

**MEPS HC-152E:  
2012 Emergency Room Visits  
July 2014**

**Agency for Healthcare Research and Quality  
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## **A. Data Use Agreement**

Individual identifiers have been removed from the micro-data contained in these files. Nevertheless, under sections 308 (d) and 903 (c) of the Public Health Service Act (42 U.S.C. 242m and 42 U.S.C. 299 a-1), data collected by the Agency for Healthcare Research and Quality (AHRQ) and/or the National Center for Health Statistics (NCHS) may not be used for any purpose other than for the purpose for which they were supplied; any effort to determine the identity of any reported cases is prohibited by law.

Therefore in accordance with the above referenced Federal Statute, it is understood that:

1. No one is to use the data in this dataset in any way except for statistical reporting and analysis; and
2. If the identity of any person or establishment should be discovered inadvertently, then (a) no use will be made of this knowledge, (b) the Director Office of Management AHRQ will be advised of this incident, (c) the information that would identify any individual or establishment will be safeguarded or destroyed, as requested by AHRQ, and (d) no one else will be informed of the discovered identity; and
3. No one will attempt to link this dataset with individually identifiable records from any datasets other than the Medical Expenditure Panel Survey or the National Health Interview Survey.

By using these data you signify your agreement to comply with the above stated statutorily based requirements with the knowledge that deliberately making a false statement in any matter within the jurisdiction of any department or agency of the Federal Government violates Title 18 part 1 Chapter 47 Section 1001 and is punishable by a fine of up to \$10,000 or up to 5 years in prison.

The Agency for Healthcare Research and Quality requests that users cite AHRQ and the Medical Expenditure Panel Survey as the data source in any publications or research based upon these data.

## **B. Background**

### **1.0 Household Component**

The Medical Expenditure Panel Survey (MEPS) provides nationally representative estimates of health care use, expenditures, sources of payment, and health insurance coverage for the U.S. civilian non-institutionalized population. The MEPS Household Component (HC) also provides estimates of respondents' health status, demographic and socio-economic characteristics, employment, access to care, and satisfaction with health care. Estimates can be produced for individuals, families, and selected population subgroups. The panel design of the survey, which includes 5 Rounds of interviews covering 2 full calendar years, provides data for examining person-level changes in selected variables such as expenditures, health insurance coverage, and health status. Using computer assisted personal interviewing (CAPI) technology, information about each household member is collected, and the survey builds on this information from interview to interview. All data for a sampled household are reported by a single household respondent.

The MEPS-HC was initiated in 1996. Each year a new panel of sample households is selected. Because the data collected are comparable to those from earlier medical expenditure surveys conducted in 1977 and 1987, it is possible to analyze long-term trends. Each annual MEPS-HC sample size is about 15,000 households. Data can be analyzed at either the person or event level. Data must be weighted to produce national estimates.

The set of households selected for each panel of the MEPS HC is a subsample of households participating in the previous year's National Health Interview Survey (NHIS) conducted by the National Center for Health Statistics. The NHIS sampling frame provides a nationally representative sample of the U.S. civilian non-institutionalized population and reflects an oversample of Blacks and Hispanics. In 2006, the NHIS implemented a new sample design, which included Asian persons in addition to households with Black and Hispanic persons in the oversampling of minority populations. MEPS further oversamples additional policy relevant subgroups such as low income households. The linkage of the MEPS to the previous year's NHIS provides additional data for longitudinal analytic purposes.

### **2.0 Medical Provider Component**

Upon completion of the household CAPI interview and obtaining permission from the household survey respondents, a sample of medical providers are contacted by telephone to obtain information that household respondents can not accurately provide. This part of the MEPS is called the Medical Provider Component (MPC) and information is collected on dates of visit, diagnosis and procedure codes, charges and payments. The Pharmacy Component (PC), a subcomponent of the MPC, does not collect charges or diagnosis and procedure codes but does collect drug detail information, including National Drug Code (NDC) and medicine name, as well as date filled and sources and amounts of payment. The MPC is not designed to yield national estimates. It is primarily used as an imputation source to supplement/replace household reported expenditure information.

### **3.0 Survey Management and Data Collection**

MEPS HC and MPC data are collected under the authority of the Public Health Service Act. Data are collected under contract with Westat, Inc. (MEPS HC) and Research Triangle Institute (MEPS MPC). Datasets and summary statistics are edited and published in accordance with the confidentiality provisions of the Public Health Service Act and the Privacy Act. The National Center for Health statistics (NCHS) provides consultation and technical assistance.

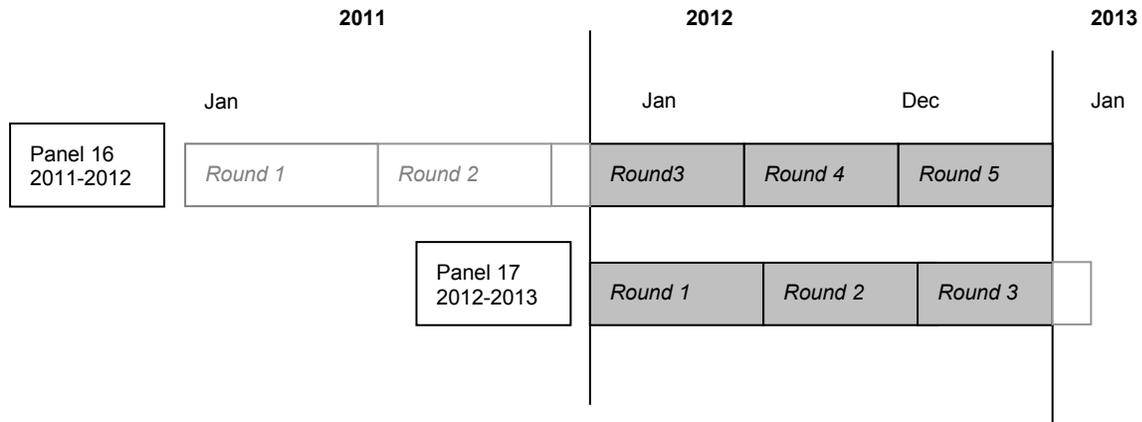
As soon as data collection and editing are completed, the MEPS survey data are released to the public in staged releases of summary reports, micro data files, and tables via the MEPS Web site: [meps.ahrq.gov](http://meps.ahrq.gov). Selected data can be analyzed through MEPSnet, an on-line interactive tool designed to give data users the capability to statistically analyze MEPS data in a menu-driven environment.

Additional information on MEPS is available from the MEPS project manager or the MEPS public use data manager at the Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, MD 20850 (301-427-1406).

## C. Technical and Programming Information

### 1.0 General Information

This documentation describes one in a series of public use event files from the 2012 Medical Expenditure Panel Survey (MEPS) Household Component (HC) and Medical Provider Component (MPC). Released as an ASCII data file (with related SAS, Stata, and SPSS programming statements) and a SAS transport file, the 2012 Emergency Room Visits (EROM) public use event file provides detailed information on emergency room visits for a nationally representative sample of the civilian noninstitutionalized population of the United States. Data from the EROM event file can be used to make estimates of emergency room utilization and expenditures for calendar year 2012. The file contains 71 variables and has a logical record length of 355 with an additional 2-byte carriage return/line feed at the end of each record. As illustrated below, this file consists of MEPS survey data from the 2012 portion of Round 3, and Rounds 4 and 5 for Panel 16, as well as Rounds 1, 2 and the 2012 portion of Round 3 for Panel 17 (i.e., the rounds for the MEPS panels covering calendar year 2012).



Emergency room events reported in Panel 17 Round 3 and known to have occurred after December 31, 2012 are not included on this file. In addition to expenditures, each record contains household-reported medical conditions and procedures associated with the emergency room visit.

Annual counts of emergency room visits are based entirely on household reports. Information from the MEPS MPC is used to supplement expenditure and payment data reported by the household and does not affect use estimates.

Data from the Emergency Room event file can be merged with other 2012 MEPS HC data files for purposes of appending person-level data such as demographic characteristics or health insurance coverage to each emergency room record.

This file can also be used to construct summary variables of expenditures, sources of payment, and related aspects of emergency room visits. Aggregate annual person-level information on the

use of emergency rooms and other health services is provided on the MEPS 2012 Full Year Consolidated Data file, where each record represents a MEPS sampled person.

This documentation offers an overview of the types and levels of data provided, and the content and structure of the file and the codebook. It contains the following sections:

- Data File Information
- Sample Weight
- Strategies for Estimation
- Merging/Linking MEPS Data Files
- References
- Variable - Source Crosswalk

Any variables not found on this file but released on previous years' files were excluded because they contained only missing data.

For more information on MEPS HC survey design, see T. Ezzati-Rice, et al. (1998-2007) and S. Cohen, 1996. For information on the MEPS MPC design, see S. Cohen, 1998. Copies of the HC and the MPC survey instruments used to collect the information on the EROM file are available in the *Survey Questionnaires* section of the MEPS Web site at the following address: [meps.ahrq.gov](http://meps.ahrq.gov).

## **2.0 Data File Information**

The 2012 Emergency Room Visits public use dataset consists of one event-level data file. The file contains characteristics associated with the EROM event and imputed expenditure data.

The 2012 EROM public use dataset contains variables and frequency distributions for 6,862 emergency room visits reported during the 2012 portion of Round 3 and Rounds 4 and 5 for Panel 16, as well as Rounds 1, 2, and the 2012 portion of Round 3 for Panel 17 of the MEPS Household Component. This file includes emergency room visit records for all household survey members who resided in eligible responding households and reported at least one emergency room visit. Records where the emergency room visit was known to have occurred after December 31, 2012 are not included on this file. Of these 6,862 records, 6,607 were associated with persons having positive person-level weights (PERWT12F). The persons represented on this file had to meet either a) or b):

- a) Be classified as a key in-scope person who responded for his or her entire period of 2012 eligibility (i.e., persons with a positive 2012 full-year person-level weight (PERWT12F > 0)), or
- b) Be an eligible member of a family all of whose key in-scope members have a positive person-level weight (PERWT12F > 0). (Such a family consists of all persons with the same value for FAMIDYR.) That is, the person must have a positive full-year family-level weight (WTFMPS12 > 0). Note that FAMIDYR and WTFMPS12 are variables on the 2012 Full Year Consolidated Data File.

Persons with no emergency room visit events for 2012 are not included on this event-level ER file but are represented on the person-level 2012 Full Year Population Characteristics file.

Each emergency room visit record includes the following: date of the visit; whether or not person saw doctor; type of care received; type of services (i.e., lab test, sonogram or ultrasound, x-rays, etc.) received; medicines prescribed during the visit; flat fee information; imputed sources of payment; total payment and total charge; a full-year person-level weight; variance strata; and variance PSU.

To append person-level information such as demographic or health insurance coverage to each event record, data from this file can be merged with 2012 MEPS HC person-level data (e.g. Full Year Consolidated or Full Year Population Characteristics file) using the person identifier, DUPERSID. Emergency room visit events can also be linked to the MEPS 2012 Medical Conditions File and the MEPS 2012 Prescribed Medicines File. Please see Section 5.0 and the 2012 Appendix File, HC-152I for details on how to merge MEPS data files.

## 2.1 Codebook Structure

For most variables on the Emergency Room Visits event file, both weighted and unweighted frequencies are provided in the accompanying codebook. The exceptions to this are weight variables and variance estimation variables. Only unweighted frequencies of these variables are included in the accompanying codebook file. See the Weights Variables list in section D, Variable-Source Crosswalk. The codebook and data file sequence list variables in the following order:

- Unique person identifiers
- Unique emergency room event identifiers
- Emergency room characteristic variables
- ICD-9-CM condition and procedure codes
- Clinical Classification Software (CCS) codes
- Imputed expenditure variables
- Weight and variance estimation variables

Note that the person identifier is unique within this data year.

## 2.2 Reserved Codes

The following reserved code values are used:

<b>Value</b>	<b>Definition</b>
-1 INAPPLICABLE	Question was not asked due to skip pattern
-7 REFUSED	Question was asked and respondent refused to answer question
-8 DK	Question was asked and respondent did not know answer
-9 NOT ASCERTAINED	Interviewer did not record the data

Generally, values of -1, -7, -8, and -9 for non-expenditure variables have not been edited on this file. The values of -1 and -9 can be edited by the data users/analysts by following the skip patterns in the HC survey questionnaire (located on the MEPS Web site: [meps.ahrq.gov/survey\\_comp/survey\\_questionnaires.jsp](http://meps.ahrq.gov/survey_comp/survey_questionnaires.jsp)).

## 2.3 Codebook Format

The EROM codebook describes an ASCII dataset (although the data are also being provided in a SAS transport file). The following codebook items are provided for each variable:

<b>Identifier</b>	<b>Description</b>
Name	Variable name (maximum of 8 characters)
Description	Variable descriptor (maximum 40 characters)
Format	Number of bytes
Type	Type of data: numeric (indicated by NUM) or character (indicated by CHAR)
Start	Beginning column position of variable in record
End	Ending column position of variable in record

## 2.4 Variable Source and Naming Conventions

In general, variable names reflect the content of the variable, with an eight-character limitation. All imputed/edited variables end with an “X”.

### 2.4.1 General

Variables on this file were derived from the HC questionnaire itself, derived from the MPC data collection instrument, derived from CAPI, or assigned in sampling. The source of each variable is identified in Section D “Variable - Source Crosswalk” in one of four ways:

1. Variables derived from CAPI or assigned in sampling are indicated as “CAPI derived” or “Assigned in sampling,” respectively;
2. Variables which come from one or more specific questions have those questionnaire sections and question numbers indicated in the “Source” column; questionnaire sections are identified as:
  - ER - Emergency Room section
  - FF - Flat Fee section
  - CP - Charge Payment section;
3. Variables constructed from multiple questions using complex algorithms are labeled “Constructed” in the “Source” column; and
4. Variables which have been edited or imputed are so indicated.

## 2.4.2 Expenditure and Source of Payment Variables

The names of the expenditure and source of payment variables follow a standard convention, are eight characters in length, and end in an “X” indicating edited/imputed. Please note that imputed means that a series of logical edits, as well as an imputation process to account for missing data, have been performed on the variable.

The total sum of payments and the 12 source of payment variables are named in the following way:

The first two characters indicate the type of event:

IP - inpatient stay	OB - office-based visit
ER - emergency room visit	OP - outpatient visit
HH - home health visit	DV - dental visit
OM - other medical equipment	RX - prescribed medicine

For expenditure variables on the ER file, the third character indicates whether the expenditure is associated with the facility (F) or the physician (D).

In the case of the source of payment variables, the fourth and fifth characters indicate:

SF - self or family	OF - other federal government
MR - Medicare	SL - state/local government
MD - Medicaid	WC - Workers' Compensation
PV - private insurance	OT - other insurance
VA - Veterans Administration/CHAMPVA	OR - other private
TR - TRICARE	OU - other public
	XP - sum of payments

In addition, the total charge variable is indicated by TC in the variable name.

The sixth and seventh characters indicate the year (12). The eighth character, “X”, indicates whether the variable is edited/imputed.

For example, ERFSF12X is the edited/imputed amount paid by self or family for the facility portion of the expenditure associated with an emergency room visit.

## 2.5 File Contents

### 2.5.1 Survey Administration Variables

#### 2.5.1.1 Person Identifiers (DUID, PID, DUPERSID)

The dwelling unit ID (DUID) is a five-digit random number assigned after the case was sampled for MEPS. The three-digit person number (PID) uniquely identifies each person within the dwelling unit. The eight-character variable DUPERSID uniquely identifies each person represented on the file and is the combination of the variables DUID and PID. For detailed

information on dwelling units and families, please refer to the documentation for the 2012 Full Year Population Characteristics file.

### **2.5.1.2 Record Identifiers (EVNTIDX, ERHEVIDX, FFEEIDX)**

EVNTIDX uniquely identifies each emergency room visit/event (i.e., each record on the Emergency Room Visits file) and is the variable required to link emergency room events to data files containing details on conditions and/or prescribed medicines (MEPS 2012 Medical Conditions File and the MEPS 2012 Prescribed Medicines File, respectively). For details on linking, see Section 5.0 or the MEPS 2012 Appendix File, HC-152I.

ERHEVIDX is a constructed variable identifying an EROM record that has its facility expenditures represented on an associated hospital inpatient stay record. This variable is derived from provider-reported information on linked emergency room and inpatient stay events that matched to corresponding events reported by the household. The variable ERHEVIDX contains the EVNTIDX of the linked event. On the 2012 EROM file, there are 392 emergency room events linked to subsequent hospital stays. Please note that where the emergency room visit is associated with a hospital stay (and its expenditures and charges are included with the hospital stay), the physician expenditures associated with the emergency room visit remain on the Emergency Room Visits file.

FFEEIDX is a constructed variable which uniquely identifies a flat fee group, that is, all events that were a part of a flat fee payment.

### **2.5.1.3 Round Indicator (EVENTRN)**

EVENTRN indicates the round in which the emergency room visit was reported. Please note: Rounds 3, 4, and 5 are associated with MEPS survey data collected from Panel 16. Likewise, Round 1, 2, and 3 are associated with data collected from Panel 17.

### **2.5.1.4 Panel Indicator (PANEL)**

PANEL is a constructed variable used to specify the panel number for the person. PANEL will indicate either Panel 16 or Panel 17 for each person on the file. Panel 16 is the panel that started in 2011, and Panel 17 is the panel that started in 2012.

### **2.5.2 MPC Data Indicator (MPCDATA)**

MPCDATA is a constructed variable which indicates whether or not MPC data were collected for the emergency room visit. While all emergency room events are sampled into the Medical Provider Component, not all emergency room event records have MPC data associated with them. This is dependent upon the cooperation of the household respondent to provide permission forms to contact the emergency room facility as well as the cooperation of the emergency room facility to participate in the survey.

### **2.5.3 Emergency Room Visit Event Variables**

This file contains variables describing emergency room visits/events reported by household respondents in the Emergency Room section of the MEPS HC questionnaire. The questionnaire contains specific probes for determining details about the emergency room event. These variables have not been edited.

#### **2.5.3.1 Visit Details (ERDATEYR-VSTRELCN)**

When a person reported having had a visit to the emergency room, the year, month, and day of the emergency room visit was recorded (ERDATEYR, ERDATEMM, and ERDATEDD, respectively). Also reported is whether or not the person saw a medical doctor (SEEDOC). The type of care the person received (VSTCTGRY) and whether or not the visit was related to a specific condition (VSTRELCN) were also determined.

#### **2.5.3.2 Services, Procedures, and Prescription Medicines (LABTEST-MEDPRESC)**

Services received during the visit included whether or not the person received lab tests (LABTEST), a sonogram or ultrasound (SONOGRAM), x-rays (XRAYS), a mammogram (MAMMOG), an MRI or CAT scan (MRI), an electrocardiogram (EKG), an electroencephalogram (EEG), a vaccination (RCVVAC), anesthesia (ANESTH), throat swab (THRTSWAB), or other diagnostic tests or exams (OTHSVCE). Whether or not a surgical procedure was performed during the visit was asked (SURGPROC). The questionnaire determined if a medicine was prescribed for the person during the emergency room visit (MEDPRESC). See Section 5.2 for information on linking to the prescribed medicines events file.

#### **2.5.4 Condition and Procedure Codes (ERICD1X-ERICD3X, ERPRO1X, ERPRO2X), and Clinical Classification Codes (ERCCC1X-ERCCC3X)**

Information on household-reported medical conditions and procedures associated with each emergency room visit is provided on this file. There are up to three condition and CCS codes (ERICD1X-ERICD3X, ERCCC1X-ERCCC3X) and up to two procedure codes (ERPRO1X, ERPRO2X) listed for each emergency room visit, as shown in the crosswalk of this document. The file includes the number of condition, CCS, and procedure codes reported in the data year, which may be fewer than the maximum three for condition and CCS codes and fewer than the maximum two for procedure codes.

In order to obtain complete condition information associated with an event, the data user/analyst must link to the MEPS 2012 Medical Conditions File. Details on how to link the 2012 EROM event file to the MEPS 2012 Medical Conditions File are provided in Section 5.3 and in the MEPS 2012 Appendix File, HC-152I. The data user/analyst should note that because of confidentiality restrictions, provider-reported condition information is not publicly available.

The medical conditions and procedures reported by the Household Component respondent were recorded by the interviewer as verbatim text, which were then coded to fully-specified 2012 ICD-9-CM codes, including medical conditions and V codes (Health Care Financing Administration, 1980) by professional coders. Although codes were verified and error rates did

not exceed 2.5 percent for any coder, data users/analysts should not presume this level of precision in the data; the ability of household respondents to report condition data that can be coded accurately should not be assumed (Cox and Cohen, 1985; Cox and Iachan, 1987; Edwards, et al, 1994; and Johnson and Sanchez, 1993). For detailed information on how conditions and procedures were coded, please refer to the documentation on the MEPS 2012 Medical Conditions File. For frequencies of conditions by event type, please see the MEPS 2012 Appendix File, HC-152I.

The ICD-9-CM condition codes were aggregated into clinically meaningful categories. These categories, included on the file as ERCCC1X-ERCCC3X, were generated using Clinical Classification Software [formerly known as Clinical Classifications for Health Care Policy Research (CCHPR)], (Elixhauser, et al., 1998), which aggregates conditions and V-codes into mutually exclusive categories, most of which are clinically homogeneous.

In order to preserve member confidentiality, nearly all of the condition codes provided on this file have been collapsed from fully-specified codes to three-digit code categories. The reported ICD-9-CM code values were mapped to the appropriate clinical classification category prior to being collapsed to the three-digit categories. Similarly, the procedure codes have been collapsed from fully-specified codes to two-digit code categories. Because of this collapsing, it is possible for there to be duplicate ICD-9-CM condition or procedure codes linked to a single medical event when different fully-specified codes are collapsed into the same code. For more information on ICD-9-CM codes, see the HC-154 documentation.

The condition codes, and clinical classification and procedure codes linked to each emergency room visit are sequenced in the order in which the conditions were reported by the household respondent, which was in order of input into the database and not in order of importance or severity. Data users/analysts who use the MEPS 2012 Medical Conditions File in conjunction with this emergency room visits file should note that the order of conditions on this file is not identical to that on the Medical Conditions file.

Analysts should use the clinical classification codes listed in the Conditions PUF document (HC-154) and the Appendix to the Event Files (HC-152I) document when analyzing MEPS conditions data. Although there is a list of clinical classification codes and labels on the Healthcare Cost and Utilization Project (HCUP) Web site, if updates to these codes and/or labels are made on the HCUP Web site after the release of the 2012 MEPS PUFs, these updates will not be reflected in the 2012 MEPS data.

## **2.5.5 Flat Fee Variables (FFEEIDX, FFERTYPE, FFBEF12, FFTOT13)**

### **2.5.5.1 Definition of Flat Fee Payments**

A flat fee is the fixed dollar amount a person is charged for a package of health care services provided during a defined period of time. Examples would be: obstetrician's fee covering a normal delivery, as well as pre- and post-natal care; or a surgeon's fee covering a surgical procedure and post-surgical care. A flat fee group is the set of medical services (i.e., events) that are covered under the same flat fee payment. The flat fee groups represented on this file include flat fee groups where at least one of the health care events, as reported by the HC respondent,

occurred during 2012. By definition, a flat fee group can span multiple years. Furthermore, a single person can have multiple flat fee groups.

## **2.5.5.2 Flat Fee Variable Descriptions**

### **2.5.5.2.1 Flat Fee ID (FFEEIDX)**

As noted earlier in Section 2.5.1.2 “Record Identifiers,” the variable FFEEIDX uniquely identifies all events that are part of the same flat fee group for a person. On any 2012 MEPS event file, every event that was a part of a specific flat fee group will have the same value for FFEEIDX. Note that prescribed medicine and home health events are never included in a flat fee group and FFEEIDX is not a variable on those event files.

### **2.5.5.2.2 Flat Fee Type (FFERTYPE)**

FFERTYPE indicates whether the 2012 emergency room visit is the “stem” or “leaf” of a flat fee group. A stem (records with FFERTYPE = 1) is the initial medical service (event) which is followed by other medical events that are covered under the same flat fee payment. The leaves of the flat fee group (records with FFERTYPE = 2) are those medical events that are tied back to the initial medical event (the stem) in the flat fee group. These “leaf” records have their expenditure variables set to zero. For the emergency room visits that are not part of a flat fee payment, the FFERTYPE is set to -1, “INAPPLICABLE.”

### **2.5.5.2.3 Counts of Flat Fee Events that Cross Years (FFBEF12, FFTOT13)**

As described in Section 2.5.5.1, a flat fee payment may cover multiple events, and the multiple events could span multiple years. For situations where the emergency room event occurred in 2012 as part of a group of events, and some event occurred before or after 2012, counts of the known events are provided on the emergency room record. Variables indicating events that occurred before or after 2012 are as follows:

FFBEF12 – total number of pre-2012 events in the same flat fee group as the 2012 emergency room visit(s). This count would not include the 2012 emergency room visit(s).

FFTOT13 –the number of 2013 emergency room visits, expected to be in the same flat fee group as the emergency room event that occurred in 2012.

## **2.5.5.3 Caveats of Flat Fee Groups**

There are 11 emergency room visits that are identified as being part of a flat fee payment group. In general, every flat fee group should have an initial visit (stem) and at least one subsequent visit (leaf). There are some situations where this is not true. For some flat fee groups, the initial visit reported occurred in 2012, but the remaining visits that were part of this flat fee group occurred in 2013. In this case, the 2012 flat fee group represented on this file would consist of one event, the stem. The 2013 events that are part of this flat fee group are not represented on the file. Similarly, the household respondent may have reported a flat fee group where the initial visit began in 2011 but subsequent visits occurred during 2012. In this case, the initial visit would not be represented on the file. This 2012 flat fee group would then only consist of one or

more leaf records and no stem. Please note that the crosswalk in this document lists all possible flat fee variables.

## **2.5.6 Expenditure Data**

### **2.5.6.1 Definition of Expenditures**

Expenditures on this file refer to what is paid for health care services. More specifically, expenditures in MEPS are defined as the sum of payments for care received for each emergency room visit, including out-of-pocket payments and payments made by private insurance, Medicaid, Medicare, and other sources. The definition of expenditures used in MEPS differs slightly from its predecessors: the 1987 NMES and 1977 NMCES surveys where “charges” rather than sum of payments were used to measure expenditures. This change was adopted because charges became a less appropriate proxy for medical expenditures during the 1990s due to the increasingly common practice of discounting. Although measuring expenditures as the sum of payments incorporates discounts in the MEPS expenditure estimates, the estimates do not incorporate any payment not directly tied to specific medical care visits, such as bonuses or retrospective payment adjustments by third party payers. Another general change from the two prior surveys is that charges associated with uncollected liability, bad debt, and charitable care (unless provided by a public clinic or hospital) are not counted as expenditures because there are no payments associated with those classifications. While charge data are provided on this file, data users/analysts should use caution when working with these data because a charge does not typically represent actual dollars exchanged for services or the resource costs of those services; nor are they directly comparable to the expenditures defined in the 1987 NMES. For details on expenditure definitions, please reference “Informing American Health Care Policy” (Monheit et al., 1999). AHRQ has developed factors to apply to the 1987 NMES expenditure data to facilitate longitudinal analysis. These factors can be accessed via the CFACT data center. For more information, see the Data Center section of the MEPS Web site [meps.ahrq.gov/data\\_stats/onsite\\_datacenter.jsp](https://meps.ahrq.gov/data_stats/onsite_datacenter.jsp).

Expenditure data related to emergency room visits are broken out by facility and separately billing doctor expenditures. This file contains six categories of expenditure variables per visit: basic hospital emergency room facility expenses; expenses for doctors who billed separately from the hospital for any emergency room services provided during the emergency room visit; total expenses, which is the sum of the facility and physician expenses; facility charge; physician charge; and total charges, which is the sum of the facility and physician charges. If examining trends in MEPS expenditures, please refer to Section 3.3 for more information.

### **2.5.6.2 Data Editing and Imputation Methodologies of Expenditure Variables**

The expenditure data included on this file were derived from both the MEPS Household (HC) and Medical Provider Components (MPC). The MPC contacted medical providers identified by household respondents. The charge and payment data from medical providers were used in the expenditure imputation process to supplement missing household data. For all emergency room visits, MPC data were used if available; otherwise, HC data were used. Missing data for emergency room visits, where HC data were not complete and MPC data were not collected, or MPC data were not complete, were imputed through the imputation process.

### **2.5.6.2.1 General Data Editing Methodology**

Logical edits were used to resolve internal inconsistencies and other problems in the HC and MPC survey-reported data. The edits were designed to preserve partial payment data from households and providers, and to identify actual and potential sources of payment for each household-reported event. In general, these edits accounted for outliers, copayments or charges reported as total payments, and reimbursed amounts that were reported as out-of-pocket payments. In addition, edits were implemented to correct for misclassifications between Medicare and Medicaid and between Medicare HMOs and private HMOs as payment sources. These edits produced a complete vector of expenditures for some events, and provided the starting point for imputing missing expenditures in the remaining events.

### **2.5.6.2.2 Imputation Methodologies**

The predictive mean matching imputation method was used to impute missing expenditures. This procedure uses regression models (based on events with completely reported expenditure data) to predict total expenses for each event. Then, for each event with missing payment information, a donor event with the closest predicted payment with the same pattern of expected payment sources as the event with missing payment was used to impute the missing payment value. The imputations for the flat fee events were carried out separately from the simple events.

The weighted sequential hot-deck procedure was used to impute the missing total charges. This procedure uses survey data from respondents to replace missing data while taking into account the persons' weighted distribution in the imputation process.

### **2.5.6.2.3 Emergency Room Visit Data Editing and Imputation**

Facility expenditures for emergency room services were developed in a sequence of logical edits and imputations. "Household" edits were applied to sources and amounts of payment for all events reported by HC respondents. "MPC" edits were applied to provider-reported sources and amounts of payment for records matched to household-reported events. Both sets of edits were used to correct obvious errors in the reporting of expenditures. After the data from each source were edited, a decision was made as to whether household- or MPC-reported information would be used in the final editing and predictive mean matching imputations for missing expenditures. The general rule was that MPC data would be used where a household-reported event corresponded to an MPC-reported event (i.e., a matched event), since providers usually have more complete and accurate data on sources and amounts of payment than households.

One of the more important edits separated flat fee events from simple events. This edit was necessary because groups of events covered by a flat fee (i.e., a flat fee bundle) were edited and imputed separately from individual events covered by a single charge (i.e., simple events). Most emergency room events were imputed as simple events because hospital facility charges are rarely bundled with other events. (See Section 2.5.5 for more details on flat fee groups). However, some emergency room visits were treated as free events because the person was admitted to a hospital through its emergency room. In these cases, emergency room charges are included in the charge for an inpatient hospital stay.

Logical edits also were used to sort each event into a specific category for the imputations. Events with complete expenditures were flagged as potential donors for the predictive mean matching imputations, while events with missing expenditure data were assigned to various recipient categories. Each event with missing expenditure data was assigned to a recipient category based on the extent of its missing charge and expenditure data. For example, an event with a known total charge but no expenditure information was assigned to one category, while an event with a known total charge and partial expenditure information was assigned to a different category. Similarly, events without a known total charge and no or partial expenditure information were assigned to various recipient categories.

The logical edits produced eight recipient categories in which all events had a common extent of missing data. Separate predictive mean matching imputations were performed on events in each recipient category. For hospital inpatient and emergency room events, the donor pool was restricted to events with complete expenditures from the MPC. Due to the low ratio of donors to recipients for hospital outpatient and office-based events, there were no donor pool restrictions.

The donor pool included “free events” because, in some instances, providers are not paid for their services. These events represent charity care, bad debt, provider failure to bill, and third party payer restrictions on reimbursement in certain circumstances. If free events were excluded from the donor pool, total expenditures would be over-counted because the distribution of free event among complete events (donors) would not be represented among incomplete events (recipients).

Expenditures for some emergency room visits are not shown because the person was admitted to the hospital through the emergency room. These emergency room events are not free, but the expenditures are included in the inpatient stay expenditures. The variable ERHEVIDX can be used to differentiate between free emergency room care and situations where the emergency room charges have been included in the inpatient hospital charges.

Expenditures for services provided by separately billing doctors in hospital settings were also edited and imputed. These expenditures are shown separately from hospital facility charges for hospital inpatient, outpatient, and emergency room care.

### **2.5.6.3 Imputation Flag (IMPFLAG)**

IMPFLAG is a six-category variable that indicates if the event contains complete Household Component (HC) or Medical Provider Component (MPC) data, was fully or partially imputed, or was imputed in the capitated imputation process (for OP and OB events only). The following list identifies how the imputation flag is coded; the categories are mutually exclusive.

IMPFLAG = 0 not eligible for imputation (includes zeroed out and flat fee leaf events)

IMPFLAG = 1 complete HC data

IMPFLAG = 2 complete MPC data

IMPFLAG = 3 fully imputed

IMPFLAG = 4 partially imputed

IMPFLAG = 5 complete MPC data through capitation imputation  
(not applicable to ER events)

#### **2.5.6.4 Flat Fee Expenditures**

The approach used to count expenditures for flat fees was to place the expenditure on the first visit of the flat fee group. The remaining visits have zero facility payments, while physician's expenditures may still be present. Thus, if the first visit in the flat fee group occurred prior to 2012, all of the events that occurred in 2012 will have zero payments. Conversely, if the first event in the flat fee group occurred at the end of 2012, the total expenditure for the entire flat fee group will be on that event, regardless of the number of events it covered after 2012. See Section 2.5.5 for details on the flat fee variables.

#### **2.5.6.5 Zero Expenditures**

There are some medical events reported by respondents where the payments were zero. Zero payment events can occur in MEPS for the following reasons: (1) the stay was covered under a flat fee arrangement (flat fee payments are included only on the first event covered by the arrangement), (2) there was no charge for a follow-up stay, (3) the provider was never paid by an individual, insurance plan, or other source for services provided, (4) charges were included in the bill for a subsequent hospital admission (emergency room events only), or (5) the event was paid for through government or privately-funded research or clinical trials.

#### **2.5.6.6 Discount Adjustment Factor**

An adjustment was also applied to some HC-reported expenditure data because an evaluation of matched HC/MPC data showed that respondents who reported that charges and payments were equal were often unaware that insurance payments for the care had been based on a discounted charge. To compensate for this systematic reporting error, a weighted sequential hot-deck imputation procedure was implemented to determine an adjustment factor for HC-reported insurance payments when charges and payments were reported to be equal. As for the other imputations, selected predictor variables were used to form groups of donor and recipient events for the imputation process.

#### **2.5.6.7 Emergency Room/Hospital Inpatient Stay Expenditures**

It is common for an emergency room visit to result in a hospital stay. While it is true that all of the event files can be linked by DUPERSID, there is no unique record link between hospital inpatient stays and emergency room visits. However, wherever this relationship could be identified (using the MPC start and end dates of the events as well as other information from the provider), the facility expenditure associated with the emergency room visit is included in the hospital facility expenditure. Hence, the expenditures (and charges) for some emergency room visits are included in the resulting hospitalization. In these situations, the emergency room record on this file will have its expenditure (and charge) information zeroed out to avoid double-counting while its corresponding hospital inpatient stay record on the MEPS 2012 Hospital Inpatient Stays File will have the combined expenditures. Please note that any physician

expenditures associated with emergency room events remain on the Emergency Room event file. The variable ERHEVIDX identifies the emergency room visits whose facility expenditures are included in the expenditures for the following hospital inpatient stay. It should also be noted that for these cases there is only one emergency room stay associated with the hospital room stay.

#### **2.5.6.8 Sources of Payment**

In addition to total expenditures, variables are provided which itemize expenditures according to major source of payment categories. These categories are:

1. Out-of-pocket by User or Family,
2. Medicare,
3. Medicaid,
4. Private Insurance,
5. Veterans Administration/CHAMPVA,
6. TRICARE,
7. Other Federal Sources - includes Indian Health Service, military treatment facilities, and other care by the federal government,
8. Other State and Local Source - includes community and neighborhood clinics, state and local health departments, and state programs other than Medicaid,
9. Workers' Compensation, and
10. Other Unclassified Sources - includes sources such as automobile, homeowner's, and liability insurance, and other miscellaneous or unknown sources.

Two additional source of payment variables were created to classify payments for events with apparent inconsistencies between health insurance coverage and sources of payment based on data collected in the survey. These variables include:

11. Other Private - any type of private insurance payments reported for persons not reported to have any private health insurance coverage during the year as defined in MEPS, and
12. Other Public – Medicare/Medicaid payments reported for persons who were not reported to be enrolled in the Medicare/Medicaid program at any time during the year.

Though these two sources are relatively small in magnitude, data users/analysts should exercise caution when interpreting the expenditures associated with these two additional sources of payment. While these payments stem from apparent inconsistent responses to health insurance and source of payment questions in the survey, some of these inconsistencies may have logical explanations. For example, private insurance coverage in MEPS is defined as having a major medical plan covering hospital and physician services. If a MEPS sampled person did not have such coverage but had a single service type insurance plan (e.g., dental insurance) that paid for a particular episode of care, those payments may be classified as “other private.” Some of the “other public” payments may stem from confusion between Medicaid and other state and local programs or may be from persons who were not enrolled in Medicaid, but were presumed eligible by a provider who ultimately received payments from the public payer.

### **2.5.6.9 Imputed Emergency Room Expenditure Variables**

This file contains two sets of imputed expenditure variables: facility expenditures and physician expenditures.

#### **2.5.6.9.1 Emergency Room Facility Expenditures (ERFSF12X-ERFOT12X, ERFXP12X, ERFTC12X)**

Emergency room expenses include all expenses for treatment, services, tests, diagnostic and laboratory work, x-rays, and similar charges, as well as any physician services included in the emergency room charge.

ERFSF12X - ERFOT12X are the 12 sources of payment. The 12 sources of payment are: self/family (ERFSF12X), Medicare (ERFMR12X), Medicaid (ERFMD12X), private insurance (ERFPV12X), Veterans Administration/CHAMPVA (ERFVA12X), TRICARE (ERFTR12X), other federal sources (ERFOF12X), state and local (non-federal) government sources (ERFSL12X), Worker's Compensation (ERFWC12X), other private insurance (ERFOR12X), other public insurance (ERFOU12X), and other insurance (ERFOT12X). ERFXP12X is the sum of the 12 sources of payment for the emergency room expenditures, and ERFTC12X is the total charge. Please note that where an emergency room visit record is linked to a hospital inpatient stay record, all facility sources of payment variables, as well as ERFTC12X, have been zeroed out.

#### **2.5.6.9.2 Emergency Room Physician Expenditures (ERDSF12X - ERDOT12X, ERDXP12X, ERDTC12X)**

Separately billing doctor (SBD) expenses typically cover services provided to patients in hospital settings by providers like anesthesiologists, radiologists, and pathologists, whose charges are often not included in emergency room visit bills.

For physicians who bill separately (i.e., outside the emergency room visit bill), a separate data collection effort within the Medical Provider Component was performed to obtain this same set of expenditure information from each separately billing doctor. It should be noted that there could be several separately billing doctors associated with a medical event. For example, an emergency room visit could have a radiologist and an internist associated with it. If their services are not included in the emergency room visit bill then this is one medical event with two separately billing doctors. The imputed expenditure information associated with the separately billing doctors was summed to the event level and is provided on the file. ERDSF12X - ERDOT12X are the 12 sources of payment, ERDXP12X is the sum of the 12 sources of payments, and ERDTC12X is the physician's total charge.

Data users/analysts need to take into consideration whether to analyze facility and SBD expenditures separately, combine them within service categories, or collapse them across service categories (e.g., combine SBD expenditures with expenditures for physician visits to offices and/or outpatient departments).

### **2.5.6.9.3 Total Expenditures and Charges for Emergency Room Visits (ERXP12X, ERTC12X)**

Data users/analysts interested in total expenditure should use the variable ERXP12X, which includes both the facility and physician amounts. Those interested in total charges should use the variable ERTC12X, which includes both facility and physician charges (see Section 2.5.6.1 for an explanation of the “charge” concept). However, please note that where the emergency room visit is linked to a hospital inpatient stay record, ERFTC12X has been zeroed out. Thus, ERTC12X may be equal to “0” or the doctor total charge (ERDTC12X).

### **2.5.7 Rounding**

The expenditure variables have been rounded to the nearest penny. Person-level expenditure information released on the MEPS 2012 Person-Level Use and Expenditure File were rounded to the nearest dollar. It should be noted that using the MEPS 2012 event files to create person-level totals will yield slightly different totals than those found on the full year consolidated file. These differences are due to rounding only. Moreover, in some instances, the number of persons having expenditures on the event files for a particular source of payment may differ from the number of persons with expenditures on the person-level expenditures file for that source of payment. This difference is also an artifact of rounding only.

## **3.0 Sample Weight (PERWT12F)**

### **3.1 Overview**

There is a single full year person-level weight (PERWT12F) assigned to each record for each key, in-scope person who responded to MEPS for the full period of time that he or she was in-scope during 2012. A key person either was a member of a responding NHIS household at the time of interview, or joined a family associated with such a household after being out-of-scope at the time of the NHIS (the latter circumstance includes newborns as well as those returning from military service, an institution, or residence in a foreign country). A person is in-scope whenever he or she is a member of the civilian noninstitutionalized portion of the U.S. population.

### **3.2 Details on Person Weight Construction**

The person-level weight PERWT12F was developed in several stages. First, person-level weights for Panel 16 and Panel 17 were created separately. The weighting process for each panel included adjustments for nonresponse over time and calibration to independent population totals. The calibration was initially accomplished separately for each panel by raking the corresponding sample weights for those in-scope at the end of the calendar year to Current Population Survey (CPS) population estimates based on five variables. The five variables used in the establishment of the initial person-level control figures were: census region (Northeast, Midwest, South, West); MSA status (MSA, non-MSA); race/ethnicity (Hispanic; Black, non-Hispanic; Asian, non-Hispanic; and other); sex; and age. A 2012 composite weight was then formed by multiplying each weight from Panel 16 by the factor .49 and each weight from Panel 17 by the factor .51. The choice of factors reflected the relative sample sizes of the two panels, helping to limit the variance of estimates obtained from pooling the two samples. The composite weight was raked to the same set of CPS-based control totals. When the poverty status information derived from

income variables became available, a final raking was undertaken on the previously established weight variable. Control totals were established using poverty status (five categories: below poverty, from 100 to 125 percent of poverty, from 125 to 200 percent of poverty, from 200 to 400 percent of poverty, at least 400 percent of poverty), the other five variables previously used in the weight calibration, as well as age categories cross-classified with categories associated with numbers of office-based visits and age categories cross-classified with categories reflecting the number of prescribed medicines purchased.

### **3.2.1 MEPS Panel 16 Weight Development Process**

The person-level weight for MEPS Panel 16 was developed using the 2011 full year weight for an individual as a “base” weight for survey participants present in 2011. For key, in-scope members who joined an RU sometime in 2012 after being out-of-scope in 2011, the initially assigned person-level weight was the corresponding 2011 family weight. The weighting process included an adjustment for person-level nonresponse over Rounds 4 and 5 as well as raking to population control totals for December 2012 for key, responding persons in-scope on December 31, 2012. These control totals were derived by scaling back the population distribution obtained from the March 2013 CPS to reflect the December 31, 2012 estimated population total (estimated based on Census projections for January 1, 2013). Variables used for person-level raking included: census region (Northeast, Midwest, South, West); MSA status (MSA, non-MSA); race/ethnicity (Hispanic; Black, non-Hispanic; Asian, non-Hispanic; and other); sex; and age. (Poverty status is not included in this version of the MEPS full year database because of the time required to process the income data collected and then assign persons to a poverty status category). The final weight for key, responding persons who were not in-scope on December 31, 2012 but were in-scope earlier in the year was the person weight after the nonresponse adjustment.

It may be noted that there were several features to the MEPS sample design employed for Panel 16 reflected in the Panel 16 weight that differed from previous panels: a sampling domain associated with those with cancer; a partitioning of the “Other” race/ethnicity sample domain into those who fully completed the NHIS survey and those who only partially completed it; and a small experiment conducted in 11 PSUs, where some nonrespondents were subsampled for fielding purposes. More details can be found in the MEPS PUF documentation for the 2012 Full Year Population Characteristics Data file (HC-149).

### **3.2.2 MEPS Panel 17 Weight Development Process**

The person-level weight for MEPS Panel 17 was developed using the MEPS Round 1 person-level weight as a “base” weight. For key, in-scope members who joined an RU after Round 1, the Round 1 family weight served as a “base” weight. The weighting process included an adjustment for nonresponse over the remaining data collection rounds in 2012 as well as raking to the same population control figures for December 2012 used for the MEPS Panel 16 weights for key, responding persons in-scope on December 31, 2012. The same five variables employed for Panel 16 raking (census region, MSA status, race/ethnicity, sex, and age) were used for Panel 17 raking. Again, the final weight for key, responding persons who were not in-scope on December 31, 2012 but were in-scope earlier in the year was the person weight after the nonresponse adjustment.

Note that the MEPS Round 1 weights for both panels incorporated the following components: a weight reflecting the original household probability of selection for the NHIS and an adjustment for NHIS nonresponse; a factor representing the proportion of the 16 NHIS panel-quarter combinations eligible for MEPS; the oversampling of certain subgroups for MEPS among the NHIS household respondents eligible for MEPS; ratio-adjustment to NHIS-based national population estimates at the household (occupied DU) level; adjustment for nonresponse at the DU level for Round 1; and poststratification to U.S. civilian noninstitutionalized population estimates at the family and person level obtained from the March CPS database.

While most of the new Panel 16 design features were not retained for Panel 17, the partitioning of the “Other” race/ethnicity domain into domains reflecting NHIS “full completes” and “partial completes” was retained.

### 3.2.3 The Final Weight for 2012

The final raking of those in-scope at the end of the year has been described above. In addition, the composite weights of two groups of persons who were out-of-scope on December 31, 2012 were poststratified. Specifically, the weights of those who were in-scope sometime during the year, out-of-scope on December 31, and entered a nursing home during the year were poststratified to a corresponding control total obtained from the 1996 MEPS Nursing Home Component. The weights of persons who died while in-scope during 2012 were poststratified to corresponding estimates derived using data obtained from the Medicare Current Beneficiary Survey (MCBS) and Vital Statistics information provided by the National Center for Health Statistics (NCHS). Separate decedent control totals were developed for the “65 and older” and “under 65” civilian noninstitutionalized decedent populations.

In developing the final person-level weight for 2012 (PERWT12F), two raking dimensions were added. One reflected the MEPS 2009-2011 estimated average annual distribution of office-based visits by age (under 65, 65 and over) while the other reflected the MEPS 2009-2011 estimated average distribution of prescription medicine purchases, also by the same age groups. These additional adjustments were included to better reflect benchmark trends for these two measures of health care utilization.

For each category of the additional two raking dimensions, the tables below show the ratio of the weighted estimate of persons that resulted from including the additional raking dimension to the weighted estimate of persons without the additional dimension.

Ratio of Adjusted to Unadjusted Weights for Office-based Raking Dimension

Number of Office-based Visits	Under 65 (AGE12X < 65)	65 or Older (AGE12X ≥ 65)
0	0.87188	0.95404
1-5	1.03549	0.94513
6-10	1.12561	0.99076
> 10	1.16699	1.09270

## Ratio of Adjusted to Unadjusted Weights for Prescribed Medicine Raking Dimension

Number of Prescribed Medicine Purchases	Under 65 (AGE12X < 65)	65 or Older (AGE12X ≥ 65)
0	0.91674	0.89169
>0	1.07082	1.01080

Overall, the weighted population estimate for the civilian noninstitutionalized population for December 31, 2012 is 309,875,841 (PERWT12F>0 and INSC1231=1). The sum of the person-level weights across all persons assigned a positive person-level weight is 313,489,853.

### 3.2.4 Coverage

The target population for MEPS in this file is the 2012 U.S. civilian noninstitutionalized population. However, the MEPS sampled households are a subsample of the NHIS households interviewed in 2010 (Panel 16) and 2011 (Panel 17). New households created after the NHIS interviews for the respective panels and consisting exclusively of persons who entered the target population after 2010 (Panel 16) or after 2011 (Panel 17) are not covered by MEPS. Neither are previously out-of-scope persons who join an existing household but are unrelated to the current household residents. Persons not covered by a given MEPS panel thus include some members of the following groups: immigrants; persons leaving the military; U.S. citizens returning from residence in another country; and persons leaving institutions. The set of uncovered persons constitutes only a small segment of the MEPS target population.

### 3.3 Using MEPS Data for Trend Analysis

MEPS began in 1996, and the utility of the survey for analyzing health care trends expands with each additional year of data. However, it is important to consider a variety of factors when examining trends over time using MEPS. Statistical significance tests should be conducted to assess the likelihood that observed trends may be attributable to sampling variation. The length of time being analyzed should also be considered. In particular, large shifts in survey estimates over short periods of time (e.g. from one year to the next) that are statistically significant should be interpreted with caution, unless they are attributable to known factors such as changes in public policy, economic conditions, or MEPS survey methodology. Looking at changes over longer periods of time can provide a more complete picture of underlying trends. Analysts may wish to consider using techniques to evaluate, smooth, or stabilize analyses of trends using MEPS data such as comparing pooled time periods (e.g. 1996-97 versus 2011-12), working with moving averages, or using modeling techniques with several consecutive years of MEPS data to test the fit of specified patterns over time. Finally, researchers should be aware of the impact of multiple comparisons on Type I error. Without making appropriate allowance for multiple comparisons, undertaking numerous statistical significance tests of trends increases the likelihood of concluding that a change has taken place when one has not.

## 4.0 Strategies for Estimation

### 4.1 Developing Event-Level Estimates

The data in this file can be used to develop national 2012 event-level estimates for the U.S. civilian noninstitutionalized population on emergency room visits as well as expenditures, and sources of payment for these visits. Estimates of total visits are the sum of the weight variable (PERWT12F) across relevant event records while estimates of other variables must be weighted by PERWT12F to be nationally representative. The tables below contain event-level estimates for selected variables.

#### Selected Event-Level Estimates

##### Emergency Room Visits

Estimate of Interest	Variable Name	Estimate (SE)	Estimate Excluding Zero Payment Events (SE)
Total number of emergency room visits (in millions)	PERWT12F	59.3 (1.96)	55.6 (1.91)
Proportion of emergency room visits with expenditures > 0*	ERXP12X	0.937 (0.0044)	-----

##### Emergency Room Expenditures

Estimate of Interest	Variable Name	Estimate (SE)	Estimate Excluding Zero Payment Events (SE)*
Mean total payments per visit	ERXP12X	\$943 (\$29.6)	\$1,006 (\$31.4)
Mean out-of-pocket payment per visit	ERDSF12X +ERFSF12X	\$117 (\$9.4)	\$125 (\$10.1)
Mean proportion of total expenditures paid by private insurance per visit	(ERDPV12X +ERFPV12X) /ERXP12X	-----	0.329 (0.0112)

\* Zero payment events can occur in MEPS for the following reasons: (1) the stay was covered under a flat fee arrangement (flat fee payments are included only on the first event covered by the arrangement), (2) there was no charge for a follow-up stay, (3) the provider was never paid by an individual, insurance plan, or other source for services provided, or (4) charges were included in the bill for a subsequent hospital admission (emergency room events only), or (5) the event was paid for through government or privately-funded research or clinical trials.

## **4.2 Person-Based Estimates for Emergency Room Visits**

To enhance analyses of emergency room visits, analysts may link information about emergency room visits by sample persons in this file to the annual full year consolidated file (which has data for all MEPS sample persons), or conversely, link person-level information from the full year consolidated file to this event-level file (see Section 5 below for more details). Both this file and the full year consolidated file may be used to derive estimates for persons with emergency room care and annual estimates of total expenditures. However, if the estimate relates to the entire population, this file cannot be used to calculate the denominator, as only those persons with at least one emergency room event are represented on this data file. Therefore, the full year consolidated file must be used for person-level analyses that include both persons with and without emergency room care.

## **4.3 Variables with Missing Values**

It is essential that the analyst examine all variables for the presence of negative values used to represent missing values. For continuous or discrete variables, where means or totals may be taken, it may be necessary to set negative values to values appropriate to the analytic needs. That is, the analyst should either impute a value or set the value to one that will be interpreted as missing by the computing language used. For categorical and dichotomous variables, the analyst may want to consider whether to recode or impute a value for cases with negative values or whether to exclude or include such cases in the numerator and/or denominator when calculating proportions. Methodologies used for the editing/imputation of expenditure variables (e.g., sources of payment, flat fee, and zero expenditures) are described in Section 2.5.6.

## **4.4 Variance Estimation (VARPSU, VARSTR)**

The MEPS is based on a complex sample design. To obtain estimates of variability (such as the standard error of sample estimates or corresponding confidence intervals) for MEPS estimates, analysts need to take into account the complex sample design of MEPS for both person-level and family-level analyses. Several methodologies have been developed for estimating standard errors for surveys with a complex sample design, including the Taylor-series linearization method, balanced repeated replication, and jackknife replication. Various software packages provide analysts with the capability of implementing these methodologies. Replicate weights have not been developed for the MEPS data. Instead, the variables needed to calculate appropriate standard errors based on the Taylor-series linearization method are included on this file as well as all other MEPS public use files. Software packages that permit the use of the Taylor-series linearization method include SUDAAN, Stata, SAS (version 8.2 and higher), and SPSS (version 12.0 and higher). For complete information on the capabilities of each package, analysts should refer to the corresponding software user documentation.

Using the Taylor-series linearization method, variance estimation strata and the variance estimation PSUs within these strata must be specified. The variables VARSTR and VARPSU on this MEPS data file serve to identify the sampling strata and primary sampling units required by the variance estimation programs. Specifying a “with replacement” design in one of the previously mentioned computer software packages will provide estimated standard errors appropriate for assessing the variability of MEPS survey estimates. It should be noted that the

number of degrees of freedom associated with estimates of variability indicated by such a package may not appropriately reflect the number available. For variables of interest distributed throughout the country (and thus the MEPS sample PSUs), one can generally expect to have at least 100 degrees of freedom associated with the estimated standard errors for national estimates based on this MEPS database.

Prior to 2002, MEPS variance strata and PSUs were developed independently from year to year, and the last two characters of the strata and PSU variable names denoted the year. However, beginning with the 2002 Point-in-Time PUF, the variance strata and PSUs were developed to be compatible with all future PUFs until the NHIS design changed. Thus, when pooling data across years 2002 through the Panel 11 component of the 2007 files, the variance strata and PSU variables provided can be used without modification for variance estimation purposes for estimates covering multiple years of data. There were 203 variance estimation strata, each stratum with either two or three variance estimation PSUs.

From Panel 12 of the 2007 files, a new set of variance strata and PSUs were developed because of the introduction of a new NHIS design. There are 165 variance strata with either two or three variance estimation PSUs per stratum, starting from Panel 12. Therefore, there are a total of 368 (203+165) variance strata in the 2007 Full Year file as it consists of two panels that were selected under two independent NHIS sample designs. Since both MEPS panels in the Full Year 2008 file and beyond are based on the new NHIS design, there are only 165 variance strata. These variance strata (VARSTR values) have been numbered from 1001 to 1165 so that they can be readily distinguished from those developed under the former NHIS sample design in the event that data are pooled for several years.

If analyses call for pooling MEPS data across several years, in order to ensure that variance strata are identified appropriately for variance estimation purposes, one can proceed as follows:

1. When pooling any year from 2002 or later, one can use the variance strata numbering as is.
2. When pooling any year from 1996 to 2001 with any year from 2002 or later, use the H36 file.
3. A new H36 file will be constructed in the future to allow pooling of 2007 and later years with 1996 to 2006.

## **5.0 Merging/Linking MEPS Data Files**

Data from this file can be used alone or in conjunction with other files for different analytic purposes. This section summarizes various scenarios for merging/linking MEPS event files. Each MEPS panel can also be linked back to the previous year's National Health Interview Survey public use data files. For information on obtaining MEPS/NHIS link files please see [meps.ahrq.gov/data\\_stats/more\\_info\\_download\\_data\\_files.jsp](http://meps.ahrq.gov/data_stats/more_info_download_data_files.jsp).

## 5.1 Linking to the Person-Level File

Merging characteristics of interest from a person-level file (e.g., MEPS 2012 Full Year Consolidated File) expands the scope of potential estimates. For example, to estimate the total number of emergency room visits for persons with specific demographic characteristics (e.g., age, race, sex, and education), population characteristics from a person-level file need to be merged onto the emergency room visit file. This procedure is illustrated below. The MEPS 2012 Appendix File, HC-152I, provides additional detail on how to merge MEPS data files.

1. Create dataset PERSX by sorting the MEPS 2012 Full Year Consolidated File by the person identifier, DUPERSID. Keep only variables to be merged onto the emergency room visit file and DUPERSID.
2. Create dataset EROM by sorting the emergency room visit file by person identifier, DUPERSID.
3. Create final dataset NEWEROM by merging these two files by DUPERSID, keeping only records on the emergency room visit file.

The following is an example of SAS code which completes these steps:

```
PROC SORT DATA=HCXXX (KEEP= DUPERSID AGE31X AGE42X
AGE53X SEX RACEV1X EDUCYR EDUYRDEG EDRECODE) OUT=PERSX;
  BY DUPERSID;
RUN;

PROC SORT DATA=EROM;
  BY DUPERSID;
RUN;

DATA NEWEROM;
  MERGE EROM (IN=A) PERSX(IN=B);
  BY DUPERSID;
  IF A;
RUN;
```

## 5.2 Linking to the Prescribed Medicines File

The prescribed medicines-event link (RXLK) file provides a link from the MEPS event files to the 2012 Prescribed Medicines Event File. When using RXLK, data users/analysts should keep in mind that one inpatient stay can link to more than one prescribed medicine record.

Conversely, a prescribed medicine event may link to more than one inpatient stay visit or different types of events. When this occurs, it is up to the data user/analyst to determine how the prescribed medicine expenditures should be allocated among those medical events. For detailed linking examples, including SAS code, data users/analysts should refer to the MEPS 2012 Appendix File, HC-152I.

### **5.3 Linking to the Medical Conditions File**

The conditions-event link (CLNK) file provides a link from MEPS event files to the 2012 Medical Conditions File. When using the CLNK, data users/analysts should keep in mind that (1) conditions are household-reported, (2) there may be multiple conditions associated with an emergency room visit and (3) a condition may link to more than one emergency room visit or any other type of visit. Data users/analysts should also note that not all emergency room visits link to the medical conditions file.

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#### **D. Variable-Source Crosswalk**

## VARIABLE-SOURCE CROSSWALK

### FOR MEPS HC-152E: 2012 EMERGENCY ROOM VISITS

#### Survey Administration Variables

<b>Variable</b>	<b>Description</b>	<b>Source</b>
DUID	Dwelling unit ID	Assigned in sampling
PID	Person number	Assigned in sampling
DUPERSID	Person ID (DUID + PID)	Assigned in sampling
EVNTIDX	Event ID	Assigned in sampling
EVENTRN	Event round number	CAPI derived
ERHEVIDX	Event ID for corresponding hospital stay	Constructed
FFEEIDX	Flat fee ID	CAPI derived
PANEL	Panel Number	Constructed
MPCDATA	MPC data flag	Constructed

#### Emergency Room Visit Event Variables

<b>Variable</b>	<b>Description</b>	<b>Source</b>
ERDATEYR	Event date – year	CAPI derived
ERDATEMM	Event date – month	CAPI derived
ERDATEDD	Event date – day	CAPI derived
SEEDOC	Did p talk to MD this visit	ER01
VSTCTGRY	Best category for care p recv on vst dt	ER02
VSTRELCN	This vst related to spec condition	ER03
LABTEST	This visit did p have lab tests	ER05
SONOGRAM	This visit did p have sonogram or ultrasd	ER05
XRAYS	This visit did p have x-rays	ER05
MAMMOG	This visit did p have a mammogram	ER05
MRI	This visit did p have an MRI/Catscan	ER05
EKG	This visit did p have an EKG or ECG	ER05
EEG	This visit did p have an EEG	ER05
RCVVAC	This visit did p receive a vaccination	ER05

<b>Variable</b>	<b>Description</b>	<b>Source</b>
ANESTH	This visit did p receive anesthesia	ER05
THRTSWAB	This visit did p have a throat swab	ER05
OTHSVCE	This visit did p have oth diag tests/exams	ER05
SURGPROC	Was surg proc performed on p this visit	ER06
MEDPRESC	Any medicine prescribed for p this visit	ER08
ERICD1X	3-digit ICD-9-CM condition code	Edited
ERICD2X	3-digit ICD-9-CM condition code	Edited
ERICD3X	3-digit ICD-9-CM condition code	Edited
ERPRO1X	2-digit ICD-9-CM procedure code	Edited
ERPRO2X	2-digit ICD-9-CM procedure code	Edited
ERCCC1X	Modified Clinical Classification Code	Constructed/Edited
ERCCC2X	Modified Clinical Classification Code	Constructed/Edited
ERCCC3X	Modified Clinical Classification Code	Constructed/Edited

#### **Flat Fee Variables**

<b>Variable</b>	<b>Description</b>	<b>Source</b>
FFERTYPE	Flat fee bundle	Constructed
FFBEF12	Total # of visits in FF before 2012	FF05
FFTOT13	Total # of visits in FF after 2012	FF10

#### **Imputed Total Expenditure Variables**

<b>Variable</b>	<b>Description</b>	<b>Source</b>
ERXP12X	Total exp for event (ERFXP12X + ERDXP12X)	Constructed
ERTC12X	Total chg for event (ERFTC12X + ERDTC12X)	Constructed

#### **Imputed Facility Expenditure Variables**

<b>Variable</b>	<b>Description</b>	<b>Source</b>
ERFSF12X	Facility amt pd, family (Imputed)	CP Section (Edited)
ERFMR12X	Facility amt pd, Medicare (Imputed)	CP Section (Edited)
ERFMD12X	Facility amt pd, Medicaid (Imputed)	CP Section (Edited)
ERFPV12X	Facility amt pd, priv insur (Imputed)	CP Section (Edited)
ERFVA12X	Facility amt pd, Veterans/CHAMPVA (Imputed)	CP Section (Edited)
ERFTR12X	Facility amt pd, TRICARE (Imputed)	CP Section (Edited)
ERFOF12X	Facility amt pd, oth federal (Imputed)	CP Section (Edited)

<b>Variable</b>	<b>Description</b>	<b>Source</b>
ERFSL12X	Facility amt pd, state/local gov (Imputed)	CP Section (Edited)
ERFWC12X	Facility amt pd, Workers Comp (Imputed)	CP Section (Edited)
ERFOR12X	Facility amt pd, oth priv (Imputed)	Constructed
ERFOU12X	Facility amt pd, oth pub (Imputed)	Constructed
ERFOT12X	Facility amt pd, oth insur (Imputed)	CP Section (Edited)
ERFXP12X	Facility sum payments ERFSF12X – ERFOT12X	Constructed
ERFTC12X	Total facility charge (Imputed)	CP Section (Edited)

### **Imputed Physician Expenditure Variables**

<b>Variable</b>	<b>Description</b>	<b>Source</b>
ERDSF12X	Doctor amount paid, family (Imputed)	Constructed
ERDMR12X	Doctor amount pd, Medicare (Imputed)	Constructed
ERDMD12X	Doctor amount paid, Medicaid (Imputed)	Constructed
ERDPV12X	Doctor amt pd, priv insur (Imputed)	Constructed
ERDVA12X	Doctor amount paid, Veterans/CHAMPVA (Imputed)	Constructed
ERDTR12X	Doctor amount pd, TRICARE (Imputed)	Constructed
ERDOF12X	Doctor amt paid, oth federal (Imputed)	Constructed
ERDSL12X	Doctor amt pd, state/local gov (Imputed)	Constructed
ERDWC12X	Doctor amount pd, Workers Comp (Imputed)	Constructed
ERDOR12X	Doctor amt pd, oth private (Imputed)	Constructed
ERDOU12X	Doctor amt pd, oth pub (Imputed)	Constructed
ERDOT12X	Doctor amt pd, oth insur (Imputed)	Constructed
ERDXP12X	Doctor sum payments ERDSF12X – ERDOT12X	Constructed
ERDTC12X	Total doctor charge (Imputed)	Constructed
IMPFLAG	Imputation status	Constructed

### **Weights**

<b>Variable</b>	<b>Description</b>	<b>Source</b>
PERWT12F	Expenditure file person weight, 2012	Constructed
VARSTR	Variance estimation stratum, 2012	Constructed
VARPSU	Variance estimation PSU, 2012	Constructed