What the Growing Medicaid Undercount Means for Data Users and Policymakers

Wednesday, April 5, 2023 | 12:00 PM Central Time

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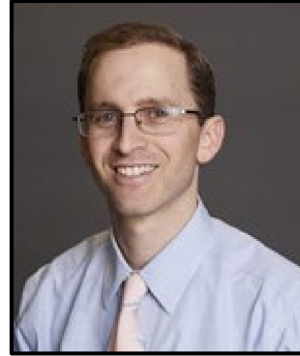
Technical Items

- Participant audio is automatically muted and video has been turned off
- Submit questions using the Q&A feature at any time during the webinar
- Problems:
  - Ask for help using the chat feature
  - Send a support request to Zoom at: https://support.zoom.us/hc/en-us/requests/new
- Slides can be downloaded at: https://www.shadac.org/publications/2023-webinar-medicaid-undercount
- Webinar recording will be posted on SHADAC's website
  - Email notice will be sent to participants

Presenters

Lynn Blewett



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The Medicaid Undercount in 2021 ACS Data: Examining the Effects of Respondent Misreporting

Robert Hest, MPP

SHADAC Medicaid Undercount Webinar | April 5, 2023

What is the Medicaid Undercount?

- Across most surveys, estimates of Medicaid/CHIP coverage are smaller than shown in administrative data — the “Medicaid Undercount”
- Caused primarily by reporting error
- Varies by state and subpopulation
- Magnitude of the Undercount varies across surveys
- Historically, the ACS’ Undercount was smaller than that of other surveys

Medicaid Continuous Coverage Requirement

- States that maintained continuous Medicaid enrollment until the end of the PHE got 6.2 percentage point increase in federal Medicaid matching funds
- Led to historic increase in Medicaid and CHIP enrollment — up 29% (20.6 million) from Feb 2020 to November 2022

Federal surveys showed smaller reduction in uninsurance

- Key federal surveys like the American Community Survey (ACS) showed unexpectedly small decreases in uninsurance in many states in 2021

What was responsible for this mismatch between the stories told by administrative data and federal survey data?

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Continuous Coverage and the Medicaid Undercount

1. Was the ACS' Medicaid Undercount larger in 2021 than in previous years?

2. What role did the continuous coverage requirement play in the increase in the undercount?

3. What does this imply about enrollees' knowledge of their continued Medicaid coverage?

Methods and Data

1. For 2014 – 2021, compare state and national weighted counts of individuals with Medicaid in the ACS to average monthly enrollment totals from CMS

2. Linked data from the 2021 & 2022 Current Population Survey Annual Social and Economic Supplement (CPS ASEC) to assess the role of the continuous coverage requirement

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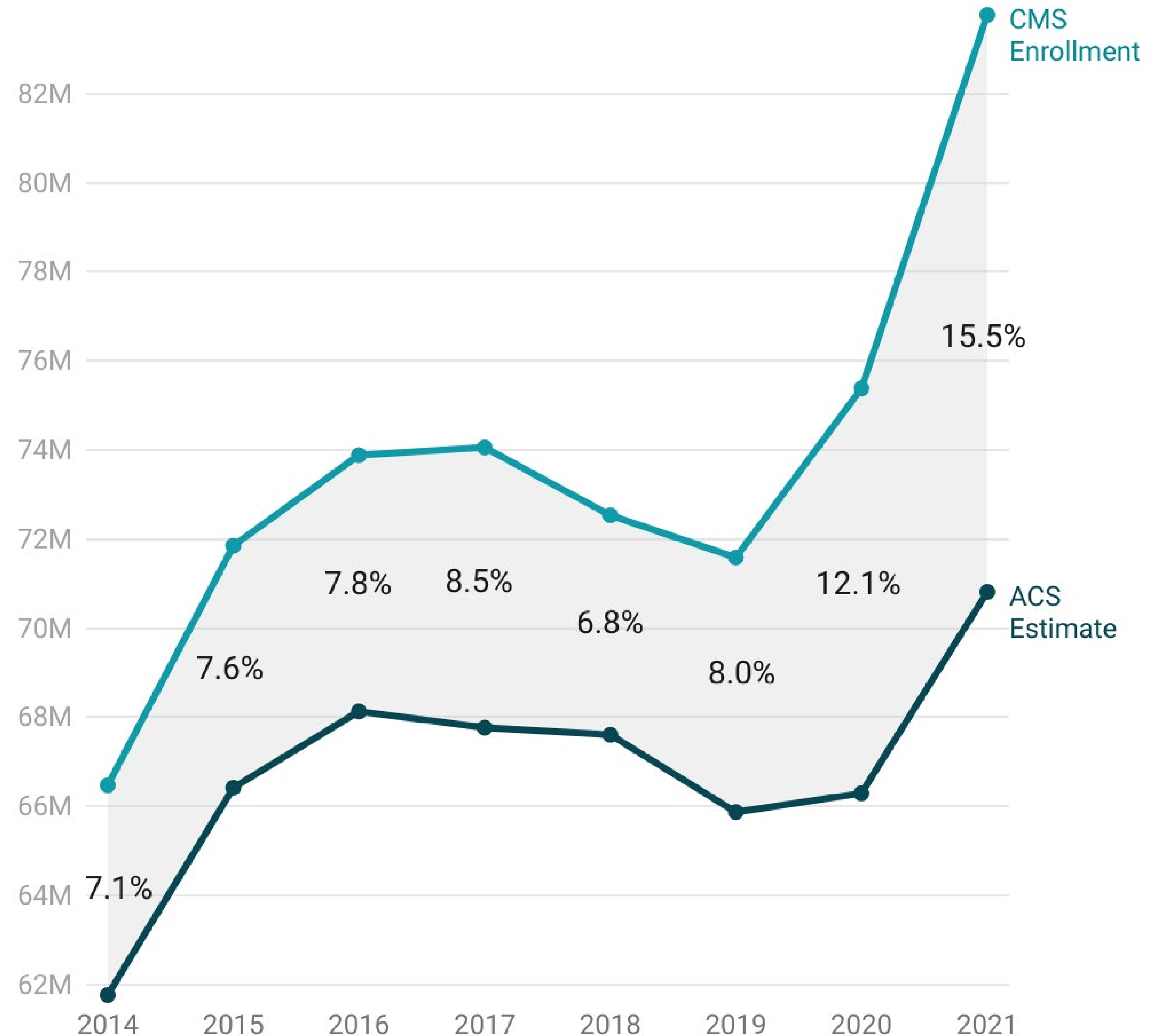
Was the ACS' Medicaid Undercount larger in 2021?

The undercount of Medicaid enrollment in the ACS grew to nearly 16% in 2021

ACS' percent undercount of Medicaid enrollment - ACS estimates compared to CMS enrollment figures, 2014-2021

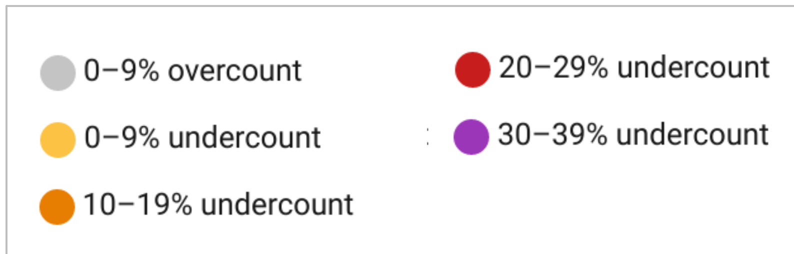


Notes: *CMS Medicaid enrollment figures represent average monthly enrollment for the calendar year. ACS estimates are an annual average. The percent undercount is the percent difference between the ACS estimate and the CMS figure. 2020 ACS estimates are based on experimental ACS data and should be treated with caution.*

Source: SHADAC analysis of 2014–2021 American Community Survey PUMS files and CMS Medicaid enrollment data via KFF.

The 2021 ACS data counts fewer with Medicaid than CMS enrollment data in nearly all states

Weighted number of individuals reporting any Medicaid coverage in the 2021 ACS versus monthly average CMS enrollment totals in calendar year 2021, by state



ACS Estimate

10M
9M
8M
7M
6M
5M
4M
3M
2M
1M
900K
800K
700K
600K
500K
400K
300K
200K
100K
90K
80K
70K
60K

Texas
Colorado
Mississippi
Kansas
Hawaii
Alaska
District of Columbia
South Dakota
North Dakota
Wyoming

60K 70K 90K 200K 300K 400K 500K 600K 800K 1M 2M 3M 4M 5M 6M 7M 8M 10M

CMS Enrollment

Notes: *CMS Medicaid enrollment figures represent average monthly enrollment for the calendar year. ACS estimates are an annual average.*

Source: SHADAC analysis of 2021 American Community Survey PUMS files and CMS Medicaid enrollment data via KFF.

What role did the continuous coverage requirement play in the 2021 Undercount?

We hypothesize that continuous coverage led to an increase in misreporting:

- Suspension of normal renewal processes largely eliminated churn
- Enrollees may not have realized they remained covered even if circumstances changed
- Few reasons for states to communicate with enrollees about their coverage

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What role did the continuous coverage requirement play in the 2021 Undercount?

- Our analysis suggests that there was a substantial degree of misreporting of Medicaid coverage in 2021
- Of those who reported having Medicaid/CHIP at some point in 2020, **30% had no self-reported Medicaid/CHIP in 2021**, despite the continuous coverage requirement
- Impact on uninsurance: of those who reported no coverage in 2021, **17% may have had (unreported) Medicaid/CHIP coverage**

2021 Health Insurance Coverage

Population Reporting Any Medicaid/CHIP Coverage in 2020 and with No Medicaid/CHIP Coverage in 2021 (n=1,056)

Reported Coverage Type	Percent	(SE)
Any private coverage (SE)	57.2%	(2.40%)
Any employer/military coverage (SE)	42.2%	(2.54%)
Any direct-purchase coverage (SE)	16.2%	(1.74%)
Any Marketplace coverage (SE)	10.4%	(1.43%)
Any subsidized Marketplace coverage (SE)	9.2%	(1.47%)
Any unsubsidized Marketplace coverage last year (SE)	1.2%^	(0.58%)
Any non-Marketplace direct-purchase coverage (SE)	5.8%	(1.21%)
Any Medicare coverage (SE)	24.5%	(2.08%)
Uninsured all year (SE)	20.6%	(2.27%)

^ Estimate is statistically unreliable (relative standard error greater than 30%) and should be treated with caution

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Implications

From a data perspective…

- 2021 survey data likely understates impact of continuous coverage policies on uninsurance
- Misreporting is one likely cause of the increase in the undercount; there may be others

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Implications

From a policy perspective…

- Despite continuous coverage, many enrollees may not have known they were covered
- More research needed to explore how people with continuous coverage understand their benefits
- The ACS remains best source of information on the full distribution of health insurance coverage and characteristics of the uninsured and individuals with Medicaid coverage

ASPE REPORT

Unwinding the Medicaid Continuous Enrollment Provision:

Projected Enrollment Effects

March 2023

U.S. Department of Health and Human Services

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ASPE Study Overview

- Analysis published August 2022 -- to assess potential disenrollment from Medicaid after the end of the Public Health Emergency's (PHE) continuous enrollment provision, starting April 1, 2023.
- ASPE estimated total disenrollment & unpacked the key difference between loss of eligibility and administrative churning (when eligible people lose coverage during redetermination) – which require different policy solutions
- The ASPE study highlights:
  - Many people leaving Medicaid will not become uninsured
  - HHS is taking robust actions to prepare for the unwinding
  - States play a key role in this process
  - Congressional action can reduce the risk of coverage losses

Key Points

- After end of the continuous coverage provision, we project that under typical disenrollment rates, 17.4% of Medicaid enrollees will leave the program - approximately 15 million individuals
    - 9.5% (8.2M) due to loss of eligibility
    - 7.9% (6.8M) disenrollment despite being eligible (‘administrative churn’)
- Coverage losses disproportionately among children, young adult, Latino and Black beneficiaries
- Many will likely obtain alternative coverage: 2.7M eligible for Marketplace tax credits, & another 5M get employer sponsored coverage or other insurance
- Depending on rate of administrative churning (which HHS is taking steps to reduce) and speed of state redeterminations, monthly coverage loss could be 684,000 to 3.1 million

Basic Approach

- Data Source – Survey for Income and Program Participation (SIPP)
    - Nationally representative, longitudinal panel
    - Respondents followed across multiple years (4 years in total for each panel); collects income & coverage info for each month

- Analysis
    - Treated March 2015-November 2016 as an analogous period to March 2020-December 2021 Public Health Emergency (PHE)
    - Estimated insurance eligibility & enrollment in Dec. 2016 (analogous to Dec. 2021) among those ever-enrolled in Medicaid during the 21-month period
    - Numbers adjusted to reflect **December 2021** Medicaid enrollment totals, which were most recently available at the time of the study

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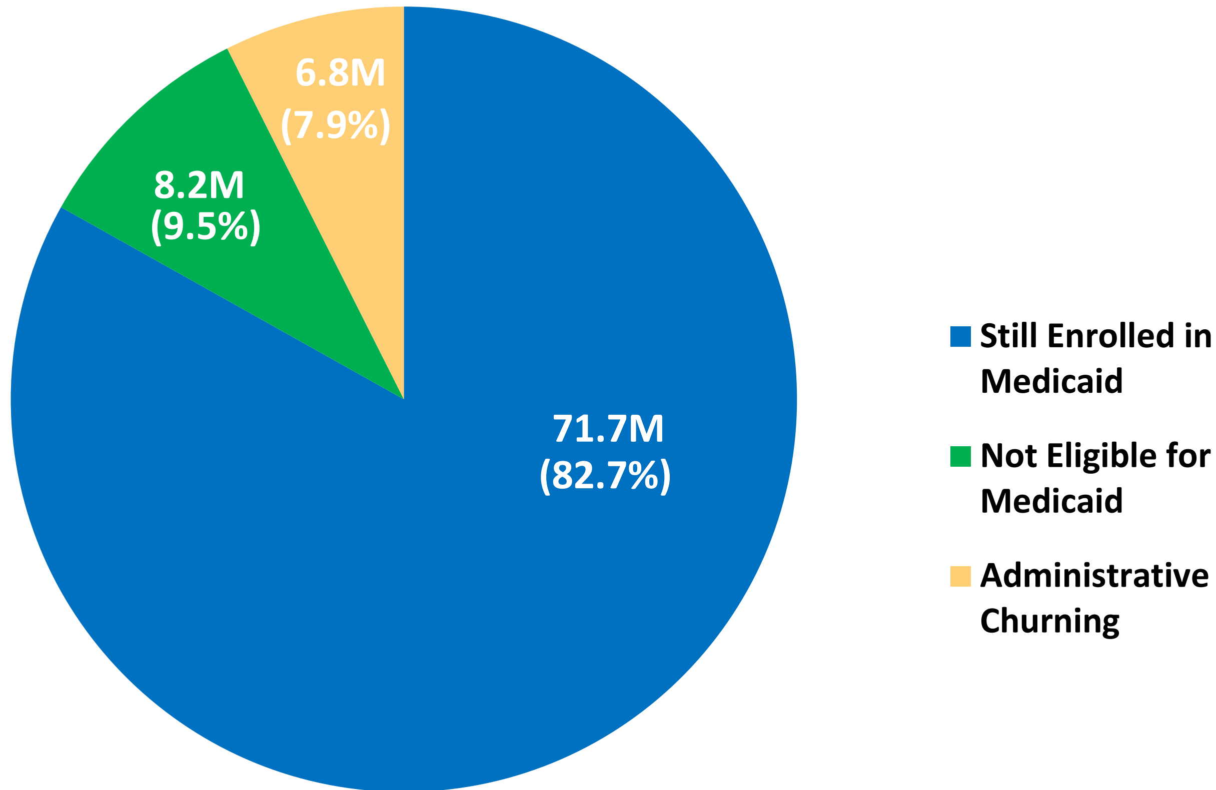
Overview of Potential Enrollment Changes



Source: Analysis of SIPP treating March 2015-Nov. 2016 as analogous to March 2020-Dec. 2021 PHE, among enrollees ever-enrolled in Medicaid during the 21-month period.

- These estimates are based on historical patterns. We also estimated high & low scenarios
- Some of this will be offset by new enrollment
- These numbers do not reflect the new April 1, 2023, date specified for redeterminations under the CAA*

*CAA = Consolidated Appropriations Act, 2023

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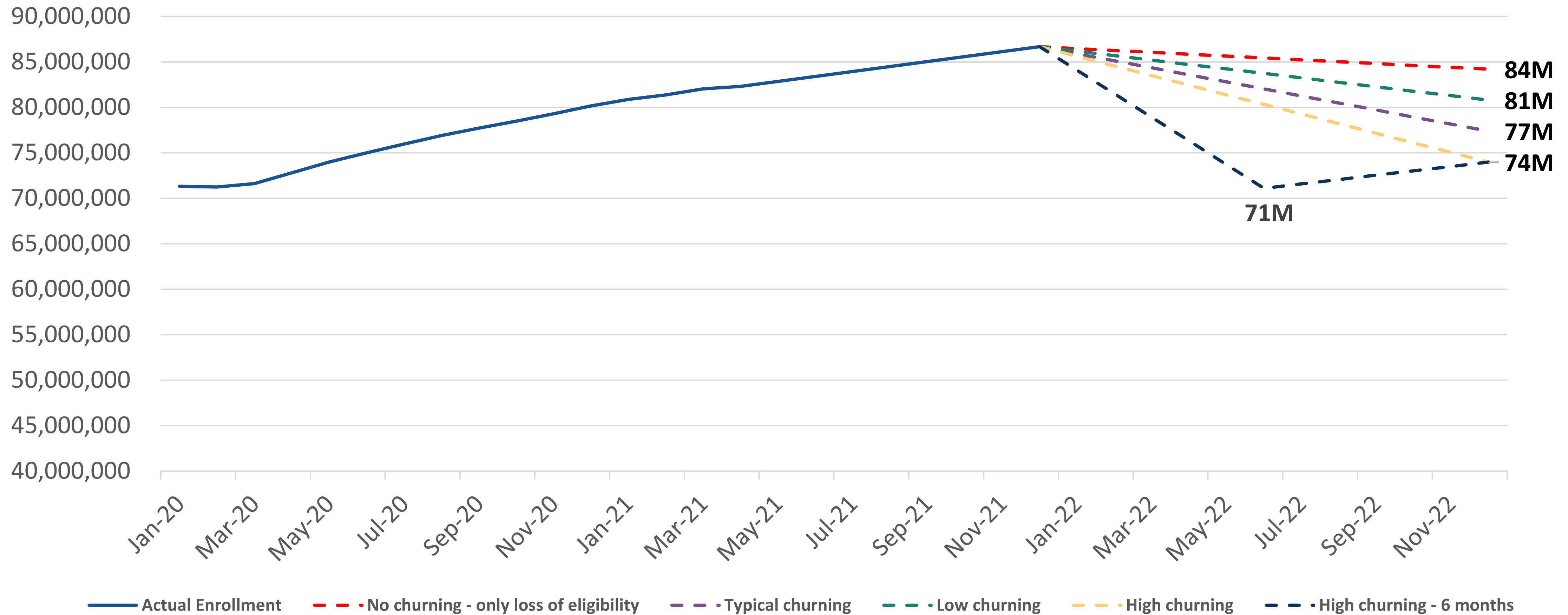
Potential Enrollment Changes Over Time



Source: Analysis of SIPP treating March 2015-Nov. 2016 as analogous to March 2020-Dec. 2021 PHE, among enrollees ever-enrolled in Medicaid during the 21-month period. New monthly Medicaid enrollment in 2021 based on monthly enrollment January-April 2021.

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Eligibility for Alternative Health Insurance

- Among the 8.2 million individuals predicted to be ineligible for Medicaid once redeterminations resume:
  - Nearly two-thirds of the individuals predicted to be ineligible for Medicaid (5.0 million) were already enrolled in ESI or other non-Marketplace insurance
  - One-third (2.7M) were potentially eligible for PTCs under the ARP – now the Inflation Reduction Act:
    - 1.6M were eligible for PTCs and cost-sharing reductions (incomes 100-250% FPL)
    - 1.7M were eligible for PTCs and likely eligible for a zero-premium Marketplace plan
  - 383,000 would fall in the coverage gap, earning less than 100% FPL and residing in the then-12 non-expansion states

Race & Ethnicity of Those Predicted to Lose Medicaid

7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
0

Number of Individuals Predicted to Lose Medicaid

52.4
47.6
40.0
60.0
47.7
52.3
44.0
56.0
44.9
55.1

Latino
White non-Latino
Black non-Latino
Asian/Native Hawaiian/Pacific Isl.
Multi-racial, other

Loss of Medicaid Eligibility
Disenrolled Despite Being Eligible for Medicaid (Administrative Churning)

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Age of Those Predicted to Lose Medicaid

Number of Individuals Predicted to Lose Medicaid

6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
0

Age	Loss of Medicaid Eligibility	Disenrolled Despite Being Eligible for Medicaid (Administrative Churning)
0-17	26.4	73.6
18-24	62.8	37.2
25-34	70.5	29.5
35-44	68.7	31.3
45-54	71.3	28.7
55-64	73.0	27.0
65+	82.1	17.9

■ Loss of Medicaid Eligibility ■ Disenrolled Despite Being Eligible for Medicaid (Administrative Churning)

Younger individuals are predicted to be impacted disproportionately at the end of the PHE

- Children ages 0-17 make up nearly one in five of the individuals predicted to be ineligible for Medicaid/CHIP and over half of those predicted to experience administrative churning
- Young adults ages 18-34 comprise more than one in three of those predicted to lose Medicaid eligibility and nearly one-quarter of those predicted to experience administrative churning
- State CHIP policies will impact how many children lose coverage:
  - 13 states have separate Medicaid and CHIP programs
  - 26 states charge an enrollment fee or premiums in their CHIP program

Policy Approaches

- The ASPE report highlights potential policies to reduce coverage losses
- CMS working with State Medicaid Agencies to reduce churning among those still eligible and providing outreach to those losing Medicaid eligibility to help them transition to other coverage (particularly Marketplace & Employer coverage)
- Extending the ARP's Marketplace subsidies past 2022 – achieved in the IRA
- Expand 12-month continuous eligibility in Medicaid – as the CAA did for children
- Eliminating the Medicaid coverage gap – ASPE estimated ~2.2 million uninsured nonelderly adults with incomes below 100% FPL would become newly eligible for Medicaid if their states were to expand, including projected 383,000 affected by unwinding. Since then, SD and NC adopted expansion plans (not yet implemented).

Implications of SHADAC Report on Survey Undercount

- The uninsured rate before & after the continuous coverage provision may not track closely with Medicaid gains and losses – many who could lose coverage may *already* describe themselves in survey as uninsured.
- Some who nominally maintained Medicaid during the PHE but don't realize it may not have been closely attached to the health care system – potential underutilization of care for the past 2 years
- Indicates ongoing confusion about coverage types & eligibility
- Future research needed to assess if this is a temporary worsening of the undercount or something more persistent

Child Medicaid Coverage Rates Using CMS and ACS Data in Top 10 States with Highest Shares of Enrolled Children, 2021

State	CMS Data (2021 Average)	ACS Data (2021)	Percentage Point Difference
United States	51.7%	39.0%	12.7
New Mexico	72.6%	58.3%	14.3
District of Columbia	72.1%	41.8%	30.3
Louisiana	68.1%	53.4%	14.7
Mississippi	64.8%	49.2%	15.6
West Virginia	61.3%	47.1%	14.2
Florida	61.1%	40.5%	20.6
Alabama	60.8%	43.6%	17.2
South Carolina	59.8%	45.8%	14.0
Oklahoma	59.5%	46.6%	12.9
New York	58.2%	43.0%	15.2

Source: Georgetown University Center for Children and Families analysis of Centers for Medicare & Medicaid Services (CMS) State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data. CCF substitutes state administrative data for Arizona and Indiana. CMS rates calculated with child population totals from U.S. Census Bureau American Community Survey (ACS) Table HIC-5, Health Insurance Coverage Status and Type of Coverage by State - Children Under 19: 2008 to 2021, Health Insurance Historical Tables.

Thank you!

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