

2012

For Tribal Affairs:
Centers for Medicare &
Medicaid Services

Edward Fox, PhD &
Verné Boerner, MPH

**HEALTH CARE COVERAGE &
INCOME OF AMERICAN INDIANS &
ALASKA NATIVES:**

A COMPARATIVE ANALYSIS OF 33 STATES WITH
INDIAN HEALTH SERVICE FUNDED PROGRAMS

Prepared by

Ed Fox, PhD
and Verné Boerner, MPH

with
Data Provided by

Carol Korenbrot, PhD
Research Director, California Rural Indian Health Board

October, 2012

Funded by

The Centers for Medicare and Medicaid (CMS) Tribal Affairs Group through the National Indian Health Board and California Rural Indian Health Board pursuant to an award from the Indian Health Service (IHS), following an intra-departmental delegation of authority (CMS IDDA-09-50 and IHS 2-RAP-09-0080-DA).

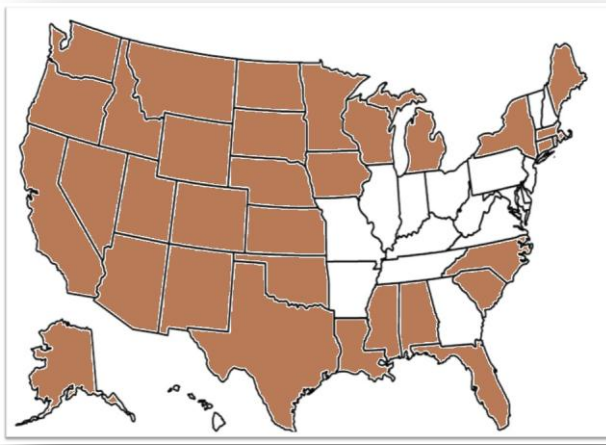


Please provide feedback to:

Ed Fox
Phone: 503-916-9098
Email: edfox_phd@yahoo.com

Background:	1
Data source limitations	3
General Overview of the 33 States	5
Income Distribution.....	6
Access to IHS.....	6
Uninsured	10
Enrolled in Medicaid	13
Enrolled in Medicare	14
Privately Insured	15
Further Research	17

HEALTH CARE COVERAGE & INCOME OF AMERICAN INDIANS & ALASKA NATIVES: A Comparative Analysis of 33 States with Indian Health Service Funded Programs



The 33 Study States include: Alabama, Alaska, Arizona, California, Colorado, Connecticut, Florida, Idaho, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming

Figure 1 Map of the 33 study states (in brown)

Background

As the nation prepares for the implementation of health exchange programs created pursuant to the Patient Protection and Affordable Care Act (ACA) passed in 2010, many health planners are working to identify what impact these new programs and rules will have on their communities. American Indian and Alaska Native (AIAN) tribes face these issues with particular interest, since a large percentage of AIAN tribal people will be eligible for the new programs. AIANs suffer the highest disparity rates in many socioeconomic and health status measures. They are also amongst the highest uninsured populations in the United States. However, a singular description of AIANs is inadequate to effectively help tribal and state

leaders design their programs and to set priorities. Just as the culture and tradition variances between Indian peoples are great, so are individual AIAN community experiences with regard to health care coverage, access to Indian Health Service (IHS) health care and income distribution.

Thirty-three states (see Figure 1) were selected for this report because these states' have counties included in the service delivery areas of Indian Health Services-funded health programs (2 additional states, Indiana and Pennsylvania also have such counties, but there are very low numbers of AIAN in the American Community Survey (ACS) sample for those counties and the states are thus not included). The AIAN populations of the 33 states represent approximately 84% of the total AIAN population of the country. The cumulative data for these 33 states provide a general picture of AIAN health insurance status and access to IHS programs, however, the individual state analyses will show how different each state can be from that national picture.

Data Description:

The initial dataset was compiled by the California Rural Indian Health Board (CRIHB) and further analyzed with ACA relevant tabulations by Edward Fox, Ph.D. The collaborative effort utilized data from the 2010 US Census and the American Community Survey (ACS) for 2008-2010 with three years of pooled data. The ACS presents, for the first time, reliable data for self-identified AIAN respondents. (2008 was the first year that questions on various types of health care coverage were

incorporated into the ACS survey question set.) The ACS three-year Public Use Microdata Set for 2008-2010 included sufficient numbers of respondents so that state, county, and metropolitan areas with at least a population of 20,000 people were reliably represented.

Data source limitations

Health care coverage is self-reported, which may differ from program definitions of enrolled AIANs. It is fair to ask: do respondents really know if they are eligible for IHS services? When compared to other data sources, such as IHS Active User Count, the ACS estimates that 1.2 million AIANs in these states have access to IHS-funded programs (or Indian Health Programs, IHP). This is 86% of the official IHS User Count of 1.5 million users nation-wide in 2010. Some IHS active users reside in states outside the 33 states and there is likely double counting of users across multiple IHS areas. Thus, it appears the ACS estimate for total population with access to IHS services in these states corresponds very well with actual figures from the Indian Health Service.

The ACS data represents new baseline data. More research is needed to determine its relative accuracy. Two points were observed in this review:

1. Medicaid coverage accuracy is hard to determine for AIANs in the ACS data, and
2. Uninsurance rates are calculated when a respondent answers 'No' to all 6 types of health insurance coverage including, employer sponsored, private (purchased by the individual), Medicare, Medicaid, Tricare (military personnel and their families),

and Veteran's Administration Health Care, regardless of whether the respondent answers 'Yes' or 'No' to IHS coverage.

IHS access is not a factor in determining health insurance status. IHP are not insurance programs but health care providers and facilities that cannot offer a set of guaranteed services, nor is the accessible health care provider necessarily a professional medical provider but may be a lay health worker such as a community health aide. Access to IHS programs is not determined by means-testing, nor are eligible AIANs charged fees or other cost sharing measures for services provided by IHS.

IHS access is important as it can have a direct impact on an individual's or family's decision-making process for enrolling in a health exchange program. The ACS simply asks, "Is the person currently covered by any of the following health insurance or health care coverage plans: . . . the Indian Health Service?" There were no definitions provided to respondents and interpretations of access may vary. Both of these issues and possible implications are detailed in the Access to IHS section.

General Overview of the 33 States

In the 33 study states, there were 4,095,371 self-identified AIANs (alone or in combination with any other racial group).¹ We first look to build a picture of insurance status and access to care in Indian Country. 84% of the nation's estimated 4.9 million AIANs live in the 33 states examined in this study. 100% of the Indian

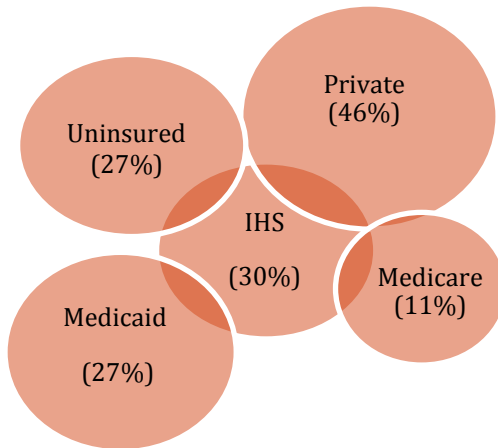


Figure 2 Venn diagram of IHS Coverage & Insurance Status

reservations are within the 33 states. It is very likely that over 90% of all members of federally recognized tribes reside in these states. The aggregate of these 33 states shows that 46% in the three-year period had private insurance, 27% were enrolled in Medicaid, 11% Medicare and 27% were uninsured.

Figure 2 is a suggestive (not precise)

representation that there is overlap in coverage and, especially overlap between IHS and other forms of coverage. The goal should be to increase this overlap and move more of both Medicaid and Private Insurance circles to cover those who feel they have access to IHS.

¹ The AIAN population estimate for the 33 states was updated as of 10/25/12 in 2009-2011 ACS data to be 4,262,753. The US AIAN population estimate was updated to 5,055,427.

Income Distribution

In these 33 states, as detailed in Figure 2,

37% had household incomes under 139% of the Federal Poverty Level (FPL); 42% had household incomes between 139% to 400% FPL, and 21% had incomes over

400% FPL. The 42% (over 1.7 million)

AIAN Income Distribution for the 33 Study States

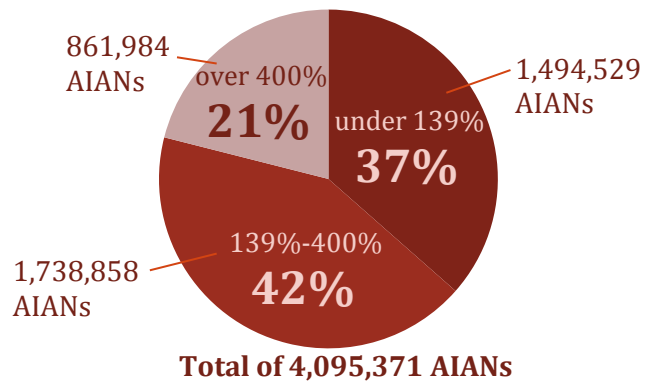


Figure 3 AIAN three-year income distribution for the 33 study states AIANs)

who are in the 139% to 400% FPL income range are those who will be most affected as the ACA stipulates that there will be subsidies to assist individuals/families to purchase health exchange offered plans. The appendix includes tables ranking the 33 states by each of the income categories. The category 139 to 400% of poverty has the least variation both across the states' AIAN population and the average for all states compared to the US all races with 30 states having between 36% to 48% in this category. There is a great deal of variation above 400% of poverty ranging from just 7% in South Dakota to 27% in Texas and 28% in California.

Access to IHS

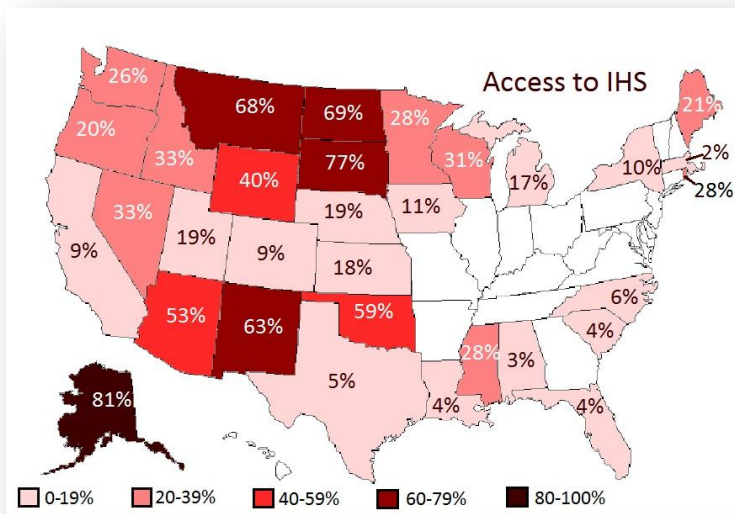


Figure 4 Percent AIAN Access to IHS by study state

Access to IHS by itself is not health insurance. Low income AIAN individuals and families with only IHS funded-services for health care

coverage will be eligible to receive subsidies for premiums to obtain health insurance through exchanges. IHS access is not means-tested as many public insurance programs are, nor is it affected by an individual's employment status. However, not every self-identified AIAN is eligible to receive services from an IHP. Each IHP has some level of determining eligibility based on whether the program is administered and run by the IHS for a Direct Service Tribe, completely run by a compacting tribe, run by a contracting tribe or group of tribes, or is an Urban Indian program. In many areas active users of IHP are only able to secure services directly provided in the health facilities of an IHP and are not eligible for services outside the clinic and paid for by what is known as Contract Health Service (CHS) funds from the IHS.

Additionally, access to an IHP does not guarantee access to all needed medical services and the level of access is impacted by the individual characteristics in an IHS Area. Access in California and Portland Areas of the IHS is affected by the fact that these areas do not have any IHS funded hospitals and the IHP's are heavily dependent on their Contract Health Service funds to provide hospital care to AIANs they serve. The Alaska Area, while having IHS funded hospitals, face a whole host of separate challenges due to the sheer remoteness and vast geography of the area coupled with an extremely high cost of living and staggering unemployment in the rural areas. Each area, like each state, faces a unique set of factors that impact access to IHS and what that means to the families in those respective areas.

Improving the proportion of AIAN individuals and families that enroll in a health exchange insurance plan (with improvements in the uptake rate for eligibles) may help alleviate the fiscal pressures on IHPs, an already highly challenged system by increasing third party billing revenues and increasing referrals paid by non-CHS payers for care outside the IHP system. However, much will depend on the design of the programs which will determine whether individuals will be willing to purchase exchange-offered health plan coverage. For example, an AIAN will likely consider favorably a health insurance plan that includes their familiar IHP in its network of providers. Another potential issue is that some AIAN families with access to IHS

Income	% AIAN with IHS Access	# AIAN with IHS Access
under 139%	41%	495,893
139%-400%	44%	532,423
over 400%	15%	186,626
Total	100%	1,218,539

coverage will factor the overall cost to their families for purchasing health exchange coverage. Their personal eligibility to access care through the IHP is not affected, but their overall cost to

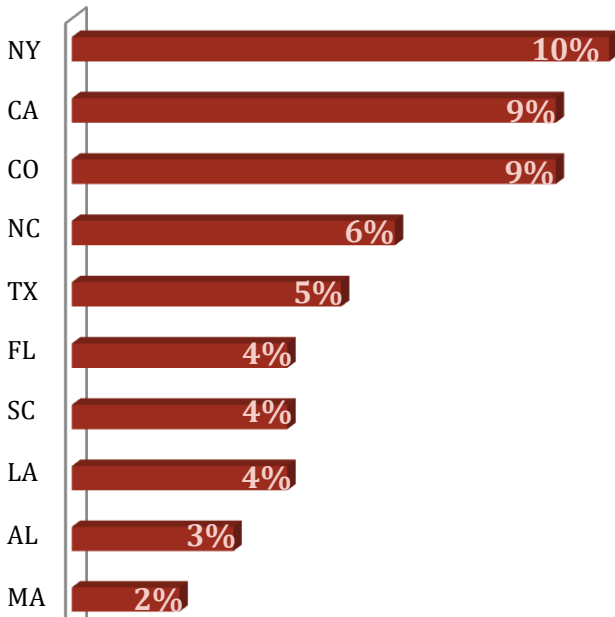
Figure 5 IHS Access in 33 Study States by income

their family may increase substantially. In the states where AIANs have a high level of access to IHPs, tribes and states (should) work closely together to design programs that ensure AIANs may elect his/her IHP as a provider under the state health exchange programs.

The meaning of “Access to IHS” is likely highly variable among the ACS survey respondents. Consider for example, the difference between the answer of a respondent in a remote Alaska Native village compared to a respondent living on a reservation in a tribe that operates its own health program in the lower 48 states of the continental US located near a large metropolitan center. The Alaska Native

villager is probably more likely to say they have ‘access to IHS,’ since that is, indeed, the only health care services available to them. On the other hand, the lower 48 respondent may be less likely to say she has access to IHS even if eligible to use her own tribe’s health program if she has private insurance and does not use the IHS-funded tribal program (and if she answered that she had private coverage to the survey question).

10 Study States w/ Least Access to IHS



■ Reported Access to IHS

Figure 6 Ten states reporting lowest IHS Access

These responses also differ in what they consider ‘coverage’ with the Alaska Native villager highly unlikely to have a doctor, nurse or other mid-level provider, but a community health aide, at times assisted by telemedicine, as their primary care provider. For specialist or hospital care they will be forced to travel, typically by air,

with longer time away from home than the respondent from the lower 48. The result is often forgone care, delayed care, or accessing care later than optimal.

IHS Coverage: The data for the three-year period shows that 30% of respondents nationally had access to Indian Health Service (IHS) paid services at an Indian Health Program (IHP). In the 33 study states, only 21% of the AIANs report having access to Indian Health Service. The range is from under 2% in Massachusetts to 81% in Alaska (again reporting access to IHS-paid services does not mean the

States Where AIANs report highest Access to IHS

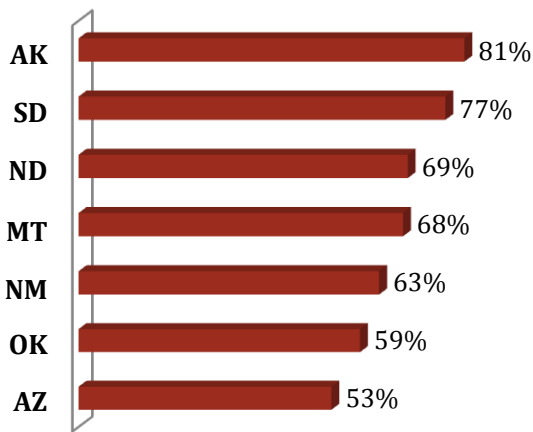


Figure 7 Seven states reporting highest Access to IHS

including some of the largest Indian populations in the nation-in this instance IHS-paid services are well-located.

respondent feels he has acceptable access to comprehensive services). Ten percent or less of AIANs in 10 states, including three with very large Indian populations (California, Texas and New York), report that they have access to IHS services. Over 50% of AIAN in seven states report access to IHS services

Uninsured

Income	% AIAN Uninsured	# AIAN Uninsured
under 139%	44%	487,641
139%-400%	42%	463,275
over 400%	14%	151,286
Total		1,102,202

Figure 8 Uninsured AIANs in 33 Study States by income

Income distribution of the Uninsured

AIANs: Of the 4.1 million AIANs in the 33 states, 1,102,202 or 27% are uninsured. A critical population to look at here is the 487,641 AIANs uninsured and earning

under the 138% FPL. States and tribes stand to benefit greatly in encouraging these

families and individuals to enroll in Medicaid and state CHIP programs, benefits and efforts can be realized even before the exchange programs are put into effect since many are undoubtedly already eligible for Medicaid.

The health benefits exchange health plan income category is nearly the same size as the Medicaid category-42%. With regard to the upcoming health exchange programs, interestingly, of those uninsured 42% are in the 139%-400% of FPL is nearly the same percentage of the overall 'all races' nationally. Not all of these 463,275 will be eligible for health exchange subsidies if their employers provide affordable coverage or if they are eligible on a family member's insurance plan. However, the vast majority will be eligible and marketing and outreach will be an important aspect as AIANs are exempted by the ACA from the penalty for not selecting a health insurance plan. This means for these families, a decision to purchase an insurance plan, even a subsidized plan, will mean newly incurred costs for which they will not be willing or able take on. If tribes are allowed to sponsor their community members by state or federal exchanges this could become an important aspect of health care reform on or near Indian reservations and communities.

AIAN Uninsurance rates: The top ten states with the highest AIAN uninsurance rates are all equal to or exceed 30% uninsurance. Twenty-six of the 33 states have AIAN Uninsurance rates exceeding 20%. Encouraging enrollment and purchase of insurance therefore could have a meaningful impact on health and security of the AIAN populations.

Ten States with Highest AIAN Uninsurance	
Montana	40%
New Mexico	39%
South Dakota	38%
Alaska	36%
North Dakota	33%
Rhode Island	32%
Mississippi	32%
Wyoming	31%
Arizona	30%
Idaho	30%

Figure 9 Top ten states highest AIAN Uninsurance

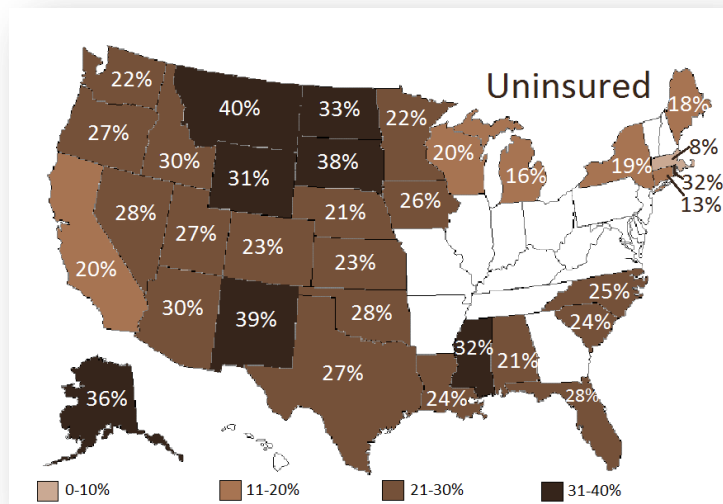


Figure 10 AIAN Uninsurance Map for the 33 Study States

Figure 9 gives the overall picture of AIAN insurance across the 33 Study States. Montana has the highest rate of uninsured with 40% uninsured.

Massachusetts has the lowest at 8%, likely due to Massachusetts' health policies, which have served as the model for the ACA as it is considerably lower than the rest of the nation.

Enrolled in Medicaid

Income	% AIAN Medicaid	# AIAN Medicaid
under 139%	66%	742,621
139%-400%	29%	326,250
over 400%	4%	48,820
Total	100%	1,117,691

Figure 11 AIAN enrolled in Medicaid in 33 Study States by income

In the 33 study states, 27% (1,117,000) of AIANs report having Medicaid coverage. Coverage under this means-tested program is dependent on not just poverty, but also the generosity of a state's Medicaid program. Over 30% of AIANs report Medicaid coverage in 8 of the 33 states. The

question on Medicaid coverage includes coverage in state-funded programs as well as Medicaid. Medicaid coverage exceeds 20% in all but two (Texas and Nevada) of the 33 states. It is surprising at first, but understandable that for these two states AIAN may face the paradox of being relative higher income in a state with somewhat

'frugal' Medicaid programs- note private insurance

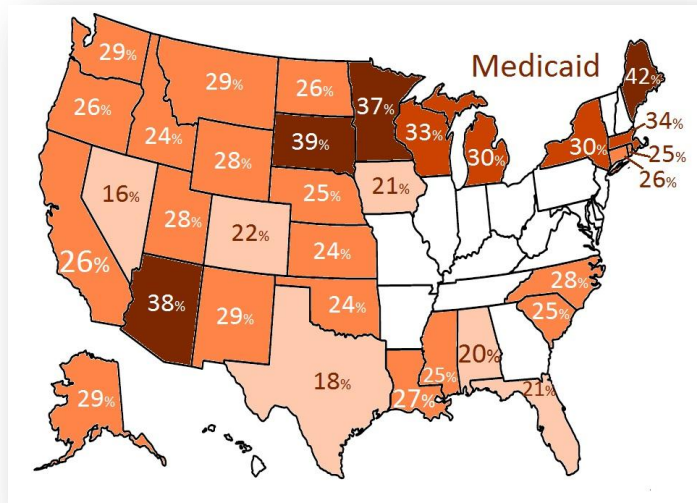


Figure 12 AIAN Medicaid Enrollment map for the 33 Study States

States with Highest AIAN Medicaid Enrollment	
Maine	42%
South Dakota	39%
Arizona	38%
Minnesota	37%
Massachusetts	34%
Wisconsin	33%
Michigan	30%
New York	30%

Figure 13. States with Highest AIAN Medicaid Enrollment

exceeds 50% in both states. Conversely, in Minnesota AIANs face extreme poverty in a state with a very generous program.

Enrolled in Medicare

Income	% AIAN Medicare	# AIAN Medicare
under 138%	37%	158,043
139%-400%	44%	190,131
over 400%	18%	78,336
Total	99%	430,437

10% of AIANs in the study report Medicare coverage. Medicare coverage ranges from 6 to 15%. The mean and the mode is 11% of AIAN reporting Medicare coverage. This

Figure 14. AIAN Enrolled in Medicare by income

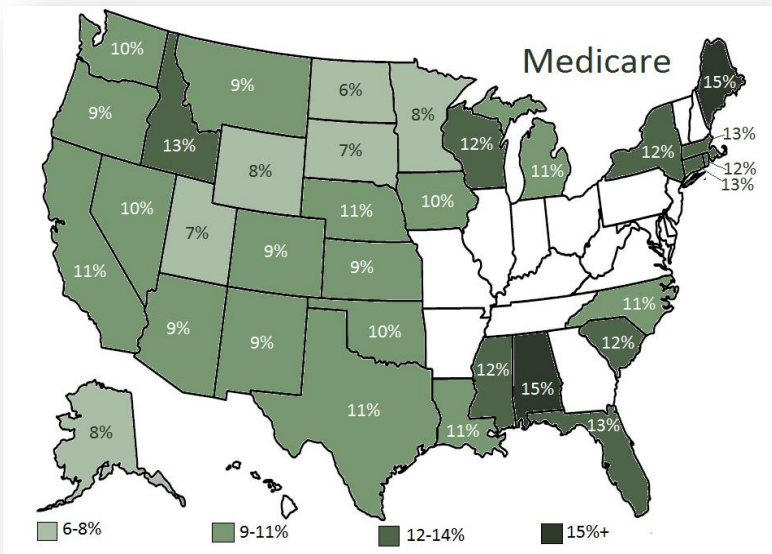


Figure 15 Percentage AIAN Enrolled in Medicare by State

measure seems valid as it matches other reported data. It is perhaps valid in states like South and North Dakota, where tragically, Indian elders are not only in extreme

poverty, but are NOT eligible for Medicare due to inability to qualify based on the work requirement of 48 quarters work history paying into Medicare.

Privately Insured

Income	% AIAN Insured	# AIAN Insured
under 138%	14%	270,342
139%-400%	49%	949,506
over 400%	37%	703,054
Total	100%	1,922,902

48% of AIANs in the study report private insurance coverage. This includes both employer sponsored and individually purchase insurance. There is a great deal

Figure 16 AIAN with Private Insurance by income

of variation across the states. Private insurance seems to have an inverse

correlation to 'access to IHS' suggesting that if IHS funded services are available AIANs may be making choices that result in less private insurance (such as not adding dependents to their employer-offered health insurance plans). Also, a cursory review of income categories also suggests a positive correlation to income and insurance-states with more AIANs over 400% of poverty have more private insurance. California and Texas, states with large Indian populations, and Massachusetts and Connecticut-all have 25% or more of their AIAN households with incomes over 400% of poverty.

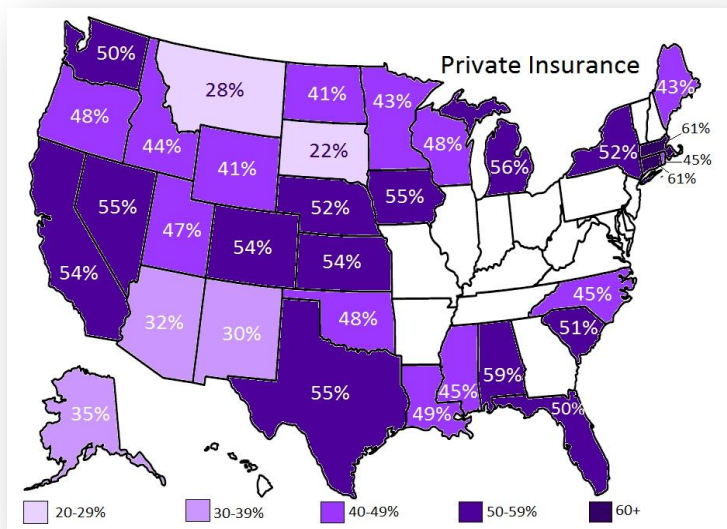


Figure 17 Percentage AIAN with Private Insurance by State

Conclusion

The availability of the American Community Survey’s 3-year pooled data for 2008-2010 containing health insurance coverage (and access to IHS) and income offers, for the first time ever, the information needed for health care planning. It is particularly propitious for planning for Medicaid expansion and the launching of Health Insurance Exchanges and their expansion of private insurance plans in 2014. Although, like any other new source of data, there are some uncertainties about the validity and reliability of some of the estimates, the ACS data marks a new era in data for American Indian and Alaska Native health insurance research. Tribes, Tribal Organizations, universities, foundations, and government agencies can now relegate to the dustbin of history, the category ‘other’ when examining the impact of new health insurance policies on Tribes and Indian people. The new ACS data and the coming wave of research products it makes possible will improve planning and guide program development in a way never before possible.

Further Research

1. Comparisons between states.
 - a. Is there variance? Even a cursory examination suggests there is great variation for all of the measures save Medicare and Medicaid, but even these exhibit variations in some states.
 - b. What are the explanations for variance?
 - c. Analysis of the significance of variations and explanations for use in policymaking
2. Comparison to other populations; “all races”, white, and Hispanic
3. Longitudinal studies to study change over time.
 - a. This data represents the first attempt to establish a baseline that could be used to:
 - i. Plan health care reform implementation
 - ii. Track success of outreach and education and enrollment
4. Examine of the ACS insurance responses for validity and reliability.
 - a. Access to IHS
 - i. Compares favorably with IHS active users database (1.2 million estimate seems very close to actual in IHS database).
 - b. Medicaid
 - i. Comparison to CMS databases and exploration of difficulty of measuring churn and other issues.
 - c. Medicare

- i. Compares very favorably to CMS/IHS data matches
 - ii. What is the relationship of income to Medicare enrollment
- d. Private Insurance
 - i. Analysis of individual plans vs. employer sponsored plans
- e. Uninsured
 - i. See number 3 above to first test validity of the measure, its reliability over time and;
 - ii. Track improvements as measured by declining rates of uninsured.
- f. Income
 - i. Compare responses on the ACS survey to other sources of information about AIAN income.

Appendix Tables

Table 1
Income Categories

Table 2
Income Ranked by % under 139%

		Under 139% FPL	139- 400%	over 400%		Under 139% FPL	139- 400%	over 400%
1	Alabama	31%	47%	20%	Iowa	16%	62%	22%
2	Alaska	49%	37%	14%	Connecticut	26%	36%	39%
3	Arizona	47%	40%	13%	Texas	28%	44%	27%
4	California	31%	41%	28%	Nevada	30%	46%	24%
5	Colorado	33%	43%	24%	Alabama	31%	47%	20%
6	Connecticut	26%	36%	39%	California	31%	41%	28%
7	Florida	33%	43%	24%	Colorado	33%	43%	24%
8	Idaho	38%	48%	14%	Florida	33%	43%	24%
9	Iowa	16%	62%	22%	Massachusetts	33%	36%	31%
10	Kansas	41%	42%	17%	Nebraska	33%	57%	10%
11	Louisiana	36%	41%	23%	Oklahoma	34%	47%	19%
12	Maine	46%	38%	15%	New York	35%	39%	26%
13	Massachusetts	33%	36%	31%	South Carolina	35%	45%	19%
14	Michigan	37%	41%	22%	Washington	35%	40%	25%
15	Minnesota	45%	38%	17%	Louisiana	36%	41%	23%
16	Mississippi	40%	48%	13%	Michigan	37%	41%	22%
17	Montana	45%	41%	15%	Idaho	38%	48%	14%
18	Nebraska	33%	57%	10%	Mississippi	40%	48%	13%
19	Nevada	30%	46%	24%	North Carolina	40%	42%	17%
20	New Mexico	42%	43%	15%	Oregon	40%	40%	20%
21	New York	35%	39%	26%	Rhode Island	40%	48%	13%
22	North Carolina	40%	42%	17%	Utah	40%	40%	20%
23	North Dakota	49%	37%	14%	Kansas	41%	42%	17%
24	Oklahoma	34%	47%	19%	Wisconsin	41%	42%	25%
25	Oregon	40%	40%	20%	Wyoming	41%	39%	19%
26	Rhode Island	40%	48%	13%	New Mexico	42%	43%	15%
27	South Carolina	35%	45%	19%	Minnesota	45%	38%	17%
28	South Dakota	59%	34%	7%	Montana	45%	41%	15%
29	Texas	28%	44%	27%	Maine	46%	38%	15%
30	Utah	40%	40%	20%	Arizona	47%	40%	13%
31	Washington	35%	40%	25%	Alaska	49%	37%	14%
32	Wisconsin	41%	42%	25%	North Dakota	49%	37%	14%
33	Wyoming	41%	39%	19%	South Dakota	59%	34%	7%
	United States	36%	42%	21%	United States	36%	42%	21%

Source: American Community Survey 2008-2010, Compiled by Ed Fox and Verne' Boerner from California Rural Indian Health Board Dataset, 2012.

Table 3 Income Categories Ranked by % Between 139% and 400%					Table 4 Income Categories Ranked by % Over 400%				
		Under 139% FPL	139- 400%	over 400%		Under 139% FPL	139- 400%	over 400%	
1	South Dakota	59%	34%	7%	South Dakota	59%	34%	7%	
2	Connecticut	26%	36%	39%	Nebraska	33%	57%	10%	
3	Massachusetts	33%	36%	31%	Mississippi	40%	48%	13%	
4	Alaska	49%	37%	14%	Rhode Island	40%	48%	13%	
5	North Dakota	49%	37%	14%	Arizona	47%	40%	13%	
6	Maine	46%	38%	15%	Idaho	38%	48%	14%	
7	Minnesota	45%	38%	17%	Alaska	49%	37%	14%	
8	New York	35%	39%	26%	North Dakota	49%	37%	14%	
9	Wyoming	41%	39%	19%	New Mexico	42%	43%	15%	
10	Arizona	47%	40%	13%	Montana	45%	41%	15%	
11	Oregon	40%	40%	20%	Maine	46%	38%	15%	
12	Utah	40%	40%	20%	North Carolina	40%	42%	17%	
13	Washington	35%	40%	25%	Kansas	41%	42%	17%	
14	California	31%	41%	28%	Minnesota	45%	38%	17%	
15	Louisiana	36%	41%	23%	Wyoming	41%	39%	19%	
16	Michigan	37%	41%	22%	Oklahoma	34%	47%	19%	
17	Montana	45%	41%	15%	South Carolina	35%	45%	19%	
18	Kansas	41%	42%	17%	Utah	40%	40%	20%	
19	North Carolina	40%	42%	17%	Alabama	31%	47%	20%	
20	Wisconsin	41%	42%	25%	Oregon	40%	40%	20%	
21	Colorado	33%	43%	24%	Michigan	37%	41%	22%	
22	Florida	33%	43%	24%	Iowa	16%	62%	22%	
23	New Mexico	42%	43%	15%	Louisiana	36%	41%	23%	
24	Texas	28%	44%	27%	Florida	33%	43%	24%	
25	South Carolina	35%	45%	19%	Colorado	33%	43%	24%	
26	Nevada	30%	46%	24%	Nevada	30%	46%	24%	
27	Alabama	31%	47%	20%	Washington	35%	40%	25%	
28	Oklahoma	34%	47%	19%	Wisconsin	41%	42%	25%	
29	Idaho	38%	48%	14%	New York	35%	39%	26%	
30	Mississippi	40%	48%	13%	Texas	28%	44%	27%	
31	Rhode Island	40%	48%	13%	California	31%	41%	28%	
32	Nebraska	33%	57%	10%	Massachusetts	33%	36%	31%	
33	Iowa	16%	62%	22%	Connecticut	26%	36%	39%	
	<i>United States</i>	36%	42%	21%	<i>United States</i>	36%	42%	21%	

Source: American Community Survey 2008-2010, Compiled by Ed Fox and Verne' Boerner from California Rural Indian Health Board Dataset, 2012.

Table 5				Table 6				
Comparison AIAN to All Races Over 400%				Rank AIAN vs. All Races Over 400%				
	All races	AIAN	Difference	Rank		All races	AIAN	Difference
Alabama	30%	20%	10%	1	Connecticut	46%	39%	7%
Alaska	28%	14%	14%	2	Massachusetts	45%	31%	14%
Arizona	29%	13%	16%	3	California	32%	28%	4%
California	32%	28%	4%	4	Texas	29%	27%	1%
Colorado	41%	11%	30%	5	New York	33%	26%	7%
Connecticut	46%	39%	7%	6	Wisconsin	36%	25%	12%
Florida	30%	24%	6%	7	Washington	37%	25%	13%
Idaho	25%	14%	12%	8	Nevada	29%	24%	5%
Iowa	34%	22%	12%	9	Florida	30%	24%	6%
Kansas	32%	17%	15%	10	Louisiana	28%	23%	5%
Louisiana	28%	23%	5%	11	Iowa	34%	22%	12%
Maine	33%	15%	18%	12	Michigan	33%	22%	12%
Massachusetts	45%	31%	14%	13	Oregon	34%	20%	14%
Michigan	33%	22%	12%	14	Alabama	30%	20%	10%
Minnesota	41%	17%	24%	15	Utah	28%	20%	9%
Mississippi	24%	13%	12%	16	South Carolina	25%	19%	6%
Montana	28%	15%	13%	17	Oklahoma	30%	19%	11%
Nebraska	37%	10%	27%	18	Wyoming	35%	18%	17%
Nevada	29%	24%	5%	19	Minnesota	41%	17%	24%
New Mexico	29%	15%	14%	20	Kansas	32%	17%	15%
New York	33%	26%	7%	21	North Carolina	31%	17%	14%
North Carolina	31%	17%	14%	22	Maine	33%	15%	18%
North Dakota	41%	14%	27%	23	Montana	28%	15%	13%
Oklahoma	30%	19%	11%	24	New Mexico	29%	15%	14%
Oregon	34%	20%	14%	25	North Dakota	41%	14%	27%
Rhode Island	38%	13%	25%	26	Alaska	28%	14%	14%
South Carolina	25%	19%	6%	27	Idaho	25%	14%	12%
South Dakota	32%	7%	25%	28	Arizona	29%	13%	16%
Texas	29%	27%	1%	29	Rhode Island	38%	13%	25%
Utah	28%	20%	9%	30	Mississippi	24%	13%	12%
Washington	37%	25%	13%	31	Colorado	41%	11%	30%
Wisconsin	36%	25%	12%	32	Nebraska	37%	10%	27%
Wyoming	35%	18%	17%	33	South Dakota	32%	7%	25%
United States	33%	21%	12%					