

The 2020 Race Question by State: AI/AN Counts and IHS Coverage, 2019–2024

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Abstract

This paper argues that the 2020 race question change raised AI/AN counts least where the IHS-connected population is largest, and most where it is smallest. Across the 39 states with more than 1,500 AI/AN people reporting IHS coverage, the AI/AN count rose 7 percent between 2019 and 2021 in states where half or more of AI/AN people reported IHS coverage before the change. It rose 33 percent in states where a quarter to a half did, and 80 percent in states where fewer than a quarter did.

The jump happened between 2019 and 2021 and then held. From 2021 through 2024, counts in every group changed little. Low-IHS states, which held only 17 percent of the 2019 IHS-reporting population, absorbed three-quarters of the national AI/AN increase. California, Texas, Illinois, Florida, and New York alone account for half of the growth in the 39 states.

The number of AI/AN people reporting IHS coverage did not follow the AI/AN count in any state group. The result, for state-level Indian health financing, is that AI/AN-wide rates in low-IHS states now describe a population most of whose members have no reported IHS connection. State measures tied to IHS-funded programs need to be anchored to the IHS-connected population.

Introduction

A companion paper, *Who Was Added? Hispanic Origin, Nativity, and IHS Coverage in the 2019–2021 AI/AN Increase*, showed that the national AI/AN count rose 55 percent in two years after the 2020 race question change, and that the entire increase was among people reporting no IHS coverage. This paper asks where in the country that increase landed.

The question matters because Indian health finance is largely state-shaped. Medicaid is a state program, Tribal consultation and state plan amendments are negotiated state by state, and the share of AI/AN residents connected to IHS-funded programs varies enormously across states. A national average can hide the fact that the same question change meant very different things in Oklahoma and in Illinois.

The analysis extends Paper IV-F, which compared high-IHS and low-IHS states (called IHS-proximate and non-proximate in that paper) using the 5-year ACS. The 5-year files blend years from before and after the change. The 1-year files used here isolate the break at 2020 and show what happened afterward, year by year, through 2024.

Data and methods

The data are state tabulations of the ACS 1-Year Public Use Microdata Sample for 2019, 2021, 2022, 2023, and 2024, weighted by person weight (PWGTP). AI/AN is the alone-or-in-combination measure (RACAIAN), and IHS coverage is the HINS7 question. No standard 1-year ACS was released for 2020.

Selection. The analysis covers the 39 states with more than 1,500 AI/AN people reporting IHS coverage in 2024. Together they held 99.7 percent of AI/AN people reporting IHS coverage in 2019 and 92 percent of the national AI/AN count. Four states (Alabama, Connecticut, Georgia, and Massachusetts) were below 1,500 in 2019; their IHS counts are small enough to swing on sampling alone.

Grouping. Following Paper IV-F, a state is high-IHS if 25 percent or more of its AI/AN residents reported IHS coverage, and low-IHS if fewer did. High-IHS states are generally those with large Tribal land bases and many IHS or Tribal facilities. This paper applies the test to 2019, before the question change, so the grouping is not itself affected by the change. That yields 16 high-IHS and 23 low-IHS states. Paper IV-F applied the same 25 percent test to the 2020–2024 period, after the new respondents had enlarged the denominator, and found 8 high-IHS states. Those 8 are exactly this paper's top tier; the other 8 high-IHS states here fell below 25 percent once the post-2020 count was used. The high-IHS group is further split at 50 percent, giving three tiers:

Tier (2019 IHS share)	States
50% or more (8)	Alaska, Arizona, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Wyoming
25% to 50% (8)	Idaho, Minnesota, Mississippi, Nebraska, Oregon, Utah, Washington, Wisconsin
Under 25% (23)	Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Missouri, Nevada, New York, North Carolina, South Carolina, Tennessee, Texas, Virginia

All state figures, formulas, and group totals are in the companion workbook *AIAN_IHS_by_State_ACS1Y_2019_2024.xlsx*.

Finding 1: The jump was largest where IHS reaches fewest AI/AN people, and it held

The size of the 2019–2021 jump lines up almost exactly with how connected a state's AI/AN population was to IHS before the change. The tighter the connection, the smaller the jump.

Tier (2019 IHS share)	AI/AN 2019	AI/AN 2021	AI/AN 2024	Change 2019–2021	Change 2019–2024
50% or more (8 states)	1,588,709	1,699,005	1,753,290	+7%	+10%
25% to 50% (8 states)	727,756	971,046	976,610	+33%	+34%
Under 25% (23 states)	2,905,062	5,232,901	5,468,703	+80%	+88%

Total population grew about 4 percent in both the high-IHS and low-IHS groups between 2019 and 2024, so none of these differences come from general population growth.

The break is a single step at 2020. Measured against 2019, each tier's growth in 2022, 2023, and 2024 stayed close to its 2021 level: 6 to 10 percent in the top tier, 28 to 34 percent in the middle tier, and 75 to 88 percent in the bottom tier. The post-2020 count is a new level, not a trend that is still climbing.

This confirms Paper IV-F's 5-year result with annual data. Of the 23 low-IHS states, 22 grew more than 20 percent between 2019 and 2024, the series' diagnostic for the question-change artifact. Only Maine (+13 percent) did not. Among the eight top-tier states, only Wyoming (+27 percent) did, and North Dakota and South Dakota were flat or lower.

Finding 2: State results

The table lists all 39 states, ordered by the number of AI/AN people reporting IHS coverage in 2024. Changes run from 2019 to 2024.

State	Tier	IHS share 2019	AI/AN 2019	AI/AN 2024	AI/AN change	IHS reporters 2019	IHS reporters 2024	IHS change
Oklahoma	50%+	63%	540,822	581,142	+7%	342,817	326,808	-5%
Arizona	50%+	55%	407,517	477,786	+17%	222,917	216,485	-3%
New Mexico	50%+	70%	226,079	266,457	+18%	159,204	151,167	-5%
Alaska	50%+	76%	148,315	155,919	+5%	113,248	121,256	+7%
California	<25%	10%	768,328	1,323,696	+72%	78,365	69,247	-12%
South Dakota	50%+	78%	95,167	95,056	0%	73,980	60,665	-18%
Montana	50%+	61%	93,553	97,557	+4%	57,234	52,463	-8%
Washington	25-50%	32%	228,666	284,486	+24%	73,093	50,463	-31%
Minnesota	25-50%	41%	123,199	144,477	+17%	50,049	32,799	-34%
Michigan	<25%	22%	143,389	203,562	+42%	31,265	27,084	-13%
North Dakota	50%+	59%	56,915	53,637	-6%	33,464	26,292	-21%

State	Tier	IHS share 2019	AI/AN 2019	AI/AN 2024	AI/AN change	IHS reporters 2019	IHS reporters 2024	IHS change
Oregon	25–50%	25%	128,950	163,130	+27%	32,537	24,166	–26%
Wisconsin	25–50%	33%	85,349	124,840	+46%	27,980	22,609	–19%
Texas	<25%	7%	348,597	779,781	+124%	26,050	20,656	–21%
North Carolina	<25%	7%	210,212	312,394	+49%	14,705	12,116	–18%
Nevada	<25%	23%	70,226	112,786	+61%	16,249	11,777	–28%
Colorado	<25%	7%	135,237	192,526	+42%	8,834	10,959	+24%
Utah	25–50%	33%	59,397	86,092	+45%	19,567	10,723	–45%
New York	<25%	5%	193,816	334,993	+73%	10,242	9,914	–3%
Nebraska	25–50%	34%	34,400	59,745	+74%	11,649	9,873	–15%
Idaho	25–50%	33%	45,300	60,364	+33%	14,868	9,360	–37%
Wyoming	50%+	54%	20,341	25,736	+27%	10,944	9,340	–15%
Arkansas	<25%	19%	53,092	88,868	+67%	9,829	8,658	–12%
Kansas	<25%	22%	63,542	95,366	+50%	14,225	7,853	–45%
Mississippi	25–50%	31%	22,495	53,476	+138%	7,021	7,260	+3%
Missouri	<25%	9%	76,241	135,332	+78%	6,804	6,427	–6%
Florida	<25%	6%	174,394	362,756	+108%	11,238	5,585	–50%
Illinois	<25%	2%	102,182	308,222	+202%	1,907	3,069	+61%
Maine	<25%	22%	21,062	23,733	+13%	4,559	3,043	–33%
Louisiana	<25%	5%	61,824	100,679	+63%	3,104	2,489	–20%
Connecticut	<25%	2%	34,916	61,763	+77%	571	2,409	+322%

State	Tier	IHS share 2019	AI/AN 2019	AI/AN 2024	AI/AN change	IHS reporters 2019	IHS reporters 2024	IHS change
Virginia	<25%	2%	72,628	155,553	+114%	1,809	2,107	+16%
Massachusetts	<25%	2%	50,907	90,970	+79%	969	2,092	+116%
South Carolina	<25%	6%	47,421	113,142	+139%	2,826	2,060	-27%
Tennessee	<25%	4%	56,284	140,808	+150%	2,187	1,805	-17%
Alabama	<25%	2%	52,443	114,962	+119%	1,160	1,674	+44%
Iowa	<25%	17%	23,706	54,808	+131%	3,999	1,626	-59%
Georgia	<25%	1%	90,316	215,812	+139%	980	1,603	+64%
Indiana	<25%	4%	54,299	146,191	+169%	2,133	1,515	-29%

California (+555,000), Texas (+431,000), Illinois (+206,000), Florida (+188,000), and New York (+141,000) account for half of the 2.98 million increase across these states. All five are low-IHS states, as are the states with the ten largest increases.

Within the high-IHS group, the jump grows as the IHS share falls. Wisconsin, Utah, Nebraska, and Idaho, all with 2019 IHS shares near one-third, rose 33 to 74 percent. Mississippi's figures swing widely from year to year because its AI/AN sample is small.

Finding 3: IHS reporting did not follow the AI/AN count

In no tier did the number of AI/AN people reporting IHS coverage rise with the AI/AN count. It fell in 30 of the 39 states. Most of the nine increases are in states with small IHS counts, such as Connecticut and Georgia, where sampling swings are large.

Tier (2019 IHS share)	IHS reporters 2019	IHS reporters 2024	Change	IHS share 2019	IHS share 2024
50% or more	1,013,808	964,476	-5%	64%	55%
25% to 50%	236,764	167,253	-29%	33%	17%
Under 25%	254,010	215,768	-15%	9%	4%

The IHS share therefore fell in every tier, for two different reasons. In the top tier, the AI/AN count rose modestly and IHS reporting dipped slightly, so the share fell from 64 to 55 percent. In low-IHS states, the denominator nearly doubled, so the share fell by more than half even though most IHS reporters remained.

The series attributes the 2021 dip in IHS reporting to pandemic-era disruption of ACS fieldwork, not to the race question; the two are separate questions. The annual data add one complication. IHS reporting did not recover after 2021, and the decline was steepest in the middle tier: Utah (–45 percent), Idaho (–37 percent), Minnesota (–34 percent), and Washington (–31 percent). These data cannot say why. It is an open question worth separate study.

Reading the state results carefully

The tiers describe states, not people. A low-IHS state is one where few AI/AN residents reported IHS coverage in 2019. It still has an IHS-connected population, often Tribal citizens living away from their home communities. California alone had about 69,000 AI/AN people reporting IHS coverage in 2024, more than Montana. Those residents are part of the IHS service picture even though they are a small share of their state's AI/AN count.

The state data do not identify who was added. This paper does not break the state counts down by Hispanic origin or place of birth. The national paper found that more than half of the increase came from Hispanic respondents, mostly U.S.-born. The largest state increases here, in California, Texas, Illinois, Florida, and New York, are consistent with that, but the paper does not test it state by state.

Neither Hispanic origin nor foreign birth places someone outside the IHS population. Hispanic AI/AN people and foreign-born AI/AN people report IHS coverage in both years nationally. Eligibility rests on Indian descent and ties to a Tribe or the Indian community a program serves, not on ethnicity or birthplace. That is true in New Mexico and Arizona, where many Tribal citizens have Hispanic heritage, as it is anywhere else.

Small states need caution. For states with a few thousand IHS reporters or fewer, year-to-year changes can be sampling noise. Connecticut's IHS count rising from about 600 to about 2,400, or Mississippi's AI/AN count swinging between 22,000 and 70,000, should not be read as real change. Michigan, Kansas, and Nevada sit just under the 25 percent line and could reasonably be grouped either way.

Implications for state-level financing measures

How much the question change distorts a state's AI/AN figures depends on its tier. That gives a practical guide for anyone using ACS data in state Medicaid discussions, Tribal consultation, or grant proposals.

1. **Top-tier states (50 percent or more): AI/AN-wide figures remain usable across the break, with a note.** Counts rose 7 to 10 percent, so rates computed on the full AI/AN count still largely describe the IHS-connected population.
2. **Middle-tier states (25 to 50 percent): report the IHS-connected population separately.** A third more AI/AN residents were added, so AI/AN-wide Medicaid or uninsured rates now blend two different populations.
3. **Low-IHS states (under 25 percent): do not use the AI/AN count for IHS-related measures.** Most AI/AN residents in these states have no reported IHS connection, and after 2020 that majority grew much larger. Measures for Tribal and urban Indian programs should rest on IHS reporting, IHS user data, or Tribal enrollment.
4. **Rank and compare states by the IHS-connected population, not the AI/AN count.** On the AI/AN count, Texas now ranks above Arizona and Illinois above New Mexico; neither was true in 2019.

On IHS reporting, as in this paper's table, the order reflects where IHS-funded programs actually operate.

5. **Watch any allocation that uses state AI/AN counts.** Without a Tribal or IHS anchor, the post-2020 counts move shares toward low-IHS states, where the increase concentrated.

Limitations and conclusion

The estimates are weighted sample counts without margins of error. State 1-year samples are much smaller than the national sample, so single-year figures for small states are approximate. IHS coverage is self-reported and is not a count of IHS users. The tier grouping uses one year, 2019, and a few states sit near its edges.

Three extensions would strengthen the analysis: state tabulations by Hispanic origin and nativity, to test whether the national pattern holds within states; a look at why IHS reporting fell most in middle-tier states and stayed down; and a comparison with IHS user population data by state.

The conclusion is straightforward. The 2020 question change added AI/AN respondents everywhere, but in sharply different proportions: about one-tenth more in the states at the core of the IHS system, a third more at its edges, and nearly double elsewhere. The new level held through 2024. For state-level Indian health financing, the AI/AN count is now reliable as a measure of the IHS-connected population only in the top tier, and IHS-related measures everywhere else should be anchored to that population directly.

Sources

Data (new to this paper)

- U.S. Census Bureau, American Community Survey 1-Year Public Use Microdata Sample, 2019, 2021, 2022, 2023, and 2024, by state. Variables RACAIAN and HINS7; person weight PWGTP. Extracted October 12, 2026, via the Microdata Access Tool. Tabulated by Edward J. Fox, PhD, in *AIAN_IHS_by_State_ACS1Y_2019_2024.xlsx*.

From the IHF Series and related papers

- Paper IV-F, AI/AN coverage trends and the 2020 race question artifact (high-IHS and low-IHS states, termed IHS-proximate and non-proximate there; the 25 percent grouping and 20 percent diagnostic).
- Dataset Note I, analytical conventions for the race question break.
- *Who Was Added? Hispanic Origin, Nativity, and IHS Coverage in the 2019–2021 AI/AN Increase* (companion paper, national results).

Other sources

- Code of Federal Regulations, [42 CFR 136.12, Persons to whom services will be provided](#).