Monitoring the Uninsured: A State Policy Perspective

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Abstract Because states have primary responsibility for the implementation of public health insurance programs, states need timely, good quality data to evaluate programs, monitor trends in the number and characteristics of the uninsured, and better understand the dynamics of health insurance coverage. This article provides a synthesis of the data sources available to states for monitoring rates of health insurance coverage. Information was collected through a comprehensive review of state and national health surveys and in-depth interviews with state analysts in all fifty states. Our findings suggest that national surveys do not meet states' needs for data, and in response, states have initiated their own household surveys. We provide information on thirty-six household surveys that are used to estimate state levels of health insurance coverage. We recommend that national and state efforts be better coordinated to facilitate efficient use of resources to achieve good state-level date.

Background

Having quality data is key to a state's ability to evaluate past access initiatives, monitor trends in the number and characteristics of the uninsured, and provide support for the development and implementation of new health coverage programs. Health care reform in the early 1990s and the later implementation of the State Children's Health Insurance Program (SCHIP) provided the incentive for states to document the number of uninsured using a variety of data sources (Bailey 1997; Call et al. 1999;

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Cautley 1999; Duncan et al. 2000; Haggard 1999; Kahn 1998; McAlearney 1999; Roman 1998; Weinstein 1998; Yegian 1999). Despite the availability of national survey data, at least thirty-seven states have conducted or are conducting large-scale household surveys to collect detailed state-specific data on health insurance coverage.

With the recent economic downturn, there are even greater pressures for states to monitor changes in the numbers and characteristics of uninsured. Rises in the unemployment rate have led to increases in Medicaid enrollment and decreases in state tax revenues (Wachino 2002; Smith and Lanoye 2001). Many state budgets are currently under duress as legislators try to balance increasing demands for public services with decreasing public revenues. For most states, Medicaid is the second largest item in their state budgets and therefore a likely candidate for cuts. In a recent survey of state officials conducted by the Kaiser Commission on Medicaid and the Uninsured, forty-one of fifty states reported they had plans to reduce their Medicaid spending (Wachino 2002).

While reduction in Medicaid may relieve some strain on state budgets, it may also introduce new financial pressures on other state programs. For example, welfare leavers who lose their Medicaid benefits have an increased likelihood of returning to the welfare program (Davidson and Moscovice 1989; Loprest 2002). States who reduce enrollment in their Medicaid programs may also expect to see increases in hospital uncompensated care.

Although low-income working adults continue to be the most at risk of being without coverage, those in the middle class are becoming more concerned about the security of their health benefits (Rowland 2002; Scott 2002: 28). The National Coalition on Health Care predicted that 600,000 to 750,000 individuals could lose their health insurance if premiums rise as sharply as expected (9 to 12 percent), forcing some employers to shift the cost to their employees or eliminate health benefits altogether (Miller 2000).

These trends increase pressure for states to better understand the dynamics of insurance coverage. State, as well as national, policy makers need unbiased, valid, state-specific data to meet the needs of those without access to health insurance coverage.

New Contribution

State-level data on the uninsured are limited despite increasing pressures to understand issues related to insurance coverage in greater depth. This

is not to say that data do not exist. The federal government sponsors at least six national household surveys that ask questions about health insurance status. However, only the Current Population Survey (CPS) routinely produces annual estimates of state uninsurance rates. In this article we examine the national surveys from the perspective of state analysts and policy makers. While several studies provide summaries of national household surveys (Bindman and Gold 1998; Eden 1998; Fronstin 2000; Gold 1998; Lewis, Ellwood, and Czajka 1998; Liska, Brennan, and Bruen 1998; Project HOPE 2000), only a few have discussed the value of the data generated from these surveys to states (Fronstin 2000; Project HOPE 2000). Based on interviews with analysts across the fifty states about the data they use to monitor the uninsured, as well as a discussion of their needs for ongoing data collection, we suggest that while states have unique and varied needs for data, there is increasing interest in having data that are representative of their states.

In this article, we present a description of the national surveys along with a comparative analysis of these surveys based on criteria states use to evaluate their usefulness and relevance. Because states' needs for data are not fully met by national surveys, at least thirty-six states have developed and implemented their own state household surveys (Blewett 2001). We provide here the first comprehensive compilation of state surveys and their key characteristics. We conclude with a discussion of the implications of these varied state and national data collection activities and the future of survey efforts to provide more useful data for state policy applications.

Methods and Approach

To gain a better understanding of states' needs for data to monitor the uninsured and current use of national and state surveys, we conducted three key activities: (1) telephone interviews with policy analysts from all fifty states to assess their use of existing state and national survey data, (2) a critical evaluation of national surveys based on their ability to meet states' data needs, and (3) documentation of existing state household surveys used to estimate health insurance coverage, describing how these state surveys go beyond what national surveys are currently able to deliver.

State Analyst Survey

To identify the appropriate person in each state to interview, we called the department of health or the state health commissioner's office in each state

and asked to speak to the person responsible for data on uninsured residents. We followed up with additional analysts if referred by the initial respondent. We used a structured interview guide to ask respondents about their knowledge of existing national data and resources available on the uninsured, the data and information that they used to inform state policy, and information about state data needs for monitoring the uninsured. The intent of the state analyst survey was to get an overview of analysts' use of national survey data and the range of data collection activities going on in their state, as well as to document state data needs with regard to monitoring health insurance coverage. The results of these interviews are included in the following two sections where we outline the criteria states use to evaluate the usefulness of national survey data and provide a critical evaluation of the ability of national surveys to meet states' data needs.

Usefulness of National Data for State-level Monitoring of the Uninsured

Based primarily on our interviews with state analysts, we identified criteria state analysts use when evaluating the usefulness of national survey data to monitor the uninsured. These criteria are critical to understanding state data needs and the use of national survey data as well as the need for additional coordination between federal and state data collection activities. When reviewing the data that are available on the uninsured, states use the following key criteria:

- A good survey design to produce policy relevant information on health insurance coverage that has been tested, evaluated, and validated over time
- Sufficient sample to produce state-level estimates
- Timely and routine release of estimates of health insurance coverage (i.e., within one year of data collection with regular follow-up releases scheduled)
- Available public use files that include state identifiers
- Sufficient sample for some direct state subpopulation estimates, including
  - Children
  - Racial and ethnic groups
  - Geographic region

We use these criteria to describe and evaluate national surveys that address health insurance coverage. We assume that all the national sur-

veys presented in our analysis meet the first criterion in that they are based on good survey design and use well-tested questionnaires. While the issue of timely and routine release of data is clearly relevant to general data users, the remaining criteria are of particular relevance for state analysts. For example, having state identifiers in the public use file is an important component, but it is critical that the survey sample be representative of the state's population. If a state-representative sample is not available, the second best option would be to have support in developing model-based estimates of coverage at the state level using population or demographic weights to support the analysis. We found that while state identifiers may be available in the public use files, the sample may not be representative of the state, thus making any use of those identifiers virtually meaningless from a state policy perspective. The National Health Interview Survey (NHIS) is one example of a national survey that has attempted to develop state estimates to maximize the potential use of national data at the state level. These state estimates, however, were for the early 1990s only.

We present below a brief review of the key national surveys and their ability to meet state data objectives with regard to monitoring health insurance coverage. Table 1 provides an overview of each of these surveys and their key characteristics, including the entity conducting the survey, sample size, and basic survey method. We then evaluate the utility of these surveys from a state policy perspective. To help guide our analysis of the national surveys we use two summary charts. Table 2 compares the abilities of six federal surveys and two privately funded surveys to meet state data needs, using the state data criteria described above. Table 3 provides an overview of each state's use of the national surveys to measure and monitor state rates of health insurance coverage. Information on states' use of national survey data was obtained through our interviews with fifty state analysts. Not surprisingly, the national surveys with low ratings based on the data criteria (Table 2) are used by fewer states to monitor health insurance coverage (Table 3), and the national surveys that meet more of the state criteria were used by more states.

Current Population Survey (CPS)

The Demographic Supplement to the CPS, administered annually by the Census Bureau, is the most commonly used data source for estimating rates of health insurance coverage at both the national and the state levels. Direct state estimates of health insurance coverage rates are produced

Table 1 Overview of National Household Surveys

Survey and Entity Conducting Survey	Years	Sample Size and Availability of State Estimates	Survey Content	Survey Method
Federal surveys				
Behavioral Risk Factor Surveillance System (Centers for Disease Control and Prevention and U.S. states and territories)	Annually since 1981	Samples range from 1,193 to 5,107 per state; direct estimates for all 50 states	Health behaviors, knowledge, use of preventive health services, and health insurance coverage	Telephone
Current Population Survey (Bureau of the Census for the Bureau of Labor Statistics)	Monthly since 1943; health insurance added in 1980 as part of March supplement	Approximately 99,000 households in 2001 and 218,000 individuals; direct estimates for all 50 states	Labor force characteristics, monthly employment statistics, and health insurance coverage	First interview in person; subsequent interviews by telephone
Medical Expenditure Panel Survey–Household Component (Bureau of the Census for the Agency for Health Research and Quality)	1977, 1987; continuous panel design since 1996	In the 1996 survey, 10,500 families and 24,000 individuals; no state estimates	Health care use, cost, sources of payment, health insurance coverage	In-person interviews and telephone
National Health Interview Survey (Bureau of the Census for the National Center for Health Statistics)	Since 1957	Approximately 43,000 households, including about 106,000 persons; state data files for 1990–1994 for select states	Health status, health insurance coverage, health services use, and activities and work limitations	In-person interviews

Table 1 (Continued)

Survey and Entity Conducting Survey	Years	Sample Size and Availability of State Estimates	Survey Content	Survey Method
State and Local Area Integrated Telephone Survey (National Center for Health Statistics)	1998	1,000 households with kids ≤200% FPL[a] and 1,000 households with kids above 200% FPL[a]; estimates for all 50 states	Health status, health insurance coverage, health services use, and access to care	Telephone
Survey of Income and Program Participation (Bureau of the Census)	Since 1983	Sample ranges from 14,000 to 37,000 household units; no state estimates	Health insurance coverage on a monthly basis; information on the sociodemographics, income, labor force participation, program eligibility	First two waves in person; all other waves, 33% in person, 67% telephone
Private surveys				
National Survey of America's Families (Urban Institute)	1997, 1999	47,900 cases total; approximately 1,000 low-income children per state; estimates for 13 states	Health insurance coverage, health status, health services use and access, child care, welfare, employment, education, housing	Telephone supplemented by in-person interviews
Community Tracking Survey (Center for Studying Health System Change)	1996, 1998	Nationally representative with 60,000 individuals from 60 communities; no state estimates	Health insurance coverage, health insurance offerings by employers, health services use and access, and satisfaction with care	Telephone supplemented by in-person interviews

[a]Federal poverty level.

Table 2 Rating of Surveys' Ability to Meet State Criteria

Survey	Sample Representative at State Level	Tabulated State Estimates Publicly Released within One Year of Data Collection	Public Use Files Available with State Identifiers	Enough Sample for Some Direct State Subpopulation Estimates		
				Children (under 18)	Race/ Ethnicity	County/ Region
CPS	✓	✓	✓	✓	✓	✓[a]
MEPS-HC						
NHIS	✓[b]	✓	✓[c]			
SLAITS	✓		✓	✓	✓	✓
SIPP			✓			
BRFSS	✓	✓	✓		✓	✓[d]
NSAF	✓	✓	✓	✓	✓	
CTS			✓			✓[e]

[a]Available for counties with a population of 100,000 or more and the largest 242 Metropolitan Statistical Areas.
[b]1995 redesign provides representative state estimates for some large states.
[c]State data file available for 1990–1994.
[d]Available for large counties only.
[e]Available for CTS sites only.

Table 3 Data Sources Used by States to Estimate Rate of Uninsurance

	Federal Surveys						Private Surveys	
State	CPS	MEPS-HC	BRFSS	NHIS	SIPP	SLAITS	NSAF	CTS
Alabama								
Alaska	✓		✓					
Arizona	✓							(Phoenix)
Arkansas	✓		✓		✓			✓ (Little Rock)
California	✓		✓	✓			✓	(Orange County)
Colorado	✓						✓	
Connecticut	✓		✓				✓	
Delaware	✓		✓		✓			
Florida	✓	✓		✓			✓	(Miami)
Georgia	✓							
Hawaii	✓		✓					
Idaho	✓		✓					
Illinois			✓					
Indiana	✓							(Indianapolis)
Iowa	✓							
Kansas	✓		✓					
Kentucky	✓							
Louisiana	✓		✓					
Maine		✓						
Maryland	✓	✓	✓					
Massachusetts							✓	(Boston)
Michigan	✓		✓				✓	(Lansing)

Table 3 Data Sources Used by States to Estimate Rate of Uninsurance (Continued)

	Federal Surveys						Private Surveys	
State	CPS	MEPS-HC	BRFSS	NHIS	SIPP	SLAITS	NSAF	CTS
Minnesota	✓	✓	✓	✓	✓		✓	
Mississippi								
Missouri	✓		✓		✓			
Montana	✓		✓					
Nebraska	✓		✓	✓				
Nevada								
New Hampshire	✓	✓			✓		✓	✓
New Jersey	✓						✓	(Northern NJ)
New Mexico	✓	✓						
New York	✓				✓	✓		(Syracuse)
North Carolina	✓		✓					
North Dakota	✓						✓	✓
Ohio	✓		✓					(Cleveland)
Oklahoma	✓							
Oregon		✓			✓			
Pennsylvania	✓							
Rhode Island	✓		✓					
South Carolina	✓		✓					(Greenville)
South Dakota	✓		✓					
Tennessee								
Texas	✓	✓	✓					

Table 3 (Continued)

	Federal Surveys						Private Surveys	
State	CPS	MEPS-HC	BRFSS	NHIS	SIPP	SLAITS	NSAF	CTS
Utah	✓		✓	✓				
Vermont	✓		✓					
Virginia	✓							
Washington							✓	(Seattle)
West Virginia	✓		✓					
Wisconsin							✓	
Wyoming	✓							
Totals	40	8	25	5	7	0	13	3

each year based on a sample that is designed to be representative of each state, plus the District of Columbia (U.S. Bureau of the Census 2000). The Census Bureau routinely releases state data tables and data on all fifty states with identifiers in its Public Use File (U.S. Bureau of the Census 2002a). These data are generally available on the Census Bureau's Web site immediately after the fall release of the health insurance coverage estimates, which is six months after data collection is completed. The CPS provides the only source of comparative information for broad categories of state populations. In addition, the Census Bureau created an algorithm for state-specific adjustments to state-level standard errors. The Census Bureau has made and continues to make adaptations to the CPS that have the potential to increase its usefulness to state policy makers, especially to those in states without the resources to collect their own state-specific data.

An example of a recent improvement to the CPS was the expansion of its sample. Appropriations to the Census Bureau included in the Balanced Budget Act (Public Law 106–113) were designed to improve the precision of CPS state-level estimates of insurance coverage. Beginning in 2000, the Census Bureau expanded the sample size within each state (Davern and Blewett 2001). The increase in the sample size of the CPS has increased the precision of state estimates of health insurance coverage for all states, with the greatest impact on states with small and/or diverse populations. In general, the amount of error associated with an annual state estimate of coverage decreased by a range of approximately 49 percent (Maine) to 15 percent (Mississippi) with an average decrease of 33 percent per state (Davern et al. 2003). The CPS sample expansion provides more precise state-level estimates of uninsurance and less variation from year to year. Single-year estimates based on the expanded sample were first available with 2001 data; three-year rolling average estimates using the expanded sample will be possible when the 2003 data are available.

Although CPS sample expansion will improve the precision of the state-level estimates, it should be noted that the sampling design itself has not changed. Because a sample is not drawn from all counties in a state, estimates for all counties are not possible. Even with recent state sample expansions, the Census Bureau still recommends that states combine three years of CPS data for reporting or monitoring coverage rates in an effort to reduce the sampling error associated with the smaller sample size (Mills 2002).

Other improvements to the CPS enhance its relevance to state analysts,

such as the inclusion of state-specific program names in the survey (e.g., Medicaid is referred to as Medi-Cal in California and Medical Assistance in Minnesota), as well as the addition of a question asking about participation in some state-run programs (e.g., TennCare, BadgerCare, MinnesotaCare).

The CPS is of particular importance to states because its state estimates of low-income uninsured children are used in the formula to allocate federal SCHIP dollars to the states (Health Care Financing Administration 2000). Although nearly all of the state analysts we interviewed were aware of the CPS, only forty states reported routine use of the CPS estimates to inform state health policy (Table 3). It is interesting to note that eight of the ten states reporting nonuse of the CPS have conducted or are developing their own state household surveys for state policy purposes.

Overall, the CPS met all six criteria for usefulness in state-level monitoring of the uninsured. Its sample size is sufficient for estimating rates of coverage at the state level, and it can be used for some direct county-level estimates (counties over 100,000 population) as well as estimates for 242 select Metropolitan Statistical Areas. The CPS may also be used to estimate rates of coverage among some state subpopulations of interest (e.g., children, racial/ethnic groups, and geographic regions). CPS data are routinely released and provided in public use files with state identifiers.

Medical Expenditure Panel Survey-Household Component (MEPS-HC)

The MEPS-HC is conducted by the Census Bureau for the Agency for Healthcare Research and Quality (AHRQ). It is a nationally representative subsample of households that participated in the prior year's National Center for Health Statistics (NCHS) National Health Interview Survey (NHIS) (AHRQ 2002a). MEPS-HC data can be used to make comparisons over time and study changes in the relationship among measures of health status, access to care, health care use and expenditures, and health insurance coverage (AHRQ 2002b).

The MEPS-HC does not meet any of the criteria outlined in Table 2 for state-level monitoring of the uninsured. While state identifiers exist, they are not available on the public use file; moreover, there is not a large enough sample in each state to produce reliable state estimates. Only eight states reported having used the publicly released MEPS-HC data (Table 3). National data on medical expenditures could be used to model state expenditures in select categories using model-based simulation techniques, but

states have not pursued the use of MEPS-HC in this regard. There is currently no readily available analytic support from AHRQ to use the MEPS-HC to pursue model-based estimates for state policy purposes. State identifiers exist only on restricted microdata files, and the potential for state policy research is largely untapped because these data are only available at one of the six Research Data Centers (RDCs) located across the country (U.S. Bureau of the Census 2002b). The process of accessing these data is costly and cumbersome and largely outside of the reach of state policy analysts, particularly when state-specific analysis is likely not possible.

National Health Interview Survey (NHIS)

The NHIS is conducted by the Bureau of the Census for the NCHS to monitor trends in illness and disability and track progress in reaching national health objectives (Fronstin 2000). The advantage of NHIS is that it is an established and tested ongoing national survey supported by federal funding. It is more likely to reach low-income populations as it includes surveys of households with and without telephones and it oversamples blacks and Hispanics (NCHS 2000a).

The NHIS met only three of the five state-level criteria (Table 2). Public use files are available and are relatively easy to obtain. The NHIS microdata are now available through NCHS's own Research Data Center, which was modeled after the Census Bureau's RDCs and follows a similar process for accessing data (NCHS 2000b). Release of data is comparable to other federal surveys that appear to be, on average, two years from data collection.

The key disadvantage of NHIS from a state policy perspective is that it is not specifically designed to be state representative. NCHS has, in the past, made "state" files available. These State Data Files include statistical adjustments to state-level estimates to address confidentiality issues, and states with a small sample size are included in groups of three to five states. These files are publicly released with state identifiers, but currently, only the files for 1990–1994 are available (Madans et al. 2001).

NCHS also made efforts in the 1995 NHIS redesign to facilitate state-level estimates. The vehicles for this effort included making the primary sampling units (PSUs) respect state boundaries and increasing the number of PSUs from 198 to 358. Nonetheless, direct state estimates are only possible when the prevalence rates are fairly high ($p = 0.15$ and $p = 0.20$) and the design effects are relatively small (1.0–1.5) (ibid.). For subpop-

ulation estimates, such as children under eighteen, the number of states with a large enough sample is very small. Currently, there is limited information on the sample size per state and what state-specific estimates would be possible through NHIS analysis.

As presented in Table 3, only five states have used survey information from the NHIS in state health policy discussions, and no state analyst has pursued the model-based estimation of state rates. We also learned that at least one state considered buying additional state samples as part of the ongoing NHIS. However, specific issues related to the key components of the sampling frame for NHIS prevented the state from pursuing this further.

State and Local Area Integrated Telephone Survey (SLAITS)

SLAITS was the response of the NCHS to the need for more detailed information at the state and local levels to support state-level policy applications of survey data. SLAITS allows researchers to collect data using customized questionnaires and the National Immunization Survey sampling frame of nearly one million households (NCHS 2001b). The funding for SLAITS does not come from ongoing core NCHS federal funds, but rather through nongovernment and nonprofit sponsors. Sponsors may implement existing SLAITS survey modules or fund the development of new SLAITS modules (NCHS 2001a). There are presently four SLAITS survey modules: Health (Iowa and Washington State, 1997), Child Well-Being and Welfare (Texas and Minnesota, 1998–1999), National Survey of Early Childhood Health (national sample, 2000), and Children with Special Health Care Needs (national and state samples, 2000–2001). Although the sampling frame is quite large, the sample size needed for each survey module is substantially smaller and varies by module. For example, for the Children with Special Health Care Needs module, the target sample was 750 completed child interviews in each state (Blumberg 2002). SLAITS has the potential to meet state data needs, and it currently meets five of the six criteria in Table 2. The key advantage of SLAITS is that it was designed specifically to produce representative state-level estimates of health characteristics. Yet, for the first large national SLAITS survey (i.e., the module for children with special health needs), the state sample sizes are too small for subpopulation analyses. For example, only fifteen states had sample sizes large enough to produce reliable estimates of uninsured low-income children. The timing of the data release also is

a drawback. The interviews commenced in October 2000; as of September 2003, the data still had not been released. It is anticipated that a public use file will be available with state identifiers, but the timing of this release is uncertain.

Microlevel data will be made available through the NCHS Research Data Center with some remote access possible, which will increase state analysts' interest in and use of the data. A key concern is ongoing funding and follow-up surveys that will vary depending on federal priorities and outside funding. Nonetheless, SLAITS has the flexibility to accommodate state-specific needs and has the potential as a mechanism for state-level comparisons. Because the data have not been released, we did not find any analysts who were using this survey for state policy purposes.

Survey of Income and Program Participation (SIPP)

SIPP is currently the best data set for analyzing the dynamics of coverage over time and may provide a starting point for states interested in learning more about the episodic nature of uninsurance (Swartz 1994). SIPP is conducted by the Census Bureau and is designed to collect data on income, labor force participation, and program participation. SIPP's purpose is to measure the effectiveness of existing federal, state, and local programs, as well as to estimate future costs and coverage for government programs. The survey design is a series of national panels tracking health insurance coverage on a monthly basis with the duration of each panel ranging from 2.5 to 4 years (U.S. Bureau of the Census 2002c). The release of SIPP data is approximately eighteen months from the end of data collection, which is relatively good given the complex design of this longitudinal survey, but still somewhat long from a state policy perspective. Because of its national focus, SIPP meets very few of the state criteria (Table 2).

SIPP was not designed to be representative at the state level and does not allow for state-level estimates (Kalton 1998). While state identifiers are available for forty-eight states in the 1996 panel, the Census Bureau warns against using SIPP to produce state-level estimates (Fronstin 2000). The availability of state identifiers makes model-based estimation an option using SIPP, but we are not aware of any state analysts pursuing this work. Neither are we aware of any Census Bureau agency technical support for model-based estimates for state policy work. Our survey results

indicate that very few states are aware of SIPP and only seven states reported using SIPP estimates in their state health policy work (Table 3).

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS was established based on the perceptions (1) that data on health status and risk behaviors collected at the national level were not available to state officials, who have the primary role of targeting resources to address behavioral risks, and (2) that state and local agency participation is essential to achieve national health goals (Centers for Disease Control and Prevention 1999). As implementers of the BRFSS, states conduct rolling monthly telephone surveys based on a common sampling methodology and a list of core questions to allow comparisons across states. An advantage for state analysts is that the states conduct the surveys themselves. Consequently, states have control over questions included in the state-specific modules and have access to the person-level survey data for ongoing state analysis. Some states have pursued additional funding to increase sample size and have developed stratification that allows them to derive estimates for regions and subpopulations within their respective states.

The BRFSS meets five of the six criteria identified by states. All fifty state identifiers, plus the District of Columbia, are included on the public use files that are readily available and accessible to state analysts. States have pursued the development of model-based estimates for subpopulations of interest, primarily for geographic areas such as county-based estimates, using demographic weights. These statistical approaches are developed locally for state and local policy applications, but currently there is not a large enough sample for direct estimates.

There are several disadvantages to the BRFSS that have led to its being underused. The central drawback is that this is a survey of working-aged adults. Although some states have added a child component, the focus of BRFSS has not been on children. In recent years, many national and state health access initiatives have primarily focused on children, so BRFSS is not very useful for evaluation of these coverage expansions. Another criticism of the BRFSS is its lack of specificity regarding insurance coverage type, as well as the limited number of questionnaire items devoted to this issue.

Although the time lag for data release is better than some national surveys, it still takes one year to collect the data (continuous sampling over

the one-year period) and one year to create estimates. Concerns have also been raised about the potential for undersampling low-income households because this is strictly a telephone survey. The BRFSS has also been criticized for its lack of sufficient data on specific subpopulations, including populations of color and city- or county-specific data needed for state health policy initiatives (Figgs et al. 2000). Another concern voiced by those doing cross-state comparisons is inconsistent monitoring of data quality. It is difficult to oversee fifty state data collection processes and assess the impact of varied methods on the states' estimates. Because of its availability and accessibility at the state level, BRFSS was used by half of the states in their efforts to monitor health insurance coverage rates (Table 3). This survey was the second most widely used survey by the states.

Community Tracking Study Household Survey

The Community Tracking Survey (CTS) is a privately sponsored nationally representative survey conducted in sixty communities across the United States (Center for Studying Health System Change 1997). The CTS provides data on access to care, use of care, financial burden, and health insurance coverage (Fronstin 2000). For twelve of the sixty communities, the CTS provides local and regional estimates of uninsurance to help identify pockets of concern or needed local intervention.

The CTS falls short from the state perspective (Table 2) as it cannot produce state-level estimates because it is not a state-representative survey. The communities in the CTS may be compared to other communities in the sample, but there is no direct link to state applications. The CTS did sample enough individuals to make small-area estimates of health insurance coverage for twelve of the areas included in the study. But, again, there are no comparable state-level estimates.

Public use files are available for researchers interested in analyzing data from the CTS, and while there are state identifiers on the public use file, they are not very useful in developing estimates of state health insurance coverage, as the survey sample is not state representative. Our interviews found that only three state analysts used information from the CTS for policy purposes (see Table 3).

National Survey of America's Families (NSAF)

The NSAF is a nationally representative household survey that provides more detailed information for thirteen states (AL, CA, CO, FL, MA, MI,

MN, MS, NJ, NY, TX, WA, and WI) on health insurance coverage, employment, income, education, housing, and other related health issues. It was fielded in 1997, 1999, and again in 2002. A timely, well-designed survey conducted by the Urban Institute, it is second only to the CPS in ratings on the state criteria (Table 2).

Public use files and microdata (1997 and 1999) are available for state-level analyses. These data are attractive to state analysts due to the oversampling of low-income households, the efforts made to include households without telephones, and the large sample in some states to provide estimates for some populations of color and immigrants. In addition, the Urban Institute recently released a software interface tool to provide additional access to those interested in analyzing the state data, and it also provides training opportunities for state analysts (SHADAC 2002). Our survey of state analysts indicates that thirteen states have used the NSAF data. Notably, ten of the thirteen states represented in the NSAF reported having used the data as a resource in state policy discussions (Table 3).

Summary of State Use of National Survey Data

Although the analysts we talked to varied in their knowledge and levels of interest in data on the uninsured, we found common issues and concerns that cut across states. As seen in Table 2, only one of the national surveys fully met all of the state-level criteria. It is fairly clear that the national surveys are for national, rather than state, policy making. Outside of CPS and NSAF, the surveys reviewed lacked an adequate sample for direct state estimates, did not have a state-representative sample, or did not have the sample needed for direct health insurance coverage estimates of subpopulations. This assessment of the monitoring capabilities of available national survey data highlights the challenges facing states as they look for data and information to monitor rates of health insurance coverage. The following represents a summary of our key findings:

States question the validity of national survey estimates. Each of the national surveys described above produces a different estimate of the number of uninsured. The estimates are routinely and independently released, creating some confusion about the estimate itself. This inconsistency leaves many states doubting the integrity of the data and frustrated when attempting to make sense of discrepant estimates. A number of states voiced a desire for a single reliable estimate. For example, Wisconsin's CPS estimate of the size of its uninsured population had been tracked with

their own state estimate for several years. When the CPS estimate jumped by approximately 50 percent between 1997 and 1998 (U.S. Bureau of the Census 1998), it created a great deal of mistrust in the CPS estimates, decreasing the use of the CPS for monitoring trends over time by Wisconsin analysts.

States' levels of technical sophistication vary. The analysts we talked to differ in their technical proficiency required to understand the complex issues involved in survey research and the development of population estimates. Some states take advantage of access to multiple sources of data and conduct sophisticated analyses of the factors associated with uninsurance. Other state analysts had access to the CPS and other data but lacked the time, resources, and technical capacity to conduct relevant analyses. Other states' policy interests were varied and health insurance coverage information was not a priority. Clearly, states have varied needs for both data and technical assistance.

States are interested in efforts to increase the availability of relevant information on the uninsured. Several states are responding to the inadequacy of national data on the uninsured by conducting their own surveys. Unfortunately, many states lack the necessary financial resources and technical skills to pursue this option and are left trying to use national survey data to the best of their abilities. The one-time funding provided by the Health Resources Services and Administration (HRSA) State Planning Grant program dramatically increased state data collection activities (HRSA 2000b). However, to assess the effectiveness of expansion initiatives, the impact of changes in the market, and trends over time, states need more than one-time funding for repeated cross-sectional surveys. The challenge will be to amass the funding and the expertise within states to support additional data collection.

States report similar needs for subpopulation analyses. Many states are interested in examining disparities in insurance coverage by race, income level, and geographic region. Additional state and local policy concerns related to subpopulations include the economic impact of uninsurance, subsidies to local providers for uncompensated and/or charity care, and increasing needs for translation services and culturally sensitive medical and social services related to access to health care. Local communities are interested in these data for planning purposes, and many state analysts are required to provide it. The design and size of national surveys' samples

do not support these subanalyses. However, many of the state-initiated surveys also lack the sampling design and size needed to provide estimates of various subpopulations.

State Survey Initiatives

In response to the need for more detailed state-specific and subpopulation data on health insurance coverage, thirty-six states are conducting their own household surveys. State analysts prefer collecting their own data because they can design their sampling strategy to support subpopulation analyses, tailor the survey instrument to address unique policy interests, and control what analyses are conducted and when the results are released (paying attention to the state legislative calendar when necessary). They can also have more control over the budget.

Table 4 provides an overview of the thirty-six states that have conducted or are in the process of conducting household surveys, as of September 2003. It describes the sample size, survey methodology, and sampling design of each state's most recent survey.

As presented in Table 4, all states but three used a random digit dialing (RDD) telephone household survey alone. Minnesota conducted supplementary in-person interviews for select subpopulation samples, Wyoming added mail and in-person components, and North Dakota conducted only a mail survey of its farm and ranch operators. Neither, however, combined the additional survey data with the telephone survey data. Sample sizes ranged from 1,500 individuals in Iowa to over 60,000 in California. Costs were comparable and ranged from $25,000 in North Dakota and Oregon to $11.6 million for California's omnibus survey. On average, state surveys cost $250,000–$500,000 and have sample sizes between 5,000 and 10,000 individuals.

One advantage of state surveys is their ability to increase sample size above what is provided in the national surveys. Another is their ability to adjust the sampling design to target and derive estimates for specific subpopulations. For example, Indiana's current household survey has a sample of 10,126 households with an oversample of low-income households and African Americans. The CPS sample size for Indiana with the recent sample expansion was 1,740. Other typical state sampling frames included oversampling for rural or other geographic areas, racial and ethnic groups, low-income populations, and children.

Several states have had ongoing state-initiated and supported surveys that have been conducted annually or on a periodic basis. Examples of

Table 4 State Household Survey Descriptions

State	Name of Survey	Date(s) Conducted	Sample Size[a]	Oversampling[a]	Methodology[a]
Alabama	Alabama Health Care Insurance and Access Survey	2003	7,299 households	Yes (children, Hispanics, 12 geographic regions)	Telephone
Arkansas	Arkansas Household Survey of Health Insurance Coverage	2001	6,596 individuals, 2,572 households	Yes (3 geographic regions)	Telephone
California	California Health Interview Survey	2000, 2001	55,428 adults, 5,801 adolescents, 12,592 children by proxy	Yes (3 city health departments, major ethnic groups, American Indians)	Telephone
Colorado	Colorado Household Survey	2001	10,217 households	Yes (rural populations, persons of color, low income, HPSA/MUAs)[b]	Telephone
Connecticut	Family Health Care Access Survey	1995, 2001	14,333 households sampled, 3,985 completed	Yes (low income)	Telephone
Florida	Florida Health Insurance Survey	1999	14,011 households, 38,000 individuals	Yes (blacks, Hispanics, low income)	Telephone
Georgia	Georgia Health Care Insurance and Access Survey	2003	10,088 households	Yes (low and middle income, rural locations)	Telephone

Table 4 (Continued)

State	Name of Survey	Date(s) Conducted	Sample Size[a]	Oversampling [a]	Methodology[a]
Hawaii	Hawaii Health Survey	Conducted annually since 1968	6,000 households	Yes (overrepresentation of smaller islands within the state)	Telephone
Illinois	Illinois Population Survey of Uninsured and Newly Insured	2001	25,735 individuals	Yes (rural populations)	Telephone
Indiana	Health Insurance for Indiana's Families Survey	2000, 2003	10,126 households	Yes (10 geographic strata, low income, African Americans)	Telephone
Iowa	Iowa Survey of the Uninsured	2001	1,500 uninsured individuals	Yes (low income)	Telephone
Kansas	Kansas Survey of Health Insurance	2001	8,004 households, 22,691 individuals	Yes (Hispanics, low income, Blacks)	Telephone
Kentucky	Kentucky Health Insurance Survey	Annually since 1996	1,200 households, 5,000–6,000 individuals	Yes (individually insured, uninsured, employees with coverage from small employers < 50)	Telephone

Table 4 State Household Survey Descriptions (Continued)

State	Name of Survey	Date(s) Conducted	Sample Size[a]	Oversampling[a]	Methodology[a]
Maine	Health Insurance Coverage and Access to Care among Maine Residents	1997, 2000, 2002	3,500 households	Stratified random sample of Maine residents	Telephone
Maryland	Maryland Health Insurance Coverage Survey	2001	5,000 households	Yes (rural below 300% FPL; families w/children)[c]	Telephone
Massachusetts	Survey of Health Insurance Status of Massachusetts Residents	Every 2 years beginning in 1998	2,362 households, 7,069 individuals	Yes (oversample 2,600 urban households, urban sites)	Telephone
Minnesota	Minnesota Health Access Survey	1990, 1995, 1999, 2001	27,310 (phone), 2,085 (in person)	Yes (blacks, Native Americans, Hispanics/ Latinos, Asians, rural, low income)	Telephone and in person
Montana	Household Survey on Montana's Uninsured	2003	4,000 households	Stratified RDD[d]	Telephone
Nebraska	Nebraska Annual Social Indicators Survey	Annually since 1977	Minimum 1,800 households	Yes, depending upon participating agencies	Telephone
New Hampshire	New Hampshire Health Insurance and Access Survey	1999, 2001	8,700 families (1999), 5,177 families (2001)	No oversampling	Telephone

Table 4 (Continued)

State	Name of Survey	Date(s) Conducted	Sample Size[a]	Oversampling[a]	Methodology[a]
New Mexico	New Mexico Health Care Coverage Survey	1998	3,389 households	No oversampling	Telephone
North Dakota	2000 Health Insurance Survey of Farm and Ranch Operators	2000	1,571 households	Yes (rural populations)	Mail
Ohio	Ohio Family Health Survey	1998 (plan to conduct every 3–4 years)	16,000 households	Yes (rural populations)	Telephone
Oregon	Oregon Population Survey	2000	10,271	Yes (Native Americans, African Americans, Asian Americans, Hispanics)	Telephone
Rhode Island	Rhode Island Health Interview Survey	Conducted every 5 years since 1975	2,580 households, 6,583 individuals (includes oversample)	Yes (racial and ethnic minorities, including Spanish- and Portuguese-speaking)	Telephone
South Carolina	South Carolina Health Care Insurance and Access Survey	2003	1,600 households	Yes (oversampled uninsured)	Telephone

Table 4 State Household Survey Descriptions (Continued)

State	Name of Survey	Date(s) Conducted	Sample Size[a]	Oversampling[a]	Methodology[a]
South Dakota	South Dakota Uninsured Study	2001	1,502 households with at least 1 uninsured individual	Yes (8 geographic regions)	Telephone
Tennessee	Tennessee Survey for Insurance Status and Health Care Status	Conducted annually since 1993	5,000 households	No oversampling	Telephone
Texas	Uninsured Texans–Household Survey of Texans without Health Insurance, 2001	2001	598 households	Yes (by county, Hispanic population)	Telephone
Utah	Utah Health Status Survey	Conducted every 4 years, beginning in 1986	7,250 households, 24,088 individuals	Yes (rural populations, persons of color, low-income, uninsured)	Telephone
Vermont	Vermont Family Health Insurance Survey	2000 (Conducted every 3–4 years, beginning in 1993)	8,622 families, 22,258 individuals	Yes (low income, seniors 65+)	Telephone

Table 4 (Continued)

State	Name of Survey	Date(s) Conducted	Sample Size[a]	Oversampling[a]	Methodology[a]
Virginia	Virginia Health Access Survey	1993, 1996, 2001	1,959 households, 4,801 individuals	Yes (specific populations not specified)	Telephone
Washington	Washington State Population Survey	1998, 2000	6,726 households	Yes (African Americans, Asians, Native Americans, Hispanics)	Telephone
West Virginia	West Virginia Healthcare Survey	2001	16,493 households	Yes (rural, African Americans)	Telephone
Wisconsin	Conducted Wisconsin Family Health Survey	annually since 1989	2,436 households, 6,368 individuals	Yes (Oversample Milwaukee areas with high rates of African Americans and other minorities. Also conducted separate surveys of farmers and young people 18 to 24 years of age.)	Telephone
Wyoming	Wyoming Health Insurance Surveys	2003	4,315 mail, 1,196 phone, 50 to 70 in person, group quarters	Yes (counties, residents, in-group quarters)	Telephone, mail, in person

[a]Reported survey details (sample size, oversampling, methods, funding) are for the most recent survey fielded.
[b]HPSA = Health Professional Shortage Area; MUAs = Medically Underserved Areas.
[c]FPL = Federal poverty level.
[d]RDD = Random Digit Dialing.

these ongoing state surveys include the Wisconsin Family Health Survey, conducted annually since 1989, and the Utah Health Status Survey, conducted every four years starting in 1986. In addition, state survey activity has been stimulated by the HRSA State Planning Grant program. As of September 2003, this program has awarded $36.8 million in grants to states to develop plans to increase access to affordable health insurance coverage to all citizens. Thirty-one states and one territory (the U.S. Virgin Islands) have received an average of $1.15 million for planning purposes (HRSA 2000a, 2001). The majority of these states have conducted both household (twenty-eight states) and employer (eighteen) surveys in their state planning activities (Blewett 2002). These grants have provided an opportunity for both experienced and inexperienced states to collect data on the uninsured. Several experienced states enhanced their existing surveys by directing their HRSA funds to survey redesign or sample expansion (e.g., MA, MN, WI). Other states are fielding surveys for the first time. Without additional federal support, these states are unlikely to conduct follow-up surveys (e.g., AL, AR, IL, TX), thereby limiting the usefulness of the data for program planning and evaluation. All states face the difficult task of securing ongoing support for survey work in the face of limited state financial resources.

State Survey Issues

Conducting a state-level household survey is a new and difficult task for many states. As mentioned, states vary in their analytic capacity and ability to manage the complexities of survey design and implementation. States that partner with local university-based statisticians and survey experts have been more successful in survey implementation. Partnering with local experts builds in-state capacity and collaborative relationships that can contribute to future efforts if additional survey funds are available. States contracting with outside vendors were less successful in building state capacity. Vendors typically have no ongoing or vested interests in providing the state continued technical assistance over time.

A key methodological issue states struggle with is getting response rates at acceptable levels. Those partnering with reputable survey research firms and local university-based survey experts are able to implement more sophisticated designs and achieve adequate response rates. Those with limited access to survey experts, limited funds, and short time frames have more difficulty. For the surveys supported by the HRSA State Planning Grant program, the response rates ranged from 39 percent in Oregon to 73 percent in New Hampshire (ibid.).

Funding is another major issue facing states that conduct surveys. Some states can only afford a one-shot, cross-sectional survey, while others have an ongoing commitment of funds to support a survey every two to five years. Wisconsin's survey, for example, enjoys both legislative and financial support and produces annual estimates based on data from a continuous monthly interview schedule. On the other hand, some states are conducting one-time surveys using HRSA funds. Unfortunately, the State Planning Grants are not being renewed, so many states (e.g., AL, AR, GA) will not conduct follow-up surveys.[1] Furthermore, current state budget constraints are also likely to reduce the number of state-initiated survey efforts, resulting in limited opportunities for capacity building at the state level.

The HRSA State Planning Grant program was successful in getting more data into the state policy arena. The key to this successful strategy was combining data collection with a policy development process. In applying for these grants, states were required to describe how their analytic efforts would be used to support the development of policy options. In addition, states were directed to describe the process for decision making and for proposing policy recommendations for coverage options. They were also directed to describe the process for gaining collaboration across all relevant agencies necessary to implement options. The State Planning Grant program was successful in that there were tight time lines (one-year grants) to collect and analyze state survey data creating a vehicle for real-time data applications. States with ongoing data collection activities (e.g., CA, HI, MA, MN, WI) routinely use data to inform policy decisions. The expertise and confidence in the data grows over time creating a demand for updates and new information to inform decisions.

The State Health Access Data Assistance Center (SHADAC), a Robert Wood Johnson Foundation–funded state policy research center, works with states on collecting data on the uninsured. Over the past two years, staff at SHADAC have fielded calls from states on several technical survey issues including request-for-proposal development, vendor selection, sampling, survey design, development of valid and reliable measures, and data collection methodologies, as well as strategies for item nonresponse and weighting. The efforts at SHADAC have helped to improve state surveys and to connect state analysts with national survey experts. SHADAC continues to work with states to document activities and provide technical assistance to improve surveys over time. The center's main efforts are to document survey activities, to determine what works and what does not,

1. In federal fiscal year 2004, ten new SPGs were awarded. Activities conducted under these awards are not included in this analysis.

and to bring states together with state and national survey experts to continue to improve state data collection activities.

Practical Implications of Multiple Surveys

There is no lack of estimates on the numbers of uninsured. There are, however, myriad surveys at both the state and national level that produce estimates of insurance coverage, characteristics of the uninsured, and barriers to coverage. Trouble is, states are left with the complex problem of trying to sift through the data and discern what rate of coverage they should use in their state. What is the correct number of uninsured and which survey is closer to the truth? These questions should not be taken lightly, as they affect state policy decisions and the design of programs for the uninsured.

Table 5 shows state uninsurance estimates among nonelderly adults (ages eighteen to sixty-four) for five states from four independent sources: the state-initiated survey, the Current Population Survey, the Behavioral Risk Factor Surveillance System, and the National Survey of America's Families.

The BRFSS estimate is typically released without any discussion of how and why it may differ from the CPS estimate. By contrast, when a state conducts its own survey, the state analysts must field questions about how their estimates were derived, as well as why the state survey estimate differs from national survey estimates. Consequently, these state analysts must have specific knowledge of the national surveys and their idiosyncrasies so they can make sense of discrepancies across estimates.

State analysts are often put in the position of defending the estimates produced by their state-specific surveys, even if the discrepancies between estimates are small and statistically insignificant. In Massachusetts, for example, the BRFSS rate of 10 percent is a point-in-time estimate and is close to the estimate provided by Massachusetts's state-specific survey. However, a difference of only one percentage point translates into over 38,000 residents in the small state of Massachusetts and can have a sizable impact on the projected costs of a coverage expansion.

In Minnesota, differences in survey estimates led to an interesting policy debate. The CPS estimate of uninsurance in Minnesota has remained relatively stable, fluctuating between 8–11 percent since 1988 (Bureau of the Census 2002d). Some legislators interpreted this to mean that MinnesotaCare, enacted in the early 1990s, had not reduced the number of uninsured in the state. The state's own survey, conducted in partnership

Table 5 Comparison of State Uninsurance Estimate by Survey for Nonelderly Adults (18–64)

State	State Survey Year	State Survey Estimate	Current Population Survey (1997–1999)[a]	Behavioral Risk Factor Surveillance System (1998)[b]	National Survey of America's Families (1997)[c]
Massachusetts	1998	9%[d]	14%	10%	11%
Minnesota	1999	7%[e]	11%	10%	9%
Oregon	1998	13%[f]	17%	15%	NA
Vermont	1997	10%[g]	14%	12%	NA
Wisconsin	1998	7%[h]	13%	11%	10%

[a]U.S. Bureau of the Census 1998
[b]Centers for Disease Control and Prevention 2000
[c]Zuckerman and Brennan 1998
[d]Weinstein 1998
[e]Call 2000
[f]Clearwater Research, Inc. 1998
[g]Kahn 1998
[h]Imm 1999

with the University of Minnesota, had a larger sample than the CPS (approximately 10,000 each year versus approximately 1,500 in the CPS March Supplement), allowing a comparison of rates by age and income category in 1990 and 1995, thereby providing detailed information about the changing composition of the uninsured in the state. The Minnesota state survey demonstrated that while the overall rate of uninsurance has been stable over time, according to both the CPS and the Minnesota survey, MinnesotaCare reduced the percentage of uninsured children by 31 percent between 1990 and 1995 and reduced the percentage of low-income (under 200 percent of poverty) uninsured by over 20 percent. Data from the state survey helped to convince many policy makers that MinnesotaCare was, indeed, reaching its intended target population.

States without access to their own data or one of the larger, privately funded surveys must rely on CPS, which has both strengths and weaknesses (Lewis et al. 1998; Liska, Brennan, and Bruen 1998). The Minnesota experience demonstrates that there are benefits to complementing the CPS data with more specific state-level information.

Each perspective has its own advantages and unique contributions. The best information for state health policy may lie somewhere in the middle where the two perspectives come together, providing detailed information that is comparable across states. The information generated should include the numbers of uninsured, but also their characteristics and reasons for uninsurance. The goal is to collect data and generate estimates that can be used to inform policy makers in an effort to increase health insurance coverage and improve the health status of all Americans.

Conclusion and Summary Recommendations

As more responsibility for programs (such as SCHIP) shifts to the state level, there is an increasing need for better and more consistent comparative data to enable states to understand the dynamics of health insurance coverage. The national surveys provide valuable information on trends in health care coverage, as well as on access and use for the nation as a whole. But national data are not sufficient in the state policy arena. State-specific information is critical as state policy makers allocate scarce resources across programs and populations, develop and implement new programs, and evaluate existing programs and services.

Responding to this need for data, many states have developed and implemented their own household surveys. These state-level data collection efforts are independent activities, not coordinated across states or with

national survey efforts. Consequently, we have a series of at least thirty-six state and nine national surveys asking similar questions about health insurance coverage, with limited overlap in survey methodology. Better coordination of these activities is needed to make the best use of information for both state and national policy purposes. Ten years ago, the need for coordination was less pressing, with only a handful of states conducting state-specific household surveys. Today, over half the states are expending resources to obtain state-level data on health insurance coverage.

The advantage of the national surveys, both federal and privately funded, is that they have an infrastructure with ongoing financial support. The core set of statisticians, methodologists, and survey experts at the Census Bureau, the Agency for Healthcare Research and Quality, the National Center for Health Statistics, the Urban Institute, and other organizations cannot be matched in terms of sheer size and numbers at the state and local levels. The advantage of surveys conducted at the state level is that they generate direct estimates and can be tailored to meet a state's unique data and policy needs. In addition, when the data collection is locally designed and controlled, analysts have greater access to the data and sample sizes can be increased to allow for subpopulation estimates.

The mechanism for coordinating data collection about health insurance coverage and access could be either centralized or decentralized. The current federal approach has been a centralized data collection strategy with only a few surveys designed to be state-representative and to allow for direct state estimates. Along this line, we suggest that federal resources be realigned to adequately fund a state-representative national survey with an adequate sample for subpopulation estimates. The CPS is one vehicle, but current limitations preclude additional state policy work without significant changes to the sampling strategy and increases in state sample sizes. SLAITS is another potential centralized survey mechanism, but there is currently no ongoing federal financial support. States have had limited involvement in the development of the survey and in the dissemination of data. Significant improvements would be required if a centralized strategy were pursued relying on existing surveys.

A second strategy would involve a decentralized model to coordinate state data collection activities by enhancing the standardization of survey methodologies across states. This approach would allow cross-state comparisons and perhaps eventually national estimates as well. This model improves the utility of the data to participating states by allowing more state-level control over survey content and greater access to data (Camburn and Hughes 2001). This approach could be pursued through enhancements to the BRFSS, which is based on this decentralized model. But

again, significant changes would need to be made to expand the required sample to include children and increase the inclusion of the health insurance coverage and use questions.

Given that both the CPS and the BRFSS are lengthy, time-intensive surveys devoted primarily to other topics (i.e., labor force participation and personal health behavior, respectively), we argue that it is time to consolidate surveys and resources to fully fund a state-representative survey devoted solely to health coverage, use, and trends. This could be pursued through the centralized model of a fully funded SLAITS module or through a federal-state cooperative decentralized data collection approach.

Models of federal-state cooperative data collection agreements to provide national and state estimates have been well established for agriculture and economic issues in this country (Lepkowski 2001). A recent example is the Workforce Information Council, a federal-state data collection initiative that facilitates the collaboration between the Bureau of Labor Statistics and local state economic analysts to collect and disseminate quality workforce data. This initiative uses states as the data collection entities through agreed-upon standardized methods to allow cross-state comparisons and national estimates (Workforce Information Council 2003).

If such an arrangement were pursued, the federal government or other independent entity could spearhead a collaborative effort among existing state data collection entities to collect and disseminate state estimates of health insurance coverage. As of September 2003, twelve of the thirty-six states conducting household surveys are using SHADAC's Coordinated State Coverage Survey tool as their base survey instrument with the goal of potentially pooling data to provide cross-state comparison and conduct joint data analysis across states. There is interest in better coordinated data at the state level and improvements in data collection methods overall.

Short of a change in state and national funding priorities, at the very minimum national survey expertise should be more readily available to states to enhance survey design, reduce nonsampling errors, and improve the precision of state-level estimates. SHADAC is promoting these linkages by encouraging communication between state and national experts through survey workshops, conference calls, and one-on-one technical assistance. Finally, joint state-federal collaborative research should be undertaken to improve item nonresponse and noncoverage through the use of telephone surveys to improve survey methods overall (Lepkowski 2001). State surveys provide an opportunity to test different approaches and methods that benefit both state and national survey researchers.

We submit that privately funded surveys play a unique role in examining the impact of programs and policies on populations. Surveys such as the CTS and NSAF provide more specific information that would be difficult to obtain in a state or national survey effort. These surveys should continue to be used to provide additional information on relevant policy topics of interest. NSAF is a good example of an effort to understand the health and social needs of low-income families, as well as the impact of welfare reform and SCHIP programs. While this in-depth data collection process is too expensive to be done in every state, the NSAF approach provides additional information and detail on programs and policies that are not provided by federally sponsored ongoing surveys.

Finally, we encourage a dialogue between national and state survey researchers and policy analysts on the best use of survey resources to meet state and national data needs. The federal perspective may be seen as coming from the top down, focusing on national data and estimates that drive national policy. The state perspective may be seen as coming from the ground up, focusing on state- and local-level data initiatives that drive state policy. Due to the established need for information on health care coverage and access, substantial resources are being devoted to data collection in many venues. It is time to rethink our national data collection strategy on health access and refocus our efforts to more effectively inform policy decisions on the uninsured at the level where they occur—the state policy level. Now more than ever, good data are needed to make informed policy decisions in an increasingly constrained state budget environment.

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