



MONITORING HEALTH ACCESS USING THE AMERICAN COMMUNITY SURVEY

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The American Community Survey: Benefits
and Challenges of Delivering the Data

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About SHADAC

- We help states collect and analyze data to inform state health policy decisions relating to health insurance coverage and access to care
- Our goal: To help states bridge the gap between health data and the policy-making process; make evidence-based policy decisions
- Based at the University of Minnesota
- Funded primarily by the Robert Wood Johnson Foundation

States' needs for monitoring coverage

- Consistent estimates
- Trends over time
 - Monitor impacts of health reform, change in economy or demographics
- Comparisons across states
- Subpopulation analysis
 - Race/ethnicity, poverty, age
 - Counties/sub-state areas
- Access to micro-data

Key federal survey data sources

- General household survey
 - **ACS**: American Community Survey
- Employment/Income survey
 - **CPS**: Current Population Survey (ASEC)
- Health surveys
 - **NHIS**: National Health Interview Survey
 - **MEPS-HC**: Medical Expenditure Panel Survey-Household Component
 - **BRFSS**: Behavioral Risk Factor Surveillance System



CPS: the good, the bad, and the ugly

Good

- Historic trends
- State-level estimates
- Several control variables available
- State-specific public health insurance program names
- Timely data release

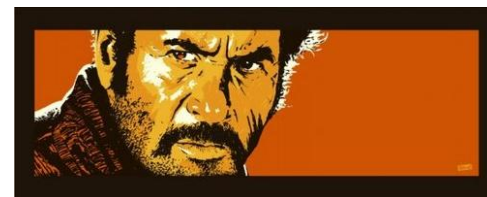


Bad

- Low sample in smaller states
- 10% of respondents have entire supplement, with health insurance coverage questions, imputed

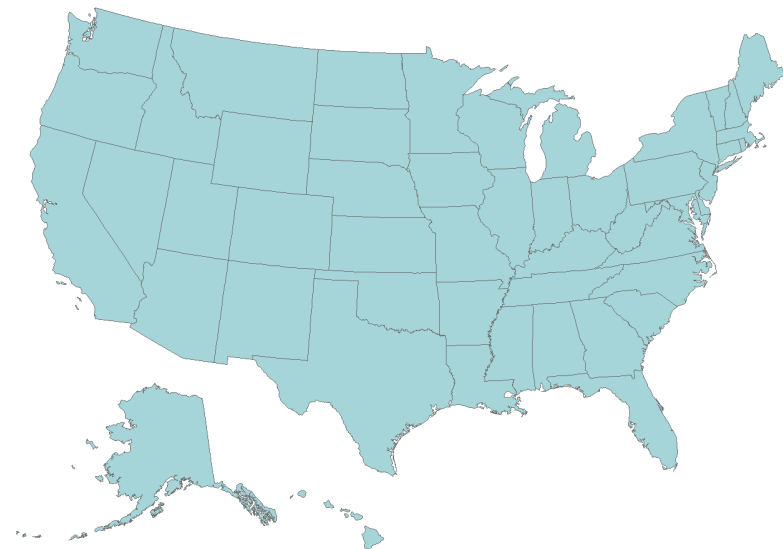
Ugly

- Concerns about the coverage questions
- No sample in some counties



ACS to the rescue

- SAMPLE SIZE!!!!!!!!!!!!!!!!!!!!
- Sub-state estimates
- Robust subpopulation analysis
- Representativeness
- Current coverage measured



The ACS Sample
is almost

15 TIMES LARGER
than the CPS Sample



Questions SHADAC helps states answer with the ACS health insurance questions

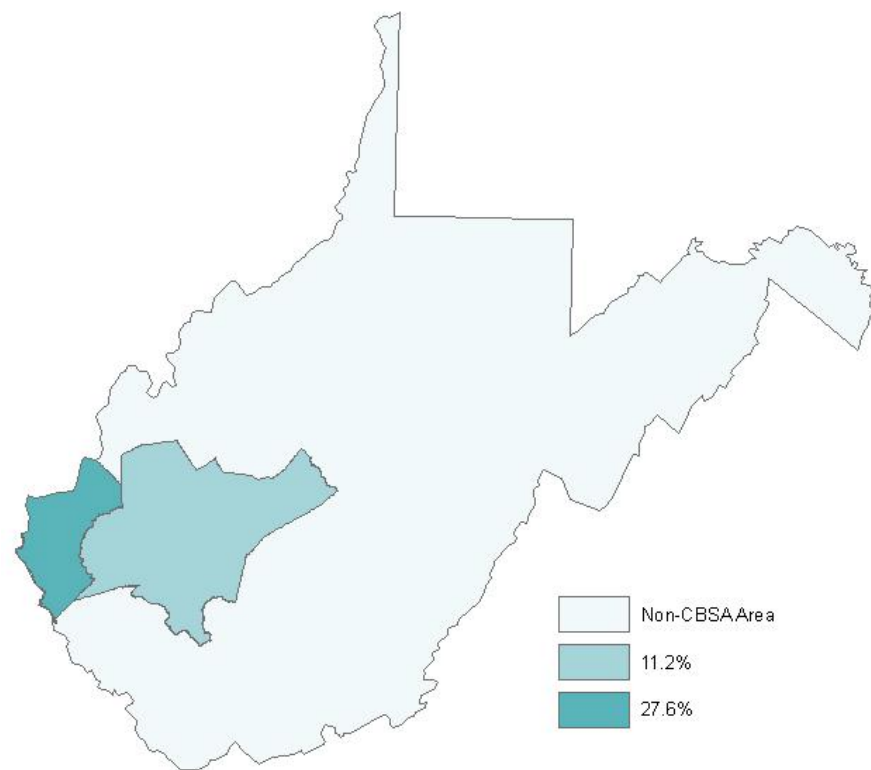
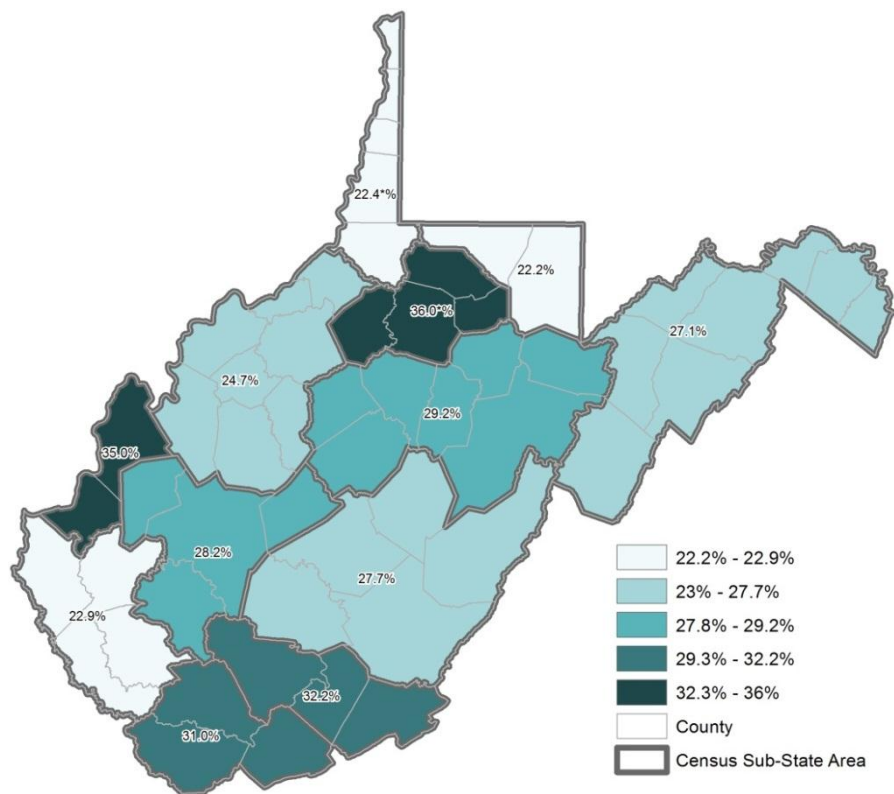
- How many uninsured are in my state and where do they live? What is their demographic profile?
- How many kids in each county are eligible for CHIP or Medicaid but not enrolled?
- How many people in my state will be eligible for Medicaid under ACA?

Where should we allocate funds for community clinics?

% Uninsured in West Virginia, Age 0-64, $\leq 200\%$ of poverty

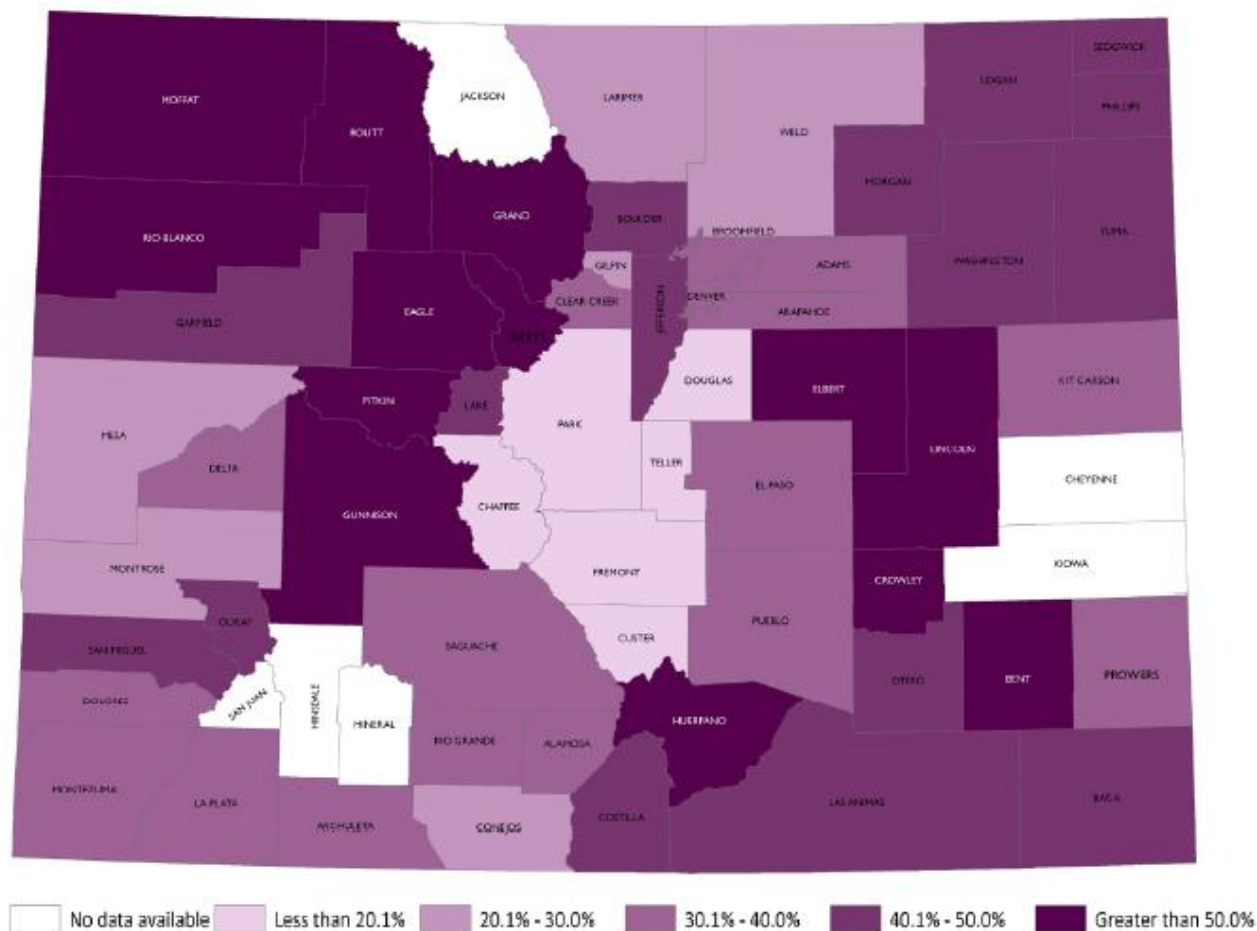
American Community Survey

Current Population Survey



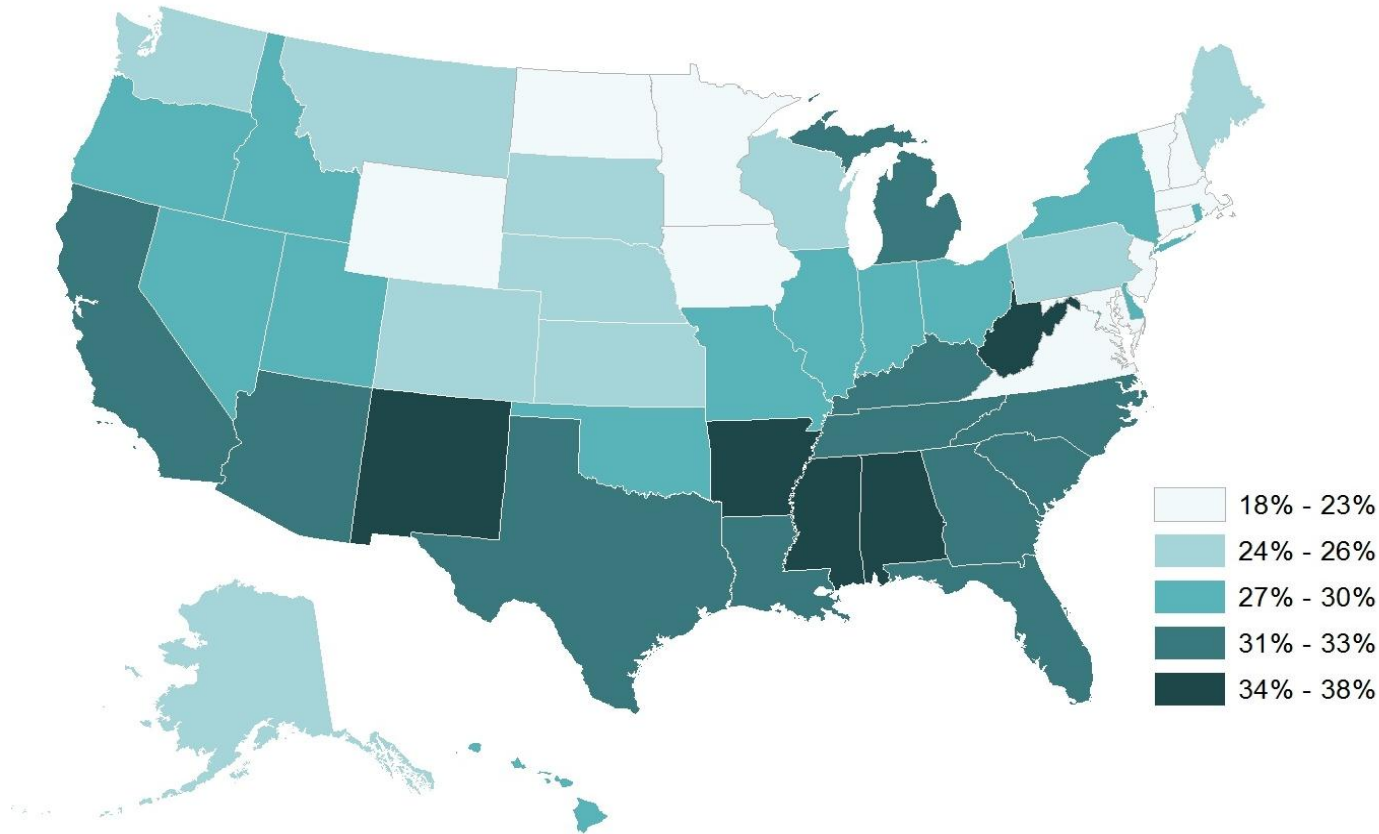
Source: 2009 American Community Survey; 2011 Current Population Survey

How many uninsured kids in Colorado are eligible for CHIP but not enrolled?



Source: Colorado Health Institute Analysis of 2008-2010 American Community Surveys

What percent of adults will be eligible for Medicaid?



Eligibility based only on health insurance unit income at or below 138% of poverty
Source: 2010 American Community Survey

SHADAC's technical assistance for states

- SHADAC's Data Center
 - Online table and chart generator of policy-relevant tables of health insurance coverage estimates from the ACS and CPS
- Education and capacity building for states
- Provides health policy relevant indicators
 - Assign family relationships according to health plan eligibility or "health insurance unit"
 - Federal poverty *guidelines* (HHS) rather than *thresholds*
 - FPG cuts at policy-specific levels (138%, 200%)
- Control totals for state-specific surveys

SHADAC's Data Center

Choose Your Data & Filters

Edit 

Choose Your Tables

Edit 

Your Results

Export Tables:  [Excel \(.csv file\)](#)  [PDF](#) Save:  [Search Settings \(Login Required\)](#)

Health Insurance Coverage Estimates, ACS, 0-64 Years, All Poverty Levels, Ohio: Calendar Year 2010

	Population	Uninsured			Insured			Private Coverage									Public Coverage								
		Total			Total			Total			Employer			Individual			Total			Medicaid			Medicare		
		Count	%	SE	Count	%	SE	Count	%	SE	Count	%	SE	Count	%	SE	Count	%	SE	Count	%	SE	Count	%	SE
Race and Ethnicity																									
Hispanic	333	87	26.3	1.66	245	73.7	1.66	155	46.5	1.86	144	43.3	1.82	16	4.8	0.55	102	30.8	1.64	97	29.2	1.62	6	1.8	0.33
White Alone	7,850	1,032	13.1	0.22	6,819	86.9	0.22	5,799	73.9	0.31	5,386	68.6	0.32	599	7.6	0.15	1,268	16.2	0.26	1,060	13.5	0.25	206	2.6	0.07
Black Alone	1,218	214	17.6	0.57	1,003	82.4	0.57	567	46.6	0.94	535	43.9	0.94	66	5.4	0.35	484	39.8	0.94	439	36.0	0.95	52	4.3	0.26
Asian Alone	183	23	12.7	1.50	160	87.3	1.50	152	83.1	1.69	128	69.7	1.98	30	16.4	1.42	10	5.4	0.98	9	4.9	0.96	1	0.7	0.21
Multiple/other non-Hispanic	226	25	11.2	1.15	201	88.8	1.15	129	56.9	1.93	120	53.0	1.94	13	5.7	0.70	83	36.6	1.87	77	34.1	1.85	5	2.3	0.38
Total	9,809	1,382	14.1	0.20	8,427	85.9	0.20	6,801	69.3	0.30	6,311	64.3	0.31	723	7.4	0.14	1,948	19.9	0.26	1,682	17.1	0.26	271	2.8	0.07
Filtered Total	9,809	1,382	14.1	0.20	8,427	85.9	0.20	6,801	69.3	0.30	6,311	64.3	0.31	723	7.4	0.14	1,948	19.9	0.26	1,682	17.1	0.26	271	2.8	0.07

www.shadac.org/datacenter

Summary: The value of the ACS

- Due to large and representative sample the ACS fills a gap in state-level data to inform policy decisions
 - Statewide and locally
 - Subpopulations: small minority, age or income groups
- The ACS is widely accessible
 - Don't need to be a data programmer
- The ACS is a great tool for modeling/linking with other data to develop state-level estimates
- Benchmarking and sub-population analysis will be compromised if ACS becomes voluntary

Wish list for future versions of the ACS

- Data updates during the year
 - e.g., NHIS midyear reporting
- Self reported health status
- Addition of health care access measure
- Addition of insurance marketplace and subsidy questions

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