

Health and American Indians and Alaska Natives Who Report Access to IHS in the American Community Survey

A source-verified descriptive essay based exclusively on edfoxphd.com

Edward J. Fox, PhD · October 2026

Scope note. This essay describes ACS-reported IHS access and related coverage measures. It distinguishes self-reported access from insurance coverage, administrative registration, actual service use, Tribal enrollment, and clinical outcomes. It uses only material published on edfoxphd.com and does not extrapolate beyond the source material.

Abstract

This essay describes what the research published at edfoxphd.com establishes about American Indian and Alaska Native (AI/AN) people who report access to Indian Health Service (IHS) services in the American Community Survey (ACS). It focuses on the website’s population-measurement and coverage papers, especially Paper IV-F, “AI/AN Health Coverage Trends, 2010–2024,” revised October 12, 2026; the earlier working paper “Change in the Share of AI/ANs Reporting IHS Access, 2010–2024”; and the site’s Data Tables and Publications pages. The essay distinguishes self-reported ACS access from insurance coverage, administrative registration, actual service use, Tribal enrollment, and clinical outcomes. It uses no external sources and makes no claims beyond those presented in the website’s materials. The site’s own documents are not fully consistent in every estimate and description; where that occurs, the essay identifies the difference rather than silently reconciling it.

Introduction: a specific population and a specific measure

The question addressed here is not the health status of every person who identifies as American Indian or Alaska Native, nor the number of people enrolled in a Tribe, nor the number of patients recorded in an IHS administrative system. It is narrower: what can be described about AI/AN people who report IHS coverage or access in the ACS, and how does the website’s research relate that measure to health insurance coverage?

That distinction sets the limits of the essay. The ACS measure is a respondent’s report. It is not an encounter record, a clinical record, or an administrative list of registered patients. It can be used to describe reported access and its overlap with reported insurance categories. It cannot, by itself, show that a respondent visited a clinic, received a specific service, obtained a referral, or experienced a particular health outcome.

The website’s Indian Health Financing Series places population measurement at the beginning of its financing analysis. Paper I, “How We Count Matters,” argues that Census identity, Tribal enrollment, residence, and IHS access represent different populations and should not be treated as interchangeable. The paper identifies the IHS-access population—described on the site as approximately 1.3 million people reporting access to IHS-funded services—as an operationally useful denominator for the series’ financing questions. This is the author’s stated analytical framework, not a claim that the ACS response is a complete count of everyone eligible for or served by Indian Health Programs. [1]

Throughout this essay, “AI/AN” refers to the population definition used in the relevant website analysis. Paper IV-F says its ACS 5-year PUMS analysis uses the AI/AN alone-or-in-combination population. That definition is retained; the essay does not substitute a single-race-only population.

1. What the ACS HINS7 response measures

The website's IHS-access trend paper identifies HINS7 as the ACS item asking whether a respondent is covered by the Indian Health Service. It states that the question was introduced in 2008. The paper distinguishes HINS7 from the Census Bureau's standard health-insurance coverage recode, HICOV. In the site's explanation, IHS coverage is not counted as health insurance under the Census definition; a respondent reporting only HINS7 is classified as uninsured in the conventional insurance measure. [2, pp. 2–3]

This is a definition of the survey measure, not a judgment about the importance of IHS access. A respondent may report IHS coverage and also report Medicaid, Medicare, employer coverage, or another insurance category. A respondent reporting IHS without another form of insurance can be classified as uninsured in the standard ACS health-insurance measure while still reporting IHS access. The two measures answer different questions.

The site's materials also caution that self-reported IHS coverage is not a count of all IHS users. The working paper summarizes a linked-record study that found a false-negative rate in the 2014 ACS, and notes that some active users did not report IHS access on the survey. The paper also discusses the way PUMS processing affects the HINS7 numerator. These are stated limitations of the measure. They do not authorize this essay to apply an adjustment to any estimate unless the particular source does so explicitly. [2, p. 2]

Consequently, the most precise description is “people reporting IHS access in the ACS.” The terms “IHS patients,” “active users,” and “people who received care” imply different statuses or events and should not be used as synonyms for the HINS7 population.

2. Population denominators: Census identity, enrollment, and access

Paper I frames the denominator question as a foundational problem for Indian health financing. Census identity is a self-identification measure. Tribal enrollment is a citizenship or membership measure governed by the relevant Tribe. Administrative IHS user counts are generated through program records. ACS HINS7 reports whether survey respondents say they have IHS coverage. These measures can overlap, but they are not interchangeable.

The practical implication is that every population figure must be labeled with its source and definition. A Census estimate of the AI/AN population cannot automatically be described as the number reporting IHS access. A Tribal enrollment count cannot automatically be treated as the IHS-access population. An administrative count of registered patients does not reveal how every person would answer the ACS question. Likewise, the ACS count does not establish the number of registered patients.

The website's research uses the IHS-access population as one denominator for its analysis of health coverage and financing. It also separately discusses a broader service population for full-funding estimates. The site's research map distinguishes Paper I's denominator work, the Paper IV data-match and coverage analyses, and Paper V's full-funding analysis. The distinction matters: an essay about ACS-reported access should not silently import the service-population denominator from a separate financing model. [1; 3]

These definitions also shape what a percentage means. A share of the total AI/AN population reporting IHS access uses the full AI/AN denominator. An insurance rate among people reporting IHS access uses only that subgroup as its denominator. A percentage calculated with one denominator cannot be reported as though it used the other.

3. The revised 2010–2024 analysis and the 2020 race-question change

The website's revised Paper IV-F compares three non-overlapping ACS five-year PUMS periods: 2010–2014, 2015–2019, and 2020–2024. It analyzes 33 states selected because each had at least 1,500 AI/AN respondents reporting IHS access in 2020–2024. This scope must be retained when describing the paper's totals; the reported figures are for the paper's 33-state analytic group, not automatically for all states or the entire United States. [4, pp. 1–3]

For those 33 states, Paper IV-F reports that the AI/AN population rose from 4,364,640 in 2010–2014 to 6,412,604 in 2020–2024, an increase of 46.9 percent. Over the same periods, the number reporting IHS access was 1,284,416 and 1,284,134, respectively—effectively unchanged in the paper’s presentation. The share reporting access fell from 29.4 percent to 20.0 percent. These are the central descriptive results of the revised paper. [4, pp. 1–2]

Paper IV-F attributes the large change in the overall AI/AN denominator principally to the 2020 Census race-question redesign and related processing changes. The paper describes changes to printed examples, write-in processing, and the tabulation of people identifying as AI/AN in combination with another race. It argues that these changes affected the number of people captured in the broad AI/AN count, particularly in states where reported IHS access is less common. [4, pp. 4–6]

The paper separates states into two analytical groups using the 2020–2024 IHS-access rate: eight high-IHS states, where at least 25 percent of the AI/AN population reports IHS access, and 25 low-IHS states, where fewer than 25 percent do. In the high-IHS group, the AI/AN population grew 15.1 percent between the first and last periods, while the IHS-access count increased 4.3 percent. In the low-IHS group, the AI/AN population grew 62.8 percent while the reported IHS-access count declined 10.2 percent. The paper presents this contrast as evidence that the overall change is not uniform across the two groups. [4, pp. 1–3]

These figures should be reported as the paper’s analysis and interpretation, rather than converted into a stronger causal claim. The document argues that the denominator change is a race-question artifact; the essay reports that conclusion as the author’s finding. It does not independently establish a causal mechanism beyond the material in the source.

4. Why the denominator affects the reported access rate

A rate is a ratio: the number reporting IHS access divided by the total AI/AN population defined for the analysis. If the denominator rises sharply while the numerator stays about the same, the percentage falls even if the count reporting access has not fallen. Paper IV-F illustrates precisely this pattern in its 33-state group: the reported IHS-access count was essentially flat across the three periods, while the total AI/AN population increased substantially. [4, pp. 1–2]

The paper reports that the combined IHS-access share fell by 9.4 percentage points, from 29.4 percent in 2010–2014 to 20.0 percent in 2020–2024. Its interpretation is that the expanded denominator drives the apparent rate decline. This is a claim about the interpretation of the paper’s ACS estimates, not direct evidence that every individual’s access remained unchanged or that health-service capacity was unchanged in every state. [4, pp. 1–2]

The distinction between a population count and a population share should therefore be maintained in both prose and graphics. “The share reporting IHS access declined” is a description of the calculated rate. “Fewer people had access” would be a different claim and would not follow from the percentage alone. For the 33-state total in Paper IV-F, the count reporting access did not decline across the endpoints; it remained effectively flat.

The source’s state-group analysis also warns against assuming that one national pattern describes every location. In the high-IHS group, the count reporting access rose modestly between the endpoint periods; in the low-IHS group, it fell. Those group-level findings are reported as published. They should not be generalized to all individual states without consulting the state-level table.

5. Reported health insurance coverage within the IHS-access population

The website’s Access & Coverage sub-series examines insurance status among people reporting IHS access, rather than treating IHS access itself as an insurance category. Paper IV-A’s abstract says that insurance coverage among the IHS-access population improved substantially over the period it examines. The revised Paper IV-F provides additional coverage trends for its 33-state analysis. [1; 4]

In the high-IHS state group, Paper IV-F reports that the population-weighted Medicaid rate rose from 31.6 percent in 2010–2014 to 36.8 percent in 2020–2024. The population-weighted uninsured rate fell from 30.5 percent to 18.9 percent. In the low-IHS group, the Medicaid rate was 28.6 percent, 31.9 percent, and 29.8 percent across the three periods, while the uninsured rate declined from 20.1 percent to 12.4 percent. These rates are group-level measures as presented in the paper, not individual-level longitudinal histories. [4, pp. 1–2]

For all 33 states combined, Paper IV-F reports a population-weighted Medicaid rate of 29.6 percent in 2010–2014, 33.2 percent in 2015–2019, and 31.6 percent in 2020–2024. The uninsured rate was 23.6 percent, 16.3 percent, and 14.1 percent. The paper describes the overall uninsured-rate decline as a genuine improvement that is less affected by the denominator change because it is a rate. That is the source’s interpretation and should be attributed to the paper. [4, pp. 2–3]

These coverage statistics do not establish where care was received, whether a respondent used an IHS or Tribal facility, or which payer paid for a specific service. The ACS coverage response identifies reported insurance status; it does not provide an encounter-level record. The website’s separate Paper IV-E examines the hypothesis that insurance gains may be associated with shifts between IHS and non-IHS providers, but that is a distinct analysis and should not be inferred from coverage percentages alone. [1]

6. Medicare, Medicaid, and overlapping coverage categories

The website’s papers analyze Medicare, Medicaid, and dual eligibility in relation to reported IHS access. Paper IV-C examines Medicare enrollment trends and overlap with IHS access; Paper IV-G examines mutually exclusive coverage categories among the IHS-access population; Paper IV-H addresses payment arrangements for dual-eligible patients in Tribal health systems. These papers address related questions but do not make the HINS7 measure equivalent to administrative enrollment. [1; 3]

Paper IV-G’s summary reports that the IHS-access dual-eligible population reached 61,648 in 2024 and that its dual-eligible rate rose from 3.5 percent in 2013 to 4.8 percent in 2024. It also reports that 682,652 people in the IHS-access population—52.7 percent—reported no Medicare or Medicaid coverage in the 2020–2024 period. The paper distinguishes dual coverage, Medicare-only, Medicaid-only, and IHS-only categories. These are the specific measures summarized on the site; they should not be confused with the broader count of all people reporting IHS access. [1]

Paper IV-C reports that the number of AI/AN people with Medicare grew from approximately 671,000 in 2014 to 792,000 in 2024, and that the population reporting both Medicare and IHS access grew from 140,990 to 196,529. The paper uses ACS one-year PUMS data for selected years and explicitly examines the overlap of coverage with reported IHS access. These values are not a Medicare Data Match. The website distinguishes its ACS analysis of Medicare from the CMS–IHS Data Match, which concerns Medicaid enrollment. [1]

An important rule for interpreting these categories is that coverage combinations overlap unless the source has defined mutually exclusive categories. Counts of IHS access, Medicaid, Medicare, and dual eligibility should not be added together as if each represented a separate set of people. The relevant paper or table’s definitions govern how the numbers may be compared.

Clarifying the coverage-rate denominator

The revised Paper IV-F and Paper IV-G answer different questions. Paper IV-F groups states by the percentage of their AI/AN populations reporting IHS access, then reports coverage rates for the AI/AN populations in those state groups. The rates are not restricted to people who answered yes to HINS7. The term “high-IHS state” describes a state group, not an individual respondent’s IHS status. [4, pp. 1–3]

Paper IV-G explicitly separates the IHS-access population from the population not reporting IHS access and analyzes mutually exclusive coverage categories within those groups. Its dual-eligibility and no-Medicare/no-

Medicaid figures refer to the IHS-access subgroup and must be labeled with that subgroup and the relevant ACS five-year period. The Data Tables page, meanwhile, reports overall AI/AN coverage combinations and separate income distributions by self-reported IHS coverage. These are three related but distinct analytic universes. [1; 4; 5]

For that reason, the figures should not be merged into a single time series. A statistic from Paper IV-F must retain the 33-state scope and state-group denominator; a statistic from Paper IV-G must retain the IHS-access subgroup definition; and a statistic from the Data Tables page must retain its 2024 five-year or one-year ACS universe. A numerical value without its denominator is not a complete finding.

7. Income characteristics of people reporting IHS access

The site's Data Tables page includes family income relative to the federal poverty level, by reported IHS coverage. Those tables are relevant because they describe socioeconomic characteristics of the survey population, but income categories are not themselves proof of program eligibility or enrollment. The page directs readers to the accompanying spreadsheets for details and notes that margins of error are not shown in its plain-text summaries. [5]

The published summary describes income bands relative to poverty for people reporting IHS coverage and compares those distributions with other groups. Such comparisons can describe the distribution of income in the survey estimates. They cannot determine an individual's eligibility without applying the relevant program rules and considering the person's circumstances, and they cannot show whether a particular person enrolled in Medicaid.

The essay does not reproduce a single income figure from the earlier draft unless it can be verified in the current Data Tables material and tied to a clear denominator. This is intentional: the first draft combined figures from summaries without a sufficiently documented source trail. A source-verified essay should make the reader able to trace each numerical statement to the table, time period, and population it describes.

8. Administrative records and the CMS-IHS Medicaid Data Match

The website has a separate research stream on the CMS-IHS Data Match. The Publications page describes that work as linking IHS registrant records with Medicaid enrollment data. It reports that the October 2025 CMS/IHS Data Match identified 941,168 AI/AN IHS registrants enrolled in Medicaid in 2023. That number describes an administrative match population, not the number of ACS respondents reporting IHS access. [1]

The distinction between the data sources is essential. ACS PUMS is used for survey-based estimates of reported access and coverage. The CMS-IHS Data Match links administrative IHS registrant records with Medicaid enrollment data. Administrative registration, Medicaid enrollment, and a survey response are different variables, and they can produce different counts without being direct contradictions.

The CMS-IHS Data Match is therefore not used in this essay as a substitute for ACS coverage estimates. It is included only to explain the boundary between the website's research streams. The subject here remains the ACS-reported IHS-access population.

9. Geographic variation and scope

Paper IV-F's principal analysis is restricted to 33 states meeting its stated threshold. It separates those states into high-IHS and low-IHS groups using the 2020–2024 reported access rate. This design means that the headline totals in the paper should always be accompanied by the 33-state scope when cited. They should not be described as nationwide totals unless a separate source establishes that they are national estimates. [4, pp. 1–3]

The paper’s state table shows different rates of population change across states. It reports especially large changes in several low-IHS states between 2019 and 2024 and more modest changes in the high-IHS states shown. The paper interprets that cross-state pattern as consistent with the effects of the race-question redesign. This essay reports the author’s interpretation but does not invent a state-specific cause where the paper does not provide one. [4, pp. 3–5]

Geographic comparisons also depend on sample size and the period covered. A state-level percentage should not be detached from its numerator, denominator, time period, and analytic definition. The website’s Data Tables page and Paper IV-F supply those contexts; a final publication should preserve them in its tables and notes.

10. What this evidence says about health—and what it does not

The source materials support a descriptive account of reported access and insurance coverage. They do not, on their own, establish the clinical health status of respondents, prevalence of particular conditions, quality of care, health outcomes, or the number and type of services received. Those questions require measures specifically designed to capture those phenomena.

The website’s broader Indian Health Financing Series places access and coverage within questions about financing, delivery systems, Purchased and Referred Care, facilities, and workforce. That broader framework explains why coverage is important to the financing discussion. It does not permit a direct leap from an ACS coverage response to a conclusion about the care received by a particular person.

The distinction is not merely terminological. A person can report IHS access and Medicaid coverage without the ACS response specifying which provider treated that person. A person can report IHS access without Medicare or Medicaid coverage. A person can be in an administrative registry but fail to report IHS access on a survey. The website’s different research products examine different parts of this system; each claim should remain within the evidence of the source that supports it.

11. Source consistency and limits of the current evidence

A source-verified essay must acknowledge that the website contains documents from different dates and stages of analysis. The earlier working paper titled “Change in the Share of AI/ANs Reporting IHS Access, 2010–2024” contains a preliminary table with some periods marked “PENDING” and discusses possible explanations requiring further analysis. The revised Paper IV-F, posted October 12, 2026, presents a different, completed three-period analysis for 33 states. The two documents should not be combined as though they were a single final analysis. [2, pp. 3–5; 4, pp. 1–3]

For that reason, this essay gives priority to the revised Paper IV-F for its 2010–2024 three-period trend figures and treats the earlier working paper as a record of the measurement framework and limitations. It does not repeat preliminary figures from the older paper as if they were the final results. Where the site’s Data Tables summaries use a different universe or period, the estimate must be cited to that table and not blended with the 33-state Paper IV-F figures.

The Data Tables page notes that its plain-text summaries do not display margins of error and directs readers to the accompanying spreadsheets. Accordingly, figures from that page should be verified against the spreadsheet before a final academic submission. This draft avoids claiming that its numerical summaries are exact counts of all people served by Indian Health Programs.

The 2019–2021 comparison: what changed in the count

The Data Tables page provides a separate national comparison using the 2019 and 2021 one-year ACS PUMS releases, the two standard one-year releases on either side of the 2020 race-question change. It reports

that the AI/AN count increased from 5.65 million to 8.73 million, or 55 percent, while the total U.S. population grew by about 1 percent. The page states that the entire increase in the AI/AN count occurred among people reporting no IHS coverage. The number reporting IHS coverage fell from approximately 1.51 million to 1.32 million. [5]

The same table reports that Hispanic respondents accounted for 56 percent of the increase and that most added respondents were born in the United States. It also explicitly cautions that Hispanic origin and foreign birth do not exclude people from the IHS-access population: the 2021 ACS included Hispanic AI/AN respondents and foreign-born AI/AN respondents who reported IHS coverage. These details describe the composition of the change; they should not be recast as eligibility rules or as claims about any person's entitlement to services. [5]

The 2019–2021 one-year comparison is not the same analysis as Paper IV-F's three non-overlapping five-year periods across 33 states. The datasets differ in period, scope, and comparison design. The Data Tables page also says that no standard one-year ACS was released for 2020. For that reason, the one-year national comparison is useful for describing the abrupt change in the broad AI/AN count, while Paper IV-F supplies the distinct multi-period trend analysis for its selected state group. The figures should remain in their own contexts. [4; 5]

The site's instruction to compare rates rather than raw counts across the 2020 race-question change follows from this measurement issue. If the population identified by the survey changes substantially, a raw count or share can change for reasons connected to population classification. The published data show a marked difference between the increase in the total AI/AN count and the count reporting IHS coverage. The essay reports that difference without claiming to independently determine the experience or identity of newly counted individuals.

The eight combinations of IHS, Medicaid, and Medicare

The Data Tables page's 2024 health coverage table is designed around all eight possible combinations of three reported coverage sources: IHS, Medicaid, and Medicare. This structure matters because the three indicators are not mutually exclusive. A person may report one, two, or all three sources, and each combination describes a different coverage profile. The table presents both five-year and one-year estimates and advises readers to compare those estimates by percentage rather than by raw population totals. [5]

In the 2020–2024 five-year ACS, the page reports that 31 percent of AI/AN people reported Medicaid, 13 percent reported Medicare, and 16 percent reported IHS coverage. The IHS figure corresponds to approximately 1.29 million people. The page also reports approximately 683,000 people with IHS coverage and neither Medicare nor Medicaid, approximately 496,000 with both IHS and Medicaid, and approximately 328,000 with both Medicare and Medicaid. These counts refer to different combinations and overlap where the definitions allow it; they cannot be summed as if they were disjoint groups. [5]

The one-year 2024 estimates are reported as 31 percent for Medicaid, 14 percent for Medicare, and 15 percent for IHS. The Data Tables page explains that the one-year AI/AN total is higher than the five-year total because the five-year period includes years before the 2020 race-question change. The page therefore recommends comparing percentages, not raw totals, between these releases. [5]

These statistics describe reported coverage. They do not indicate whether a particular source paid for a particular service, whether care occurred at an IHS or Tribal facility, or whether the respondent received care during the reference period. The site's wording is careful on this point: IHS coverage is self-reported, IHS alone is not counted as health insurance under the Census Bureau's standard definition, and the estimates are not a count of IHS users. Those limits should accompany any use of the coverage figures.

Income bands and the meaning of poverty thresholds

The Data Tables page divides family income into three bands that correspond to ranges often used in coverage policy: 0–138 percent of the federal poverty level, 139–400 percent, and 401 percent or above. The page presents these bands separately for AI/AN people reporting IHS coverage and those not reporting it, and it includes non-AI/AN comparisons. The bands are descriptive categories in the ACS analysis; the site explicitly states that they describe likely eligibility ranges, not enrollment. [5]

For AI/AN people reporting IHS coverage in the 2024 five-year ACS, the page reports approximately 434,000 people, or 34 percent, at or below 138 percent of poverty. Approximately 567,000, or 45 percent, were in the 139–400 percent band, and approximately 263,000, or 21 percent, were at 401 percent or above. The page reports that the share at or below 138 percent was higher among AI/AN people reporting IHS coverage than among other AI/AN people (24 percent) or non-AI/AN people (18 percent). [5]

The comparison between the 2015–2019 and 2020–2024 five-year periods shows the share of IHS-reporting AI/AN people at or below 138 percent of poverty declining from 36.9 percent to 34.3 percent. The page reports a larger decline for the AI/AN population overall, from 30.9 percent to 25.3 percent, and attributes the broader shift to the higher-income composition of people added to the AI/AN count after the 2020 race-question change. It also notes that the IHS-connected group’s shift was similar in scale to the change among non-AI/AN people, from 20.0 percent to 18.1 percent. [5]

The website warns that these are separate cross-sections, not individual-level histories. A difference between the two periods does not show that the same individuals experienced income increases or decreases. It describes how the distribution of the estimated population changed between survey periods. The same restraint applies to any discussion of Medicaid: a person’s position within an income band is not proof of program eligibility, application, or enrollment.

State-group comparisons in Paper IV-F

Paper IV-F separates the 33 states into two groups based on the share of the AI/AN population reporting IHS access in 2020–2024. Eight states are classified as high-IHS states, with at least 25 percent reporting access; 25 states are classified as low-IHS states, with a share below 25 percent. This classification is a property of the state-level population measure. It does not classify individual respondents as high- or low-access people. [4, pp. 1–3]

The paper reports that, between 2010–2014 and 2020–2024, the AI/AN population grew 15.1 percent in the high-IHS group and 62.8 percent in the low-IHS group. The count reporting IHS access increased 4.3 percent in the high-IHS group and declined 10.2 percent in the low-IHS group. The paper presents this contrast alongside the overall 33-state result: the AI/AN denominator rose sharply while the number reporting access remained essentially unchanged. [4, pp. 1–3]

The groups also differ in the coverage rates shown in Paper IV-F. As noted earlier, those Medicaid and uninsured rates apply to the AI/AN populations in the state groups, not only to the people reporting IHS access. For the combined 33-state analysis, the Medicaid rate was 29.6 percent in 2010–2014 and 31.6 percent in 2020–2024; the uninsured rate was 23.6 percent and 14.1 percent, respectively. These values describe changes in group-level estimates and should not be written as if they were individual trajectories or as if they applied only to HINS7=Yes respondents. [4, pp. 1–2]

The 33-state scope is a necessary part of each claim. Paper IV-F selected states with at least 1,500 AI/AN respondents reporting IHS access in the 2020–2024 period. The result should not be presented as a complete national state-by-state analysis. The site’s separate Data Tables page contains other estimates, including

national one-year comparisons and 39-state summaries; those results use different designs and should be cited separately.

A necessary distinction: no Medicare or Medicaid is not the same as no insurance

Paper IV-G defines four coverage categories within the IHS-access population using Medicare (HINS3), Medicaid (HINS4), and IHS access (HINS7). In that paper’s taxonomy, “IHS-only” means a respondent reports IHS access but neither Medicare nor Medicaid. It does not, by itself, rule out employer-sponsored coverage, Marketplace coverage, or another insurance source. The phrase “no Medicare or Medicaid” is therefore more exact than saying that every person in this category is uninsured under the ACS’s full health-insurance measure. [6, pp. 1–2]

This is an important distinction because the Data Tables page explains that HINS7 is not counted as health insurance in the Census Bureau’s standard insurance definition, but it also presents coverage combinations using only selected variables. A table based on three indicators cannot establish all insurance statuses unless the analysis also includes the other relevant ACS insurance variables. Accordingly, this essay describes Paper IV-G’s category as “IHS access without Medicare or Medicaid” and avoids converting that label into a broader statement about all possible coverage.

The same principle applies to the phrase “coverage gap.” A count of people reporting IHS access without Medicare or Medicaid identifies a specific group for further analysis. It does not establish, from those variables alone, whether each person has no other insurance, whether a person is eligible for Medicaid, or whether that person received care during the survey period.

How the source papers fit together

The website’s papers form a sequence, but they do not all use the same population or data design. Paper I establishes the distinction among Census identity, Tribal enrollment, residence, and IHS access. Paper IV-A addresses changes in the share reporting access and coverage over time. Paper IV-F provides the revised three-period trend analysis for a defined 33-state group. Paper IV-G analyzes coverage categories among people with and without reported IHS access. The Data Tables page provides additional 2024 one-year and five-year ACS estimates, plus income and race-question-change comparisons. Each source contributes a different view; their estimates should be connected conceptually, not merged numerically. [1; 4; 5; 6]

Paper IV-B addresses the Affordable Care Act and coverage expansion, while Paper IV-E examines a separate hypothesis about whether insurance gains were accompanied by shifts toward non-IHS providers. The Publications page summarizes these papers as finding that Medicaid expansion produced important coverage gains in some states and that patterns of potential provider “leakage” varied by state. Those papers broaden the policy discussion, but their conclusions require their own methods and measures. HINS7 alone does not establish the provider where a respondent received care. [1; 7; 8]

Paper IV-C uses ACS one-year PUMS data to describe Medicare trends and the overlap between Medicare and reported IHS access. Paper IV-G uses five-year PUMS data to analyze Medicare–Medicaid dual coverage among the IHS-access population. The 140,990-to-196,529 Medicare-and-IHS figure from Paper IV-C is not the same measure as the 44,425-to-61,648 Medicare-and-Medicaid dual-eligible count in Paper IV-G. The first concerns Medicare plus reported IHS access; the second concerns Medicare plus Medicaid within the IHS-access group. They must not be conflated. [1; 6]

Paper IV and the CMS–IHS Data Match address Medicaid enrollment using linked administrative records. The website reports 941,168 AI/AN IHS registrants enrolled in Medicaid in 2023. That administrative count

is not a survey estimate of everyone reporting IHS access, nor is it a Medicare data match. The distinction protects the reader from treating separate sources as interchangeable merely because they concern overlapping populations. [1]

Methodological limitations for interpreting the estimates

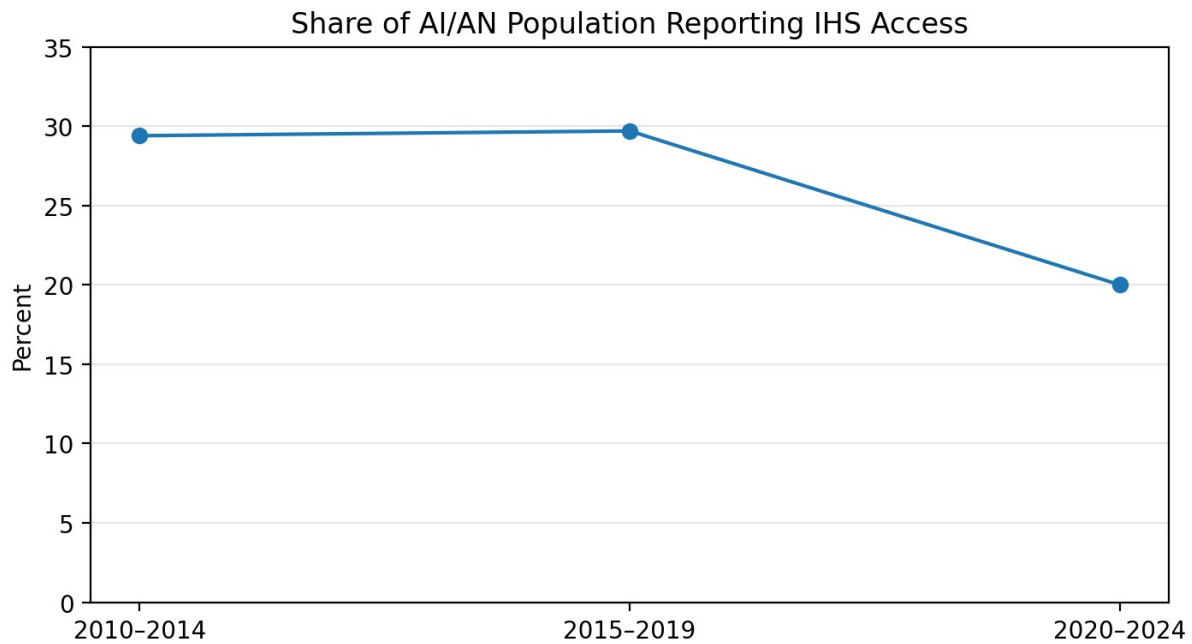
The source audit identified several rules that should govern any final version. First, every statistic must carry its source, time period, and population definition. Second, the 33-state Paper IV-F series must be labeled as such. Third, overall AI/AN coverage estimates from the Data Tables page must not be presented as if they describe only the IHS-access subgroup. Fourth, the state-group Medicaid and uninsured rates in Paper IV-F must not be described as rates among HINS7=Yes respondents. Fifth, Paper IV-G's category of IHS access without Medicare or Medicaid must not automatically be called uninsured under all ACS insurance categories.

Sixth, the March 2026 working paper contains preliminary material and should not replace the revised Paper IV-F for the three-period 2010–2024 analysis. Seventh, the Data Tables page says its plain-text summaries do not show margins of error and directs readers to the linked spreadsheets. For publication, figures should be checked against the linked spreadsheet where available, with uncertainty and sample limitations noted where the source provides them. Eighth, any explanation of why the race-question redesign changed the population count should be clearly attributed to the relevant paper rather than presented as a new independent finding by this essay.

Finally, the essay's subject is health access and coverage measurement, not clinical health outcomes. No conclusion about disease prevalence, treatment quality, or an individual's receipt of care should be inferred from a survey response about IHS access or insurance. The paper can describe the health-system financing context, but only where the website's published analysis directly supports the claim.

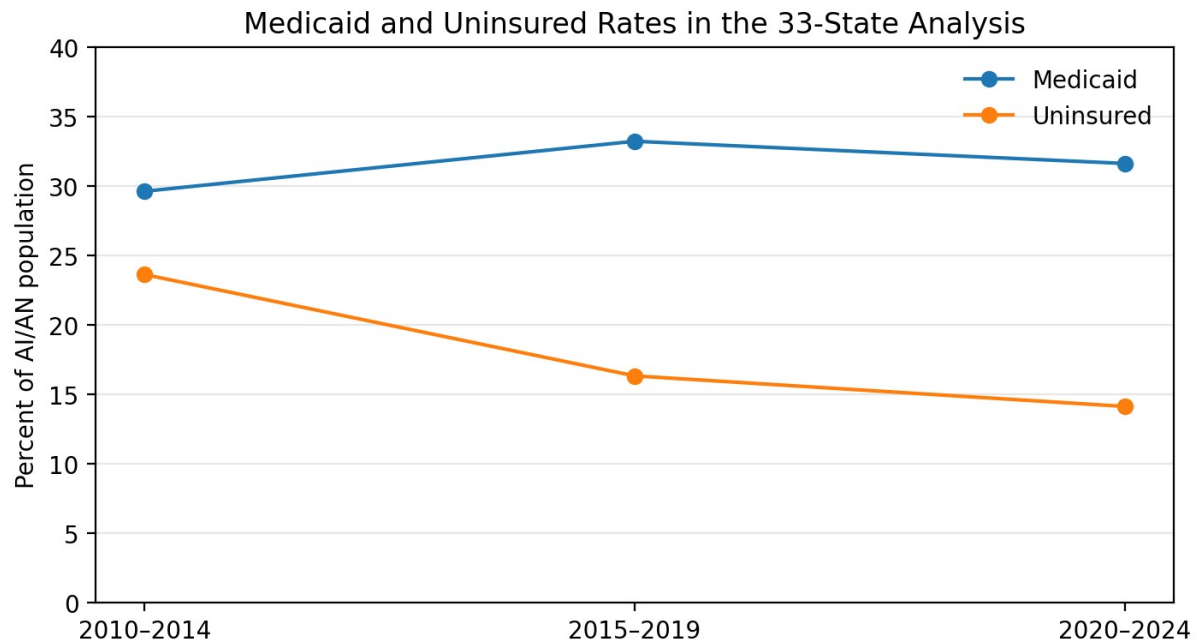
Figures

Figure 1. Share of AI/AN population reporting IHS access, 2010–2024



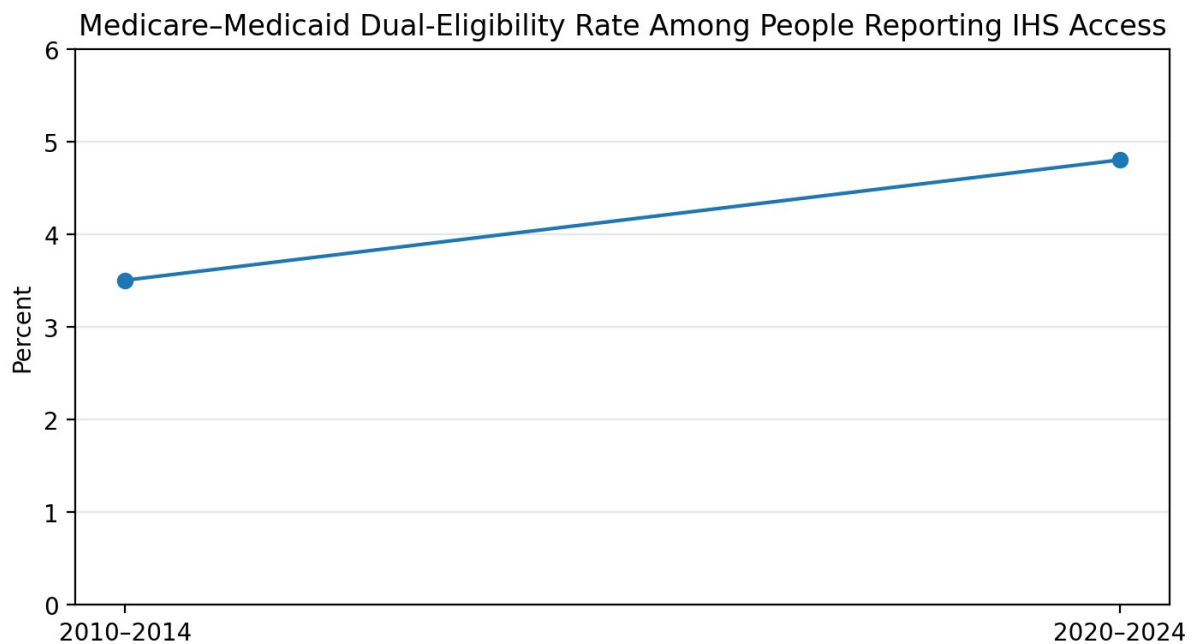
Source: Fox, “AI/AN Health Coverage Trends, 2010–2024,” Paper IV-F, revised October 12, 2026, pp. 1–2. The analysis covers 33 states and three non-overlapping ACS five-year periods. The reported share fell from 29.4% to 20.0%, while the count reporting access was essentially unchanged between the endpoint periods (1,284,416 and 1,284,134). The paper attributes the rate change principally to growth in the AI/AN denominator associated with the 2020 race-question redesign.

Figure 2. Medicaid and uninsured rates in the 33-state analysis



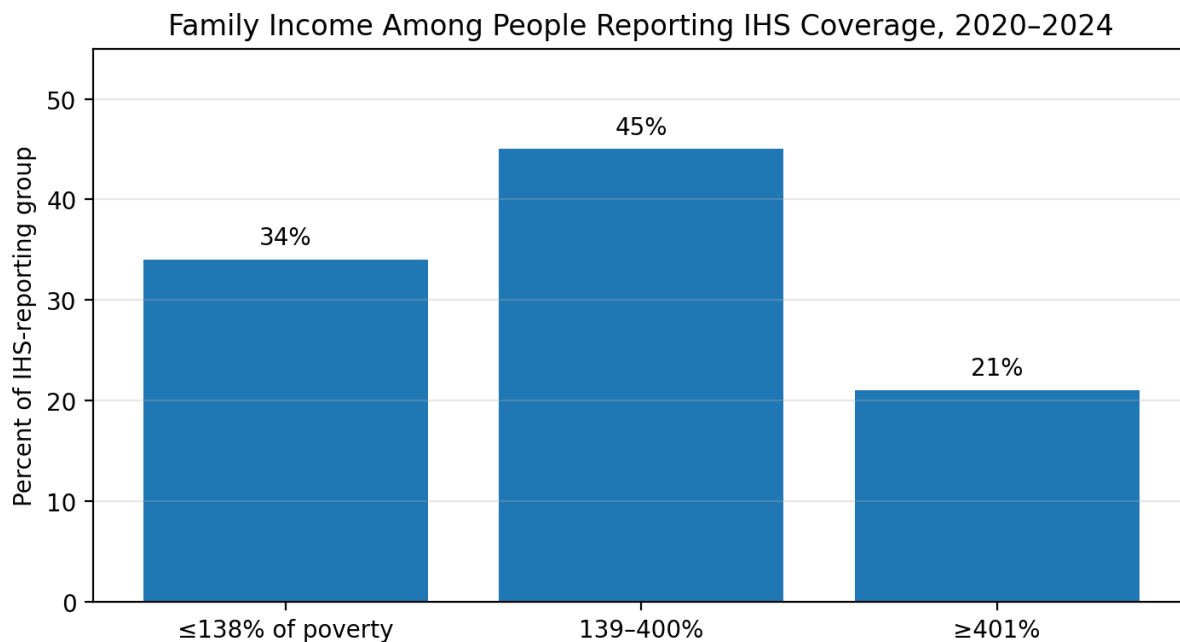
Source: Fox, Paper IV-F, pp. 1–2. Rates are for the AI/AN populations in the 33 selected states, not only respondents reporting IHS access. Medicaid rates: 29.6%, 33.2%, and 31.6%; uninsured rates: 23.6%, 16.3%, and 14.1%, for 2010–2014, 2015–2019, and 2020–2024, respectively.

Figure 3. Medicare–Medicaid dual-eligibility rate among people reporting IHS access



Source: Fox, Paper IV-G, “Dual Medicare–Medicaid Coverage Among AIAN Populations,” abstract and pp. 1–2. The reported dual-eligibility rate increased from 3.5% in 2010–2014 to 4.8% in 2020–2024. The paper reports the IHS-access dual-eligible population rising from 44,425 to 61,648 (+38.8%). The plotted endpoints are not a continuous annual series.

Figure 4. Family income distribution among people reporting IHS coverage



Source: Fox, Data Tables page, “Income Relative to Poverty, by IHS Coverage,” 2024 ACS five-year estimates. Rounded shares: 34% at or below 138% of poverty; 45% between 139% and 400%; 21% at 401% or above. Income bands describe the survey group; they do not establish program enrollment or individual eligibility.

Conclusion

The website’s research supports a clear but bounded description of AI/AN people who report IHS access in the ACS. HINS7 measures self-reported IHS coverage; it is distinct from the standard ACS health-insurance recode and from administrative IHS registration. The population reporting IHS access is analytically useful for the website’s coverage research, but it is not a complete count of all users, eligible people, or services delivered.

The revised Paper IV-F’s 33-state analysis reports that the AI/AN population grew 46.9 percent between the 2010–2014 and 2020–2024 ACS five-year periods, while the number reporting IHS access remained effectively unchanged at approximately 1.284 million. It reports that the corresponding access share declined from 29.4 percent to 20.0 percent and attributes this pattern primarily to changes in the AI/AN denominator associated with the 2020 race-question redesign. Those figures must be described with their 33-state scope and the paper’s own interpretation.

The website also reports changes in Medicaid, uninsured, Medicare, and dual-eligibility measures among people reporting IHS access. These findings show why access and coverage are best analyzed together while still keeping their definitions separate. They do not show where each respondent received care or establish clinical outcomes.

The methodological conclusion is central: the population definition, data source, time period, numerator, and denominator must be visible whenever a figure is presented. ACS-reported access, administrative enrollment, actual service use, and health outcomes answer different questions. A descriptive essay can be informative without extrapolating beyond those questions; indeed, its credibility depends on that restraint.

Source notes and bibliography

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- [2] Fox, Edward J. “Change in the Share of AI/ANs Reporting IHS Access, 2010–2024: An Analysis Using ACS HINS7 Across Four 5-Year PUMS Periods.” Indian Health Financing Series working paper, March 2026, pp. 2–5. https://edfoxphd.com/wp-content/uploads/2026/08/ihf_ihs_access_trends_styled.pdf. Used for the HINS7 definition and stated limitations; preliminary trend tables are not treated as the final 2010–2024 analysis.
- [3] Fox, Edward J. “Indian Health Finance Research Map & Index.” edfoxphd.com/indian-health-finance-research-map-index/. Accessed October 16, 2026. Used to identify the organization and scope of the site’s research series.
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- [5] Fox, Edward J. “Data Tables.” edfoxphd.com/resources/data-tables/. Accessed October 16, 2026. The page directs readers to accompanying spreadsheets for underlying tables and cautions that plain-text summaries do not display margins of error.
- [6] Fox, Edward J. “Dual Medicare–Medicaid Coverage Among AIAN Populations: IHS-Access vs. Non-IHS Populations, 2013–2024.” Indian Health Financing Series, Paper IV-G, April 2026, pp. 1–3. https://edfoxphd.com/wp-content/uploads/2026/08/10_paper_iv-g_dual_medicare-medicaid_coverage-1.pdf.
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Author’s methodological note

This draft uses only material published on edfoxphd.com. It does not add outside literature, estimate missing values, fill gaps in source tables, or infer individual-level experiences from aggregate survey estimates. The revised Paper IV-F is treated as the controlling source for its stated 33-state analysis. Before publication, each figure intended for a final exhibit should be checked against the cited PDF page or the source spreadsheet, including the estimate’s universe, time period, weighting, and denominator.