

2022 Prenatal-to-3 State Policy Roadmap Additional Notes and Errata

Last Updated: May 2023

This document includes additional notes from the 2022 Roadmap and explanations of errors and corrections in previous Roadmaps.

The Impact of COVID-19 on Data

The COVID-19 pandemic affected many programs' abilities to serve families and collect data. As a result, the 2021 Prenatal-to-3 Roadmap relied on data for 2019 for comprehensive screening and connection programs, group prenatal care programs, evidence-based home visiting programs, and Early Head Start, due to the concerns about the COVID-19 pandemic on 2020 service data. In the 2022 Roadmap, we rely on data for these strategies from 2021 due to the same concerns. 2020 data are not included in any Roadmap. However, 2019 data for Early Head Start are used again in Roadmap 2022. Older data were used due to concerns regarding data from the American Community Survey used for the denominator (for additional details see the [Early Head Start Methods and Sources](#) documentation); 2021 ACS data were not yet available, although 2021 Early Head Start service data were available. Data will be updated in the 2023 Roadmap.

Reduced Administrative Burden for the SNAP

In the 2021 Roadmap, 26 states were identified implementing a combination of low administrative burden policies, including, assigning 12-month recertification and simplified reporting to all eligible families with children, and offering online services, including at minimum, an online application. This count was incorrect; the total count of states meeting these criteria should have been 31. The states that were erroneously excluded include: Illinois, Michigan, Minnesota, Pennsylvania, and Tennessee. This error was corrected in the 2022 Roadmap.

Paid Family Leave

Errors were found in state-specific Paid Family Leave (PFL) content for the District of Columbia, Massachusetts, and Rhode Island in the 2021 Roadmap. For the District of Columbia, the benefit as a percentage of employee wages was incorrectly reported and has been corrected. Premiums for Massachusetts were reported for the combined family and medical leave program; this figure has been corrected to reflect only the premiums for the paid family leave program. In the 2021 Roadmap, the Prenatal-to-3 Policy Impact Center incorrectly reported the number of weeks of paid leave passed in Rhode Island. The original bills, H.B. 6090 and S.B. 688, would have increased the benefits to 6 weeks in 2022 and 8 weeks in 2023, however, the bills were amended in the House committee to 5 weeks in 2022 and 6 weeks in 2023. The House committee sub version is what was enacted. The 2021 Roadmap has been updated to correctly show a 6-week program in Rhode Island.

State Earned Income Tax Credit (EITC)

The 2020 and 2021 Roadmaps reported the percentage of federal EITC-eligible tax filers who did not claim the federal EITC; the 2022 Roadmap did not include this calculation.

In preparing to analyze new data for the 2022 Roadmap, our team discovered that the variable “eit_cred” from the Annual Social and Economic Supplement of the Current Population Survey (CPS ASEC) previously used for this calculation was inappropriate for this measure. This variable is an imputed dollar amount assigned to all imputed tax filers showing how many dollars they *should* receive from the EITC (the aggregate refunded portion if any plus the amount it offsets positive tax liabilities). The code previously used by the Prenatal-to-3 Policy Impact Center relied on a misinterpretation of the universe of people given a value for eit_cred. The code previously assumed that eit_cred was a self-reported variable in which only individuals eligible for the EITC reported a dollar value for eit_cred (\$0 or otherwise). However, all individuals were assigned a dollar value for eit_cred based on their income and household structure, regardless of EITC eligibility, and those who were ineligible for the EITC were assigned a dollar value of \$0 in eit_cred. The previous code constructed the numerator by assigning everyone with \$0 in eit_cred to not having received the EITC and everyone with a positive dollar amount to receiving the EITC. This was incorrect because a dollar amount is assigned to everyone – it takes the value \$0 if the tax filer is estimated to have no EITC. Previous calculations assumed that individuals with a value of \$0 for eit_cred were eligible for the EITC but did not receive it, whereas a value of \$0 in eit_cred actually means that the tax filer is not eligible for the EITC. It is inappropriate to calculate participation from this variable. Furthermore, previous analyses were conducted at the household, rather than tax unit, level. These errors were missed because the code produced results that look similar to the [take up rates reported by the IRS](#). However, these results were incorrect and the CPS ASEC cannot be used these purposes.

As a result of these errors, we have removed the “Variation in Expanded Eligibility Among States With an EITC” graphic and measure from the 2021 Roadmap (identified as Measure 3 in [Methods and Sources](#)). 2020 Roadmap data from this measure should not be used; these data are incorrect.

Comprehensive Screening and Connection Programs

Due to an error in the examination of the evidence base in 2021, comprehensive screening and connection programs was reported as *not* aligned with optimal child health and development in the 2021 Roadmap. This was an error and was corrected in the 2022 Roadmap and the evidence review within the Clearinghouse.

Group Prenatal Care

A small error in the percentage served measure was reported for Maryland and South Carolina in some sections of the 2021 Roadmap; both figures have been corrected.

Evidence-Based Home Visiting Programs

In the 2021 Roadmap, it was erroneously reported that the California implemented all seven evidence-based programs. California implemented six programs; no state had all seven programs implemented last year. The number of evidence-based program models reported for the following

states was miscalculated and was corrected in the 2021 Roadmap: California, Connecticut, Delaware.

2021 Methods & Sources Corrections

The incorrect data year was reported in the 2021 Methods and Sources documentation for the State EITC measure “percentage of federal EITC-eligible tax filers who did not claim the federal EITC.” The data years were reported as 2017–2019 CPS ASEC but should be the 2018–2020 CPS ASEC.

Methods and Sources documentation for the following strategies did not explain the impact of COVID-19 on program data: comprehensive screening and connection programs, group prenatal care, evidence-based home visiting programs, and Early Head Start. Notes on data decisions were included in the evidence-based home visiting and group prenatal care 2021 Roadmap pages, but these notes were unintentionally excluded from 2021 comprehensive screening and connection programs and Early Head Start Roadmap pages as well as Methods and Sources documentation for these strategies. Any notes on COVID-19 impacts are included in the 2022 Roadmap Methods and Sources documentation.

The American Rescue Plan Act (ARPA)

As discussed in [2021 Methods and Sources documentation](#), the American Rescue Plan Act (ARPA) of 2021 invested unprecedented amounts of funding in the prenatal-to-3 period. As a result of this investment, states have more support and choices to effectively build a comprehensive and equitable prenatal-to-3 system of care. The \$1.9 trillion dollar stimulus bill has major implications for the prenatal-to-3 period because it:

- Expands eligibility for programs;
- Increases the value and refundability of tax credits for families; and
- Provides substantial funding increases to public programs serving families and caregivers.

As with our measures tracking state progress toward the prenatal-to-3 policy goals, in tracking state generosity and variation in the adoption and implementation of each of the 11 evidence-based policies and strategies we opted to minimize the impact of ARPA on these measures of state variation in the 2022 Prenatal-to-3 State Policy Roadmap.

Puerto Rico Exclusion

Puerto Rico’s resident population of 3.2 million people¹ in 2022 is larger than that of 20 states and the District of Columbia. The Commonwealth faces a number of challenges that the Prenatal-to-3 Policy Impact Center has identified as impediments to the health and well-being of young children and their families. These include high levels of poverty, unemployment, employment instability, and childhood food insecurity as well as low levels of labor force participation when compared to

¹US Census Population Estimates. (2023). *State population totals and components of change: 2020–2022*. Retrieved March 24, 2023 from <https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html>

the rest of the United States.^{2,3} Even so, due to systematic differences in policy implementation in Puerto Rico and data limitations, Puerto Rico data are excluded from the Prenatal-to-3 State Policy Roadmap. For a fuller explanation of the Puerto Rico exclusion, please see the [2021 Additional Notes Methods and Sources Documentation](#).

Data Sources, Quality, and Accuracy in the Prenatal-to-3 State Policy Roadmap

Large, national datasets provide high-quality information on the familial circumstances and overall wellbeing for children and their families and allow for the consistent comparison of this information across states. Unfortunately, with the narrowed focus of the [2022 Prenatal-to-3 State Policy Roadmap](#) on children and their families in this prenatal-to-3 age group, even the large, nationally representative datasets have more limited sample sizes that frequently prohibit the measurement of state-level data and racial and ethnic disparities in outcomes without combining multiple years of data. Pooling data across years, however, restricts a state's ability to track progress toward the prenatal-to-3 policy goals over time.

For the majority of our measures, we prioritized data sources using the following criteria:

- Consistent measurement across states
- Adequate sample size when limiting the analytic sample to the under three population and/or their families/households
- Recency of data
- Availability of annual data updates to facilitate tracking state-level changes across time
- Ability to create pooled, multi-year datasets (both for improving data quality and accuracy and for potential subgroup analyses, such as by race/ethnicity; income level; geography; etc.)
- Availability of population weights (for national and state-level representativeness) and replicate weights or other sampling indicators (to adjust standard errors and associated confidence intervals to account for sampling parameters)

Descriptions of national data sources follow.

American Community Survey

The American Community Survey (ACS) is the largest of the annual US Census Bureau's data collection efforts, targeting an estimated 3.5 million households every year (approximately 1% of the US population). The ACS includes questions associated with a variety of household and family topics, such as: household composition, family status, education, employment, income, transportation, housing, health insurance, and the access and use of various programs and services. The information collected by the ACS is used in the allocation and distribution of over \$675 billion in federal and state funding each year. Data from the ACS is not expected to match

² Kids Count Data Center. (2020). *Child wellbeing indicators & data: Puerto Rico*. Retrieved August 1, 2021 from <https://datacenter.kidscount.org/data#PR/4/0/char/0>

³ Center on Budget and Policy Priorities. (2015). *Puerto Rico has higher poverty and unemployment, lower labor force participation than US as a whole*. As of December 4, 2015. Retrieved August 1, 2021 from <https://www.cbpp.org/puerto-rico-has-higher-poverty-unemployment-lower-labor-force-participation>

decennial census counts or data from other US Census Bureau surveys (e.g., the Current Population Survey).⁴

ACS data collection occurs on a rolling basis throughout the calendar year, with respondents providing data on the prior 12-month period; this collection methodology allows the ACS to capture nationally representative information across two calendar years with each annual survey administration. For example, respondents completing the survey in January of 2020 are providing information on the prior 12-month period (or most of 2019); whereas, survey takers who respond in December of 2020 will primarily be providing information for the 12-month period falling almost entirely in 2020. All responses collected in 2020 are part of the 2020 ACS 1-Year PUMS file.

For the majority of information from the ACS included in the [2022 Prenatal-to-3 State Policy Roadmap](#), data are based on calculated estimates from the Public-Use Microdata Sample (PUMS) files. Using the PUMS data files to calculate estimates allows us to limit the sample to our population of interest, depending upon the measure (e.g., children under age 3; women of childbearing age with family incomes at or below 138% of the federal poverty level; children under age 3 living with parents of various employment status; etc.). There are a few differences between the data included in the PUMS files and data available in tables and the data interactive on the US Census Bureau website. Most notably, the PUMS files include approximately two-thirds of the original ACS sample used in creating the estimates released by the Census Bureau in other products (such as the supplemental tables and data interactive). The PUMS data files also include some top-and bottom coding of information; both of these truncation measures are incorporated to assure respondent confidentiality in the microdata.

In addition to the one-year ACS PUMS files, each year the US Census Bureau also releases five-year PUMS data files that cover the most recent five years of ACS data collection, incorporating weighting adjustments to account for both the national representation and sample selection of the combined files. These five-year files lose some of the advantage of recency of data that the one-year files have, but substantially increase the precision of estimates based on calculations from the five-year file given the increased sample size. While the one-year estimates are recommended for geographies with a population of at least 65,000, the five-year estimates can be used in calculating estimates for smaller areas or for smaller subgroups.⁵ Currently, none of the measures included in the [2022 Prenatal-to-3 State Policy Roadmap](#) are based on these 5-year data files. Upcoming Policy Impact Center analyses exploring variations across specific subgroups within and across states will require the sample size and increased precision of these five-year data files.

[Census Population and Housing Unit Estimates](#)

The US Census Bureau's Population Estimates Program (PEP) produces annual estimates of the US resident population as of July 1 of each year, disaggregated by various demographics (e.g., age, gender, race/ethnicity, and geography). These annual estimates provide information on the

⁴ US Census Bureau (n.d.). *Differences between the American Community Survey (ACS) and the Annual Social and Economic Supplement to the Current Population Survey (CPS ASEC)* [Fact Sheet]. As of May 16, 2016. Retrieved February 23, 2020 from <https://www.census.gov/topics/income-poverty/poverty/guidance/data-sources/acs-vs-cps.html>

⁵ US Census Bureau. (n.d.). Distinguishing features of ACS 1-year, 1-year supplemental, 3-year, and 5-year estimates. As of September 10, 2020. Retrieved August 1, 2021 from <https://www.census.gov/programs-surveys/acs/guidance/estimates.html>

current population during the ten-year gap between decennial census data collections. To estimate each year's population, the PEP begins with the most recent decennial census and then estimates the population for each year since that decennial census, incorporating information associated with population change and mobility, such as births, deaths, immigration/emigration rates, tax return data, enrollment in federal programs, etc.. Each release, or vintage, includes revised versions of all years between the decennial census and the current vintage updated to account for more recently available information. For example, the 2019 Vintage Census Population Estimates included the 2019 estimates plus revised estimates for all years between 2010 and 2019.

[Current Population Survey](#)

The Current Population Survey (CPS), a joint project between the US Census Bureau and Bureau of Labor Statistics, is a monthly, nationally representative survey that serves as the main source for labor force data in the US.

Current Population Survey – Food Security Supplement (December Supplement):

The Current Population Survey – Food Security Supplement (CPS FSS) is one of the annual supplements collected along with the CPS basic monthly survey collection and is the primary source of national data on access and spending on food and household and child food insecurity. The CPS FSS is collected in December of each year (and is therefore sometimes referred to as the CPS December supplement). Like the CPS ASEC, the US Census Bureau recommends combining three years of CPS FSS data when calculating estimates at the state-level.

[National Child Abuse and Neglect Data System](#)

The National Child Abuse and Neglect Data System (NCANDS) collects annual, state-level data associated with suspected and substantiated incidents of child abuse and neglect, including age and demographic information associated with victims, details about the allegations, and information related to the suspected perpetrator. NCANDS data collection began in 1988 following the passing of the Child Abuse Prevention and Treatment Act of 1988 (CAPTA) and is a federally mandated and sponsored reporting system maintained by the Children's Bureau, an office of the Administration for Children & Families (ACF). Data are collected annually from states (including the District of Columbia and Puerto Rico) according to the federal fiscal year (October 1 to September 30) and are included in the annual Child Maltreatment and Child Welfare Outcomes reports to Congress. The Children's Bureau is also partnered with the [National Data Archive on Child Abuse and Neglect \(NDACAN\)](#) housed at Cornell University, a research center that manages the restricted-use versions of the agency and child files that comprise the annual data collection efforts. The Prenatal-to-3 Policy Impact Center currently holds a restricted-use license with NDACAN for the data collected from 2014 through the most recent data release.

[National Immunization Survey – Child](#)

The National Immunization Survey – Child sample (NIS-Child) is part of the Center for Disease Control's (CDC) National Immunization Surveys and is an annual, nationally representative survey primarily focused on collecting vaccination information for children ages 19 to 35 months of age. Survey collection is coordinated by the National Center for Immunization and Respiratory Diseases (NCIRD) and initial data collection for the NIS-Child began in 1994 following several measles outbreaks across the US during the early 1990s.

Data are collected annually from parents or guardians of children ages 19 to 35 months with vaccine data verified by providers for whom the parent or guardian has given permission and contact information. Approximately 50% of the NIS-Child sample each year have vaccination information that has been verified by providers. Guidelines for determining the appropriate type and number of vaccines by age are based on recommendations from the Advisory Committee on Immunization Practices (ACIP) and the NIS-Child survey classifies children as being “up-to-date” on each vaccine based on these guidelines. As of July 2021, the NIS-Child has added a COVID section to the survey (the NIS-Child COVID Module [NIS-CCM]) designed to capture COVID-19 vaccination coverage among children in vaccine-eligible populations.

While the primary focus of the NIS-Child is collecting national and state-level data on vaccination coverage, the survey also includes items associated with child and family demographics, the child’s early nutrition history (e.g., receipt of breast milk and/or formula), and information associated with the family’s receipt of early nutrition support, such as participation in the Women, Infant, and Children (WIC) program.

[National Survey of Children’s Health](#)

The National Survey of Children’s Health (NSCH) is an annual survey sponsored by the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB) and is designed to provide national and state-level information on the health and wellbeing of children, focusing on familial, school, and neighborhood contexts, health care, and general physical and emotional growth and development. Beginning in 2016, the NSCH underwent a substantial redesign, combining two previously separate surveys – the National Survey of Children’s Health (NSCH) and the National Survey of Children’s Health with Special Health Care Needs (NS-CSHCN).

NSCH typically recommends combining two-years of data for increased estimate accuracy and data quality for sub-national, e.g., state-level estimates. With the additional limitation of focusing primarily on the NSCH sample of children under three, we added an additional year of data to create a dataset that combined three years of data to improve the quality and reliability of estimates. With the most recent release of NSCH 2020, there were five consecutive years of NSCH data available for analysis (NSCH 2021 was released fall 2022, too late for Roadmap production). Data prior to 2016 (e.g., the 2012 NSCH) cannot be combined with data from 2016 and later, due to the survey redesign.

[Vital Statistics](#)

The National Vital Statistics System (NVSS) is a branch of the National Center for Health Statistics (NCHS) at the Centers for Disease Control (CDC) and provides the most complete data available on births and deaths in the United States. Both birth and death certificate data are mandated by federal law to be collected and published as part of vital statistics reporting, with NCHS working collaboratively with states on the format and compilation of these data. Most data are available through the [CDC WONDER Interactive Database](#) (Wide-Ranging OnLine Data for Epidemiologic

Research), with additional information provided through annual briefs and reports on various aspects of US natality⁶ and mortality.⁷⁸

Natality Files

The NVSS Birth files, referred to in CDC WONDER as the Natality files, provide various birth certificate data associated with the birth (e.g., geographic location, gestational age, birthweight, type of delivery); maternal and paternal demographics (e.g., age, race, ethnicity, education); maternal health risk factors; pregnancy history and risk factors, including prenatal care; and any other pertinent medical information associated with the delivery. Data collected by NCHS from states has changed over the years, with substantial changes occurring in 2003 with the introduction of the US standard Certificate of Live Birth and again in 2016, when natality information was expanded to include additional medical and background health information. As a result of the changes in data collection, the public-use natality data are available on CDC WONDER in 4 online databases, with data available at multiple geographic levels (national, state, county, census region, etc.).

Mortality File

The NVSS Mortality data includes data from death certificates for US residents and provides information on underlying cause, location, and day of death and basic demographic data (e.g., race, ethnicity, age, gender) for the deceased. As with the birth data, this information is available at multiple geographic levels (national, state, census region, etc.). The underlying cause of death is indicated using the International Classification of Disease Tenth Revision codes (ICD-10; used for mortality data since 1999), which includes specific classification groups for the cause list for infant deaths. Mortality rate data in CDC WONDER are available as “crude” rates (out of 100,000) and as “age-adjusted” rates, which adjust the mortality rate based on an age-specific death rate. The population used for standard age-adjusted mortality rates is based on the year 2000.⁹

Linked Birth/Infant Death File

In addition to providing infant death data in the mortality file, NVSS also provides linked birth/infant death records, which link birth certificate with death certificate data for deaths of children under 1 year of age following a live birth. Much of the information in the linked birth/infant death file is based on maternal information provided on the birth certificate (e.g., county of residence, race, ethnicity) and for the child based on the birth (e.g., gender, birthweight, gestational age at birth). The mortality file and linked birth/infant death files each have advantages – the mortality file provides the overall infant mortality rate for all infants residing in the US, regardless of place of birth; however the linked birth/infant death file provides better

⁶ E.g., Martin, J.A., Hamilton, B.E., & Osterman, M.J.K. (September 2021). Births in the United States, 2020. NCHS Data Brief No. 418. Hyattsville, MD: National Center for Health Statistics. DOI: <https://dx.doi.org/10.15620/cdc:109213>

⁷ State Estimates: CDC National Center for Health Statistics (NCHS). (n.d.) States of the States: Infant Mortality Rates by State. As of March 3, 2022. Retrieved August 11, 2022 from https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm

⁸ National estimates: Ely, D.M., & Driscoll, A.K. (2022). Infant mortality in the United States, 2020: Data from the period linked birth/infant death file. National Vital Statistics Reports, 71 (5), 7-8.

⁹ [National](#) Center for Health Statistics, Centers for Disease Control. (n.d.). *Dataset documentation: Underlying cause of death 1999-2019*. Last reviewed March 11, 2021. Retrieved on September 1, 2021 from <https://wonder.cdc.gov/wonder/help/ucd.html#>

accuracy with respect to demographic characteristics such as race and ethnicity given the correlation of the death and birth certificate data.¹⁰

Prenatal-to-3 Data Sources and Samples Sizes

| Data Source | Unweighted Prenatal-to-3 Sample Size | Data Vintage | Number of Years Combined |
|--|---|--------------|--------------------------|
| American Community Survey (ACS) | 92,118 <i>(160 – 10,795)</i> | 2019 | 1 |
| Census Population Estimates | 11,361,919 <i>(16,370 – 1,352,608)</i> | 2020 | 1 |
| Current Population Survey – Food Security Supplement (CPS-FSS) | 6,848 <i>(41 – 596)</i> | 2018-2020 | 3 |
| National Survey of Children’s Health (NSCH) | 12,804 <i>(180 – 540)</i> | 2018-2020 | 3 |
| National Immunization Survey – Child (NIS-Child) | 35,655 <i>(347 – 1,878)</i> | 2020 | 1 |
| NIS-Child – Vaccine Sample | 19,342 <i>(188 – 988)</i> | 2020 | 1 |
| Vital Statistics (Births) | 3,613,647 <i>(5,133 – 420,259)</i> | 2020 | 1 |

Notes:

1. Unweighted state minimum and maximum sample sizes are presented italicized in parentheses below the national unweighted value.
2. For most of the data sets the unweighted prenatal-to-3 sample size refers to the number of children under age 3 in the data file. For the CPS-FSS file, the sample reflects the unweighted number of households with at least one child under age 3. The Vital Statistics data refer to births in 2019.
3. The NIS-Child sample only includes children between the ages of 19 and 35 months. The NIS-Child sample with adequate provider data for examining vaccination status is approximately half the size of the overall NIS-Child sample size.
4. The ACS sample does not include children living in group quarters.

¹⁰ National Center for Health Statistics, Centers for Disease Control. (n.d.). Dataset documentation: Linked Birth/Infant Death Records Data Summary. Last reviewed August 5, 2021. Retrieved on September 1, 2021 from <https://wonder.cdc.gov/wonder/help/lbd.html#>

Suppression and Data Quality Criteria Used to Evaluate National and State-Level Estimates

| Data Source | Suppression Criteria | Data Quality Criteria | Minimum Number of Years Combined |
|--|---|---|----------------------------------|
| American Community Survey (ACS) | A sample size of fewer than 30 in the denominator | A 90% confidence interval width greater than 10% OR an estimate with a standard error = .00 and weighted sample size of less than 3,000 | 1 |
| Census Population Estimates | N/A | N/A | 1 |
| Current Population Survey – Food Security Supplement (CPS-FSS) | A sample size of fewer than 30 in the denominator | A 90% confidence interval width greater than 10% OR an estimate with a standard error = .00 and weighted sample size of less than 3,000 | 3 |
| National Survey of Children’s Health (NSCH) | A sample size of fewer than 30 in the denominator | A 95% confidence interval width greater than 20% | 3 |
| National Immunization Survey – Child (NIS-Child) | A sample size of fewer than 30 in the denominator | A 95% confidence interval width greater than 20% | 1 |
| Vital Statistics | A sample size of fewer than 9 in the denominator | In the mortality data, rates are noted as unreliable if the count is less than 20. | 1 |

Notes:

1. Estimates that were larger than the noted confidence interval width (or other data quality criteria) were noted in all [2022 Prenatal-to-3 State Policy Roadmap](#) materials.
2. To improve the quality and accuracy of state-level estimates, the CPS supplements recommend combining three years of data.
3. NSCH recommends combining a minimum of two years of data for better data accuracy. However, with the limitations of the prenatal-to-3 sample (children under age 3), a minimum of three years of data are required to obtain estimates that meet recommended data quality criteria.

Disaggregation by Race and Ethnicity

Examining estimates by race/ethnic subgroups at the state level for our sample of interest, children under age 3 and their families, is challenging as even in the largest of the available data sets (the American Community Survey) several states have unweighted sample sizes below the recommended value. As seen in the table below, in the 2019 ACS one-year Public-Use Microdata Sample, eighteen states (including the District of Columbia) have at least one of the four race/ethnic groups of interest with an unweighted sample size that falls in the US Census Bureau’s recommended suppression range.

It is also possible that even when a state and/or subgroup's sample size exceeds the recommended suppression value, the available sample size and information for that sample may not be sufficient to produce estimates with good data quality. As an example, in the 2019 ACS microdata sample nine states had estimates of children under age 3 living in near poverty (those living in families whose income was below 150% of the federal poverty level) that fell outside of the US Census Bureau's recommended confidence interval range.

States with fewer than 30 children under age 3 (unweighted sample size) by race/ethnic group in the 2019 American Community Survey

| State | White, non-Hispanic | Hispanic | Black, non-Hispanic | Other, non-Hispanic |
|----------------------|---------------------|----------|---------------------|---------------------|
| Alaska | | X | X | |
| Delaware | | X | | |
| District of Columbia | | X | | X |
| Hawaii | | | X | |
| Idaho | | | X | |
| Iowa | | | X | |
| Maine | | X | X | X |
| Montana | | X | X | |
| New Hampshire | | X | X | X |
| New Mexico | | | X | |
| North Dakota | | X | X | |
| Oregon | | | X | |
| Rhode Island | | | X | X |
| South Dakota | | X | X | |
| Utah | | | X | |
| Vermont | | X | X | X |
| West Virginia | | X | X | |
| Wyoming | | X | X | X |

Note: This sample does not include children under age 3 living in group quarters.