

INDIAN HEALTH FINANCING SERIES *I. Population
Measurement and Tribal Identity*

How We Count Matters:

*Tribal Enrollment, Census Identity, and the Mismeasurement of American Indian
Populations*

Edward J. Fox, PhD

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

Abstract

Federal and state policies affecting American Indian and Alaska Native (AI/AN) populations depend on population estimates that often conflate tribal citizenship with Census self-identification—two measures that capture fundamentally different things. Using the 2021 U.S. Department of the Treasury Tribal Enrollment Data Call and the 2019 American Community Survey estimates of AI/AN individuals living on tribal homelands, this analysis shows that both enrollment and homeland residence are highly concentrated: seven tribes account for 47.0 percent of all enrolled citizens across 573 federally recognized tribes, and just three homelands account for more than 40 percent of the approximately one million AI/AN individuals living on tribal lands nationally. A fourth, often overlooked population—the tribal community—extends beyond both enrollment and homeland residence. Aligning population measures with program purpose is essential to avoid systematic bias in AI/AN policy.

Introduction

Federal policy for American Indian and Alaska Native (AI/AN) populations rests on a question that is rarely examined directly: who counts as the population being served? The answer varies widely depending on the measure used. The U.S. Census reports approximately 9.7 million individuals identifying as AI/AN. Federal agencies and tribal governments operating under trust responsibility rely on a much smaller figure—approximately 2.65 million enrolled citizens of federally recognized tribes, based on the 2021 Tribal Enrollment Data Call. A third measure, the 2019 American Community Survey, estimates approximately one million AI/AN individuals residing on tribal homelands. A fourth concept—the tribal community—encompasses the full population a tribe intends to serve.

These figures measure fundamentally different things. Census data reflects self-identified racial or ethnic identity; tribal enrollment defines legal citizenship in sovereign nations; ACS tribal homeland data capture physical presence within tribal geographic areas; and tribal community reflects the scope of a tribe's intended service population. Conflating them introduces systematic bias into resource allocation, needs assessment, and disparity analysis.

Data and Approach

This analysis draws on two primary sources. The first is the April 2021 Tribal Enrollment Data Call, in which 573 federally recognized tribes submitted certified counts of enrolled citizens. The second is the 2019 American Community Survey five-year estimates, which report AI/AN individuals residing within 245 named tribal homelands. The 2019 ACS five-year estimates are used rather than more recent data because the 2020 Census question redesign—including expanded write-in coding and added example tribal names—nearly doubled the

reported AI/AN population through methodological changes rather than actual population growth. The 2019 data provide a more stable baseline.

Findings

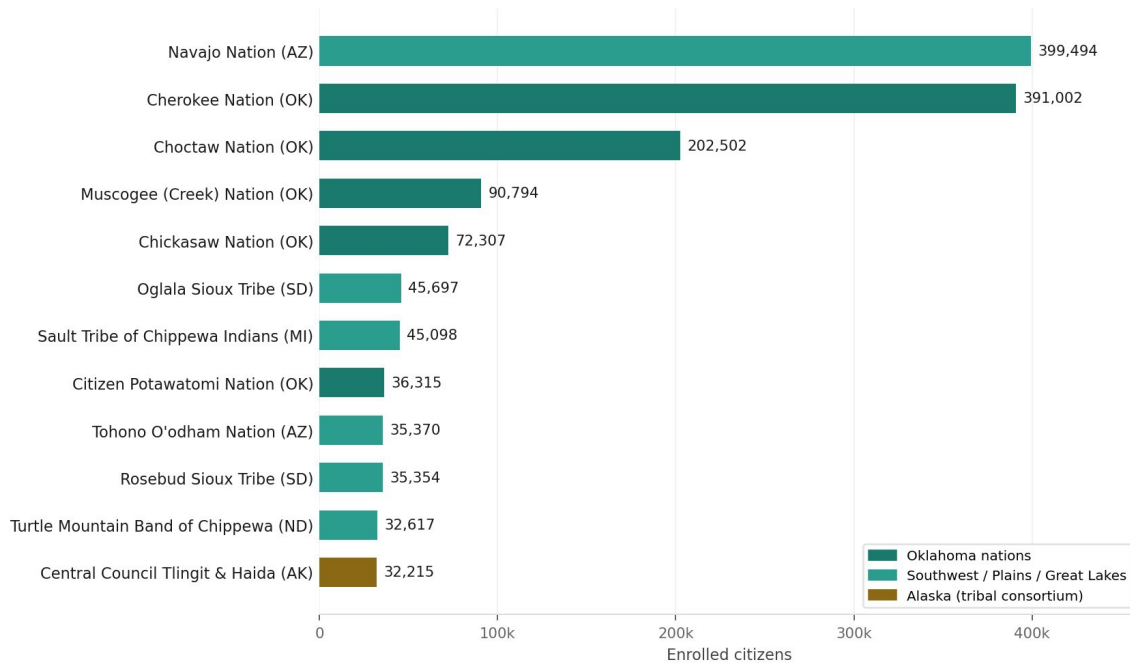
Enrollment Is Highly Concentrated

Tribal citizenship is far more concentrated than commonly recognized. Seven tribes—just over 1 percent of federally recognized nations—account for 47.0 percent of all enrolled citizens. At the other end of the distribution, 494 tribes (86 percent) each have fewer than 5,000 citizens and collectively represent about one-fifth of the total.

Exhibit 1. Tribal Enrollment by Size Category, 2021

Enrollment Category	# Tribes	Enrolled Citizens	Percent of Total
0–4,999	494	519,840	19.6%
5,000–15,000	51	422,701	15.9%
15,001–40,000	21	462,909	17.5%
>40,000	7	1,246,895	47.0%
Total	573	2,652,345	100%

Exhibit 1a. Twelve Largest Tribes by Enrolled Citizens, 2021



Source: Henson, Jorgensen, Kalt & Leonaitis, Harvard Kennedy School Ash Center, Policy Brief No. 7 (Nov. 2021), Table 1a. Figures back-calculated from Treasury SLFRF disbursements using self-certified tribal enrollment submitted April 2021. Total enrolled citizens implied across all 578 funded entities: 2,652,345. Central Council Tlingit & Haida is a tribal consortium.

Source: Henson, Jorgensen, Kalt & Leonaitis, Harvard Kennedy School Ash Center, Policy Brief No. 7 (Nov. 2021), Table 1a. Figures back-calculated from Treasury SLFRF disbursements using self-certified tribal enrollment submitted April 2021. Total implied enrollment across 578 funded entities: 2,652,345.

Homeland Residence Is Equally Concentrated

Of the approximately 1,008,759 AI/AN individuals residing on tribal homelands nationally, the Navajo Nation alone accounts for 168,139—but that figure represents only 42.1 percent of the Nation's 399,494 enrolled citizens. The Cherokee OTSA (132,262) and Creek OTSA (108,921) add another 24 percent of the national total. Nearly half of all tribal homelands—111 of 245—have fewer than 500 AI/AN residents. Nationally, homeland residents represent only 38 percent of total enrolled citizens—meaning nearly two in three enrolled tribal citizens do not live on a tribal homeland.

Exhibit 3. AI/AN Population on Tribal Homelands and Enrolled Citizens by State and Area

State / Area	Largest Tribal Homeland(s)	AI/AN on Homelands (ACS 2019)	Enrolled Citizens (2021)	% on Homeland
OK	Cherokee OTSA (132,262); Creek OTSA (108,921)	437,688	983,784	44.5%
Navajo Nation (AZ–NM–UT)	Navajo Nation Reservation and Off-Reservation Trust	168,139	399,494	42.1%

	Land			
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AZ (other)	Fort Apache (15,009); San Carlos (10,522); Gila River (9,939)	73,464	—	—
SD	Rosebud (10,290); Cheyenne River (6,744)	35,771	136,023	26.3%
WA	Yakama (7,627); Colville (4,267)	31,996	70,886	45.1%
MN	Red Lake (5,641); White Earth (5,277)	22,231	59,336	37.5%
Total	245 tribal homelands	1,008,759	2,652,345	38.0%

Sources: U.S. Census Bureau, 2019 ACS Five-Year Estimates; Henson et al. (2021), Harvard Kennedy School Ash Center, Policy Brief No. 7. Navajo Nation listed separately as a three-state geographic unit (AZ–NM–UT). Oklahoma figures reflect tribal statistical areas (OTSAs).

Enrollment and Homeland Residence Diverge Systematically

Oklahoma illustrates the most extreme divergence: 983,784 enrolled citizens but only 437,688 AI/AN individuals living on Oklahoma tribal homelands—a 44.5 percent ratio. The Navajo Nation shows a similar ratio at 42.1 percent despite having a large contiguous land base; many enrolled Navajo citizens live in border towns and urban areas. California shows the widest gap in absolute terms: 80,508 enrolled citizens but only 19,464 homeland residents, shaped by the fragmented rancheria system and high urban dispersion.

Tribal Citizenship, Homeland Residence, and Tribal Community

IHS Eligibility: Who Qualifies for IHS-Funded Health Care Services

Federal regulation (25 C.F.R. § 136.12; Indian Health Manual, Part 2, Chapter 1) provides that IHS-funded health care services are available to any individual who is a descendant of an enrolled member of a federally recognized tribe and who is regarded as a member of the Indian community served by the local IHS program.

Eligibility is therefore broader than tribal enrollment: an individual does not need to be personally enrolled to qualify, only to be a descendant of an enrolled member of a federally recognized tribe.

Practice note: At many tribal facilities it can appear that only enrolled members receive services. This reflects administrative convenience and local intake procedures, not the legal eligibility standard. Descendants who are not personally enrolled retain their federal entitlement to IHS-funded care and cannot be excluded on the basis of non-enrollment alone.

Enrollment and ACS homeland data together still do not capture the full population that tribal governments must plan to serve. Under the Indian Health Manual, Part 2, Chapter 1, IHS

eligibility reaches beyond enrolled tribal members to individuals of AI/AN descent who belong to the Indian community served by the local IHS program. This includes descendants of tribal members—all of whom are eligible for IHS-funded services regardless of enrollment status. Beyond IHS-eligible descendants, tribal communities routinely include non-Indian family members of eligible individuals.

Planning Note: Non-Indians in the Tribal Service Population

Tribal health planners must sometimes account for non-Indian community members when designing services and facilities—yet federal funding streams are generally restricted to IHS- or BIA-eligible individuals. This creates a practical planning tension: the population a tribe serves on the ground may be larger than the population for which federal reimbursement is available.

Tribes address this in several ways: using tribally generated revenue for broader community services, applying state Medicaid funds, or structuring programs so that non-Indian services are funded through non-federal sources. Accurate planning requires distinguishing among these populations and carefully matching each to appropriate funding sources.

Exhibit 2. Conceptual Relationship Among Tribal Population Measures

Population Concept	Definition and Policy Role	Appropriate Use
Tribal citizens (enrollment)	Legal membership in a federally recognized tribe. Used for governance, sovereignty-based funding formulas, and BIA eligibility.	Governance allocations
ACS tribal homeland residents	AI/AN individuals physically residing within tribal geographic areas. Approximates the IHS direct-service population.	Physical infrastructure need
Tribal community	The full population a tribe intends to serve: enrolled members, IHS-eligible descendants, non-Indian family members of eligibles, and others. Extends beyond enrollment and homeland residence.	Service planning; facility sizing
Census AI/AN population	Broad, identity-based population. Useful for disparities analysis but overstates the IHS-eligible population, especially for large tribes.	Disparities analysis (pre-2020 methodology)

Why This Matters for Health Policy

Medicaid Financing

Medicaid includes unique provisions for AI/AN populations, most notably 100 percent federal matching for services delivered through tribal and IHS facilities. The approximately one million AI/AN individuals living on tribal homelands represent the core IHS-access population for most financing purposes, but enrollment-based denominators—2.6 times larger—will systematically overstate per-capita capacity in large-tribe states.

Indian Health Service Eligibility and Service Planning

IHS eligibility under the Indian Health Manual extends beyond enrolled tribal members to descendants who belong to the Indian community served by the local program. The population that IHS-funded facilities must be designed and staffed to serve is larger than enrolled citizen counts suggest—and the gap is widest in communities with large descendant populations or high rates of intermarriage.

Note on IHS service population figure: The IHS service population of approximately 2.6 million used in this series reflects estimates from earlier IHS Congressional Budget Justifications and the NIHB FY 2022 Budget Formulation brief. The FY 2027 IHS Congressional Budget Justification (Indian Health Service, 2026) reports a higher figure of approximately 2.8 million AI/ANs served through the IHS network; this increase likely reflects updated user population counts or revised reporting methodology. Per-capita calculations throughout this series are not revised to reflect the FY 2027 figure pending further methodological review.

Federal Funding Formulas

The Treasury's use of enrolled citizen counts for ARPA allocations anchors funding to sovereignty, but the ACS homeland data reveal that the relationship between enrollment and the physical service population varies enormously—from 26 percent in South Dakota to 44 percent in Oklahoma. Funding formulas that do not account for this variation could systematically misallocate resources.

Policy Implications

- 1.** Match the measure to the purpose. Enrollment counts are appropriate for governance-related allocations. ACS homeland population estimates are appropriate for evaluating physical infrastructure need. Tribal community measures are most appropriate for service planning and facility sizing. Census-based measures remain useful for disparities analysis using pre-2020 methodology.
- 2.** Recognize descendants and non-Indian household members in service planning. Planning that ignores this distinction will underestimate demand and create structural funding gaps.
- 3.** Account for distributional concentration. Oklahoma and the Navajo Nation together account for more than 60 percent of the national homeland population. Funding formulas relying on national averages will systematically underserve the many small tribes with thin residential populations and large off-homeland descendant communities.
- 4.** Avoid uniform metrics. One-size-fits-all population measures introduce systematic bias across tribes of different sizes, geographic settings, and demographic structures.

5. Avoid the easy solution of allocating new resources to the ‘way we distributed it last time,’ since such distribution are seldom ideal and often need adjustment over time.

Conclusion

Population measurement in Indian Country is not a neutral technical exercise—it is a policy choice with real consequences. Nationally, only 38 percent of enrolled tribal citizens reside on a tribal homeland. Neither measure alone captures the tribal community—the population that tribal health planners must actually serve. Distinguishing among tribal citizenship, homeland residence, tribal community, and Census identity is a prerequisite for effective and equitable policy in Indian Country.

This analysis establishes that population measurement in Indian Country is not a neutral exercise but a policy choice with direct implications for financing analysis. The next question is whether the available data systems can support these distinctions in practice. Historically, they have not. Federal administrative data have struggled to accurately identify AI/AN populations, limiting the ability to translate conceptual clarity into empirical analysis. The following paper examines how those limitations emerged—and how they have been partially resolved.

Methodological Note: The 2020 Census Question Change and Its Implications for IHS Access Data

A significant methodological discontinuity affects all post-2020 ACS-based estimates of the AIAN population and requires explicit treatment in any analysis drawing on these data. The 2020 Census introduced revised race question design and expanded write-in coding that substantially increased the number of individuals recorded as AIAN alone or in combination. The ACS PUMS AIAN denominator (RACAIAN) grew from approximately 5.2 million in the 2010–2014 period to nearly 8.0 million in the 2020–2024 period — a 53 percent increase of roughly 2.8 million persons. This growth reflects primarily expanded racial self-identification, not a change in the legally or administratively defined Indian health population.

The critical diagnostic is what happened to the IHS-access count (ACS variable HINS7) over the same period. Despite the 2.8 million increase in the AIAN denominator, the absolute number of AIAN individuals reporting IHS access was essentially unchanged: 1,294,785 in 2010–2014 versus 1,294,264 in 2020–2024, a difference of just 521 persons. The IHS-access share of the

AIAN population therefore fell from 24.9 percent to 16.2 percent — but this apparent decline is entirely a denominator artifact, not evidence of reduced IHS access.

Why IHS Access Did Not Share in the Population Gain

The explanation is structural. IHS access, as measured by HINS7, captures whether a respondent reports receiving care through the Indian Health Service. That relationship requires physical proximity to an IHS or Tribal facility, prior registration with the IHS system, and actual utilization. The 2020 Census question change identified millions of additional individuals who self-identify as AIAN — but the overwhelming majority of those newly counted individuals are urban or suburban residents far from any IHS facility, individuals with distant or partial Native ancestry who have no prior relationship with the IHS system, or members of the growing AIAN-in-combination population whose primary care relationship has always been outside the IHS network. None of these characteristics change with a question wording revision. IHS registration is not automatic upon racial self-identification.

The 2020 Census question change is best understood as revealing a large population with AIAN ancestry that had always existed but was previously undercounted in survey data. It did not create new IHS-eligible individuals; it identified individuals whose geographic, economic, and institutional circumstances place them outside the IHS-access population regardless of how they answer a race question.

What IHS Access Stability Reveals About the Non-IHS Population Gain

Because the IHS-access count was stable and the entire 2.8 million population increase went into the non-IHS AIAN category, the non-IHS population grew from approximately 3.9 million to approximately 6.7 million. The non-IHS uninsured count grew modestly (from 717,040 to 794,692), while the non-IHS insured count grew by nearly 2.7 million. This pattern is analytically informative: the newly identified AIAN population is, on net, substantially more insured than the historic IHS-access population, with a non-IHS insurance rate of 88.1 percent in 2020–2024 compared to 76.7 percent for the IHS-access group.

This means that apparent increases in the non-IHS uninsured AIAN population after 2020 should not be interpreted as policy failures or deteriorating coverage without first accounting for the denominator change. The growth of the non-IHS AIAN population is primarily compositional — an influx of more insured, urban, multiracial individuals — not evidence of expanding uninsurance among the historically served Indian health population.

Three Analytical Consequences for the IHS Series

- 1. The IHS-access share denominator is broken as a trend measure after 2020.** A 16.2 percent IHS-access rate in 2024 is not comparable to 24.9 percent in 2014 — they use the same numerator against radically different denominators. Trend lines crossing the 2019–2022 boundary must be labeled as discontinuous.
- 2. The non-IHS AIAN population is now a heterogeneous category.** It contains both the long-standing off-reservation population with genuine IHS eligibility and a new, larger group with distant or partial ancestry, urban residence, and no IHS relationship. Using the full non-IHS AIAN count as a planning population for Indian health purposes would substantially overstate the relevant universe.
- 3. The stable IHS-access count (~1.3 million) is the most reliable post-2020 AIAN health policy denominator.** Because HINS7 is anchored to actual system contact rather than survey self-identification, it is not inflated by the question change. This is convergent with the CMS–IHS Data Match figure of 941,168 confirmed IHS-access Medicaid enrollees — two independent measures pointing to the same order of magnitude for the actively served IHS population. Papers IV-A, IV-F, and V of this series use this denominator accordingly.

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