Center for Health
Economics and Policy

INSTITUTE FOR PUBLIC HEALTH AT WASHINGTON UNIVERSITY

The Medical Expenditure Panel Survey (MEPS), which began in 1996, is a set of large-scale surveys of families and individuals, their medical providers (doctors, hospitals, pharmacies, etc.), and employers across the United States. MEPS reports data on the specific health services that Americans use, how frequently they use them, the cost of these services, and how they are paid for, as well as data on the cost, scope, and breadth of health insurance held by and available to U.S. workers. The MEPS Household Component provides data from individual households and their members, which is supplemented by data from their medical providers. It fields questionnaires to individual household members to collect nationally representative data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. The MEPS design is one of overlapping panels, in which respondents participate for two years, but medical conditions files are available for each calendar year. They contain data on about 35,000 people per year, half of whom are new to the sample each year. Merging several years of data can easily generate expenditure data on 100,000 unique individuals. See www.meps.ahrq.gov for more details.

From a policy perspective, the public use data are limited to analysis of policies that are national in scope. However, the restricted MEPS contains variables on the state and county of residence of each survey respondent. Upon identifying the policy topic, the researcher must only create a dataset at the state (or county) level that contains the relevant policy variables. One example, available shortly as a Center for Health Economics and Policy resource, is a state-level file on Medicaid eligibility rates and population categories over time. The researcher-created policy-by-geography file must then be merged with MEPS restricted data. The process is as follows:

1. Decide whether speed or cost is more important.
   a. The faster approach is to plan to work with restricted data at the AHRQ Data Center in Rockville, MD, which is outside Washington, D.C. Costs associated are a $300 set-up fee, additional technical support if needed, and all associated travel costs.
   b. The less expensive approach is to access MEPS data at the closest Census RDC, which is located at the University of Missouri at Columbia. At this time there is no charge for Washington University researchers to access via this method. However, because the researcher is gaining physical access to a restricted Census facility, he or she must apply for and be granted Special Sworn Status. This process can take up to six months and requires significant paperwork.
2. Apply for permission to use restricted data. Center staff can assist with the proposal process. The key element is to explain that geocodes are needed to identify policies, but that summary statistics and output to be removed will be calculated in relation to the policy variables only. The policy variables themselves may need to be grouped into categories in order to protect the data, depending on the nature of those variables.
3. Write code that performs the tasks indicated. It is important to test the code ahead of time, using simulated data combined with MEPS public use files, to be sure the output will meet the criteria for removal from the data center. Center staff can assist with this process as well.

Note: MEPS health conditions are fully-specified ICD-9-CM codes. They are determined through the interview process by probing respondents' answers to questions in the categories of (1) condition enumeration, (2) medical events, and (3) disability days and are professionally coded. However, the public-use files have been "top coded," meaning that many conditions have been combined or collapsed. Depending upon the research focus, it may also be necessary to request the fully-specified codes, in order to assess policies that are targeted toward individuals with specific conditions. This is readily doable within the process described above; the only addition is that the proposal must describe and justify why the restricted health condition data are necessary.

For more information, contact the Center Manager for Data and Methods at arbarker@wustl.edu.