

# Visualizing the Uninsured: A Data Science Perspective on U.S. Health Coverage

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## Part 1 – Identify a Social Problem

### 0.1 Describe the Social Problem

The substantial number of uninsured people in the United States represents a significant public health challenge with serious implications for individuals and the healthcare system. Current data shows that over 27 million Americans, approximately one in twelve people, lack health insurance coverage as of 2022 (KFF, 2023). This coverage gap creates considerable barriers to healthcare access and produces widespread effects on both individual and population health outcomes.

For uninsured individuals, the consequences are particularly severe. Research indicates that people without insurance are significantly more likely to postpone or forgo necessary medical care due to cost concerns, leading to poorer health outcomes, increased emergency department utilization for preventable conditions, and higher mortality rates from treatable diseases. The economic burden is equally substantial, as uninsured individuals face full payment responsibility for medical services, frequently resulting in medical debt, compromised credit status, and prolonged financial hardship (Davis, 2007).

The impact extends beyond individual consequences to affect the broader healthcare system. When uninsured patients cannot meet their payment obligations, healthcare institutions must absorb these costs as uncompensated care. This financial burden creates strain on healthcare providers and contributes to cost increases that ultimately affect insured populations through higher premiums and increased public spending. Davis (2007) emphasizes that the uninsured population includes “our neighbors, co-workers, and family members,” demonstrating how this issue affects entire communities and has implications for society as a whole.

### 0.2 Provide Background on the Problem

The Affordable Care Act (ACA), implemented in 2010, substantially expanded health insurance coverage through Medicaid expansion and subsidized insurance marketplaces. Nevertheless, millions of Americans continue to lack insurance coverage despite these policy reforms. According to the Kaiser Family Foundation, the majority of uninsured individuals today are low-income workers, with disproportionate representation among communities of color and residents of states that declined to expand Medicaid under the ACA (KFF, 2023).

A primary contributing factor to persistent uninsurance is the employment-based structure of the U.S. health insurance system. Many uninsured individuals are employed in positions that do not provide health benefits, including part-time, temporary, or service sector roles. These workers frequently earn incomes that exceed traditional Medicaid eligibility thresholds while remaining insufficient to afford private insurance premiums, creating what Davis (2007) characterizes as falling “through the cracks” of the existing system.

Geographic variation in coverage also contributes significantly to uninsurance patterns. States that implemented Medicaid expansion under the ACA demonstrate considerably lower uninsured rates compared to non-expansion states, resulting in unequal access to coverage nationwide. This policy divergence has produced particularly elevated uninsured rates in numerous Southern and certain Western states.

The continued prevalence of uninsurance reflects fundamental structural limitations within American healthcare policy, including affordability constraints, accessibility barriers, and coverage gaps that leave vulnerable populations without viable insurance options.

# 1 Part 2 – Describe and Acquire Data

## 1.1 Describe the Data sets

This analysis employs two primary datasets to examine health insurance coverage patterns and their relationship to economic conditions across U.S. states.

**U.S. Census Bureau Data** The principal dataset derives from the U.S. Census Bureau’s American Community Survey (ACS) 1-Year Estimates, specifically the table “Selected Characteristics of the Uninsured in the United States.” This dataset encompasses the period from 2010 to 2023, with 2020 excluded due to the unavailability of 1-year estimates for that year.

Eight smaller states and territories were excluded from the analysis: Delaware, District of Columbia, Hawaii, Puerto Rico, North Dakota, Rhode Island, Vermont, and Wyoming, as they are not consistently represented in the 1-year estimates. The 1-year estimates were selected over 5-year estimates because they provide more current data capable of capturing short-term variations resulting from economic fluctuations or policy modifications.

The ACS dataset provides state-level information on the civilian non-institutionalized population, including total population counts, numbers of uninsured individuals, and various demographic and socioeconomic characteristics. This analysis focused on total population figures and household income data (inflation-adjusted) to calculate uninsured rates and assess the economic context.

**Bureau of Economic Analysis Data** Economic data originates from the Bureau of Economic Analysis (BEA) table SAGDP1 – State Annual Gross Domestic Product Summary. This dataset provides real GDP figures in millions of chained 2017 dollars for each state from 1997 through 2024. The use of inflation-adjusted GDP facilitates consistent comparisons across time periods and between different states.

**Data Integration** These two datasets collectively provide a comprehensive perspective on how health insurance coverage has evolved across the United States over time and how coverage patterns may correlate with state-level economic conditions. This combination enables analysis of both temporal trends and interstate variation in uninsured rates.

## 1.2 Import and Prepare the Data set

**First data set: “Selected Characteristics of The Uninsured in the U.S.”**

Here we imported the first data set from the U.S. Census Bureau and named them “data set\_uninsured\_population\_year” from 2010-2023, excl 2020.

**Second Data set: “SAGDP1 State Annual Gross Domestic Product Summary”, Statistic: “Real GDP (millions of chained 2017 dollars)”**

Here we imported the second data set from the Bureau of Economic Analysis of the annual GDP of the states from 2009-2023 and named it “table\_GDP”

## 1.3 Data cleaning: Data sets of Uninsured Population and The Creation of The New Variable: The Uninsured Share

To prepare the data for analysis, we removed margins of error from the original Census datasets, as they were unnecessary for comparing overall trends in health insurance coverage across states and years. A structural challenge involved smaller states and territories, since the Census Bureau’s 1-year estimates no longer cover certain low-population areas after 2016. To ensure consistency, we excluded eight jurisdictions: Delaware, the District of Columbia, Hawaii, Puerto Rico, North Dakota, Rhode Island, Vermont, and Wyoming. This ensured our dataset included only states present in every applicable year from 2010 to 2023, excluding 2020 when no data was published due to COVID-19.

We streamlined the data structure by removing extensive metadata not essential to our analysis, including variables related to demographics, citizenship status, education, employment, and poverty ratios. We retained only total civilian non-institutionalized population and household income data (inflation-adjusted), which were directly relevant to our research questions. We also converted numeric values stored as character strings into actual numeric variables to enable mathematical operations.

Most importantly, we created an uninsured share variable by dividing total uninsured individuals by total population and multiplying by 100 for each state and year. This percentage enables easier comparisons across time and states regardless of population differences. After these steps, we combined the individual yearly datasets into a single comprehensive dataset covering 2010 to 2023, excluding 2020, enabling consistent analysis of long-term trends.

## **1.4 Data cleaning: Annual GDP Table and The Creation of The New Variable: Annual Real GDP Growth per year and state**

For the economic data from the Bureau of Economic Analysis, we used the SAGDP1 – State Annual Gross Domestic Product Summary table, which reports real GDP per state in millions of chained 2017 dollars. We cleaned this dataset to align with our health insurance data by removing columns for years outside our scope (1997 through 2008, plus 2020 and 2024) and filtering out states not included in our main dataset. We excluded Delaware, District of Columbia, Hawaii, North Dakota, Puerto Rico, Vermont, Wyoming, and Rhode Island, as well as regional aggregates such as New England, Mideast, Great Lakes, Plains, Southeast, Southwest, Rocky Mountain, and Far West. We converted the stored values to numeric format and renamed the cleaned dataset `table_GDP`.

From this cleaned table, we created a new variable: annual real GDP growth, calculated for each state and year by measuring the year-over-year percentage change in real GDP. This variable captures how rapidly each state's economy was expanding or contracting over time. Including GDP growth adds important economic context to our analysis, allowing us to explore whether changes in economic performance relate to shifts in health insurance coverage. We can examine whether periods of economic expansion correspond with improvements in coverage rates, providing a more comprehensive understanding of how economic conditions may influence healthcare access.

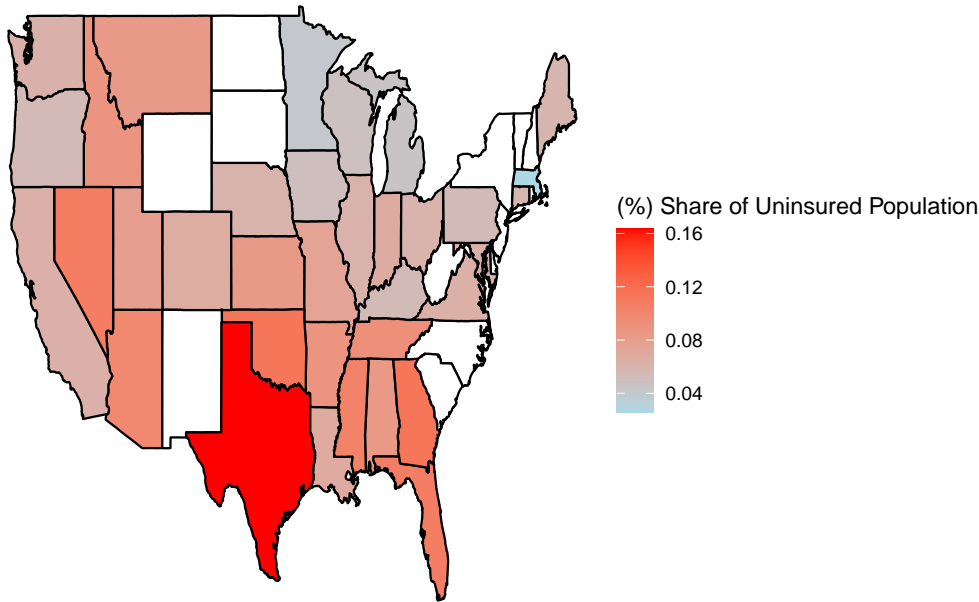
## **2 Part 3 – Visualize and Analyze the Data**

### **2.1 Create Initial Visualizations**

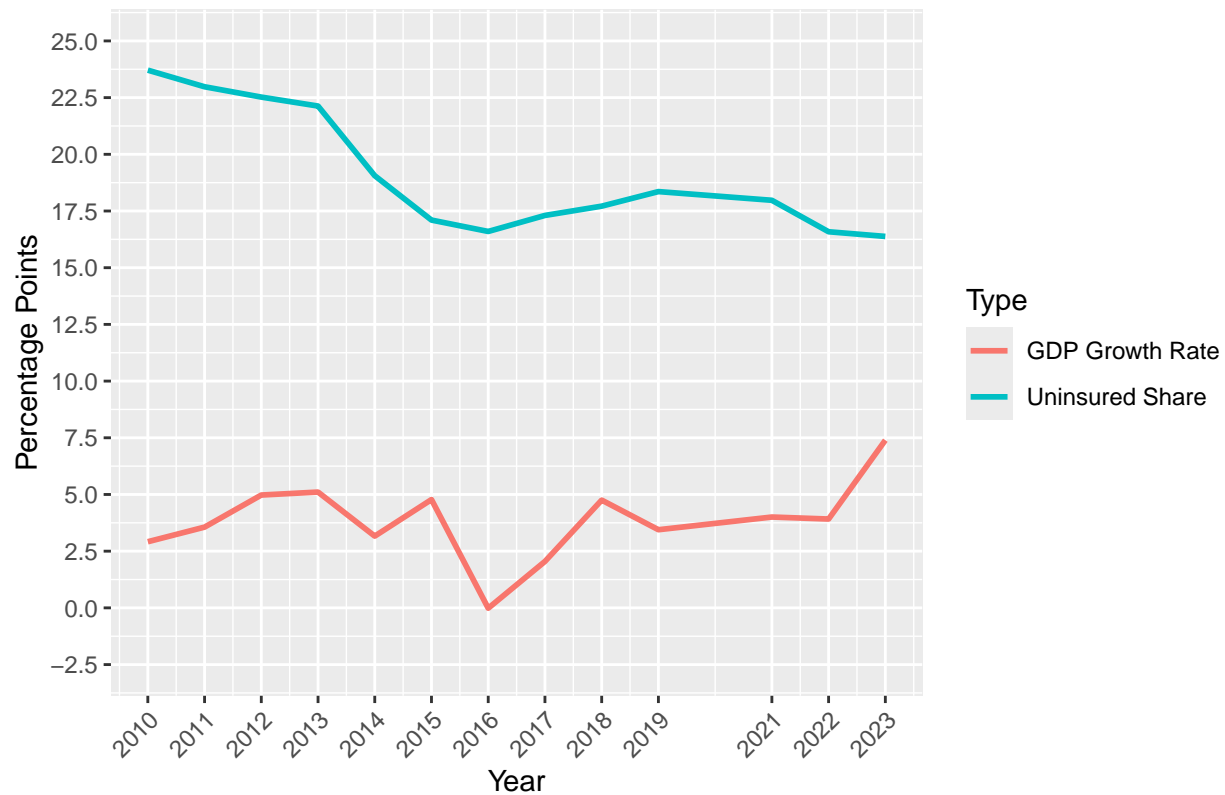
#### **Spatial Variation Visualization, U.S. Share of The Uninsured Population in 2023**

To examine the spatial distribution of uninsured populations across the United States, we mapped the geographic variation using American Community Survey (ACS) one-year estimates for available states. Initially, we created a subset of the comprehensive `all_states_100` data set, focusing specifically on 2023 data to ensure temporal consistency. Subsequently, we generated separate visualizations for Alaska due to its substantial geographic scale, which would otherwise compromise the readability and detail of the continental United States map when displayed at the same resolution.

Share of Uninsured Population in the US, 2023



### GDP growth rate and Uninsured Share in Texas 2010 – 2023, except 2020



### Temporal Variation Visualization, Texas's Share of Uninsured Population and Texas's GDP growth rate over time

Texas emerged as a notable outlier in our spatial variation analysis, prompting us to conduct a more comprehensive temporal examination of the state's uninsured population dynamics. Consequently, we analyzed Texas's proportion of uninsured residents across a thirteen-year period from 2010 to 2023, excluding 2020 data due to potential pandemic-related anomalies. Furthermore, we sought to investigate whether economic growth served as a contributing factor in explaining the observed patterns in insurance coverage rates throughout this time frame.

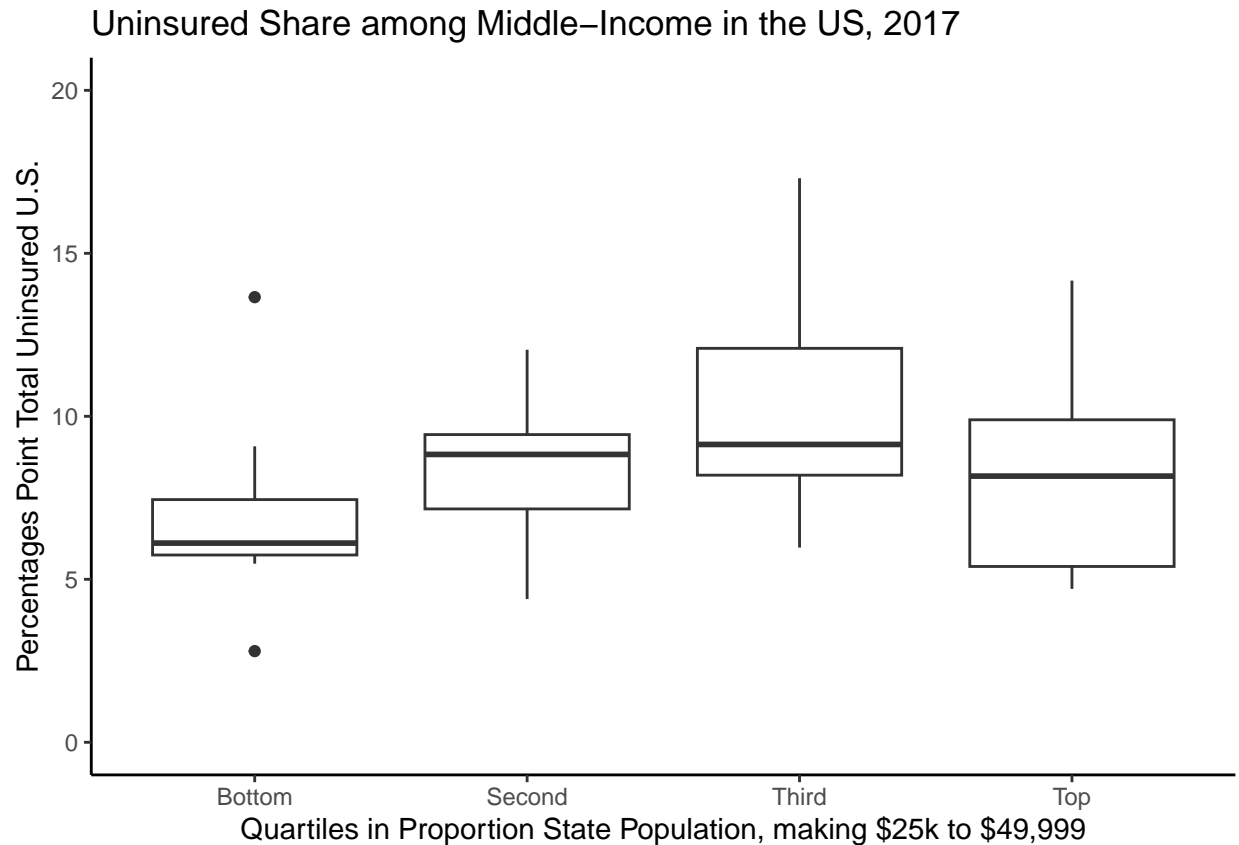
### Sub-Group Variation Visualization, The Uninsured Rates of the Middle-Income Group in 2017 in the U.S.

Building upon findings from the Kaiser Family Foundation (2024), which established that uninsured individuals in the United States are disproportionately represented among low-income populations, we sought to examine the insurance coverage status of middle-income groups who often find themselves in a precarious position. Specifically, this demographic typically earns insufficient income to afford private insurance yet exceeds the eligibility thresholds for Medicaid assistance. Moreover, we selected 2017 as our focal year, representing the first full year following President Trump's inauguration in 2016, thereby capturing potential early policy implications on this vulnerable middle-income segment.

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## [1] "First quartile (Q1): 26.625"
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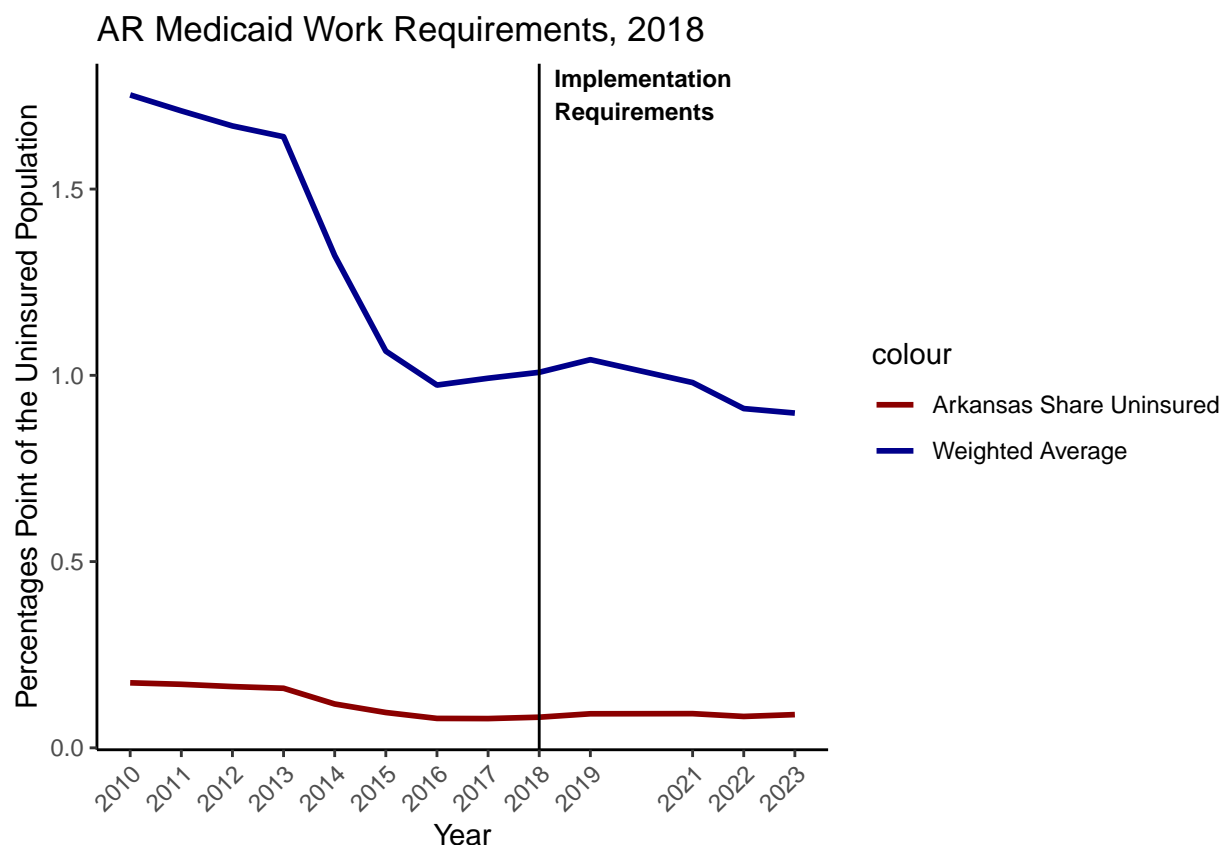
```
## [1] "Second quartile (Q2): 29.35"
```

```
## [1] "Third quartile (Q3): 31.25"
```



#### Event Analysis Visualization, The Impact of The Implementation of Work Requirements for Medicaid in Arkansas, 2018

In 2018, Arkansas became the first state to implement work requirements for Medicaid recipients as part of its Arkansas Works program, mandating that able-bodied adults aged 19-49 demonstrate at least 80 hours of monthly employment, education, or training activities to maintain their Medicaid eligibility. This policy initiative was designed to encourage workforce participation and reduce dependency on government assistance programs. To evaluate the causal impact of this intervention, we employed a comparative analysis framework where Arkansas serves as the treatment group, while the remaining 43 states with available data constitute the control group. Subsequently, we examined whether the implementation of work requirements produced statistically significant changes in Arkansas's uninsured rates relative to the weighted average change observed across the control states, thereby isolating the policy's specific effects from broader national trends in insurance coverage.



## 2.2 Identify Trends and Patterns

### Spatial Variation Visualization, U.S. Share of The Uninsured Population in 2023

The spatial distribution of uninsured rates across the U.S. in 2023 reveals a pronounced regional divide. Southern states, particularly Texas and Florida, report the highest uninsured shares. In contrast, North-eastern and Upper Midwestern states demonstrate substantially lower rates, likely attributable to more expansive Medicaid programs, higher employer-based coverage, and more generous state-level health initiatives (Bailey et al., 2017).

Western states like Nevada and Arizona present a more complex pattern, exhibiting elevated uninsured rates despite relatively progressive policy environments. This may reflect distinct labor market characteristics, including higher prevalence of gig work, part-time employment, and self-employment, which are associated with reduced access to employer-sponsored insurance (Collins et al., 2020).

These findings support existing literature demonstrating that health coverage in the U.S. is not solely determined by state policy, but is fundamentally linked to employment structures, income levels, and demographic characteristics (Davis, 2007; Sommers et al., 2012). Consequently, even among states with similar political orientations, uninsured rates can vary significantly based on labor market and population dynamics.

### Temporal Variation Visualization, Texas's Share of Uninsured Population and Texas's GDP growth rate over time

The line graph illustrates the relationship between GDP growth rate and uninsured share in Texas from 2010 to 2023, excluding 2020. We observe a clear downward trend in the uninsured share, declining from approximately 23% to 17% over this period. However, despite economic fluctuations, particularly a GDP growth decline around 2016 and a spike in between 2017 and 2018, the uninsured rate remained relatively high and stable, especially after 2016.



This pattern suggests that economic growth alone does not ensure increased health insurance coverage. Even during years with strong GDP growth, Texas maintained one of the highest uninsured rates nationally. A likely explanation is Texas’s decision not to expand Medicaid under the ACA, leaving many low-income adults without affordable coverage options (KFF, 2023; Davis, 2007). Policy choices, rather than solely economic performance, fundamentally shape insurance access.

### **Sub-Group Variation Visualization, The Uninsured Rates of the Middle-Income Group in 2017 in the U.S.**

The box plot displays total uninsured share per U.S. state in 2023, grouped by quartiles of middle-income earners (those earning \$25,000–\$49,999). The y-axis reflects overall uninsured rates, not exclusively middle-income individuals. The second and third quartiles demonstrate nearly identical median uninsured rates, suggesting that higher proportions of middle-income residents do not clearly relate to higher or lower uninsured shares.

This supports the premise that income alone does not determine insurance coverage. Other factors including cost of living, Medicaid eligibility requirements, and state-level policy differences play substantial roles. Two states may have similar income distributions yet vastly different uninsured rates due to variations in insurance affordability, healthcare access, or Medicaid expansion status (Davis, 2007; KFF, 2023).

### **Event Analysis Visualization, The Impact of The Implementation of Work Requirements for Medicaid in Arkansas, 2018**

The graph shows uninsured share in Arkansas compared to the national weighted average from 2010 to 2023, excluding Arkansas. Arkansas experienced a sharp decline in uninsured rates after expanding Medicaid under the Affordable Care Act, reaching a low around 2016–2017. However, after implementing work requirements for Medicaid in 2018, this trend reversed: Arkansas’s uninsured rate increased while the national average remained low and stable.

This suggests the policy negatively affected coverage. Although intended to encourage employment, research indicates many people lost coverage not due to unwillingness to work, but because of administrative barriers and confusion about reporting requirements (Sommers et al., 2019). Consequently, thousands of eligible individuals were removed from Medicaid, increasing the uninsured share. The work requirements likely influenced uninsured percentages by creating new obstacles to maintaining insurance coverage, particularly for low-income adults.

## **3 Part 4 – Communicate Findings**

### **3.1 Summarize Key Insights**

To summarize our key insights, the spatial variation analysis demonstrated that regional policy choices and labor market structures significantly influence uninsured rates beyond political ideology alone. Western states like Nevada and Arizona exhibited elevated uninsured rates despite progressive policy environments, reflecting distinct employment patterns including higher prevalence of gig work and self-employment that reduce access to employer-sponsored insurance. The temporal analysis revealed that economic growth does not automatically translate into improved health coverage, particularly in non-expansion states like Texas, where strong GDP growth coincided with persistently high uninsured rates due to the absence of Medicaid expansion.

The subgroup analysis provided evidence that income distribution alone does not fully explain variation in uninsured rates across states. States with similar proportions of middle-income earners demonstrated vastly different uninsured rates, indicating that factors such as cost of living, state-specific policies, and insurance market accessibility play substantial roles in coverage outcomes. Finally, the event analysis of Arkansas’s Medicaid work requirements illustrated how administrative barriers can reverse coverage gains, with the policy leading to increased uninsured rates as eligible individuals lost coverage due to reporting difficulties and employment instability rather than unwillingness to work. These findings collectively underscore that

achieving universal coverage requires comprehensive policy approaches that address structural employment changes, administrative complexity, and regional economic variations rather than relying solely on economic growth or income-based solutions.

## 3.2 Propose Solutions or Policy Recommendations

### 3.3 Key Policy Solutions

Based on the analysis findings, four targeted policy interventions are recommended to address persistent uninsurance across the United States.

Enhanced federal funding should be provided to encourage remaining non-expansion states like Texas and Florida to adopt Medicaid expansion. The temporal analysis of Texas demonstrates that economic growth alone cannot close coverage gaps without accompanying policy action. Despite periods of strong GDP growth, Texas maintained one of the highest uninsured rates nationally, suggesting that macroeconomic performance is insufficient to guarantee insurance access. Federal incentives could include increased matching funds or temporary enhanced federal medical assistance percentages to make expansion financially attractive for holdout states. This approach would address the fundamental policy gap that leaves millions of low-income adults without affordable coverage options.

Portable benefits systems should be developed for independent contractors and part-time workers to address the changing nature of employment. Western states' elevated uninsured rates reflect evolving labor markets that traditional employer-based coverage cannot adequately address, particularly the rise of gig work, part-time employment, and self-employment. These workers often fall into coverage gaps, earning too much for traditional Medicaid but lacking access to employer-sponsored insurance. Policy solutions could include portable benefit accounts that workers maintain across jobs, expanded association health plans for freelancers, or modified marketplace subsidies specifically designed for non-traditional employment arrangements.

Medicaid work requirements should be eliminated and enrollment processes streamlined to remove administrative barriers that impede coverage access. The Arkansas case study provides compelling evidence that work requirements reverse coverage gains and disproportionately harm vulnerable populations. Research indicates that many people lost coverage not due to unwillingness to work, but because of administrative hurdles and confusion about reporting requirements. Simplifying enrollment procedures, reducing paperwork burdens, and eliminating punitive work requirements would help maintain coverage continuity and ensure that eligible individuals can access and retain benefits without navigating unnecessarily complex bureaucratic processes.

Premium subsidies should be expanded beyond current income thresholds to address affordability challenges that persist across income levels. The middle-income analysis reveals that affordability problems are not confined to the lowest income brackets, as state-level variations in costs and policies create different financial pressures across regions. Current subsidy structures may not adequately account for geographic cost variations or the reality that middle-income families in high-cost states face significant premium burdens. Expanding eligibility for premium tax credits and cost-sharing reductions, potentially through sliding scale adjustments based on regional cost indices, would help address coverage gaps among moderate-income populations who currently find insurance unaffordable despite not qualifying for existing assistance programs.

## 4 Appendix

### 4.1 A.1 References

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## 4.2 A.2 Session Info

<https://github.com/catherinamikhail/Programming-for-Economists-uninsured-US-population.git>