Medicaid Undercount Webinar: Additional Q&A

Q: 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. Is this estimate among who reported (non-imputed) or including the imputed record as well?	*A: The individuals who self-reported coverage in 2020 did not include imputed or edited information, but the information about coverage in 2021 does include imputed and edited information.*
Q: Do you have an estimate of the [undercount] proportion that will have turned 65 since March 2020?	*A: That isn't something we estimated specifically. It is likely that some individuals in our sample aged onto Medicare in the year we observed them. This wouldn't automatically mean that they lost Medicaid eligibility or coverage, but it would mean that their primary form of coverage would then most likely be Medicare.*
Q: Given the impact on people of color and immigrant communities, I'm curious if any of the researchers looked at the differences between rural and urban areas.	*A: At SHADAC, we were not able to examine differences between rural and urban areas. The longitudinal CPS ASEC data from IPUMS-CPS that we used does allow many individuals' metropolitan status to be identified (which is a similar but distinct concept to urban/rural). However, our analytic sample was relatively small, so it may be difficult to produce high quality estimates by metropolitan status.*
Q: Many analysts and researchers are using the Census' Household Pulse Survey to monitor coverage trends during the pandemic. Is there any impression on how accurate the Medicaid estimates from the Pulse are compared to the ACS and administrative databases?	*A: That is something we are actively working on evaluating. Because of the HPS' sample design and intention as a 'real-time' monitoring survey, there is reason to believe that it is under-representative of many of the lower-SES groups that Medicaid historically covered and it has a meaningful amount of nonresponse bias. It is almost surely less accurate than the data from ACS or administrative data, though that may not be a relevant comparison as the HPS was designed to do a very different job than ACS. With those limitations in mind, it still may be a useful tool for monitoring who is losing coverage and providing pieces of information that are unavailable in the administrative data.*
Q: Some sources are reporting "private pay" as a growing source of coverage for certain regions of the United States (e.g., the state of Oregon) with a variety of healthcare providers forming "boutique networks/affiliations" where an individual person and/or a family pays a flat fee annually for health care. Is there any possibility of analyzing this development?	*A: This is certainly an issue worth studying. However, this phenomenon was not in scope for our analysis and likely plays an insignificant role in the issues of the Medicaid Undercount and the now ongoing unwinding of the continuous coverage requirements.*