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Steven B. Cohen

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THE CAPACITY OF MEPS TO INFORM PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Steven B. Cohen

ABSTRACT

In the Spring of 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) was enacted with major provisions to expand health insurance coverage, control health care costs, and improve the health care delivery system. While the major coverage expansions envisioned by the legislation are not scheduled to be implemented until 2014, several provisions of the law have already been adopted and planning efforts have been initiated for the core components of the act. In order to effectively plan, operationalize, implement and manage the vast array of programs set in motion by this act, there is critical need for content specific data that is both timely and accessible. Essential data resources will be required to facilitate effective program planning, administration and management, in addition to facilitating evaluations of program performance. While new data development efforts are essential to insure the effective administration of the various components of the Affordable Care Act (ACA), several existing data platforms helped inform the underlying framework of the legislation and will continue to be invaluable to its implementation.

The Medical Expenditure Panel Survey (MEPS), sponsored by the Agency for Healthcare Research and Quality, is one of the core data resources utilized to inform several provisions of the Affordable Care Act. In this paper, attention will be given to the current capacity of the MEPS to inform program planning, implementation, and evaluations of program performance for several components of the ACA. In addition, attention will be given to planned enhancements to the survey to help achieve related programmatic needs identified by the Department of Health and Human Services.

Steven B. Cohen
Center for Financing, Access, and Cost Trends
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850
Phone: (301)427-1466
Email: Steven.Cohen@ahrq.hhs.gov

The Capacity of MEPS to Inform Provisions of the Patient Protection and Affordable Care Act

Steven B. Cohen, Agency for Healthcare Research and Quality

1. Introduction

In the Spring of 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) was enacted with major provisions to expand health insurance coverage, control health care costs, and to improve the health care delivery system. While the major coverage expansions envisioned by the legislation are not scheduled to be implemented until 2014, several provisions of the law have already been adopted and planning efforts have been initiated for the core components of the act. In order to effectively plan, operationalize, implement and manage the vast array of programs set in motion by this act, there is critical need for content specific data that is both timely and accessible. Essential data resources will be required to facilitate effective program planning, administration and management, in addition to facilitating evaluations of program performance. While new data development efforts are essential to insure the effective administration of the various components of the Patient Protection and Affordable Care Act (PPACA), several existing data platforms helped inform the underlying framework of the legislation and will continue to be invaluable to its implementation.

The Medical Expenditure Panel Survey (MEPS), sponsored by the Agency for Healthcare Research and Quality, is one of the core data resources utilized to inform several provisions of the Affordable Care Act. In this paper, attention is given to the current capacity of the MEPS to inform program planning, implementation, and evaluations of program performance for several components of the ACA. In addition, a summary of recent enhancements to the survey that advance related programmatic needs identified by the Department of Health and Human Services is also provided.

2. Overview of the Patient Protection and Affordable Care Act (P.L. 111-148)

The Patient Protection and Affordable Care Act is a comprehensive initiative that includes health insurance coverage expansions, health care cost control mechanisms, programmatic efforts to advance health care quality and efficiency, preventive care enhancements and targeted actions to improve the healthcare delivery system at large. While several of the health insurance coverage reforms have already been implemented in 2010, many of the coverage related provisions of the law will not take effect until 2014.

2.1 Health Insurance Coverage Initiatives

Among the health insurance coverage initiatives implemented in 2010, young adults up to age 26 are now eligible for dependent coverage under family plans; pre-existing condition exclusions for children's coverage have been eliminated; and all new group and individual health plans now provide first dollar coverage for preventive services. In addition, the law provides eligible uninsured individuals access to coverage with no exclusions permitted for pre-existing health conditions. The initial phase of a small business tax credit for qualified small businesses that contribute to employee coverage purchases has also been triggered. Furthermore, Medicare Part D enrollees that enter the "donut hole" now receive rebates. This year (2011), Medicare Part D enrollees that enter the "donut hole" will receive 50 percent discounts on brand-name drugs, and Medicare beneficiaries will receive a free annual wellness visit and personalized preventive services. In 2014, Health Insurance Exchanges will be established in each state to enable individuals and small employers to comparison shop for standardized health benefits. Premium tax credits for coverage will be made available through the Exchange for individuals with incomes above Medicaid eligibility levels and below 400% of poverty who are not eligible for or offered acceptable coverage. Medicaid eligibility for non-elderly individuals will increase to 133% of poverty. Annual limits on the amount of coverage individuals may receive will be eliminated and health insurance regulations will be enacted that prohibit insurance carriers from refusing to sell or renew policies due to

health status. In addition, most individuals will be required to obtain acceptable coverage or pay a penalty, and most employers with 50 or more employees who do not offer coverage will incur cash penalties as well.

2.2 Healthcare Cost Control Initiatives

In 2010, the Affordable Care Act created a grant program to support States in holding insurance carriers accountable for unreasonable rate increases. This year, health insurers are required to report on the share of premium dollars spent on medical care and provide consumer rebates where less than 80 to 85 percent of the premiums are used for benefits. By 2013, the income threshold is increased to 10% of adjusted gross income for claiming itemized deductions for medical expenses, health flexible saving account contributions will be limited to \$2,500, and the hospital insurance tax for high wage workers will be increased by 0.9% on earnings over \$200,000 for individual taxpayers and \$250,000 for married coupled filing jointly. In 2015, an Independent Advisory Board is to be established to submit proposals to Congress and the private sector to help lower health costs. For Medicare beneficiaries, a physician value-based payment program will be established to promote quality of care over volume of services. By 2018, an excise tax on the most expensive health plans is to be adopted.

2.3 Healthcare Delivery System Initiatives

In 2010, the Affordable Care Act provided additional resources to the Department of Health and Human Services to develop a national quality strategy and support quality measure development for the Medicare, Medicaid and CHIP programs. In addition, a private, non-profit Patient Centered Outcomes Research Institute was established to support comparative effectiveness research. An interagency council was also established to promote federal health policies and a prevention and public health investment fund created to advance these efforts. In 2012, physician payment reforms are to be adopted that enhance payment for primary care services and promote the formation of accountable care organizations to improve health care quality and efficiency. Quality outcomes for

acute care hospitals are promoted by setting up a hospital value-based purchasing program. By 2013, health plans must adhere to uniform standards for the electronic exchange of health information to streamline administrative tasks and limit associated costs. In 2015, a planned Independent Advisory Board will also develop proposals for improving quality, efficiency and health outcomes in health care delivery, and expanding access to evidence-based care.

3. Measurement of Trends in Health Care Cost, Coverage, Access and Use: MEPS Data Infrastructure

Health care expenditures represent nearly one-sixth of the United States gross domestic product, exhibit a rate of growth that exceeds other sectors of the economy, and constitute one of the largest components of the Federal and states' budgets. Although the rate of growth in health care costs has slowed in the past few years, costs continue to rise, in particular for hospital care and prescription medications. As a result, the question of how to design a system that encourages the provision of high quality care as efficiently as possible remains an issue of continuing concern to both private and public payers. In a similar vein, an evaluation of the current health care system requires an understanding of the patterns and trends in the use of health care services and their associated costs and sources of payment. To effectively address these issues, researchers and policymakers need accurate nationally representative data to better permit an understanding of how individual characteristics, behavioral factors, financial incentives, and institutional arrangements affect health care utilization and expenditures in a rapidly changing health care market.

The growing demand for accurate and reliable information on the populations health care utilization, expenditures, insurance coverage, sources of payment and access to care served as the catalyst to initiate the implementation of the family of national medical expenditure surveys sponsored by the Agency for Healthcare Research and Quality (AHRQ) and its predecessor agencies. AHRQ's Medical Expenditure Panel Survey (MEPS) collects detailed information regarding the use and payment for health

care services from a nationally representative sample of Americans. The survey is cosponsored by the National Center for Health Statistics, CDC. Westat and RTI are the primary data collection organizations.

The MEPS research program, broadly defined to encompass data collection, data development, research and the translation of research into practice, is directly tied to the strategic goal of identifying strategies to improve access, foster appropriate use and reduce unnecessary expenditures. Few other surveys provide the foundation for estimating the impact of changes on different economic groups or special populations of interest, such as the poor, elderly, veterans, the uninsured, and racial/ethnic groups. The public sector relies upon the MEPS research findings to evaluate health reform policies, the effect of tax code changes on health expenditures and tax revenue, and proposed changes in government health programs such as Medicare. In the private sector, these data are also used to develop economic projections.

The Medical Expenditure Panel Survey (MEPS), initiated in 1996, is designed as a continuous on-going survey to permit annual estimates of health care utilization, expenditures, insurance coverage and sources of payment for the U.S. civilian noninstitutionalized population. Over the past several years, the MEPS data and associated research findings have quickly become a linchpin for the nation's economic models and their projections of health care expenditures and utilization. This combination of breadth and depth of the data enables public and private sector analysts to develop economic models designed to produce national and regional estimates of the impact of changes in financing, coverage, and reimbursement policy, as well as estimates of who benefits and who bears the cost of a change in policy. Since 1977, AHRQ's expenditure surveys have been an important and unique resource for public and private sector decision makers. The survey is unique in the level of detail of information obtained on the health care services used by Americans at the household level and their associated expenditures (for families and individuals); the cost, scope, and breadth of private health insurance coverage held by and available to the U.S. population; and the specific services purchased through out-of-pocket and/or third-party payments.

The MEPS data support a wealth of basic descriptive and behavioral analyses of the U.S. health care system. These include studies of the population's access to, use of, and expenditures and sources of payment for health care; the availability and costs of private health insurance in the employment-related and non-group markets; the population enrolled in public health insurance coverage and those without health care coverage; and the role of health status in health care use, expenditures, and household decision making, and in health insurance and employment choices (Cohen et al., 2009; Cohen, 2003).

The MEPS consists of a family of three interrelated surveys: the Household Component (HC), the Medical Provider Component (MPC), and the Insurance Component (IC). The MEPS Household Component was designed to provide annual national estimates of the health care use, medical expenditures, sources of payment and insurance coverage for the U.S. civilian non-institutionalized population. In addition to collecting data to yield annual estimates for a variety of measures related to health care use and expenditures, MEPS also provides estimates of measures related to health status, demographic characteristics, employment and access to health care. Estimates can be provided for individuals, families and population subgroups of interest. Additional details about the MEPS component surveys can be found at www.meps.ahrq.gov .

Efforts to address inequities in the availability of private health insurance and to control health insurance premiums and medical care costs must necessarily focus on the employment-related health insurance market. Historically, the analyses of data from the MEPS family of surveys has figured prominently in this arena. As is evidenced in the recent Institute of Medicine (IOM) Report on "Health Insurance is a Family Matter", the report notes that "the most comprehensive data on who uses what health care service and how much is paid for those services comes from the Medical Expenditure Panel Survey" (IOM, 2002). MEPS related analyses are prominently used to inform components of this IOM report focused on issues of insurance coverage and cost.

MEPS derived estimates of the health insurance status of the U.S. civilian noninstitutionalized population are critical to policymakers and others concerned with access to medical care and the cost and quality of that care. Health insurance helps people get timely access to medical care and protects them against the risk of expensive and unanticipated medical events. When estimating the size of the uninsured population, it is critical to consider the distinction between those uninsured for short periods of time and those who are long term uninsured across several years in duration. Compared to people with healthcare coverage, uninsured people are less likely to visit a doctor, have a usual source of medical care, receive preventive services, or have a recommended test or prescription filled. Consequently, individuals that experience extended periods of being uninsured are particularly at risk for restrictions in access to care and exposure to serious illness and significant financial jeopardy. Since many individuals undergo transitions in the acquisition and loss of health insurance coverage over time, an important consideration is the length of duration of spells of un-insurance and the capacity of this lack of coverage to lead to less efficient use of health care services and facilities. In this regard, MEPS research efforts have demonstrated that individuals who experience short spells of being uninsured differ significantly from those who have been uninsured for more than a year on several dimensions which include access to employer sponsored coverage, their attitudes and preferences regarding the need for coverage and their sensitivity to the cost of acquiring coverage. In addition to providing cross-sectional estimates of health insurance coverage each year, the MEPS has the added analytical capacity to identify individuals with gaps in coverage over time as well as the duration of the spells of being uninsured for up to four years.

In addition to measuring actual out-of-pocket financial burdens for health care, MEPS provides the only nationally representative data that can be used to measure the extent of underinsurance in the U.S. Underinsurance is defined as being at risk of spending more than a certain amount of family income on out of pocket expenses in the event of a catastrophic medical illness. Estimates of the underinsured require linked information on families health insurance benefits, family income, and risk of experiencing catastrophic medical events that are found in the MEPS.

With health care absorbing increasing amounts of the nation's resources, the question of how to implement health system design innovations that encourage the provision of high quality and efficient healthcare delivery is a sentinel concern of both private and public payers. To effectively address this issue, researchers and policymakers have benefited from MEPS research findings to better understand how individual characteristics, behavioral factors, financial incentives, and institutional arrangements affect health care expenditures in a rapidly changing health care market. Research findings for the MEPS have also served to provide health care decision makers with a better understanding of the highly concentrated nature of health care expenditures and the persistence of these high expenditures over time. MEPS studies that examine the persistence of high levels of expenditures over time have been essential to help discern the factors most likely to drive health care spending and the characteristics of the individuals who incur them.

Recently, greater attention and prioritization has been given to data collection procedures, predictive modeling and estimation strategies that help improve the precision and quality of the survey estimates that characterize this policy relevant population subgroup of individuals with high levels of medical expenditures. Research findings from MEPS also provide clear evidence of the utility and appropriateness of probabilistic models as prediction tools for identifying individuals likely to incur high levels of medical expenditures in future years. To the extent that this policy relevant subset of the population is amenable to successful prediction through the application of well developed models, the methodology continues to find several venues for application. Prominent examples of applications ripe for implementation include adoption of oversampling strategies for national health care surveys, and the identification of individuals whose health status improvements through disease management programs could most significantly result in potential reductions in overall future year health care expenditures.

Given the growing attention being given to achieving a better understanding of the impact of rising prescribed medicine costs on health and the consumption of health services, it is also important to note the utility of the MEPS to inform studies examining the association between the use of newer medicines and morbidity, mortality, and health spending. Using this data resource, researchers have been able to determine the direction of the association between the use of newer drugs and all other types of nondrug medical spending. Attention has also focused on studies that identify inappropriate medication use, which is a major patient safety concern and has significant consequences with respect to health care costs. With its wealth of data on health conditions, prescribed medication utilization and expenditures and associated therapeutic drug classifications, the MEPS data have also been helpful to researchers attempting to identify potentially inappropriate medication use in the community.

3.1 How MEPS related research has shaped or influenced decisions, policy formulation or public discourse: examples of impact on health care policy and practice

Since its inception, MEPS has been used in several hundred scientific publications, and many more unpublished reports. It has served as a core data resource for estimating the impact of changes on different economic groups or special populations of interest, such as the poor, elderly, veterans, the uninsured, or racial/ethnic groups. Government and non-governmental entities rely upon these data to evaluate health reform policies, the effect of tax code changes on health expenditures and tax revenue, and proposed changes in government health programs such as Medicare. In the private sector (e.g., RAND, Heritage Foundation, Lewin-VHI, and the Urban Institute), these data are used by many private businesses, foundations and academic institutions to develop economic projections. These data represent a major resource for the health services research community at large. Since 2000, data on premium costs from the MEPS Insurance Component have been used by the Bureau of Economic Analysis to produce estimates of the GDP for the nation. The data are also used to inform the national health care cost estimates in the National Health Expenditure Accounts and to assess time trends in the provision of employer health benefits by States. Additional examples of how the

research has shaped or influenced decisions and policy formulation follow:

- MEPS data on national and state estimates of the percentage of employees enrolled in high cost health insurance plans were used by the Senate Finance Committee to develop their Healthcare Reform bill.
- MEPS data produced detailed estimates of children eligible for S-CHIP who were uninsured. The information provided on number of children who were eligible for such coverage but remained uninsured had a significant impact on the Reauthorization of the Child Health Insurance Program (CHIP).
- MEPS data on national estimates of gaps and trends in health insurance coverage over two year period was used by Secretary Sebelius in a speech on Insurance Insecurity and the related HHS Report.
- The MEPS data have been used extensively by the Department of Health and Human Services' Office of the Secretary, Office of Health Reform, and Assistant Secretary for Planning and Evaluation; in addition to the White House, to inform recent health policy initiatives focused on health insurance coverage availability and take-up; health insurance premiums; and medical expenditures.
- The MEPS data have been used extensively by the Congressional Budget Office, Congressional Research Service, Department of Treasury, Joint Taxation Committee, and Department of Labor to inform Congressional inquiries related to health care expenditures, insurance coverage and sources of payment and to analyze potential tax and other implications of Federal Health Insurance Policies.
- MEPS data on health care quality, access, and health insurance coverage have been used extensively in the Department's two annual reports to Congress, the National Healthcare Disparities Report and the National Healthcare Quality Report.
- The MEPS was awarded the American Association for Public Opinion Research's 2008 Policy Impact Award in recognition of their extraordinary, long-term group effort in contributing timely data and research that has informed U.S. health care policy decisions.
- The MEPS has been used in Congressional testimony on the impact of health insurance coverage rate increases on small businesses.
- The MEPS data have informed studies of the value of health insurance in private markets and the effect of consumer payment on health care.

- The MEPS-IC has been used by a number of States in evaluating their own private insurance issues including eligibility and enrollment by the State of Connecticut and by the Maryland Health Care Commission; and community rating by the State of New York. As part of the Robert Wood Johnson Foundation's State Coverage Initiative, MEPS data was cited in 69 reports, representing 27 States.
- The MEPS data have been used extensively by the Government Accountability Office to determine trends in Employee Compensation, with a major focus on the percentage of employees at establishments that offer health insurance, the percentage of eligible employees who enroll in the health insurance plans, the average annual premium for employer-provided health insurance for single workers, and the employees' share of these premiums.
- MEPS data have been used in HHS Reports to Congress on expenditures by sources of payment for individuals afflicted by conditions that include acute respiratory distress syndrome, arthritis, cancer, chronic obstructive pulmonary disease, depression, diabetes, and heart disease.
- MEPS data are used to develop estimates provided in the *Consumers Checkbook Guide to Health Plans*, of expected out of pocket costs (premiums, deductibles and copayments) for Federal employees and retirees for their health care. *The Checkbook* is an annual publication that provides comparative information on the health insurance choices offered to Federal workers and retirees.
- The MEPS has been used to estimate the impact of the Medicare Modernization Act (MMA) by the Employee Benefit Research Institute (the effect of the MMA on availability of retiree coverage), by the Iowa Rural Policy Institute (effect of the MMA on rural elderly) and by researchers to examine levels of spending and co-payments.
- MEPS data have been used by CDC and others to evaluate the cost of common conditions including arthritis, injuries, diabetes, obesity, and cancer.

Longitudinal Capacity: Research efforts build on the analytical strengths of the MEPS to support longitudinal analyses and takes advantage of its integrated survey design linked to the National Health Interview Survey to expand the time period and analytical profiles of the sample respondents to these integrated surveys. With the MEPS longitudinal design, analysts have assessed the persistence of high health care expenditures by examining whether individuals in high expenditure percentiles of the

health care expenditure distribution in a given year remain in upper percentiles in the following year or shift to another higher or lower percentile. The overlapping panel design of the MEPS has also been used to assess the impact of survey attrition on the resultant survey estimates by comparing the national health care estimates produced by the first year of a sample panel (with a higher response rate) with the estimates derived from the second year of a MEPS sample panel covering the same time period. In addition, with the linkage of MEPS and NHIS files, longitudinal analyses of transitions in health insurance coverage and health status characteristics have been examined over a 3-year period. All the survey estimates and analyses conducted with the MEPS adjust for survey design complexities and include adjustments for survey nonresponse and poststratification. The survey and resultant analyses have also benefited from ongoing statistical and methodological research initiatives to improve the accuracy, precision, efficiency, timeliness and overall data quality and analytical capacity of the survey.

4. MEPS and Implementation of the Affordable Care Act

In this section, attention is given to the current capacity of the MEPS to inform program planning, implementation, and evaluations of program performance for several components of the ACA.

4.1 Use of MEPS to determine the amount of the small employer health insurance tax credit.

Section 1421 of the Patient Protection and Affordable Care Act, specifies the rules for determining the amount of the small employer health insurance credit as follows.

HEALTH INSURANCE CREDIT AMOUNT.—Subject to subsection (c), the amount determined under this sub section with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—“(1) the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health plans

offered by the employer to its employees through an Exchange, or.....“(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.

In collaboration with the Office of the Secretary, DHHS and the Department of Treasury, AHRQ staff provided MEPS national and State level estimates of average premiums that were utilized to determine the small business tax credits for 2010. More specifically, data from the 2009 MEPS Insurance Component were used to provide estimates of health insurance premiums by state for employer sponsored coverage provided by small employers of size 50 or less. The small employer health insurance tax credit was then determined based on the MEPS derived estimates of the average premium for the small group market in each State for the 2010 taxable year. These respective average premiums for insurance in the small group market in each State were also posted on the following IRS website <http://www.irs.gov/pub/irs-drop/rr-10-13.pdf>

The Secretary of Health and Human Services (HHS) also determines whether separate average premiums will apply for areas within a State (“sub-State areas”) and also determines the average premium for a State or sub-State area. Data from the MEPS Insurance Component are currently being used help facilitate the derivation of comparable estimates of average premiums at the sub-State rating area level.

4.2 Use of MEPS to Evaluate the Health Insurance Status of Young Adults, Ages 22-26.

Health insurance helps people get timely access to medical care and protects them against the risk of expensive and unanticipated medical events. Young adults are less likely to be covered by health insurance than their older counterparts. Effective September 2010, one component of the Patient Protection and Affordable Care Act permits adult dependents to

remain on their parents' insurance plans until their 26th birthday. This coverage provision also applies to adult dependents under age 26 who no longer live with their parents, are not dependents on their parents' tax returns, or are no longer students.

Using information from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC) analyses have been conducted to obtain detailed estimates for the U.S. civilian noninstitutionalized population between the ages of 22-26, a group that would typically be ineligible for continuance of coverage under their parents' insurance plans prior to 2010 (Cohen and Rhoades, 2010).

http://www.meps.ahrq.gov/mepsweb/data_files/publications/st305/stat305.shtml . The MEPS will continue to be utilized to discern the changes in health insurance coverage take up by this vulnerable population that are attributable to enactment of the Affordable Care Act in the Fall of 2010. In addition, the MEPS will be utilized to assess changes in health care access, related health care utilization, out of pocket and total expenditures incurred by such young adults as a consequence of this legislation and its impact on health status.

4.3 Use of MEPS to Set the Excise Tax on the Most Expensive Employer Sponsored Health Plans

Based on requests from the White House in the Summer of 2009, AHRQ staff provided detailed estimates of the of the distribution of employer-sponsored health insurance premiums as of 2008. These estimates were derived from the MEPS—Insurance Component private coverage data. Particular attention was given to the cost of premiums at the 90th, 95th and 99th percentiles. Based on similar requests from the House Ways and Means Committee in early 2010, AHRQ staff provided distributional estimates of employer-sponsored premiums, with a focus on premiums above the 80th percentile in the cost distribution, further disaggregated by industry type. These estimates were also derived from the MEPS—Insurance Component private coverage data. These findings from the MEPS were instrumental in setting the excise tax provision of the Affordable Care Act on the most expensive employer sponsored health plans.

The 40% “Cadillac plan” excise tax is supposed to take effect in 2018 and initially apply to health benefits packages that cost more than \$10,200 for single coverage and more than \$27,500 for family coverage. The MEPS data on the distribution of employer-sponsored health insurance premiums will continue to be utilized this decade to improve estimates of the number of plans that will likely be subject to this excise tax as we move closer to 2018. In addition, other characteristics of these plans, including employer and employee contributions, plan co-pay levels, and deductibles will be evaluated to assess trends in benefit structures over time.

4.4 Use of MEPS to Evaluate the Health Insurance Status of High Risk Individuals.

The Affordable Care Act now provides eligible uninsured individuals access to coverage with no exclusions for pre-existing health conditions. In the past, many high-risk individuals with multiple chronic conditions were virtually uninsurable. Using information from the Household Component of the Medical Expenditure Panel Survey (MEPS-HC) analyses are underway to determine the scale and characteristics of individuals under the age of 65 with multiple chronic conditions who were without health insurance coverage prior to enactment of the PPACA.

The MEPS will continue to be utilized to discern changes in health insurance coverage take up by this vulnerable population that are attributable to enactment of the Affordable Care Act. In addition, the MEPS will be utilized to assess changes in health care access, health care utilization, out of pocket expenses and total expenditures incurred by high-risk, chronically ill individuals as a consequence of this legislation and their subsequent impact on the health status of this vulnerable population.

4.5 MEPS to Inform Allocation of Federal Medical Assistance Percentages (FMAP) Matching Funds for State Medicaid programs

The Affordable Care Act simplifies Medicaid eligibility rules and unifies them across all States by expanding Medicaid eligibility to 133 percent of the federal poverty line beginning in 2014. The federal government’s share of a state’s expenditures for most

Medicaid services is called the federal medical assistance percentage (FMAP). The remainder is referred to as the nonfederal share, or state and local share. Generally determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes) (Peterson, 2010). The new eligibility rules eliminate asset tests and require less information to be collected from applicants. A complication arises, however, in determining which Federal match rate applies to the enrolled population. Beginning in 2014, the portion of the Medicaid enrolled population eligible under “old” State-specific rules will receive the existing FMAP, which ranges from 50 to 75 percent depending on the state. The proportion of the enrolled population eligible under the “new” rules will receive 100 percent FMAP. This means the federal government will pay 100 percent of the costs of the newly eligible population under the expanded eligibility rules, which translates to billions of federal dollars. Clearly, States are concerned about receiving the appropriate level of FMAP dollars.

It is not a straight-forward process to determine who is eligible for Medicaid under old versus new rules. Old rules based eligibility on categorical status related to age, parental and disability status as well as assets, income, and family structure. Several states disregard certain amounts of income related to employment and other expenses. Family units are defined differently across states. It would be a very costly and time consuming process for States to determine eligibility under both the old and new rules in order to determine the proportions of their enrolled populations that receive the higher FMAP. Through a collaboration with staff from the Assistant Secretary for Planning and Evaluation, AHRQ is in the process of applying our micro-simulation models based on detailed MEPS data in order to develop algorithms that will simplify the process of predicting whether an individual is eligible for a specific state Medicaid program under the new or old rules based on a reduced set of factors including age, gender, family structure and income. These algorithms have the potential to improve the ability and ease through which States determine what level of FMAP applies to their Medicaid populations.

5. *Summary*

AHRQ's Medical Expenditure Panel Survey helped inform the underlying framework of the Patient Protection and Affordable Care Act legislation and will continue to be an invaluable resource for its implementation. Over the past several years, the MEPS data and associated research findings have become a central facet of the nation's economic models and their projections of health care expenditures and utilization. As discussed in this paper, the MEPS data and research findings have directly contributed to the planning and implementation to several components of the ACA, and will contribute to forthcoming evaluations of program performance.

To date, the MEPS has been utilized to determine the amount of the small employer health insurance tax credit; to evaluate the health insurance status of young adults up to age 26; to establish the excise tax on high cost employer sponsored health plans; to evaluate the health insurance status of high risk individuals and their health care experiences; and to inform the allocation of Federal Medical Assistance Percentages (FMAP) matching funds for State Medicaid programs. Several content enhancements have also been incorporated into the 2011 MEPS, to further enhance its capacity to inform provisions of the Affordable Care Act. With respect to monitoring the take up of coverage by individuals with chronic conditions, questions have been added to the survey to explicitly determine whether anyone in the family has purchased coverage directly from a "high risk pool" and to obtain the name of the high risk pool. Additional questions have also been added on the topic of Health Savings Accounts to discern the level of the plan deductible and whether there is a special account or fund associated with the plan that can be used to pay for medical expenses. The MEPS has also added questions on flexible spending accounts (FSAs) to determine whether anyone in the family has a Flexible Spending Account for health expenses, who that individual is, and what the total amount the family asked to have placed in the medical Flexible Spending Account (FSA) is for the respective calendar year.

As a consequence of its representativeness, scope, content and breadth, the MEPS is well positioned to continue to serve as vital resource to inform provisions of the Affordable

Care Act. Its capacity to measure the impact of changes in health insurance coverage on access to care, service utilization and related expenditures, health outcomes and quality coincides with several evaluative needs of the Affordable Care Act legislation. Additional enhancements to the MEPS in these areas may serve to optimize its alignment with Departmental needs to effectively plan, operationalize, implement, manage and evaluate several of the Patient Protection and Affordable Care Act programs.

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