Medical Expenditure Panel Survey – Insurance Component (MEPS-IC)

SHADAC Data Information Session

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I. Overview of MEPS-IC

Background

- MEPS-IC is an establishment survey of characteristics of employer sponsored health insurance
- Funded by the Agency for Healthcare Research and Quality (AHRQ)
- Conducted by the Census Bureau
- Nationwide, annual survey of both private and public sector establishments
- Survey data available for 1996 through 2001
- Data for 2002 will be available August 2004

Information Collected

- Establishment (location) characteristics
- Health insurance plan characteristics
- Firm (company) characteristics

Establishment (Location) Characteristics

- Number of employees
- Whether or not they offer health insurance
- Number of plans offered
- Number of employees eligible for health insurance and number enrolled

Health Insurance Plan Characteristics

- Premiums, contributions, self insurance, co-payments/deductibles, plan types, enrollments by plan type

Firm (Company) Characteristics

- Size, industry, age, retiree offerings, employee characteristics

Sample Size

- Nationally, approximately 47,000 establishments each year
- In a typical state, approximately 800 establishments in years where estimates are produced (large states have larger sample)

Data Availability

- Microdata (confidential) only available at Census Bureau Research Data Centers
- Standard set of data tables are produced and posted on AHRQ
- Special request tables can be produced by AHRQ for State and Federal agencies

II. Past, Present, and Future Publication Plans

1996 through 2000, 40 States each year (DC = State). In 1996, we started with the 40 states with the largest populations, then in the second year realized that there was enough interest for State-level data that we developed a plan to rotate the 20 smallest states such that there would be state level estimates for each state at least once every four years.

The rotation schedule appears on the second page of the technical notes that are accessible from the tables on the web site. The technical notes are updated for each year, so you should access the technical notes associated with the most recent tables.http://www.meps.ahrq.gov/MEPSDATA/ic/2001/technote2001.htm

There have been occasions where Federal agencies, State governments, and non-profit organizations have provided additional funding to increase samples in selected States. The two reasons for funding larger samples in a given State are 1) to improve the accuracy of the State estimates for that year or 2) to provide sufficient sample for production of State estimates in a year where no estimates would have been produced otherwise. In the table below, States that received increased samples are listed by year. In 2001 and 2002, the increased samples resulted in additional States for which estimates could be produced. These additional estimates will be made available on the MEPS IC web site to all data users.

Year	States With Additional Sample Purchases
1998	Arizona, Massachusetts, Washington
2000	Arkansas, Wisconsin
2001 (42)	Delaware*, Vermont*, Kansas**, New Hampshire**, South Dakota**, Wisconsin
2002 (43)	Hawaii*, Maine*, Montana*, Maryland, Virgin Islands***

* States received additional sample supporting full set of state estimates not otherwise possible.
** States received additional sample supporting estimates for smaller firms only.
*** U.S. Virgin Islands received special sample supporting full set of estimates. These data are not included in the calculation of totals for the United States.

Future MEPS-IC data availability

2002	End of August, 2004
2003	For 50 states + DC, end of August, 2005
2004	For 50 states + DC
2005 & beyond	?

We were able to increase our coverage of States because we suspended collection of the other part of the MEPS-IC survey – the part that links to the MEPS household survey.

Our budget is not growing at a pace to keep up with production costs. At some point in time – unless there is a change in the budget – we will probably have to return to some sort of rotation schedule. If the household cases return (and there is certainly are advocates for that position), the effect on the state-level estimates could be significant. Among cost savings measures being considered are:

- reducing the number of questions;
- reducing sample size by optimizing the sample further;
- asking questions less frequently (rotation of questions);
- and collecting retiree health insurance information in a more efficient manner.

III. Current Versus Retrospective Data Collection

Some of you may have heard us mention this at previous meetings. We have asked for feedback and have received a response from several States. One of the major drawbacks of the MEPS-IC data is the length of time before the data are released for a given year. For example, in August 2004 we will be releasing the estimates for 2002. The primary factor that delays us is that we collect data for the prior year and not the current year. Using the same example, the 2002 data was collected from respondents in the latter half of 2003 and it then takes about 8 months to complete the processing. The proposal is to collect the data in the latter half of the current year, thus producing estimates approximately one year earlier than the current schedule.

The following issues have to be resolved before this can become a reality:

- The MEPS-IC link sample in its current configuration requires retrospective data.
- National expenditure estimates for BEA and CMS are critical and they are concerned that companies can't report a premium equivalent value for self-insured plans until after the end of the year. We are canvassing respondents to determine if this is or is not a problem.

- The Census Bureau has moved to a new sample frame structure for the frame used for the MEPS-IC survey and there are issues yet to be resolved.

Our upcoming collection in 2004 will be for 2003 data. Our 2005 collection will most likely remain retrospective as well (collecting 2004 data in 2005). Beyond that, a change to current is still a possibility. Note that if we do decide to collect current data, a year's data would be lost.

IV. Areas Being Consider for Estimation or New Data Collection

John Sommers is working on a report outlining typical deductibles and co-payments for doctor's office visits and hospitalizations.

For 2003 collection year:

- Expansion of questions on Prescription Drug Coverage to include copays and deductibles
- More additions to the retiree health insurance section

Proposed testing for 2004 collection:

- Consumer-Driven Health Plans
- Health Savings Accounts
- Changes to Retiree health insurance coverage – prescription drugs
- Restrictions on spousal coverage
- Ability of self-insured to respond for current year

With provisions in the recently signed Medicare Modernization Act, it is important for us to improve our measures of retiree health insurance coverage. We produce retiree data only at the national level. We do not make state-level estimates of retirees because the state reported by the employer would not represent retirees living in the state:

- State to which they retired? We can not collect that information from employers.
- State in which they worked? Employers tend to coordinate retiree benefits from headquarters. Once you retire from a company, you are no longer linked to a specific site.
- State where the company is headquartered? Possible, but what would that information mean to state-level data users?

V. Data Formats and Special Tabs

- Special tabulations by purchased vs. self-insured plans (by e-mail if you are on mailing list)

  Firm Size – All, LT 50, GE50
  State
  PSI – All, Purchased, Self-insured
  Desc - Description of Estimate

  Total Active Single Enrollees
  Total Active Employee-Plus-One Enrollees
  Total Active Family Enrollees
  Total Active Enrollees

  Average Single Premium
  Average Family Premium
  Average Employee Plus One Premiums
  Average Employee Contribution to Single Premium
  Average Employee Contribution to Family Premium
  Average Employee Contribution to Employee Plus One Premium

  NAME - Name used by programmer to identify value
  ESTIMATE1 - Estimate
  STANDARD_ERROR1 – Standard Error of the Estimate
  RSE – Relative Standard Error – Standard Error of Estimate / Estimate

- Reason for the disclaimer – Pay attention to the size of the standard errors.
- Reason why numbers may differ slightly from other tables. Primarily railroads
- Warning - Most self-insured plans are offered by large employers so when you are looking at the self-insured estimates for less than 50 employees – the data are poor.

VI. Questions for participants

We would love to hear from you regarding any of the following topics:

- What current state-level estimates do you find useful? How are they being used?
- What current state-level estimates are not useful? Could they be improved or should we drop them?
- Are there state-level estimates that you get requests for that are not provided? (obviously we'd have to have the data to compute them, but it doesn't hurt to as.)
- Would the MEPS-IC data be more useful if estimates were released a year earlier? Would this affect how you use MEPS-IC data? Would it increase the use of this data?

VII. Questions from States

Is the number of active enrollees the same as the number of family members covered?
No. Because MEPS-IC is a survey of employers, this measures the number of employees enrolled, not the number of covered persons.

Will data collection for the 50 states continue?
It may or may not, depending on budget constraints and priorities.

Will data from the Territories be collected in future MEPS?
There are no plans to include the Territories in future MEPS. The U.S. Virgin Islands received a special sample supporting a full set of estimates for 2002.

Are you able to share the upcoming year's prescription drug coverage questions with states?
Yes, please see below.

VIII. New Prescription Drug Coverage Questions

MEPS-IC will contain the follow new prescription drug coverage questions in the upcoming year:

1. Were outpatient prescription drugs covered under this health plan? (Yes, No, Don't Know)

2. (If Yes) Was outpatient prescription drug coverage based on a formulary that restricted which drugs were covered?

   A formulary is a list of prescription drugs that are preferred by the health plan for use. A formulary may include brand names and generic drugs.

3. How much and/or what percentage did an enrollee pay out-of-pocket for the different tiers of prescription drug coverage?

   If reporting for one tier, enter your response in the Lowest Cost to Enrollee box. If reporting for two tiers, enter your response in the Lowest and Highest Cost to Enrollee boxes. Report for the least expensive pharmacy available to the enrollee under the plan, excluding any mail-order programs.

Lowest cost to enrollee (Tier 1)	Middle cost to enrollee (Tier 2)	Highest cost to enrollee (Tier 3)
$_____.00 Copayment and/or _____% Coinsurance	$_____.00 Copayment and/or _____% Coinsurance	$_____.00 Copayment and/or _____% Coinsurance