



Comparing Federal Government Surveys That Count the Uninsured: 2023

INTRODUCTION

The ability to obtain and keep affordable and comprehensive health insurance coverage is one of the most fundamental steps to improving individual and population health through better access to and utilization of health care services. Timely and accurate estimates of the number of people who do not have health insurance, therefore, are important for understanding trends in coverage and the impacts of actions (like policy changes), events (like public health emergencies), or shifts in the economic landscape (like periods of recession) that may in turn affect health insurance coverage nationally and among individual states.

This brief provides an annual update to comparisons of uninsurance estimates from five federal surveys. As in prior years, we have included estimates fromⁱ:

- The American Community Survey (ACS)
- The Current Population Survey (CPS) and the Annual Social and Economic Supplement (CPS ASEC)
- The Medical Expenditure Panel Survey – Household Component (MEPS-HC)
- The National Health Interview Survey (NHIS)

Additionally, this year we have added data from a previously included source:

- The Behavior Risk Factor Surveillance System (BRFSS)

The BRFSS is an annual state-based survey sponsored by the U.S. Centers for Disease Control and Prevention (CDC) that is administered at an individual state level. The survey is uniquely composed of three different sections: 1) the core component (which itself has three sections, the fixed core, rotating core, and emerging core), 2) optional modules, and 3) state-added questions. All participating states must ask the survey questions contained in the core component, but are not required to ask anything from the optional or state-added question sections. The BRFSS has included a question for respondents regarding current health insurance coverage within the core component since 1991, with several breaks in series as noted in a later section of this brief.

In this brief, we present current and historical national estimates of uninsurance along with the most recent available state-level estimates from these surveys. We also discuss the main reasons for variation in the estimates across the different surveys, including how these surveys and their estimates were affected by the ongoing COVID-19 pandemic and how data users should consider these impacts when considering if and when to use these data.

National Estimates

Table 1 shows the most recent available estimates of uninsurance from each of these four surveys. Some of the surveys produce estimates of the number of adults who were uninsured for an entire year, some estimate uninsurance at a specific point in time (i.e., at the time of the survey), and others collect multiple measures of uninsurance.ⁱⁱ

ⁱ See Appendix A for key information from each of these surveys, such as who is included in the survey, when and how the survey is conducted, response rates, and the availability of state-level insurance estimates.

ⁱⁱ The CPS also collects point-in-time estimates, which are a newer inclusion in this brief. The point-in-time estimates are collected during the ongoing survey year (i.e., 2022 estimates are collected in 2022), but published along with the estimates for the previous data year (i.e., 2022 point-in-time estimates are published with entire-year estimates for the 2021 data year).

Table 1. National Uninsurance Estimates from Five Federal Surveys

Survey	Time Period	Uninsured for the Entire Year		Uninsured at a Specific Point in Time	
		Number (Millions)	Percent of Population	Number (Millions)	Percent of Population
ACS	2022	N/A	N/A	26.4	8.0
CPS	2022	25.9	7.9	28.0	8.5
BRFSS	2022	N/A	N/A	21.7	8.7
MEPS	2021	20.2	6.1	N/A	N/A
NHIS	2022	18.8	5.8	27.6	8.4

Sources: ACS estimates for civilian noninstitutionalized population from SHADAC analysis of U.S. Census Bureau. (2023). "2022 ACS 1-Year Data Tables [Table S2701. Selected Characteristics of Health Insurance Coverage in the United States]"; CPS entire year estimates from U.S. Census Bureau. (2023). "Health Insurance Coverage in the United States: 2022"; CPS point-in-time estimates from U.S. Census Bureau. (2023). "Health Insurance: Tables 2018-forward [Table H-02. Health Insurance Current Coverage Status and Type of Coverage by Selected Characteristics for All People: 2022]"; BRFSS estimates from SHADAC analysis of Centers for Disease Control and Prevention (CDC). (2023). "BRFSS Survey Data: 2022"; MEPS estimates from Agency for Healthcare Research and Quality (AHRQ). (2023). "Medical Expenditure Panel Survey: Number of people in thousands by insurance coverage, all ages, United States [1996 to 2021]"; NHIS estimates from Cohen, R.A. & Cha, A.E. (2023, May 1). "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2022" and SHADAC analysis of the 2022 NHIS Public Use Files.

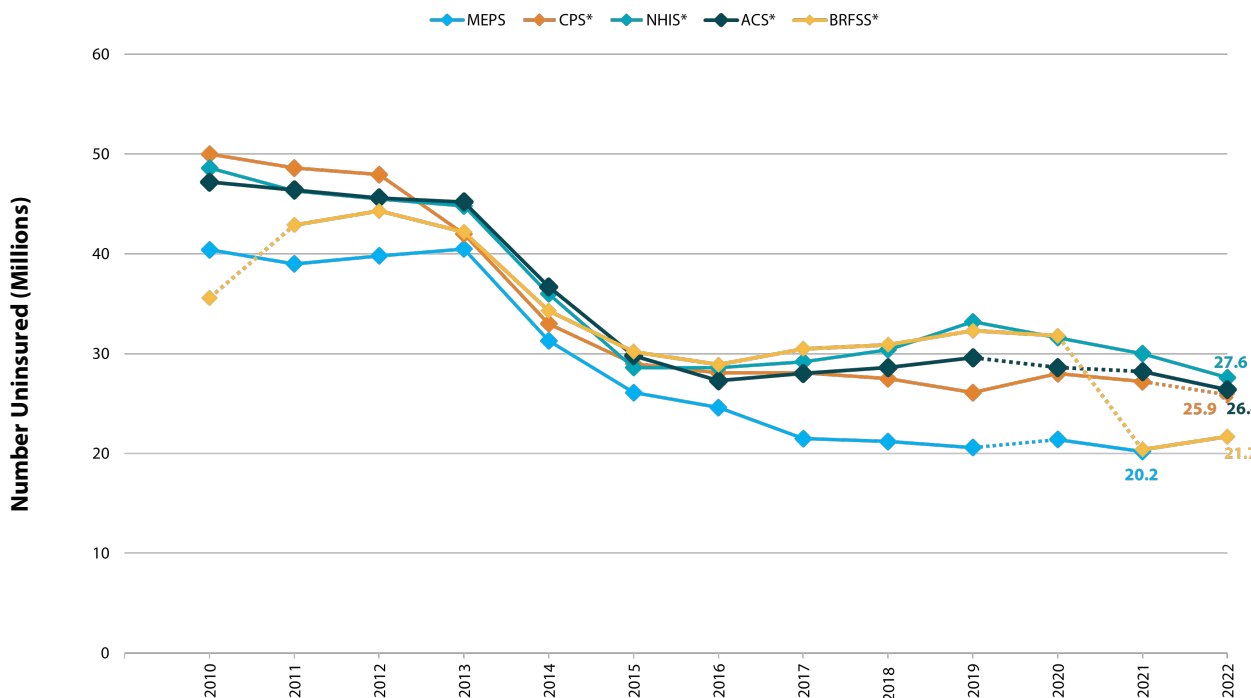
National Trends

The uninsurance estimates from the five surveys have demonstrated generally similar national trends over time, rising and falling in mirroring patterns even when yearly differences between survey data could fluctuate, and even during potentially disruptive periods such as the COVID-19 pandemic, as shown below in Figure 1.

While the unwinding of the Medicaid continuous coverage requirement began in April 2023, only provisional administrative data or near-real-time survey data (such as that from the Census Bureau’s [Household Pulse Survey](#)) are available at the federal level, which is not the “gold standard” of long-running annual surveys such as the ones included in this brief. Those data will not be available until later in 2024 or early in 2025. SHADAC will continue to monitor these data and will note any changes to data or data collection efforts.

Trend analysis of insurance estimates across years can be affected in several ways. For more information on environmental factors such as the Medicaid unwinding or the COVID-19 public health emergency (PHE), please see the section entitled “Impacts on Survey Data.” For more information on historical changes to the CPS ASEC, BRFSS, and NHIS surveys themselves that may impact this type of longitudinal analysis, see Appendix A.

Figure 1. Trend in National Number of Uninsured, 2010 to 2022: All Ages
 ACS, BRFSS, and NHIS point-in-time estimates of the uninsured; CPS ASEC and MEPS estimates of the full-year uninsured



*Dashed line “---” indicates a break in series.

Sources: ACS estimates for civilian noninstitutionalized population from SHADAC analysis of U.S. Census Bureau. (2023). "2022 ACS 1-Year Data Tables [Table S2701. Selected Characteristics of Health Insurance Coverage in the United States]"; CPS entire year estimates from U.S. Census Bureau. (2023). "Health Insurance Coverage in the United States: 2022"; CPS point-in-time estimates from U.S. Census Bureau. (2023). "Health Insurance: Tables 2018-forward [Table H-02. Health Insurance Current Coverage Status and Type of Coverage by Selected Characteristics for All People: 2022]"; BRFSS estimates from SHADAC analysis of Centers for Disease Control and Prevention (CDC). (2023). "BRFSS Survey Data: 2022"; MEPS estimates from Agency for Healthcare Research and Quality (AHRQ). (2023). "Medical Expenditure Panel Survey: Number of people in thousands by insurance coverage, all ages, United States [1996 to 2021]"; NHIS estimates from Cohen, R.A. & Cha, A.E. (2023, May 1). "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2022" and SHADAC analysis of the 2022 NHIS Public Use Files.

State-Level Estimates

The ACS and CPS are designed to produce state-level uninsurance estimates for all 50 states and the District of Columbia. The core component of the BRFSS is similarly designed to produce uninsurance estimates for all 50 states and D.C.; however, state-level data can vary for the optional modules. No state-level estimates of uninsurance are currently published from the MEPS-HC; the NHIS no longer publishes state-level estimates as part of their “Early Release” reports (see NHIS information box for more detail).

Table 2 presents the most recent state-level estimates of uninsurance from the ACS, CPS, and BRFSS. As with the national estimates, the estimated level of uninsurance for states varies across the three surveys. However, general patterns are consistent, insofar as states with low uninsurance levels typically have low levels in each survey, and states with high levels of uninsurance have high levels in each survey, etc.

Until 2019, a multitude of health insurance coverage breakdowns, including marketplace type, Medicaid expansion and non-expansion states, high-deductible health plan enrollment, expanded regional, and partial state-level uninsurance estimates (among others) were included in full-year “Early Release” estimate reports.

However, in 2019, the NHIS survey was redesigned, and the sample size significantly reduced. After this redesign, a smaller number of state-level estimates of the uninsured have been released each year via annual National Health Statistics Reports found [here](#), which aim to provide specialized analysis of health topics or convey new measurements or methodologies. The [latest report for 2022](#) includes data for 32 states and D.C.

Table 2. 2022 State-Level Uninsured Rates from Three Federal Surveys: Total Population

	ACS (Point-in-Time)	CPS (Full Year)	BRFSS (Point-in-Time)
United States	8.0	7.9	8.7
Alabama	8.8	8.3	9.9
Alaska	11.0	12.2	12.7
Arizona	10.3	10.6	11.6
Arkansas	8.4	6.5	9.9
California	6.5	6.2	7.0
Colorado	7.1	7.4	8.8
Connecticut	5.2	5.1	6.5
Delaware	5.6	6.0	6.4
Dist. of Columbia	2.9	2.1	2.9
Florida	11.2	10.6	11.9
Georgia	11.7	12.9	12.9
Hawaii	3.5	3.2	2.3
Idaho	8.2	8.1	8.1
Illinois	6.6	6.9	9.7
Indiana	7.0	5.9	7.6
Iowa	4.5	3.8	5.1
Kansas	8.6	6.8	8.6
Kentucky	5.6	6.3	4.3
Louisiana	6.9	8.0	7.1
Maine	6.6	2.7	4.5
Maryland	6.1	7.9	7.7
Massachusetts	2.4	3.4	2.2
Michigan	4.5	3.0	4.3
Minnesota	4.5	2.8	4.8
Mississippi	10.8	10.3	10.2
Missouri	8.6	7.4	8.9
Montana	8.3	7.5	7.8
Nebraska	6.7	6.5	8.7
Nevada	11.1	10.6	12.5
New Hampshire	4.9	4.2	4.9
New Jersey	6.8	5.7	8.0
New Mexico	8.2	10.5	10.4
New York	4.9	5.7	6.3
North Carolina	9.3	10.9	10.1
North Dakota	6.4	2.8	5.1
Ohio	5.9	4.0	5.7
Oklahoma	11.7	11.5	14.5
Oregon	6.0	5.9	5.8
Pennsylvania	5.3	5.3	5.1
Rhode Island	4.2	3.1	5.0
South Carolina	9.1	8.5	11.0
South Dakota	8.1	7.2	9.3
Tennessee	9.3	7.2	10.7
Texas	16.6	16.9	17.8
Utah	8.1	5.8	8.9
Vermont	3.9	1.8	4.2
Virginia	6.5	7.1	7.1
Washington	6.1	5.5	6.4
West Virginia	5.9	4.6	5.2
Wisconsin	5.2	5.1	5.2
Wyoming	11.5	8.1	10.7

Sources: ACS estimates for civilian noninstitutionalized population from SHADAC analysis of U.S. Census Bureau. (2023). “2022 ACS 1-Year Data Tables [Table S2701. Selected Characteristics of Health Insurance Coverage in the United States]”; CPS estimates for civilian noninstitutionalized population from SHADAC analysis of 2022 CPS ASEC microdata via U.S. Census Bureau Microdata Analysis Tool (MDAT); BRFSS estimates from SHADAC analysis of Centers for Disease Control and Prevention (CDC). (2023). “BRFSS Survey Data: 2022.”

Impacts on Survey Data

COVID-19-Related Disruptions to Survey Data Collection and Data Quality

The myriad issues regarding data collection and dissemination in 2020 and 2021 for the ACS, CPS, MEPS, and NHIS due to the COVID-19 pandemic have been well documented in previous versions of this brief.^{1,2} For a more detailed discussion of the pandemic's effect on the operations, data collection, and dissemination of the four major surveys that have been historically included in this brief for 2020, please see SHADAC's "[Changes in Federal Surveys Due to and During COVID-19](#)" brief.

Since the MEPS releases data a full year behind the other surveys, they are still actively accounting for impacts of the COVID-19 pandemic on the 2021 data. Potential effects (and solutions), include: data collection efforts (e.g., the creation of new longitudinal survey panels and extension of previous panels to mitigate nonresponse bias, changes to collection methods, switching from in-person to telephone, etc.),³⁻⁵ low response rates (e.g., the creation of new longitudinal survey panels and extension of previous panels),⁶ and continue to urge caution when attempting to compare or pool 2021 data with other years.

While BRFSS data were not previously included in the 2020 and 2021 versions of this brief, it's important to note that the BRFSS did also experience disruptions due to COVID-19. However, since the BRFSS is administered by state agencies instead of a centralized organization at the federal level, the changes to operations were much more varied than for other larger surveys (though as a telephone-based survey, methodologies were not impacted as they were with other surveys that used in-person and mailing operations). While all states experienced interruptions and pauses in data collection, the way states handled these changes varied. Some were able to resume remote data collection very rapidly, some experienced greater delays but were eventually able to restart data collection, and still other states were not able to resume or finish data collection for 2020 at all. Technically, "all states met the minimum requirements to be included in the public-use data set for 2020"; nonetheless, the CDC urges researchers to use caution when considering comparing 2020 estimates to other years or analyzing trends over time.⁷

More broadly, after a large dip in response rates in 2020, each of these surveys (except the BRFSS) continued to experience lower response rates in the second and third years of the pandemic (2021 and 2022) and, in the case of the ACS and CPS, measurable nonresponse bias.⁸⁻¹¹ As a result, we advise data users to evaluate how lower response rates could affect data quality and reliability when using pandemic-era data for any survey.

Forthcoming Impacts from the Medicaid Unwinding

During the COVID-19 pandemic, a provision in the Families First Coronavirus Response Act (FFCRA) mandated continuous Medicaid enrollment for individuals already enrolled in the program through the end of the public health emergency (PHE). This requirement officially ended on March 31, 2023, which triggered the resumption of Medicaid eligibility redeterminations and renewals (and potential disenrollments) - a process commonly referred to as the "Medicaid unwinding," or simply "the unwinding." Each state has 12 months to resume normal enrollment operations while also meeting reporting requirements set by Centers for Medicare and Medicaid Services (CMS) for publicly sharing coverage transitions and outcomes data during this time. The shifts in coverage that could potentially occur as a result of the unwinding have the potential to be the largest since the implementation of the Affordable Care Act (ACA) in 2014. Estimates from multiple federal organizations place the number of individuals, both adults and children, that could lose Medicaid is in the millions.¹²⁻¹⁴ Further complicating reporting for 2023, specifically, will be the fact that the unwinding started in April, and therefore survey data that cover an entire year may not be able to fully reflect a mid-year shift.

Factors Contributing to Differences in Survey Estimates

Aside from disruptions such as the ones discussed above, there are many other reasons why health insurance estimates typically vary across surveys. Each survey is designed to fulfill different goals, and they use different questions, statistical designs, and data collection and processing methods. Each of these factors likely contributes to differences in uninsurance estimates. The following section articulates more specific differences between the surveys that are included in this brief.

Conceptual Differences in Measures of Uninsurance

As noted earlier, some surveys collect information about whether a person lacked health insurance coverage for a full year, while others collect information on insurance status at a particular point in time, and some collect multiple measures of insurance coverage.

Reference Period

Differences in the time period for which coverage is being reported contribute to differences in the survey estimates. Differences in the length of time for which respondents are being asked to recall their insurance coverage status can also result in differences in measurement error across the surveys.¹⁵⁻²⁰

The CPS Annual Social and Economic Supplement (CPS ASEC), conducted from February through April each year, has historically asked respondents about their health insurance coverage during the entire previous calendar year, with respondents being asked to report their coverage for a time period extending as far back as 16 months prior to the interview. For their measures of coverage during the prior year, the NHIS and MEPS have shorter recall periods than the CPS. The ACS collects information about current coverage only, as does the BRFSS.

Differences in Survey Questions

Differences in the ways that health insurance questions are asked can also lead to differences in uninsurance estimates. For example, when the Census Bureau added a verification question to the CPS in 2000 that asked people who did not report any coverage if they were in fact uninsured for all of 1999, the estimated number of people without health insurance declined by 8%, from 42.6 million to 39.3 million.²¹ The NHIS and MEPS also verify insurance status for people who do not report any of the specific types of coverage that the survey asks about, but the ACS does not.

Another difference in survey questions that can lead to different estimates across surveys is the fact that the CPS, NHIS, and MEPS use state-specific names for Medicaid and Children's Health Insurance Program (CHIP) programs while the ACS and the BRFSS do not, instead referring to these programs as Medicaid, Medigap, Medical Assistance, or any kind of government-assistance program for those with low incomes or a disability.

Missing data and imputation

The CPS and ACS surveys have processes in place to manage missing data and impute missing values. In the CPS ASEC, about 40.4% of households did not answer any questions in the 2023 survey (2022 data), and this nonresponse was corrected by the Census Bureau using survey weights.⁹ Similarly, in the 2022 ACS about 21% of responses had one or more of the health insurance items missing (information is not available for 2020); these missing data were imputed by the Census Bureau.²² In contrast, the NHIS and MEPS impute little or no health insurance coverage information because the data for these two surveys are much more complete than either the CPS or ACS data.

Within-Survey Changes Over Time: Questions & Methodology

In the same way that estimates *across* different surveys may not be comparable, estimates *within* the same survey may not always be comparable over time. This incomparability can be due to changes in survey questions and/or changes in survey methodology.

In addition to the changes described below, beginning in 2020, the ACS, CPS, MEPS-HC, and NHIS all underwent substantial methodological and content changes in response to the COVID-19 pandemic that may present problems for comparability. See SHADAC brief "[Changes in Federal Surveys Due to and During COVID-19](#)" for a more thorough discussion of a majority of these modifications.

Changes in the BRFSS

In 2011, the BRFSS began using a new sampling frame, adding cell phones to the landlines it had historically sampled. The purpose of this revision was to capture the growing segment of the U.S. population that uses cellphones exclusively so that the survey estimates would more closely reflect the overall population.²³ Because of this methodological change, the CDC advises against comparing BRFSS estimates from 2011 onward against those from 2010 and earlier.

Changes in the CPS

In 2014, the CPS incorporated a revised set of survey questions designed to improve the accuracy of its uninsurance estimates, which researchers have suggested more closely resembled a point-in-time measure than a measure of insurance coverage during the previous year (as was intended).²⁴⁻²⁶ Because of these revisions, CPS data from 2013 and onward are not comparable to data from 2012 and earlier.

Data year 2018 represents another break in series for the CPS, as the CPS file for 2018 is the first official file to feature a new processing system that fully incorporates the information contained in the 2014 survey redesign.^{27,28} The updated data processing system uses a new method of estimating health insurance coverage and refines the ways in which respondents' demographic, income, and health insurance data are cleaned, imputed, and weighted. With these new processing mechanisms in place, CPS data from 2018 and onward are not comparable to previous data years.

Changes in the NHIS

In 2019, the content and structure of the NHIS were both updated in order to improve the measurement of health topics, reduce respondent burden by shortening the questionnaire, harmonize overlapping content with other federal health surveys, establish a long-term structure of ongoing and periodic topics, and incorporate advances in survey methodology and measurement.²⁹ Although the 2019 changes do not constitute an official break in series, the National Center for Health Statistics (NCHS) notes that any differences observed between estimates for 2018 and 2019 may be due either to real change in the population or partly attributable to the 2019 NHIS questionnaire redesign and/or the updated weighting approach.³⁰

Deciding Which Survey Estimates to Use

Health policy analysts must decide which estimates to use among the multiple options available. No single survey provides the “best” overall estimates; rather, the most appropriate estimates will depend on the specific policy or research question being examined.

The timeliness of the estimates, the geographies for which estimates are available, and the demographic or socioeconomic characteristics that are included in the estimates—along with the other factors described above—are among key considerations when choosing which estimates to use. For example, those interested in a “first look” at new health insurance coverage estimates will want to use the NHIS, since the NHIS estimates are released before the ACS and CPS estimates. If, on the other hand, sub-state estimates are of interest, the ACS will typically be the best source due to its large sample size, which allows for sub-state analyses. Every research question will require consideration of survey characteristics in relation to analytic requirements.

Both the COVID-19 pandemic and the Medicaid unwinding (and the resulting disruptions to the collection and quality of survey data) present new factors to consider when deciding which data sources to use. Ultimately, when examining or evaluating any measure of health insurance coverage during 2020 and 2021, it may be prudent to use more than one of the data sources discussed here to gain additional context on the range of estimates. Analysts should also consider using other sources of information about uninsurance and coverage, such as administrative data, state-administered surveys, and other nationally representative government surveys such as the CDC’s Behavioral Risk Factor Surveillance System (BRFSS) or the Household Pulse Survey, also administered by the Census Bureau and specifically designed to provide near-real-time data about and during the COVID-19 pandemic.

CONCLUSION

Federal surveys are essential resources for estimating the number of uninsured. Each survey provides a unique view of the problem of uninsurance, and together the surveys provide a wealth of information about how uninsurance varies by population characteristics and how it is associated with differences in access to and use of health care services and with health status. Data users should seek to understand how the pandemic affected surveys measuring coverage in 2020 and 2021 and follow guidance from the conducting organizations when using data from surveys collected in these years.

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APPENDIX A

Table A1. Comparison of Federal Surveys Used to Estimate Uninsurance

	ACS	CPS	MEPS-HC	NHIS	BRFSS
Sponsor(s)	Census Bureau	Bureau of Labor Statistics, U.S. Dept. of Labor conducted by Census Bureau	Agency for Healthcare Research & Quality conducted by Census Bureau	National Center for Health Statistics, Centers for Disease Control and Prevention	Centers for Disease Control and Prevention
Primary Focus	General household survey; replaced decennial census long form	Labor force participation and unemployment	Health care access, utilization, and cost	Population health	State-level data on health-related risk behaviors, health conditions, and utilization
Target Population	Entire population	Civilian non-institutionalized population	Civilian non-institutionalized population	Civilian non-institutionalized population	Civilian non-institutionalized population
Sample Frame	Address-based (National Master Address File)	Address-based (Census 2020 sampling frame updated with new construction)	NHIS respondents	Commercial address list	State-based, random-digit-dialed telephone numbers
Data Collection Mode	Mail; in-person; phone; internet	In-person; phone	In-person; phone [^]	In-person, phone [†]	Phone
Type of Uninsurance Measures	Point-in-time	All of prior calendar year; part of prior calendar year; point-in-time (added in 2014)	Point-in-time; all of prior year; if uninsured, length of time uninsured; uninsured at some point in past year	Point-in-time; all of prior year; if uninsured, length of time uninsured; uninsured at some point in past year	Point-in-time
Insurance Coverage: Verification Question for Uninsured	No	Yes	Yes	Yes	No
State-Specific Names Included for Medicaid/CHIP	No	Yes	Yes	Yes	No
Response Rate	84.4% (2022)	72.2% (2022)	21.8% (2021)	49.6% (2022)	45.1% (2022) ^{^^}
Survey Period	Continuous	February through April	Panel over two calendar years	Continuous	Continuous
State Health Insurance Estimates	50 states and D.C.	50 states and D.C.	Not published	Select number of states published via specialized reports	50 states and D.C.
Years Available	2008 to 2022 ^{**}	1987 to 2022 (plus limited point-in-time estimates for 2023)	1996 to 2021	1998 to 2022	1998 to 2022

Sources: U.S. Census Bureau. (2023). American Community Survey Response Rates: United States [Data set]. Available at <https://www.census.gov/acs/www/methodology/sample-size-and-data-quality/response-rates>; U.S. Census Bureau. (2022). Current Population Survey: 2022 Annual Social and Economic (ASEC) Supplement. <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar22.pdf>; Centers for Disease Control and Prevalence (CDC). (2023). 2022 BRFSS Overview. Available at https://www.cdc.gov/brfss/annual_data/2022/pdf/Overview_2022-508.pdf; Agency for Healthcare Research and Quality (AHRQ). (2022). MEPS-HC Response Rates by Panel [Data set]. Available at https://meps.ahrq.gov/survey_comp/hc_response_rate.jsp; National Center for Health Statistics (NCHS). (2023). National Health Interview Survey: 2022 Survey Description. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2022/srvydesc-508.pdf.

[^] The 2020 MEPS-HC switched to telephone-only data collection due to the COVID-19 pandemic.

[†] The 2020 NHIS added phone data collection due to the COVID-19 pandemic, which continued a few months into 2021 and at the discretion of individual interviewers where COVID rates were high and safety of conducting in-person interviews was a concern.

^{*} The point-in-time file (and corresponding response rate) for the MEPS-HC was discontinued in 2020, and only full-year files and response rates will be available moving forward.

^{**} 2020 1-Year ACS data are considered an “experimental” data product and should not be compared with other ACS data. The Census Bureau urges caution when using the 2020 experimental data.

^{^^} The median survey response rate for all states, territories and Washington, DC, in 2022 was 45.1% and ranged from 22.8% to 66.8%. https://www.cdc.gov/brfss/annual_data/2022/pdf/2022-DQR-508.pdf

APPENDIX B

In addition to overall estimates of health insurance coverage, federal surveys also provide rates for a variety of demographic categories, such as age, sex, geographic area, income level, etc. When examining or comparing coverage rates by category, it is important to understand how each survey defines a particular category. For instance, when looking at health insurance coverage for nonelderly adults, some surveys use age 18 to 64, while others use age 19 to 64.

Table B1. National Uninsurance Estimates from Five Federal Surveys: Nonelderly Adults (Age 18-64)

Survey	Time Period	Uninsured for the Entire Year		Uninsured at a Specific Point in Time	
		Number (Millions)	Percent of Population	Number (Millions)	Percent of Population
ACS (ages 19-64)	2022	N/A	N/A	22.0	11.3
CPS (Entire year: age 18-64; Specific PIT: age 19-64)	2022	21.6	10.8	23.2	11.9
BRFSS	2022	N/A	N/A	21.0	11.0
MEPS	2021	20.0	7.3	N/A	N/A
NHIS	2022	16.8	8.6	24.3	12.2

Source: ACS estimates for civilian noninstitutionalized population from SHADAC analysis of U.S. Census Bureau. (2023). "2022 ACS 1-Year Data Tables [Table S2701. Selected Characteristics of Health Insurance Coverage in the United States]"; CPS entire year estimates from U.S. Census Bureau. (2023). "Health Insurance Coverage in the United States: 2022"; CPS point-in-time estimates from U.S. Census Bureau. (2023). "Health Insurance: Tables 2018-forward [Table H-02. Health Insurance Current Coverage Status and Type of Coverage by Selected Characteristics for All People: 2022]"; BRFSS estimates from BRFSS estimates from SHADAC analysis of Centers for Disease Control and Prevention (CDC). (2023). "BRFSS Survey Data: 2022."; MEPS estimates from Agency for Healthcare Research and Quality (AHRQ). (2023). "Medical Expenditure Panel Survey: Number of people in thousands by insurance coverage, all ages, United States [1996 to 2021]"; NHIS estimates from Cohen, R.A., Cha, A.E., Terlizzi E.P., & Martinez, M.E. (2023, May 1). "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2021" and SHADAC analysis of the 2022 NHIS Public Use Files.

Table B2. 2022 State-Level Uninsured Rates from Three Federal Surveys: Nonelderly Adults

	ACS	CPS	BRFSS		ACS	CPS	BRFSS
	(Age 19-64, Point-in-Time)	(Age 18-64, Full Year)	(Age 18-64, Point-in-Time)		(Age 19-64, Point-in-Time)	(Age 18-64, Full Year)	(Age 18-64, Point-in-Time)
United States	11.3	10.8	11.0				
Alabama	13.6	11.8	12.9	Missouri	12.2	10.7	11.4
Alaska	14.4	15.3	14.7	Montana	11.6	10.1	10.0
Arizona	14.1	14.2	15.0	Nebraska	9.3	9.8	11.0
Arkansas	11.9	9.4	12.7	Nevada	15.3	13.4	15.5
California	9.1	8.6	8.5	New Hampshire	6.9	5.7	6.4
Colorado	9.6	10.9	11.0	New Jersey	9.6	8.0	10.1
Connecticut	7.2	6.7	8.3	New Mexico	12.5	14.9	13.1
Delaware	8.3	7.6	8.6	New York	6.8	7.3	7.9
Dist. of Columbia	3.9	2.1	3.4	North Carolina	13.6	14.7	12.6
Florida	16.2	14.9	15.8	North Dakota	8.3	4.2	6.3
Georgia	16.6	17.1	15.8	Ohio	8.1	6.4	7.3
Hawaii	4.8	4.8	3.0	Oklahoma	16.8	16.2	18.2
Idaho	11.5	11.0	10.3	Oregon	8.8	9.0	7.4
Illinois	9.4	9.9	12.2	Pennsylvania	7.0	6.6	6.4
Indiana	9.4	9.9	12.2	Rhode Island	6.1	3.7	6.3
Iowa	6.1	5.9	6.6	South Carolina	13.6	11.8	14.3
Kansas	12.5	10.0	10.9	South Dakota	11.4	9.7	12.1
Kentucky	7.6	8.9	5.4	Tennessee	13.4	10.6	13.5
Louisiana	10.3	11.6	8.7	Texas	22.4	22.8	21.4
Maine	9.6	4.2	6.2	Utah	10.6	7.2	10.7
Maryland	8.2	10.6	9.6	Vermont	5.6	2.5	5.4
Massachusetts	3.3	4.2	2.8	Virginia	8.9	8.5	8.8
Michigan	6.6	3.8	5.5	Washington	8.8	7.6	7.9
Minnesota	6.2	3.9	6.1	West Virginia	9.1	6.5	7.1
Mississippi	16.4	14.8	13.1	Wisconsin	7.0	5.7	6.8
				Wyoming	16.6	11.4	14.0

Source: ACS estimates for civilian noninstitutionalized population from SHADAC analysis of U.S. Census Bureau. (2022). "2021 ACS 1-Year Data Tables [Table S2701. Selected Characteristics of Health Insurance Coverage in the United States: Age]"; CPS estimates for civilian noninstitutionalized population from SHADAC analysis of 2021 CPS ASEC microdata via U.S. Census Bureau Microdata Analysis Tool (MDAT); BRFSS estimates from SHADAC analysis of Centers for Disease Control and Prevention (CDC). (2023). "BRFSS Survey Data: 2022"