INDIAN HEALTH FINANCING POLICY SERIES

Medicare Enrollment Among American Indians and Alaska Natives

Coverage Trends, IHS Access Overlap, and the Dual-Eligibility Pathway, 2014–2024

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Data Source

American Community Survey 1-Year Public Use Microdata Sample (ACS 1-Year PUMS), survey years 2014, 2016, 2018, 2022, and 2024. Variable HINS3 (Medicare) cross-tabulated with HINS7 (Indian Health Service access) and RACAIAN (American Indian and Alaska Native race recode). All estimates use person-level weights (PWGTP).

Carved mask, gift to the author from the Port Gamble S?Klallam Tribe

ABSTRACT

Background. Medicare serves as the primary federal health insurance program for Americans aged 65 and older, as well as for individuals with qualifying disabilities including end-stage renal disease (ESRD). For American Indian and Alaska Native (AI/AN) populations, Medicare eligibility is shaped by two countervailing demographic forces: lower life expectancy that reduces survival to age-based eligibility, and elevated rates of Type 2 diabetes and ESRD that create a disproportionate under-65 eligibility pathway. This paper examines Medicare enrollment trends within the AI/AN population from 2014 to 2024 using the ACS 1-Year PUMS, with particular attention to the overlap between Medicare and Indian Health Service (IHS) access.

Methods. Cross-tabulations of HINS3 (Medicare) × HINS7 (IHS access) × RACAIAN were computed from five ACS 1-Year PUMS releases (2014, 2016, 2018, 2022, 2024). National enrollment counts and rates are presented for five mutually exclusive coverage combinations. State-level results are reported for 15 states with large IHS-access populations. A methodological note addresses the confounding effect of the 2020 Census-driven AIAN population reclassification, which inflated denominators in 2022 and 2024 and creates an artificial break in rate series.

Results. National Medicare enrollment among AIAN grew from 671,309 (12.6% of AIAN population) in 2014 to 1,260,848 (13.8%) in 2024. The dual Medicare+IHS population — enrollees who report both Medicare coverage and IHS access — grew from 140,990 to 196,529 over the same period. State-level Medicare rates are notably compressed (10.5%–17.6%), in contrast to IHS access rates, which range from 3.9% to 77.8%. States with high IHS access (Alaska, New Mexico, North Dakota, South Dakota, Oklahoma) show the highest dual enrollment rates, suggesting Medicare and IHS serve as complementary rather than substituting coverage mechanisms for reservation-based elders and ESRD patients.

Conclusions. Medicare enrollment among AI/ANs is shaped by disease burden as well as age structure. The ESRD/disability pathway, driven primarily by diabetes-related complications, produces a level of Medicare enrollment that exceeds what the AIAN age distribution alone would predict. Any cross-racial comparison of Medicare enrollment rates must account for these countervailing forces. The dual Medicare+IHS population represents a clinically complex group dependent on both federal programs simultaneously, with implications for IHS resource allocation, 638 compact financing, and Medicaid third-party liability recovery.

KEY FINDINGS

1. **Medicare enrollment grew substantially in absolute terms but modestly in rate.** From 2014 to 2024, the number of AIAN Medicare enrollees grew 88% (671K to 1.26M). The enrollment rate increased only 1.2 percentage points (12.6% to 13.8%), reflecting parallel growth in the total AIAN population, in part due to the 2020 Census reclassification.
2. **The dual Medicare+IHS population is a growing, clinically significant group.** Enrollees reporting both Medicare and IHS access increased 39% (141K to 197K). These individuals are disproportionately concentrated in reservation-dominant states

and are likely to include a high share of ESRD patients dependent on IHS facilities for primary care coordination alongside Medicare-covered dialysis.

3. **State Medicare rates are compressed; dual rates are not.** Medicare enrollment rates vary modestly across states (10.5%–17.6%), reflecting Medicare's age-based eligibility. Dual Medicare+IHS rates vary far more widely (0.6%–9.7%), tracking IHS access geography. New Mexico (9.7%), Alaska (8.0%), North Dakota (7.9%), and Oklahoma (7.8%) lead on dual enrollment, consistent with their high IHS access shares.
4. **The observed Medicare rate is the net result of two countervailing forces.** Lower AIAN life expectancy depresses age-based eligibility relative to the general population. Higher diabetes and ESRD rates elevate under-65 eligibility. The net observed rate likely understates what it would be if AIAN survival to age 65 matched national averages, while simultaneously being elevated above a purely age-driven baseline. Cross-racial comparisons that do not account for both effects are methodologically misleading.
5. **The 2022–2024 denominator break requires caution in trend interpretation.** The 2020 Census reclassification substantially increased the number of individuals identified as AIAN alone or in combination, inflating denominators for 2022 and 2024 rates. The IHS access rate appears to drop from 26% (2018) to 15% (2022) — this is a denominator artifact, not a real coverage decline. Medicare rates are less affected because Medicare enrollment counts are administrative, not survey-derived.

SECTION I — RESEARCH QUESTION AND POLICY CONTEXT

1.1 Research Question

How has Medicare enrollment evolved within the American Indian and Alaska Native population from 2014 to 2024, and what is the extent of overlap between Medicare coverage and IHS access? To what extent does the observed enrollment rate reflect disease burden (particularly ESRD from diabetes) versus age structure?

1.2 Policy Context

Medicare's relevance to the Indian health system is structurally distinct from Medicaid's. Medicaid's 100% Federal Medical Assistance Percentage (FMAP) for IHS and 638-facility services has made it the dominant third-party revenue source for tribal health programs. Medicare does not carry an equivalent special FMAP provision, but it is nonetheless a significant payer for IHS-served elders and disability enrollees — particularly for inpatient hospital care, skilled nursing, and end-stage renal disease treatment, which IHS facilities largely cannot provide directly.

The dual Medicare+IHS population is particularly significant for tribal finance. Medicare covers services that IHS cannot provide on-site (dialysis, inpatient surgery, specialty care), while IHS or 638 programs provide primary care, preventive services, and care coordination. For tribes operating under PL 93-638 self-governance compacts, Medicare third-party revenue is an increasingly important component of the compact funding base.

POLICY SIGNIFICANCE: THE ESRD PATHWAY

End-stage renal disease, the leading complication of uncontrolled Type 2 diabetes, triggers Medicare eligibility regardless of age. AI/ANs experience Type 2 diabetes at approximately 2–3× the rate of the general U.S. population (IHS, 2024; CDC, 2023), making ESRD-driven Medicare eligibility disproportionately common. This means a meaningful share of AIAN Medicare enrollees are working-age adults whose eligibility reflects disease burden rather than age. IHS facilities and 638 tribal programs serving this population simultaneously bear primary care costs while Medicare covers the downstream dialysis and inpatient costs — creating a cost-shifting pattern with direct implications for IHS appropriations adequacy.

SECTION II — DATA SOURCES AND METHODOLOGY

2.1 ACS 1-Year PUMS

This analysis uses five ACS 1-Year Public Use Microdata Sample releases: 2014, 2016, 2018, 2022, and 2024. The 1-year PUMS provides annual cross-sectional estimates suitable for trend analysis, though with larger margins of error for small state-level AIAN populations than the 5-year PUMS. Three insurance-status variables are used:

1. **HINS3** — Medicare coverage for people 65+ or with qualifying disabilities
2. **HINS7** — Indian Health Service or tribal health facility access (not counted as insurance under Census definitions)
3. **RACAIAN** — American Indian and Alaska Native race recode (alone or in combination with one or more other races)

Cross-tabulating HINS3 × HINS7 × RACAIAN, weighted by PWGTP, produces four mutually exclusive AIAN subgroups: (1) Medicare+IHS (dual), (2) Medicare only, (3) IHS only, and (4) neither. All national and state counts are weighted population estimates.

2.2 Measurement Caveats

DENOMINATOR BREAK: 2020 CENSUS RECLASSIFICATION

The 2020 Census employed revised race question design and coding that substantially increased the number of respondents identified as AIAN alone or in combination. This inflated the AIAN population denominator used in the 2022 and 2024 ACS estimates relative to the 2014–2018 series. Rate comparisons across this break — particularly for IHS access, which appears to drop from 26% in 2018 to 15% in 2022 — should be interpreted as a denominator artifact rather than a real change in IHS access patterns. Medicare enrollment counts are less affected because they are administratively determined, but Medicare rates as a share of the AIAN population are subject to the same denominator inflation.

CONFOUNDING IN CROSS-RACIAL COMPARISONS

Comparing AIAN Medicare enrollment rates to all-races figures is confounded by two divergent forces. Lower AIAN life expectancy reduces survival to age 65, depressing age-based eligibility relative to the general population. Higher diabetes and ESRD rates elevate the under-65 disability/ESRD eligibility pathway. These forces partially offset each other, meaning the net observed AIAN rate likely understates what it would be if AIAN survival to age 65 matched national averages, while simultaneously being elevated above a purely age-driven baseline. Any cross-racial comparison of Medicare enrollment rates must account for both effects before drawing conclusions about coverage adequacy.

SECTION III — NATIONAL ENROLLMENT TRENDS, 2014–2024

3.1 Medicare Enrollment Counts and Rates

Table 1 presents national Medicare enrollment counts and rates for the AIAN population across five ACS 1-Year PUMS releases. The table distinguishes Medicare-only enrollees from those reporting both Medicare and IHS access (dual), providing the first systematic longitudinal picture of the dual Medicare+IHS population.

Table 1. AIAN Medicare Enrollment, National Estimates, 2014–2024

Year	Total AIAN	Medicare (any)	MCR Rate	MCR Only	MCR + IHS	Dual Rate
2014	5,330,450	**671,309**	**12.6%**	530,319	140,990	**2.6%**
2016	5,535,521	**734,708**	**13.3%**	572,869	161,839	**2.9%**
2018	5,695,353	**768,761**	**13.5%**	583,603	185,158	**3.3%**
2022	8,558,399	**1,155,043**	**13.5%**	973,991	181,052	**2.1%**
2024	9,129,771	**1,260,848**	**13.8%**	1,064,319	196,529	**2.2%**

* IHS access rates for 2022 and 2024 are suppressed by the 2020 Census denominator reclassification; see Section 2.2. Source: ACS 1-Year PUMS, 2014, 2016, 2018, 2022, 2024. Author calculations.

3.2 Trend Interpretation

Three patterns merit attention across the 2014–2024 series:

Steady rate increase, 2014–2018. The Medicare enrollment rate rose from 12.6% to 13.5% between 2014 and 2018, reflecting both aging of the AIAN population and continued accumulation of ESRD-driven eligibility. Over the same period, the dual Medicare+IHS rate rose from 2.6% to 3.3%, a 0.7 percentage point increase representing approximately 44,000 additional dual enrollees.

Denominator break, 2018–2022. The total AIAN population jumps from 5.7M (2018) to 8.6M (2022) due to the 2020 Census reclassification. Medicare enrollment counts continue rising (768K to 1,155K), but the denominator inflation holds the rate flat at 13.5%. The dual rate appears to fall from 3.3% to 2.1% — this reflects the inflated denominator rather than a real decline in dual enrollment, as the absolute dual count actually fell slightly due to COVID-era survey disruption.

Continued absolute growth, 2022–2024. Medicare enrollment grew from 1,155K to 1,261K and the dual population from 181K to 197K in this two-year interval, consistent with the aging of the large post-war AIAN birth cohorts and ongoing ESRD incidence. The enrollment rate reached 13.8% in 2024.

SECTION IV — STATE-LEVEL FINDINGS, 2024

4.1 Medicare, Dual, and IHS Access Rates by State

Table 2 presents 2024 Medicare enrollment rates, dual Medicare+IHS rates, and IHS access rates for 15 states with significant IHS-served AIAN populations. The juxtaposition of these three rates reveals the structural relationship between IHS access geography and Medicare enrollment patterns.

Table 2. State-Level AIAN Medicare Enrollment, 2024

State	AIAN Pop.	MCR Rate	Dual Rate (MCR+IHS)	IHS Access Rate	Note
Alaska	155,919	11.6%	8.0%	77.8%	Highest IHS access; ESRD pathway prominent
Arizona	477,786	12.9%	6.3%	45.3%	
California	1,323,696	12.9%	0.8%	5.2%	Urban AIAN; minimal IHS access
Kansas	95,366	15.3%	1.2%	8.2%	
Michigan	203,562	17.6%	2.2%	13.3%	Highest Medicare rate; older age structure
Minnesota	144,477	10.5%	3.3%	22.7%	Lowest Medicare rate
Montana	97,557	13.4%	6.8%	53.8%	
New Mexico	266,457	17.1%	9.7%	56.7%	Highest dual rate; strong IHS+MCR overlap
North Carolina	312,394	13.8%	0.6%	3.9%	Lumbee and urban AIAN; minimal IHS
North Dakota	53,637	12.5%	7.9%	49.0%	
Oklahoma	581,142	13.3%	7.8%	56.2%	Largest AIAN pop. with high IHS access
Oregon	163,130	13.7%	2.5%	14.8%	
South Dakota	95,056	13.3%	7.0%	63.8%	Reservation-dominant; high dual enrollment
Washington	284,486	14.2%	3.3%	17.7%	
Wisconsin	124,840	14.3%	3.4%	18.1%	

Source: ACS 1-Year PUMS, 2024. Author calculations. RACAIAN = alone or in combination. Medicare rate = HINS3=Yes ÷ total AIAN. Dual rate = HINS3=Yes AND HINS7=Yes ÷ total AIAN. IHS access rate = HINS7=Yes ÷ total AIAN.

4.2 State Typologies

Reservation-dominant states (Alaska, Arizona, Montana, New Mexico, North Dakota, South Dakota, Oklahoma). These states show the highest IHS access rates (45–78%) and the highest dual Medicare+IHS rates (6–10%). Medicare rates are moderate and compressed (11.6–17.1%). The dual rate closely tracks IHS access, confirming that Medicare-eligible elders

and ESRD patients in IHS-intensive states disproportionately retain IHS as a complementary coverage source. New Mexico is notable for combining the highest dual rate (9.7%) with the second-highest IHS access rate (56.7%), suggesting strong institutional retention of IHS among Medicare-eligible AIAN in Pueblo and Navajo communities.

Mixed-access states (Minnesota, Oregon, Washington, Wisconsin). These states show moderate IHS access (15–23%) and moderate dual rates (2.5–3.4%). Medicare rates are near the national average. The AIAN populations in these states include both reservation-based and urban communities, producing intermediate dual enrollment patterns.

Low-IHS states (California, Kansas, Michigan, North Carolina). These states have minimal IHS access (4–13%) and correspondingly low dual rates (0.6–2.2%). Michigan's notably high Medicare rate (17.6%) — the highest in the dataset — may reflect the older age structure of the Ojibwe and Odawa communities in the Upper Peninsula. North Carolina's low dual rate (0.6%) despite a large AIAN population (312,000, primarily Lumbee) reflects that Lumbee Tribe members are not federally recognized for IHS services under the Lumbee Act's exclusion.

SECTION V — POLICY IMPLICATIONS

5.1 IHS Resource Allocation and ESRD

The dual Medicare+IHS population (196,529 nationally in 2024) represents a group whose primary care and care coordination costs fall primarily on IHS/638 facilities while Medicare covers downstream inpatient, specialty, and dialysis costs. IHS per capita funding does not adjust for the higher primary care burden associated with ESRD patients — a structural gap with direct implications for IHS appropriations adequacy. Tribes operating compact programs that serve large ESRD populations effectively cross-subsidize Medicare from compact funds.

5.2 Medicare as Third-Party Revenue for 638 Programs

Unlike Medicaid, Medicare does not carry a 100% FMAP enhancement for IHS and 638 facilities. However, Medicare remains an important third-party revenue source for services 638 programs can bill — particularly skilled nursing, home health, and some outpatient services. The 39% growth in the dual population from 2014 to 2024 suggests this revenue stream is growing in absolute terms, even as the dual rate as a share of AIAN population has held approximately flat.

5.3 Medicaid Third-Party Liability and Dual Enrollees

Dual Medicare+Medicaid enrollees who are also IHS-access (the triple-covered subgroup visible in 5-year PUMS data) generate the maximum possible federal reimbursement at IHS/638 facilities: 100% FMAP on the Medicaid component plus Medicare cost-sharing recovery. The 2025 NIHB Insurance Report documents that 22.7% of AI/ANs aged 65 and older are dually enrolled in Medicare and Medicaid, compared to 15.0% nationally — a 7.7 percentage point differential. This premium above the national dual rate is consistent with the disease burden argument and has direct implications for state Medicaid third-party liability recovery programs at IHS facilities.

SECTION VI — CONCLUSION

Medicare enrollment among American Indians and Alaska Natives grew from 671,309 to 1,260,848 between 2014 and 2024, with an enrollment rate rising modestly from 12.6% to 13.8%. The dual Medicare+IHS population grew 39% over the same period, reaching 196,529 enrollees concentrated in reservation-dominant states.

The AIAN Medicare rate reflects a demographic and epidemiological paradox. Lower life expectancy suppresses age-based eligibility relative to the general population, while higher diabetes and ESRD rates create a disproportionate under-65 eligibility pathway. The net observed rate understates coverage relative to an age-standardized baseline while simultaneously being elevated above what age structure alone would produce. Cross-racial comparisons of Medicare enrollment rates are methodologically confounded unless both effects are accounted for.

For tribal health finance, the implications are practical: the dual Medicare+IHS population is growing, generates the highest per-enrollee federal reimbursement at 638 facilities, bears the highest primary care burden from ESRD and diabetes complications, and is geographically

concentrated in the states with the strongest IHS infrastructure. Ensuring IHS per capita funding reflects the clinical intensity of this population — and that 638 compact programs can fully capture Medicare third-party revenue — are among the more tractable near-term financing policy priorities.

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