

What the Series Establishes

A Synthesis of Findings, Unresolved Questions, and a Priority Research Agenda

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April 2026 · Indian Health Financing Series · Coda

I. Purpose and Scope

This coda does not introduce new data. It steps back from the individual papers to ask what the series, taken as a whole, has established — and where the most important gaps remain. The Indian Health Financing Series spans seven papers covering population measurement, Medicaid financing architecture, IHS access trends, federal funding adequacy, administrative data history, and the urban Indian health financing structure. This document synthesizes the connective tissue.

The papers were written to be read independently. But they were designed to build a cumulative argument: that the federal government's financial obligation to American Indian and Alaska Native health care is real, large, structurally undermet, and chronically mismeasured. This coda traces that argument from beginning to end.

II. What the Series Establishes

Paper I: How We Count Matters

Population measurement for AI/AN people involves at least three overlapping systems — Tribal enrollment, Census self-identification, and IHS registration — none of which is a subset of the others. The total enrolled Tribal citizen population (2,652,345 across 573 federally recognized Tribes as of 2021) is the most legally grounded denominator for trust responsibility analysis. ACS self-identification yields a broader but methodologically distinct count. The choice of denominator is not neutral: it directly affects estimates of the funding gap, Medicaid enrollment rates, and coverage disparities.

Paper III: The Effective FMAP Subsidy

Medicaid's 100% Federal Medical Assistance Percentage for IHS and Tribal facilities functions as a structural subsidy to state Medicaid programs — not merely a financing mechanism for Indian health. When AI/AN Medicaid enrollees receive care at I/T/U facilities instead of state-reimbursed facilities, states pay nothing. The estimated annual state savings range from \$1.3 to \$2.3 billion nationally, using the 941,168 IHS-access Medicaid enrollees from the CMS–IHS Data Match as the population anchor. This subsidy is invisible in state Medicaid budget documents and absent from most federal Indian health policy analysis.

Papers IV-A through IV-D: IHS Access Trends

The share of AI/AN people reporting IHS access declined across most IHS Areas between 2010 and 2019, with partial recovery in some Areas by 2024. The ACA's Medicaid expansion

increased coverage substantially without proportionally increasing IHS access — suggesting that expanded eligibility reached a population that was already receiving care through other channels, or that IHS capacity constraints prevented absorption of newly insured patients. Private insurance coverage among IHS users increased, but remains a secondary rather than primary financing source.

Paper V: The Full-Funding Requirement

The IHS is legally obligated to provide health care to eligible AI/AN people but is chronically funded at levels far below what parity with the U.S. general population would require. The obligation-based framework developed in this paper estimates the full-funding requirement at approximately \$37–38 billion annually, against current IHS appropriations of roughly \$7.5–8 billion — a gap of \$17.8–\$18.0 billion per year. This estimate is anchored to enrolled Tribal citizens (Population A, IHS-access) and treats Medicaid, Medicare, and VA reimbursements as credits against the obligation. It is almost certainly a floor relative to actual need, and it is also a different kind of estimate than the NTBFWG’s \$73 billion system-completion figure — the two answer different questions, use different population denominators, and treat Medicaid differently; they are not directly comparable. See Section IV below.

Paper II: A History of CMS–IHS Tribal Data Improvement

The administrative data infrastructure that makes the preceding analyses possible was built incrementally over three decades through the CMS Tribal Technical Advisory Group (TTAG) Data Committee, the NIHB Tribal Data Project, and the landmark 2023 CMS–IHS Data Match. The Data Match — linking 941,168 IHS-access Medicaid enrollees to \$6.4–6.6 billion in Medicaid expenditures and a composite CMS investment of \$10.86 billion — is the most authoritative cross-agency dataset in Indian health financing. Its governance architecture (the DUA, the Tribal Advisory Committee, the VRDC access protocol) is as significant as its findings.

Key Analytical Anchors

941,168 AI/AN Medicaid enrollees with IHS access (CMS–IHS Data Match, 2023)

\$6.4–6.6B Annual Medicaid expenditures for IHS-access enrollees

\$10.86B Total composite CMS investment (Medicaid + Medicare + other; Medicare component incorporates ACS-based estimates)

2,652,345 Enrolled Tribal citizens across 573 federally recognized Tribes (2021)

\$37–38B Estimated full-funding requirement (obligation-based framework)

\$17.8–18.0B Estimated annual funding gap (a floor, not a ceiling)

\$1.3–2.3B Estimated annual state Medicaid savings from 100% FMAP

27% Higher HHS-HCC risk score for AI/AN Medicaid enrollees vs. comparison population (Mathematica/NIHB interim, 2025)

Note: The NTBFWG system-completion model estimates full funding at approximately \$73 billion annually (FY2027). That figure and the \$37–38B obligation-based estimate are not directly comparable: they use different population denominators, treat Medicaid differently (supplemental vs. integral federal investment), and answer different policy questions. See Section IV below.

III. What the Series Does Not Resolve

The series is honest about its limits. The following questions were identified but could not be resolved with currently available data.

The dual-eligible reconciliation. The CMS–IHS Data Match identifies 102,865 dual-eligible (Medicare and Medicaid) AI/AN enrollees in the IHS-access population. The ACS five-year estimates suggest a somewhat lower dual-eligible count among the broader AI/AN Medicaid population. The sources use different population definitions and different measurement approaches. A definitive reconciliation requires a five-way T-MSIS cross-tabulation that has not yet been completed.

The non-enrolled descendant population. IHS provides direct services to many individuals who are descendants of enrolled Tribal citizens but are not themselves enrolled. This population appears in IHS user registries but not in Tribal enrollment counts. Its size is unknown and its inclusion or exclusion substantially affects the trust responsibility denominator.

Tribal own-source health expenditures. Tribes spend substantial own-source revenues on health programs — in some cases more than they receive from IHS. These expenditures are real and economically significant but are not captured in any federal data system. They are structurally invisible, which means the true federal contribution to Indian health financing is smaller than it appears when measured against total health expenditures.

The private insurance intersection. Papers IV-A through IV-D document rising private insurance coverage among AI/AN populations. The interaction between private insurance, Medicaid, IHS direct care, and PRC (Purchased/Referred Care) at the individual level cannot be resolved without a five-way ACS PUMS cross-tabulation (RACAIAN × HINS1–7 × IHS access × income × geography) that is computationally demanding and has not been produced for this series.

State-level CHSDA variation. The Contract Health Service Delivery Area (CHSDA) designation determines PRC eligibility for off-reservation AI/AN residents. CHSDA boundaries vary enormously by state, and the effect of this variation on PRC demand measurement is substantial but incompletely documented in the published literature.

IV. Priority Research Agenda

The following research questions are organized by feasibility — from analyses that could be conducted with existing data and current access protocols, through questions that require new data collection, to longer-term questions that require either policy change or infrastructure development.

Near-Term: Existing Data, Existing Access

T-MSIS five-way cross-tabulation. A study using T-MSIS data to cross-tabulate AI/AN Medicaid enrollees by dual-eligible status, IHS access, private insurance coverage, income band, and state would resolve the dual-eligible reconciliation, clarify the private insurance

intersection, and produce the most complete population picture available from administrative data. This analysis could be completed within the VRDC access framework.

CHSDA county-level mapping. A systematic analysis of CHSDA boundaries across all IHS Areas, linked to county-level AI/AN population counts, would quantify the gap between the PRC-eligible population and the IHS direct-service-eligible population. This analysis requires GIS capacity and IHS enrollment data but no new data collection.

Facility-level referral data disaggregated by enrollment status. IHS collects PRC referral request data but these data are not publicly available in disaggregated form. A request to IHS for facility-level PRC referral counts disaggregated by enrollment status, CHSDA status, and referral outcome (funded vs. deferred) would substantially advance understanding of the PRC substitution mechanism.

Medium-Term: New Data Collection Required

Tribal employer health insurance expenditure survey. Tribes that self-insure or purchase group health coverage for employees and their dependents are effectively funding a portion of AI/AN health care from own-source revenues. No systematic national survey of Tribal employer health expenditures exists. A survey conducted through NIHB or the National Congress of American Indians would produce the first national estimate of the own-source phenomenon and establish the true federal share of total Indian health financing.

Non-enrolled descendant population estimation. Using IHS user registration data (which records genealogical eligibility separately from Tribal enrollment status), it is possible to estimate the size of the non-enrolled descendant population receiving direct IHS services. This analysis requires IHS cooperation and data access but not new external data collection. It would substantially refine the trust responsibility denominator used in Paper V.

Longer-Term: Policy or Infrastructure Change Required

Full Mathematica/NIHB mandatory funding estimate. The Mathematica/NIHB full-funding study, funded by the Robert Wood Johnson Foundation and presented in interim form at the 2025 Tribal Health Data Symposium, uses HHS-HCC risk scores to estimate what actuarially fair, mandatory-funded AI/AN health coverage would cost. The interim Medicaid-only findings (27% higher risk score, suggesting a substantially higher Medicaid-component cost — an illustrative extrapolation from the risk score, not a study finding) must be extended to include Medicare and IHS components before a final estimate is available. When complete, this study will be the most rigorous external benchmark for the obligation-based framework in Paper V.

CHSDA reform analysis. The CHSDA system was designed in a different era of AI/AN residential geography. A substantial share of AI/AN Medicaid enrollees live outside CHSDA boundaries and are therefore ineligible for PRC funding even when IHS is their primary care source. A policy analysis of standardized national CHSDA definitions—what expansion scenarios would cost, how many currently ineligible enrollees would gain access, and what the state savings implications would be—would directly inform the 100% FMAP subsidy

analysis in Paper III. No change should be made without Tribal input since the health system has utilize the current process to establish delivery areas for many years.

State typology–informed prioritization framework. The three-state typology developed in the series (reservation-dominant, mixed, urban-dominant) predicts meaningfully different relationships between IHS appropriations, Medicaid enrollment, and health access outcomes. A prioritization model built on this typology—asking where incremental IHS funding would produce the greatest health gain per dollar across the 12 IHS Areas—would make the funding gap analysis actionable for appropriations advocacy in a way that aggregate national figures cannot. Any such consideration would include input from Tribes.

V. Conclusion

The Indian Health Financing Series makes one central argument: the funding gap in Indian health is not primarily a story of insufficient appropriations. It is a story of structural architecture — of how eligibility definitions, data systems, financing mechanisms, and governance arrangements interact to produce the access outcomes we observe. Fixing the funding gap requires understanding that architecture.

The five papers establish that the population is mismeasured (Paper I), that the existing financing system contains an invisible structural subsidy that states have not claimed credit for creating (Paper III), that expanded coverage has not proportionally expanded access (Papers IV-A through IV-D), that the full-funding obligation is substantially larger than the IHS appropriations debate usually acknowledges (Paper V), that the administrative data to make this argument more precisely and credibly than at any prior point now exists — and is the product of decades of sustained Tribal advocacy (Paper II) — and that enrolled Tribal citizens outside IHS service boundaries face a structurally distinct and underfunded financing environment that the trust responsibility equally requires addressing (Papers VI and VII).

The \$17.8–\$18.0 billion annual shortfall estimated in Paper V is almost certainly a floor rather than a ceiling. The PRC understatement, the non-enrolled descendant population, and the Tribal own-source phenomenon all push the true gap higher. The research agenda outlined in this coda does not promise that answering these remaining questions will make the gap easier to close. But it will make the gap harder to mischaracterize — and that is where every serious policy reform has to begin.

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