Capacity of MEPS to Inform Provisions of the Affordable Care Act

Steven B. Cohen, Ph.D.
Overview of Medical Expenditure Panel Survey (MEPS)

Analytic Capacity

Capacity to Inform the Affordable Care Act

Modeling Efforts
AHRQ Mission Statement

To improve the quality, safety, efficiency, and effectiveness of health care for all Americans.
AHRQ Activities

- Knowledge Creation
  - Creating data, research findings and tools

- Synthesis and Dissemination
  - Disseminating information to multiple stakeholders to improve the system

- Implementation
  - Partnering with stakeholders to implement proven strategies for health care improvement
Affordable Care Act

2010 Initiatives

- dependent coverage up to age 26
- employer tax credits for contributions toward their employees' health insurance premiums
- temporary reinsurance program to offset costs of employer provided retiree benefits
- High-risk pools for uninsured with preexisting conditions
- greater availability of consumer insurance information on coverage choices
Affordable Care Act

2011 Initiatives

- New payment and delivery approaches: CMS Center for Innovation
- Physician Quality Reporting: physician compare website
- Medicare doughnut hole discounts

2012 Initiatives

Medicare value-based purchasing
Affordable Care Act

- **2013 Initiatives**
  - Flexible spending limits

- **2014 Initiatives**
  - Medicaid expansions
  - Insurance exchanges
  - Premium subsidies
  - Shared Responsibility for coverage

- **2018 Initiatives**
  - High cost insurance plans
MEPS Components

- Household Component (HC)
- Medical Provider Component (MPC)
- Insurance Component (IC)
Medical Expenditure Panel Survey (MEPS)

Data resources:

Annual Survey of 14,000 households:
provides national and state estimates (most populous) of health care use, expenditures, insurance coverage, sources of payment, access to care and health care quality

Permits studies of:
- Distribution of expenditures and sources of payment
- Role of demographics, family structure, insurance
- Expenditures for specific conditions
- Trends over time
HC - Purpose

- Estimates annual health care use and expenditures
- Provides distributional estimates
- Supports person and family level analysis
- Tracks changes in insurance coverage and employment
- Longitudinal design; linkage to National Health Interview Survey (NHIS)
Key Features of MEPS-HC

- Survey of U.S. civilian noninstitutionalized population
- Sub-sample of respondents to the National Health Interview Survey (NHIS)
- Oversample of minorities and other target groups
- Panel Survey – new panel introduced each year
  - Continuous data collection over 2 ½ year period
  - 5 in-person interviews (CAPI)
  - Data from 1st year of new panel combined with data from 2nd year of previous panel
MEPS Overlapping Panels (Panels 13 and 14)

MEPS Household Component

MEPS Panel 13
2008-2009

1/1/2008

NHIS 2007

Round 1  Round 2  Round 3  Round 4  Round 5

1/1/2009

NHIS 2008

Round 1  Round 2  Round 3  Round 4  Round 5

MEPS Panel 14
2009-2010

1/1/2008

NHIS 2007

Round 1  Round 2  Round 3  Round 4  Round 5

1/1/2009

NHIS 2008

Round 1  Round 2  Round 3  Round 4  Round 5

MEPS Panel 14
2009-2010
Definition and estimation of uninsured

Types of estimates of uninsured – calendar year focus:

1. First half of calendar year
2. Annual profiles
3. Two consecutive years
4. Point in time
5. Long-term uninsured: 4 consecutive years

As a longitudinal survey MEPS can examine health insurance dynamics, changes in coverage, and spells without insurance
Research on Health Insurance

- Tracks overall health insurance status of the U.S. population
  - Estimates of uninsured by population characteristics
  - Duration of spells of uninsurance
  - Trends in estimates of the uninsured

- More focused research examines
  - Factors associated with insurance take up
  - Financial consequences of being uninsured
  - Relationship between uninsurance and health status
Trends in medical care costs, coverage and use

Impact of economic and behavioral factors, payment and individual demand on health care service utilization and expenditures

- Distribution of expenditures, concentration and persistence of high levels
- Expenditures for chronic conditions: focus on patients with multiple chronic conditions
- Trends in prescription medications by drug class
Targeted Sample

- All associated hospitals and associated physicians
- Sample of associated office-based physicians
- All associated home health agencies
- All associated pharmacies

Data Collected

- Dates of visits
- Diagnosis and procedure codes
- Charges (except Rx) and payments
MEPS Insurance Component

Annual survey of 40,000 establishments
National and state level estimates of employer sponsored coverage:

- Availability of health insurance
- Access to health insurance
- Cost of health insurance
- Benefit and payment provisions of private health insurance
Significance of the Issue

Health care expenditures:

- Over one-sixth of the U.S. GDP
- Rate of growth exceeds other sectors of the economy
- Recent moderation in rate of growth
- Expenditure distribution is highly concentrated
- Among the largest components of the Federal and states’ budgets
- Cost containment of continuing concern to private and public payers
Most Recent Cost Statistics

- In 2010 total expenditures = $2.6 trillion
  - 17.9% of GDP
  - 3.9% increase over 2009
  - growth remained slow
  - $8,402 per capita

- Projected to be ~20% of GDP in next decade

Source: Anne B. Martin, David Lassman, Benjamin Washington, Aaron Catlin and the National Health Expenditure Accounts Team, Health Affairs, January 2012
Assess Trends in Concentration of Healthcare $s and Distributional Cost Estimates

5% of patients account for half of health care spending

By Kelly Kennedy, USA TODAY

WASHINGTON – Just 1% of Americans accounted for 22% of health care costs in 2009, according to a federal report released Wednesday.

That's about $90,000 per person, according to the Agency for Healthcare Research and Quality. U.S. residents spent $1.26 trillion that year on health care.

Five percent accounted for 50% of health care costs, about $36,000 each, the report said.
Factors for Cost Projection Models

- Demographic/economic characteristics: Age; sex; race/ethnicity; marital status; region; MSA classification, family size, poverty status

- Health status measures: health status; activity limitations

- Health insurance coverage: full year insured; part year insured; uninsured

- Health conditions: Diagnosis of arthritis; cancer; BMI; cerebrovascular disease; diabetes; heart disease; high blood pressure; high cholesterol; mental health; back pain; pregnancy

- Accidental events: trauma

- Utilization measures: inpatient events; ambulatory visits; number of prescribed medicine purchases

- Expenditure measures: prior yr. total health care spending
Capacity of MEPS to Inform Provisions of the Patient Protection and Affordable Care Act

- Assess trends in health care spending by source of payment
- Assess trends in health insurance coverage, ESI, insurance take-up, eligibility for subsidies
- Evaluations of the health insurance status of young adults and their health care use and costs, ages 22-26
- Analysis of trends in the health insurance status of high risk individuals and their health care use and costs
- Inform allocation of Federal Medical Assistance Percentages (FMAP) matching funds for state Medicaid programs
- Determination of the amount of the small employer health insurance tax credit
- Evaluations of the impact of the planned excise tax on the most expensive employer sponsored health plans
Assess Trends in Healthcare Burdens Pre and Post ACA:
Percent of individuals with high out of pocket health care burdens, elderly & non-elderly, 2008 (MEPS).
Burden=out of pocket medical expenditures + premiums/ family income

<table>
<thead>
<tr>
<th>Poverty Group</th>
<th>10% of family income</th>
<th>20% of family income</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td>52.5</td>
<td>26.1</td>
</tr>
<tr>
<td>Non-elderly</td>
<td>17.0</td>
<td>7.7</td>
</tr>
<tr>
<td><strong>Poor</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly</td>
<td>54.1</td>
<td>43.5</td>
</tr>
<tr>
<td>Non-Elderly</td>
<td>33.2</td>
<td>24.5</td>
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<tr>
<td><strong>Low Income</strong></td>
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<tr>
<td>Elderly</td>
<td>70.8</td>
<td>40.7</td>
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<tr>
<td>Non-Elderly</td>
<td>22.4</td>
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<tr>
<td><strong>Middle Income</strong></td>
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<tr>
<td>Elderly</td>
<td>63.5</td>
<td>26.0</td>
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<tr>
<td>Non-elderly</td>
<td>18.8</td>
<td>5.9</td>
</tr>
<tr>
<td><strong>High Income</strong></td>
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<td></td>
</tr>
<tr>
<td>Elderly</td>
<td>27.4</td>
<td>7.8</td>
</tr>
<tr>
<td>Non-elderly</td>
<td>7.5</td>
<td>2.1</td>
</tr>
</tbody>
</table>

Banthin and Bernard, 2009, CFACGT
MEPS, 2009:
Percentage uninsured by age

Source: Center for Financing, Access, and Cost Trends, AHRQ, Household Component of the Medical Expenditure Panel Survey, 2009 Full-Year File
Cumulative percent change in total premiums by coverage type for employer-sponsored health insurance, private industry, 2001-2011

Insurance Component estimates are not available for 2007.
Cumulative percent change in employee contributions by coverage type for employer-sponsored health insurance, private industry, 2001-2011

Insurance Component estimates are not available for 2007.
MEPS-IC State-Level Premiums Key To Tax Credit for Small Employers

• The Affordable Care Act offers a tax credit for small employers providing health insurance
  • Credit effective beginning in 2010
  • Amount of credit limited by the average premium paid by small employers by State
  • Treasury & HHS have begun joint effort to define these limits
  • MEPS-IC is only source of State-level premium data for all States
    • In later years, sub-State small group markets may be designated by HHS secretary
    • Research underway to improve MEPS-IC sub-State estimates of health insurance premiums

Source: Center for Financing, Access, and Cost Trends, AHRQ, Insurance Component of the Medical Expenditure Panel Survey
2010
Instructions for Form 8941

Credit for Small Employer Health Insurance Premiums

Section references are to the Internal Revenue Code unless otherwise noted.

General Instructions

Purpose of Form

Eligible small employers (defined below) use Form 8941 to figure the credit for small employer health insurance premiums for tax years beginning after 2009. The maximum credit is a percentage of premiums the employer paid during the tax year for certain health insurance coverage the employer provided to certain employees. But the credit may be reduced by limitations based on the employer's full-time equivalent employees, average annual wages, state average premiums, and state premium subsidies and tax credits.

For tax-exempt small employers, the credit is generally 25% of premiums paid, is also limited to the amount of certain payroll taxes paid, and is claimed as a refundable credit on Form 990-T, Exempt Organization Business Income Tax Return. A tax-exempt small employer is an eligible small employer described in section 501(c) that is exempt from taxation under section 501(a). A tax-exempt employer not described in section 501(c) is generally not eligible to claim this credit.

However, a tax-exempt farmers’ cooperative subject to tax under section 1381 may be able to claim the credit as a general business credit as discussed next.

For all other small employers, the credit is generally 35% of premiums paid, can be taken against both regular and alternative minimum tax, and is claimed as part of credit under other rules for qualifying arrangements. This may include, for example, employers who offer more than one type of health insurance coverage or whose insurance provider does not charge the same premium for all employees enrolled in single (employee-only) coverage. For details, see Notice 2010-82 as discussed under More Information on page 5.

For more details, see Employer Premiums Paid, Health Insurance Coverage, and Qualifying Arrangement, later.

2. You had fewer than 25 full-time equivalent employees (FTEs) for the tax year. You may be able to meet this requirement even if you had 25 or more employees. For details, see Individuals Considered Employees and FTE Limitation, later.

3. You paid average annual wages for the tax year of less than $50,000 per FTE. For details, see Individuals Considered Employees and Average Annual Wage Limitation, later.

If you had more than 10 FTEs and average annual wages of more than $25,000, the FTE and average annual wage limitations (discussed later) will separately reduce your credit. This may reduce your credit to zero even if you had fewer than 25 FTEs and average annual wages of less than $50,000.

Employers treated as a single employer. Treat the following employers as a single employer to figure the credit:
- Employers who are corporations in a controlled group of corporations.
MEPS-based Data

For this purpose, if you are entitled to a state tax credit or a state premium subsidy paid directly to you for premiums you paid, do not reduce the amount you paid by the credit or subsidy amount. Also, if a state pays a premium subsidy directly to your insurance provider, treat the subsidy amount as an amount you paid for employee health insurance coverage.

For a special rule that applies to multiemployer health and welfare plans, see Notice 2010-82 as discussed under More Information on page 5.

State Average Premium Limitation
Your credit is reduced if the employer premiums paid are more than the employer premiums that would have been paid if individuals considered employees enrolled in a plan with a premium equal to the average premium for the small group market in the state in which the employee works. The following table lists the average premium for the small group market in each state for tax years beginning in 2010. Family coverage includes any coverage other than single (employee-only) coverage.

Table A. State Average Premiums for Small Group Markets

<table>
<thead>
<tr>
<th>State</th>
<th>Single (Employee-Only) Coverage</th>
<th>Family Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>8,441</td>
<td>11,275</td>
</tr>
<tr>
<td>Alaska</td>
<td>6,204</td>
<td>13,723</td>
</tr>
<tr>
<td>Arizona</td>
<td>4,485</td>
<td>10,239</td>
</tr>
<tr>
<td>Arkansas</td>
<td>4,329</td>
<td>9,677</td>
</tr>
<tr>
<td>California</td>
<td>4,628</td>
<td>10,947</td>
</tr>
<tr>
<td>Colorado</td>
<td>4,972</td>
<td>11,437</td>
</tr>
<tr>
<td>Connecticut</td>
<td>5,419</td>
<td>13,484</td>
</tr>
<tr>
<td>Mississippi</td>
<td>4,533</td>
<td>10,501</td>
</tr>
<tr>
<td>Missouri</td>
<td>4,633</td>
<td>10,681</td>
</tr>
<tr>
<td>Montana</td>
<td>4,772</td>
<td>10,212</td>
</tr>
<tr>
<td>Nebraska</td>
<td>4,715</td>
<td>11,169</td>
</tr>
<tr>
<td>Nevada</td>
<td>4,563</td>
<td>10,297</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>5,519</td>
<td>13,624</td>
</tr>
<tr>
<td>New Jersey</td>
<td>5,607</td>
<td>13,521</td>
</tr>
<tr>
<td>New Mexico</td>
<td>4,754</td>
<td>11,404</td>
</tr>
<tr>
<td>New York</td>
<td>5,442</td>
<td>12,867</td>
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<tr>
<td>North Carolina</td>
<td>4,920</td>
<td>11,583</td>
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<td>North Dakota</td>
<td>4,469</td>
<td>10,506</td>
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<tr>
<td>Ohio</td>
<td>4,667</td>
<td>11,293</td>
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<tr>
<td>Oklahoma</td>
<td>4,898</td>
<td>11,002</td>
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<td>Oregon</td>
<td>4,681</td>
<td>10,880</td>
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<tr>
<td>Pennsylvania</td>
<td>5,039</td>
<td>12,471</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>5,887</td>
<td>13,786</td>
</tr>
<tr>
<td>South Carolina</td>
<td>4,890</td>
<td>11,780</td>
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<tr>
<td>South Dakota</td>
<td>4,497</td>
<td>11,482</td>
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<tr>
<td>Tennessee</td>
<td>4,611</td>
<td>10,369</td>
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<tr>
<td>Texas</td>
<td>5,140</td>
<td>11,972</td>
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<tr>
<td>Utah</td>
<td>4,238</td>
<td>10,935</td>
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<td>Vermont</td>
<td>5,244</td>
<td>11,748</td>
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<tr>
<td>Virginia</td>
<td>4,990</td>
<td>11,338</td>
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<tr>
<td>Washington</td>
<td>4,543</td>
<td>10,725</td>
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<tr>
<td>West Virginia</td>
<td>4,986</td>
<td>11,811</td>
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<tr>
<td>Wisconsin</td>
<td>5,222</td>
<td>12,819</td>
</tr>
<tr>
<td>Wyoming</td>
<td>5,266</td>
<td>12,163</td>
</tr>
</tbody>
</table>
2010 MEPS-IC Family Premium Estimates Now Available
For Use in Setting State Tax Credits for Small, Private Sector Firms under Health Care Reform

Arkansas
$9,574
Idaho
$9,891
South Carolina
$10,873
Utah
$10,994
South Dakota
$11,245
United States
$13,170
Illinois
$15,130
Massachusetts
$15,132
Connecticut
$15,306
Alaska
$15,623
New Hampshire
$15,976

Small firms have fewer than 50 employees; Source: Center for Financing, Access, and Cost Trends, AHRQ, Insurance Component of the Medical Expenditure Panel Survey, 2010
Trends for Employers that Self-Insure

Provisions in the Affordable Care Act impact on self-insured plans

- Impact on plan design

- Implications on preventive care coverage

- Assess trends in offers of employment-based group coverage and self-insured plans, their cost and benefit provisions

Source: Center for Financing, Access, and Cost Trends, AHRQ, Insurance Component of the Medical Expenditure Panel Survey, 2009
Percent of enrollees with employer-sponsored coverage in self-insured plans, private sector by firm size, 2000 and 2010

Source: Center for Financing, Access, and Cost Trends, AHRQ, Insurance Component of the Medical Expenditure Panel Survey, 2009
Figure 1. Percentage of private establishments that offer health insurance to retirees under age 65, by firm size, 2004 and 2009

- **All firms**: 2004: 14.0%, 2009: 11.2%
- **Large firms**: 2004: 30.6%, 2009: 23.4%
- **Small firms**: 2004: 1.6%, 2009: 1.5%

Small firms have fewer than 50 employees; large firms have 50 or more employees.
Source: Center for Financing, Access, and Cost Trends, AHRQ, Insurance Component of the Medical Expenditure Panel Survey, 2004 and 2009
Questionnaire Changes to the 2013 MEPS-IC Survey

Pretest Results
To MEPS plan-level forms:

(6c.) What is the specific stop-loss coverage amount per employee? $___,___,____.00

Question for aggregate stop-loss was not added
Questions Added

To MEPS plan-level forms:

(12a.) Did the premiums charged for this insurance plan vary by any of these characteristics?
   - Smoker/non-smoker
   The question will also have a (Yes, No, Don't Know) answer option. (Premiums did not vary option will be deleted.)

(12b.) Did the amount an employee contributed toward his/her own coverage vary by any of these employee characteristics?
   - Participation in a fitness/weight loss program
   - Participation in a smoking cessation program
   The question will also have a (Yes, No, Don't Know) answer option. (Contributions did not vary option will be deleted.)
(25) Which of the services listed were covered by the plan?

- Routine vision care for children
- Routine vision care for adults
- Routine dental care for children
- Routine dental care for adults
- Mental health care
- Substance abuse treatment
- Chiropractic care (kept from current survey)
Is this a grandfathered health plan as defined by the Affordable Care Act?
Yes/No/Don’t Know

Question was added to plan-level form
Unmarried Domestic Partners Question Tested

a) Did your organization offer health insurance coverage to unmarried domestic partners of the same sex? Yes/No/ Don’t Know

b) Did your organization offer health insurance coverage to unmarried domestic partners of the opposite sex? Yes/No/ Don’t Know

Questions were added to establishment-level form
Next Steps

- Obtain approval from OMB to make these substantive changes to the survey
- Make changes to private-sector and State/local government forms, CATI instruments, and databases
- Modify support documentation such as Definition of Terms and training materials for CATI interviewers
HHS survey data used to model costs and impacts of various proposed reforms

- Costs of reform to households
- Costs to nation
- Changes in coverage
- Tax impacts
How much lower would out-of-pocket expenditures for care for adults with individual insurance be if they had more generous benefits typical of employment-related insurance?

- Small employers
- Large employers
# Annual Out-of-Pocket Spending for Medical Care and Drugs

## Table of Out-of-Pocket Spending

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Small</th>
<th>Large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>$1,005</td>
<td>$583**</td>
<td>$517**</td>
</tr>
<tr>
<td>Percent positive</td>
<td>80.4</td>
<td>80.2</td>
<td>82.5**</td>
</tr>
<tr>
<td>Percent &gt; $3,000</td>
<td>7.4</td>
<td>3.7**</td>
<td>2.2**</td>
</tr>
</tbody>
</table>


** Significant difference at 1% level.
Characteristics Controlled for:

- Socioeconomic factors
  - Education and demographics
  - Income, asset income, home ownership
- Geographic factors
  - Providers per capita, region, urbanicity
- Health: SF-12, chronic conditions
- Attitudes and health behaviors
  - Smoking, regular exercise
  - Family members’ attitudes
Results

- If adults with individual insurance gained benefits typical of small employers:
  - Mean out-of-pocket expenditures for medical care and drugs would likely decrease by over 30% from $1,005 per year in 2008 $s
  - The probability of out-of-pocket expenditures exceeding $3,000 would likely fall by a third

- If adults with individual insurance gained benefits typical of large employers:
  - Mean out-of-pocket expenditures for medical care and drugs would likely decrease by over 40% from $1,005 per year in 2008 $s
  - The probability of out-of-pocket expenditures exceeding $3,000 would likely fall by two-thirds

Out-of-Pocket Spending for Health Care and Individual Insurance, Steve Hill AHRQ
Summary

- Overview of Medical Expenditure Panel Survey (MEPS)
- Analytic Capacity
- Capacity to Inform the Affordable Care Act
- Modeling Efforts