

Medicaid Undercount Doubles, Likely Tied to Enrollee Misreporting of Coverage

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The Medicaid Undercount

The “Medicaid undercount” refers to the discrepancies that exist between survey estimates of enrollment in Medicaid and the number of enrollees that are actually reported in state and national administrative data—a pattern in which the former estimate is consistently reported lower than the latter. Studies on the subject show that nearly all surveys undercount Medicaid/CHIP enrollment relative to administrative sources, however the magnitude of the undercount can vary considerably between major federal surveys.

Introduction

The Medicaid and Children’s Health Insurance Plan (CHIP) programs have played a key role in the response to the COVID-19 pandemic, providing an important safety net for health insurance coverage for millions of people during this unprecedented public health crisis. The Families First Coronavirus Response Act enacted the continuous coverage requirement, which provides a 6.2 percentage point increase in federal matching funds for states that maintain continuous Medicaid enrollment until the end of the public health emergency.^{1,2} Subsequently, enrollment in Medicaid and CHIP has grown 27% since February 2020, with over 19.3 million enrollees added to state rosters as of July 2022.³

Advocates, analysts, and policymakers are now looking at results from key annual federal surveys to show the impacts of these changes on the distribution of health insurance coverage.⁴ Given the large rise in Medicaid/CHIP enrollment during the pandemic, many were surprised to see lower-than-expected estimates of Medicaid/CHIP coverage and relatively small declines in uninsurance rates in many states.⁵

This brief describes our analysis of these estimates, focused on the size of the “Medicaid undercount,” the misalignment between survey estimates of self-reported Medicaid coverage and enrollment counts obtained from Medicaid/CHIP administrative data.

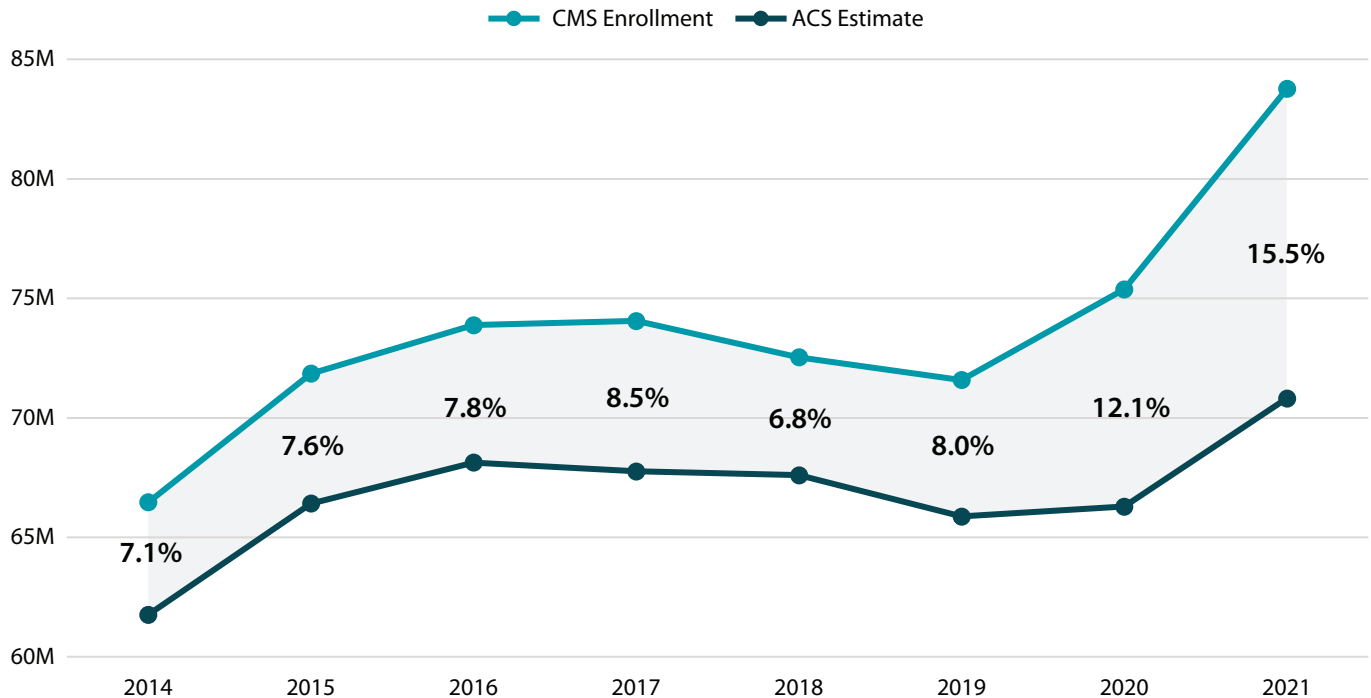
The Medicaid undercount in the 2021 American Community Survey (ACS) was larger than in earlier years, which we believe was tied, at least in part, to the Medicaid continuous coverage requirement. We also present analysis of two years of linked data from the Current Population Survey Annual Social and Economic and Supplement (CPS ASEC). Our results suggest that despite having continuous coverage, many enrollees may not have known they were still covered by Medicaid.

The Medicaid undercount doubled in the 2021 ACS

Studies have consistently shown that in most surveys, there are differences between survey estimates of Medicaid/CHIP coverage and the number of enrollees reported in administrative data, with survey-based estimates typically showing smaller estimates of Medicaid/CHIP coverage than administrative data.^{6,7,8,9}

In the ACS, which is widely used to study state-level trends in health insurance coverage, the undercount has been relatively stable in magnitude over time. Pre-pandemic survey estimates of Medicaid enrollment have generally followed enrollment trends in administrative data (at least since 2014) and have ranged from 7.1% to 8.5% (see exhibit below). In this newest year of data, however, the undercount increased notably, jumping to 15.5% in 2021. This is despite ACS data collection operations mostly returning to normal in the second year of the pandemic and the survey having an overall response rate similar to that of 2019 (85.2% versus 86.0%, respectively).¹⁰

The undercount of Medicaid enrollment in the American Community Survey grew to nearly 16% in 2021
The ACS' percent undercount of Medicaid enrollment with 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 Medicaid continuous coverage requirement likely contributed to respondent misreporting of Medicaid coverage

We hypothesize that a meaningful portion of the growth in the 2021 undercount was due to an increase in respondents misreportingⁱ their coverage status related to the Medicaid continuous coverage requirement. To qualify for enhanced federal Medicaid funding during the COVID-19 pandemic, states were required to provide continuous Medicaid eligibility through the end of the public health emergency for anyone who was enrolled on or after March 18, 2020. This resulted in the suspension of normal renewal procedures and all but eliminated the churn off of Medicaid associated with the renewal process.¹¹ But, though very few enrollees were (and are) churning off of Medicaid during the PHE, it is plausible that many did not realize that they were still enrolled in Medicaid even if their circumstances had changed (e.g., they moved out of state, gained employer-sponsored insurance, or had a change in income). States are not required to notify enrollees of their continuous coverage and have not had reason to notify enrollees of automatic renewals or ask them to respond to renewal forms, communications that could have made enrollees aware of their continuous Medicaid enrollment status.

We estimate that as many as 30 percent of 2020 enrollees misreported Medicaid coverage in 2021

To examine the role of misreporting in the 2021 Medicaid undercount, we used data from the linked 2021 and 2022 CPS ASEC drawn from IPUMS-CPS, which links survey respondents who are matched across adjoining years of the ASEC.^{12,13,14} Our 2021–2022 linked ASEC file contains all respondents who were in both the 2021 and 2022 surveys (n=37,344), which allows us to observe respondent reported health insurance coverage at two points in time—2020 and 2021.ⁱⁱ

ⁱ Misreporting includes any associated error from Census [procedures](#) to correct for missing data that in turn use misreported data. The term “misreporting” is not meant to assign blame to respondents.

ⁱⁱ The CPS ASEC’s primary [measure](#) of health insurance coverage asks what types of coverage respondents held in the previous calendar year.

Our analysis relies on the assumption that because of the continuous coverage requirement, nearly all respondents who reported being covered by Medicaid in 2020 remained covered by Medicaid in 2021. This implies that respondents who reported having Medicaid coverage in 2020 and not in 2021 misreported their Medicaid enrollment status.

In our sample population, 12.7% (SE 0.47%) of civilian noninstitutionalized individuals reported having Medicaid/CHIP coverage at some point in 2020. In 2021, among those same individuals (n=3,639), 30.1% (SE 1.40%) had no self-reported Medicaid/CHIP coverage at any point in 2021, despite the continuous coverage requirement. This indicates that there was likely a substantial degree of misreporting of Medicaid coverage in 2021.

This misreporting of Medicaid coverage also has impacts on 2021 estimates of uninsurance. In our linked sample, among the population uninsured for all of 2021 (n=2,471), we estimated that 17.0% (SE 1.32%) had (unreported) Medicaid/CHIP coverage in 2021. This implies that 2021 uninsurance figures could be overestimated by as much as 17.0% (see table below).

Individuals Likely Covered by Medicaid in 2021 Reported Private Coverage

As shown in the table below, among those who reported any 2020 Medicaid coverage but no 2021 Medicaid coverage (n=1,056), most had health insurance coverage at some point in 2021. Among this group in 2021, 57.2% had some form of private coverage, 42.2% had any employer-sponsored or military coverage, 16.2% had any direct-purchase coverage, 24.5% had any Medicare coverage, and 20.6% were uninsured all of 2021.

2021 Health Insurance Coverage of 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

Based on these estimates, it seems that many in this group who misreported their 2021 Medicaid/CHIP coverage had plausible reasons for doing so:

- First, the 42.2% with employer coverage may have assumed they lost Medicaid coverage because they had employer-sponsored coverage, which in a time before the continuous coverage requirement would not have automatically resulted in disenrollment, but may have if a change in employment also resulted in an increase in income above Medicaid eligibility thresholds;
- Second, the 10.4% with any Marketplace coverage could have been unclear about the source of their coverage if they originally got their Medicaid coverage through the Marketplace portal;¹⁵ and
- Third, the 24.5% with any Medicare coverage may have aged onto Medicare (which in many cases would lead to ineligibility for Medicaid under the more restrictive eligibility rules for adults age 65+), may have had a more tenuous connection with their Medicaid benefits (which primarily help Medicare enrollees with premiums and out-of-pocket costs but often do not directly provide coverage), or may have simply confused Medicare and Medicaid (which have similar-sounding names).

Conclusion

Our analysis shows a dramatic increase in the Medicaid undercount in 2021 within federal surveys related, at least in part, to misreporting resulting from the Medicaid continuous coverage requirement under the COVID-19 PHE. This has analytic and policy consequences. From a data analysis perspective, those looking to use the 2021 ACS or 2022 CPS to measure the impact of pandemic-era coverage policies on uninsurance rates and other outcomes may be disappointed by the results. From a survey methodology perspective, though our analysis provides evidence for *one* likely cause of the increase in the undercount, it does not preclude other, perhaps more concerning explanations such as persistent nonresponse bias. More work should be done to evaluate other potential causes of the increase in the undercount and to monitor its size moving forward.

From a policy perspective, the extent of misreporting of Medicaid coverage leads to estimates that do not reliably reflect the impact of the continuous coverage requirement which expanded Medicaid access and effectively eliminated churn. These results seem to indicate that despite having continuous coverage, many enrollees—particularly those who reported that they were uninsured—did not know they were covered and therefore were not able to take advantage of their coverage. Most reported that they had private health insurance in 2021, suggesting a continuation of coverage and benefits. Further research and analysis should be done to explore how people with continuous coverage understood and used their benefits and whether the continuous coverage requirements should include annual notification to beneficiaries that their Medicaid coverage was extended.

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