INDIAN HEALTH FINANCING POLICY SERIES

IV-G. Dual Medicare–Medicaid Coverage Among AIAN Populations: IHS-Access vs. Non-IHS Populations, 2013–2024

ACS 5-Year PUMS Analysis — Three Periods · Edward J. Fox, PhD · April 2026

Abstract

Dual-eligible individuals — enrolled in both Medicare and Medicaid — represent a clinically and fiscally significant subgroup within the AIAN population served by the Indian health system. Using ACS 5-Year PUMS data from three non-overlapping periods (2010–2014, 2015–2019, 2020–2024), this paper constructs a complete coverage taxonomy for AIAN individuals, distinguishing those with IHS access (HINS7=Yes) from those without, and tracking four mutually exclusive coverage categories: dual (Medicare + Medicaid), Medicare-only, Medicaid-only, and IHS-only (no CMS coverage). National analysis shows that the dual-eligible population within the IHS-access AIAN group grew 38.8% between 2013 and 2024 (44,425 to 61,648), outpacing IHS-access population growth overall. The dual rate within the IHS-access population rose from 3.5% to 4.8%, exceeding the non-IHS dual rate for the first time in 2024. Despite coverage gains, 682,652 IHS-access AIAN individuals in the 2020–2024 period reported no Medicare or Medicaid coverage — representing 52.7% of the IHS-access population, down from 64.1% in 2013. State-level analysis across 21 states with significant IHS-served populations reveals substantial variation: dual rates range from 2.9% (Idaho, Kansas) to 7.0% (New Mexico), and IHS-only uninsured rates range from 36.4% (New Mexico) to 69.3% (Kansas). Oklahoma has the largest absolute concentration of uninsured IHS-access AIAN — 200,617 individuals with no CMS coverage. These findings have direct implications for the federal investment framework and the PRC rationing problem.

Section I — Background and Analytical Purpose

Dual-eligible individuals — those enrolled in both Medicare and Medicaid — occupy a strategically important position in Indian health financing. Medicare covers individuals aged 65 and older and certain disability-qualified individuals; Medicaid covers low-income populations. For AIAN populations, the intersection is significant because of the age structure and poverty rates in IHS-served communities, and because the federal government bears the full cost of Medicaid services delivered through IHS and Tribal facilities under the 100% Federal Medical Assistance Percentage (FMAP) provision. A dual-eligible AIAN individual whose care is delivered through an IHS or Tribal facility generates both Medicare reimbursement and 100% FMAP Medicaid reimbursement — maximizing federal investment in care that would otherwise fall entirely on discretionary IHS appropriations.

Prior analyses in this series (Paper IV-C) tracked Medicare and dual Medicare+IHS enrollment using ACS 1-Year PUMS data, documenting growth from 140,990 dual Medicare+IHS individuals (2014) to 196,529 (2024). This paper extends that analysis using ACS 5-Year PUMS data to add the Medicaid dimension — distinguishing dual (Medicare+Medicaid), Medicare-only, Medicaid-only, and uninsured categories — separately for IHS-access and non-IHS AIAN populations across three periods.

Section II — Data and Methods

Data are drawn from three non-overlapping ACS 5-Year PUMS periods: 2010–2014, 2015–2019, and 2020–2024. The analysis cross-tabulates four ACS variables for all RACAIAN=Yes respondents: HINS3 (Medicare), HINS4 (Medicaid), HINS7 (Indian Health Service), and RACAIAN (AIAN race recode, alone or in combination). This produces eight mutually exclusive cells — four coverage categories × two IHS-access groups — for each geographic unit and period. All estimates use person-level survey weights (PWGTP). State-level analysis covers 21 states with analytically significant IHS-served populations. National estimates are drawn from the total row. The 2020–2024 period reflects the 2020 Census race question redesign, which inflated the AIAN denominator substantially; however, the IHS-access count (HINS7) is not affected by this artifact, as IHS registration requires actual system contact.

Section III — National Findings: Three-Period Trend

3.1 Coverage Category Trends Within the IHS-Access Population

Table 1 presents the full coverage profile for all AIAN individuals by IHS access status across three periods. Several findings merit emphasis.

The dual-eligible population within the IHS-access group grew from 44,425 in 2010–2014 to 55,871 in 2015–2019 to 61,648 in 2020–2024 — a 38.8% increase over the decade. As a share of the IHS-access population, duals rose from 3.5% to 3.9% to 4.8%. This trajectory is consistent with the aging of the IHS-access population and the growing reach of Medicare into reservation-based communities documented in Paper IV-C.

Medicaid-only enrollment within the IHS-access population grew from 331,535 (26.0%) in 2013 to 432,345 (30.5%) in 2019 to 434,812 (33.6%) in 2024, consistent with ACA Medicaid expansion reaching reservation-based populations. This is the same Medicaid enrollment growth that the CMS–IHS Data Match now quantifies at $6.4–6.6 billion annually.

The IHS-only population — individuals with IHS access but no Medicare or Medicaid — fell from 817,810 (64.1%) in 2013 to 814,229 (57.4%) in 2019 to 682,652 (52.7%) in 2024. Despite substantial gains, this group remains the single largest coverage category within the IHS-access population. Their care is financed entirely by discretionary IHS appropriations and the Purchased/Referred Care program. The decline from 64.1% to 52.7% over a decade represents approximately 135,000 individuals who gained CMS coverage — a meaningful reduction that Medicaid expansion and Medicare growth drove — but 682,652 remain wholly outside the CMS reimbursement system.

3.2 IHS-Access vs. Non-IHS Dual Rate Comparison

Table 2 presents a focused comparison of dual-eligible rates between IHS-access and non-IHS AIAN populations across three periods, including a ratio of the two rates. In 2013, the IHS-access dual rate (3.5%) was lower than the non-IHS dual rate (4.1%), yielding a ratio of 0.85 — consistent with the younger age structure and lower insurance rates of the IHS-access population relative to the broader Census-identified AIAN population. By 2024, the IHS-access dual rate (4.8%) exceeded the non-IHS rate (4.0%), yielding a ratio of 1.19. This is a structural shift: the IHS-access population now has a higher dual rate than the non-IHS AIAN population for the first time in this series. This likely reflects the aging of the actively IHS-served population alongside the compositional change in the non-IHS AIAN group — which, after the 2020 Census question redesign, includes large numbers of younger, higher-income, multiracial urban individuals who are unlikely to be dual-eligible.

The non-IHS dual count grew substantially in absolute terms (156,853 to 266,401), but most of this reflects the 74% growth of the non-IHS denominator driven by the 2020 Census artifact — not real expansion of dual eligibility in that population.

Section IV — State-Level Findings, 2024

4.1 Full Coverage Profile by State

Table 3 presents the complete coverage breakdown for AIAN individuals with IHS access across 21 states, including dual count and rate, Medicare-only, Medicaid-only, and IHS-only (uninsured) count and rate.

4.2 High-Dual States

New Mexico leads all states with a dual rate of 7.0% among IHS-access AIAN, consistent with the Navajo Nation's older age structure and high poverty rates that simultaneously generate both Medicare and Medicaid eligibility. Arizona (6.2%), California (6.3%), Colorado (6.1%), and Nevada (5.9%) follow. California and Nevada are notable because their IHS-access populations are smaller and more urban — dual rates this high in those contexts likely reflect Urban Indian Organization enrollees with significant disability-related Medicare qualification, a pathway disproportionately associated with end-stage renal disease and Type 2 diabetes in AI/AN populations.

4.3 High-Uninsured States: The PRC Rationing Problem

Oklahoma presents the most analytically significant finding in the state-level data: 200,617 IHS-access AIAN individuals — 63.4% of the state's entire IHS-access population — carry no Medicare or Medicaid coverage. This is the largest absolute count of uninsured IHS-access AIAN in any state and exceeds the

combined uninsured IHS-access count of the next four states (South Dakota, Alaska, Arizona, and Montana). Their care is funded entirely by discretionary IHS appropriations and Purchased/Referred Care (PRC). When PRC funds are exhausted — typically in the second or third quarter of the federal fiscal year in most IHS areas — specialty care referrals for this population are denied or deferred. Oklahoma's uninsured concentration is the structural explanation for why PRC rationing is most severe in the Cherokee, Chickasaw, Choctaw, Creek, and Seminole tribal service areas despite those tribes operating among the most fully developed tribal health systems in the country.

Kansas (69.3% IHS-only), Idaho (62.4%), and Colorado (59.4%) also show high uninsured concentration among IHS-access AIAN. These are states with moderate IHS infrastructure and limited Medicaid expansion reach into IHS-access communities. Alaska shows 56,869 IHS-only individuals (50.4%) despite having the most fully integrated tribal health system in the country — suggesting that even at maximum tribal system development, CMS coverage penetration leaves roughly half of active users without a Medicare or Medicaid billing mechanism.

4.4 Medicaid Concentration and the 100% FMAP Implication

Medicaid-only enrollment is highest in New Mexico (48.8% of IHS-access AIAN), Montana (44.2%), and Minnesota (43.3%) — all states where Medicaid expansion reached reservation-based populations substantially. These states generate the largest Medicaid expenditures in the CMS–IHS Data Match and the largest estimated state savings from the 100% FMAP mechanism (Paper III). The co-location of high Medicaid-only enrollment, high IHS access, and 100% FMAP is the mechanism by which Medicaid became a structural rather than supplemental financing pillar in the Indian health system — visible here in the state-level coverage profiles.

Section V — Policy Implications

The dual-eligible analysis has three direct policy implications for Indian health financing.

First, the growing dual population within the IHS-access group strengthens the fiscal case for tribal health system investment. A dual-eligible individual whose primary and specialty care is delivered through a Tribal compact facility generates both Medicare cost-sharing recovery and 100% FMAP Medicaid reimbursement — maximizing the federal investment available per patient. Tribal health systems that build Medicare billing infrastructure alongside Medicaid billing infrastructure capture both revenue streams simultaneously. The 61,648 dual-eligible IHS-access AIAN in 2024 represent a potential combined revenue base of approximately $2.0–2.5 billion annually at NHE per-capita rates — revenue that flows to tribal facilities rather than mainstream providers only if the tribal health system has the billing infrastructure to capture it.

Second, the 682,652 IHS-only uninsured require distinct policy attention from the rest of the IHS-access population. Coverage expansion strategies — Medicaid expansion in remaining non-expansion states, streamlined enrollment, tribal sponsorship models — that successfully enroll members of this group into Medicaid generate 100% FMAP reimbursement for care already being delivered at IHS and Tribal facilities. Every 10,000 IHS-only individuals enrolled in Medicaid at NHE Medicaid PMPY rates (~$11,000) generates approximately $110 million in new 100% FMAP revenue for the tribal health system — at zero net state cost.

Third, the state-level variation in both dual rates and uninsured concentrations reveals that the coverage gap problem is not uniformly distributed. Oklahoma's 200,617 uninsured IHS-access AIAN represent a structurally different policy problem than New Mexico's 57,736, even though both states have large IHS-proximate populations. Strategies effective in one state may not translate to the other. Federal and tribal policy responses should be state-specific and tiered by the relative concentration of duals, Medicaid-only enrollees, and IHS-only uninsured in each state's IHS-access population.

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