests for high school equivalency; — = not applicable.

---

Research Report 2015-08, November 2015

© **AARP PUBLIC POLICY INSTITUTE**

601 E Street, NW  
Washington, DC 20049

202.434.3840 **T**

202.434.6480 **F**

Follow us on Twitter @AARPolicy,  
on facebook.com/AARPolicy, and at  
<http://www.aarp.org/ppi>.

For more reports from the Public Policy  
Institute, visit <http://www.aarp.org/ppi>.



Real Possibilities

**Public Policy  
Institute**