The Capacity of the Medical Expenditure Panel Survey to Inform the Affordable Care Act

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Abstract

The Affordable Care Act (ACA) was enacted with major provisions to expand health insurance coverage, control health care costs, and improve the health care delivery system. Essential data resources will be required for effective program planning, administration, and management, in addition to facilitating evaluations of program performance. The Medical Expenditure Panel Survey (MEPS) is one of the core data resources that has been used to inform several provisions of the ACA. This paper provides a summary of the capacity of the MEPS to inform program planning, implementation, and evaluations of program performance for several components of the ACA.

Keywords

MEPS, Affordable Care Act, health insurance

In spring 2010, the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) was enacted with major provisions to expand health insurance coverage, to control health care costs, and to improve the health care delivery system. While the major coverage expansions envisioned by the legislation are not scheduled to be implemented until 2014, several provisions of the law already have been adopted, and planning efforts have been initiated for the core components of the act (Committees on Ways & Means, Energy and Commerce, and Education & Labor 2010; 111th Congress of the United States of America 2011). To effectively plan, implement, and manage the vast array of programs set in motion by this act—and to evaluate their impact—there is critical need for content-specific data that are both timely and accessible. While new data development efforts are essential to achieve these goals, several existing data platforms have helped inform the underlying framework of the legislation and will continue to be invaluable to its implementation.

The Medical Expenditure Panel Survey (MEPS), sponsored by the Agency for Healthcare Research and Quality (AHRQ), is one of the core data resources used to inform several provisions of the ACA. In this paper, we discuss the current capacity of the MEPS to inform program planning, implementation, and evaluation of several components of the ACA. In addition, we summarize recent enhancements to the survey that advance related programmatic needs identified by the Department of Health and Human Services (DHHS).

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

Health care expenditures represent more than one-sixth of the U.S. gross domestic product,

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

The growing demand for accurate and reliable information on the population's health care utilization, expenditures, insurance coverage, sources of payment, and access to care served as the catalyst to initiate the family of national medical expenditure surveys sponsored by the AHRQ and its predecessor agencies. AHRQ's MEPS collects detailed information regarding the use of and payment for health care services from a nationally representative sample of Americans. The survey is cosponsored by the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention (CDC). Westat, Research Triangle Institute (RTI) International, and the Bureau of the Census are the primary data collection organizations.

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

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

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

2003; J. Cohen, Cohen, and Banthin 2009; Hill 2011).

Components of the MEPS

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

Design of the HC. The households selected for the MEPS-HC are a subsample of those participating in the National Health Interview Survey (NHIS), an ongoing annual household survey of approximately forty-five thousand households conducted by NCHS/CDC to obtain national estimates of health care utilization, health conditions, health status, insurance coverage, and access to care. The MEPS-HC consists of an overlapping panel design in which any given sample panel is interviewed a total of five times in person over thirty months to yield annual use and expenditure data for two calendar years. These rounds of interviewing are spaced about five to six months apart, with the first round occurring in late January (for each new MEPS panel). The interview is administered through a computer-assisted personal interview (CAPI) mode of data collection and takes place with a family respondent who reports for himself or herself and for other family members. The current MEPS annual survey consists of approximately fourteen thousand families and thirty-five thousand individuals, and reflects an oversample of the following policy-relevant population subgroups: Hispanics, blacks, and Asians. Data from two panels are combined to produce estimates for each calendar year (S. Cohen and Buchmueller 2006).

As noted, each new MEPS panel is a nationally representative subsample from the NHIS and carries forward the cross-sectional host survey's response rate. In the past several years, this response rate has varied between 85 and 87 percent. In addition, the round-specific response rates in the MEPS, conditioned on survey participation in the prior round of data collection, have varied in the following manner: 78 percent for Round 1, 95 percent for Round 2, 96 percent for Round 3, 97 percent for Round 4, and 98 to 99 percent for Round 5. Consequently, the overall response rates in the MEPS for the distinct time-dependent estimates produced from the survey are a multiplicative function of the corresponding round-specific response rates.

The MPC. To supplement the expenditure data provided from the MEPS-HC respondents and improve the accuracy of resultant expenditure estimates, the MEPS includes a medical provider survey. The MEPS-MPC collects data from a sample of providers (physicians, hospitals, home health agencies, and pharmacies) who provided medical care to MEPS-HC respondents. The MPC collects data on dates of visits/services, use of medical care services, charges, and sources of payments and amounts, and diagnoses and procedure codes for medical visits/encounters. The expenditure data collected from this survey also are used as an imputation source to correct for item nonresponse in the household survey.

The IC. Efforts to address inequities in the availability of private health insurance and to control health insurance premiums and medical care costs must necessarily focus on the employment-related health insurance market. Most Americans under age sixty-five obtain their health insurance through their employers. As a result, data on employers' behavior with respect to offering and paying for health care coverage for their employees are critical to understanding the current operation of the health care system in the United States and to evaluating how changes in policy are likely to affect that coverage. The MEPS-IC is a nationally representative annual survey of

more than forty thousand business establishments and state/local governments sponsored by the AHRQ. The survey is designed to produce estimates at the national and state level on the number and types of private health insurance plans offered, benefits associated with these plans, premiums, contributions by employers and employees, eligibility requirements, and employer characteristics. The survey is characterized by an integrated design, whereby the sample is selected from the Business Register, a confidential list of nearly all establishments in the United States maintained by the Census Bureau, and from the Census of Governments. Use of the register as the MEPS-IC sampling frame permits efficient oversampling of establishments by location, size, and industry and also serves as a poststratification source. Additional details about the MEPS component surveys can be found at www.meps.ahrq.gov.

MEPS health insurance estimates. MEPS-derived estimates of the health insurance status of the U.S. civilian noninstitutionalized population are critical to policymakers and others concerned with access to medical care and the cost and quality of that care. Health insurance helps people get timely access to medical care and protects them against the risk of expensive and unanticipated medical events. When estimating the size of the uninsured population, it is critical to consider the distinction between those uninsured for short periods of time and those who are long-term uninsured across several years in duration. Compared with people with health care coverage, uninsured people are less likely to visit a doctor, have a usual source of medical care, receive preventive services, or have a recommended test or prescription filled. Consequently, individuals who experience extended periods of being uninsured are particularly at risk for restrictions in access to care and exposure to serious illness and significant financial jeopardy.

Since many individuals undergo transitions in the acquisition and loss of health insurance coverage over time, an important consideration is the length of the spells of uninsurance and the capacity of this lack of coverage to lead to less efficient use of health care services and facilities. In this regard, MEPS research efforts have demonstrated that individuals with partial-year coverage differ significantly from those who have been uninsured for more than a year along a number of demographic and employment characteristics. In addition, MEPS research has shown that attitudes toward the value and need for health insurance and toward risk determine whether individuals obtain jobs that offer employer-sponsored health insurance (Monheit and Vistnes 2008). Also with providing cross-sectional estimates of health insurance coverage each year, the MEPS has the added analytical capacity to identify individuals with gaps in coverage over time, as well as the duration of the spells of being uninsured for up to four years (S. Cohen and Rhoades 2007).

Underinsurance. In addition to measuring actual out-of-pocket financial burdens for health care, the MEPS provides the only nationally representative data that can be used to measure the extent of "underinsurance" in the United States. Underinsurance is defined as being at risk of spending more than a certain amount of family income on out-of-pocket expenses in the event of a catastrophic medical illness. Estimates of the underinsured require information on families' health insurance benefits, family income, and risk of experiencing catastrophic medical events—all of which are found in the MEPS (Banthin, Cunningham, and Bernard 2008).

Uses of the MEPS

With health care absorbing increasing amounts of the nation's resources, the question of how to implement health system design innovations that encourage the provision of high-quality and efficient health care delivery is a sentinel concern of both private and public payers. To effectively address this issue, researchers and policymakers in the past have benefited from MEPS research findings to better understand how individual characteristics, behavioral factors, financial incentives, and institutional arrangements affect health care expenditures in a rapidly changing health care market. Research findings for the MEPS have also served to provide health care decision makers with a better understanding of the highly concentrated nature of health care expenditures and the persistence of these high expenditures over time (Monheit 2003). MEPS

studies that examine the persistence of high levels of expenditures over time have been essential to help discern the factors most likely to drive health care spending and the characteristics of the individuals who incur them. Historically, the analyses of data from the MEPS family of surveys have figured prominently in this arena. As noted in the Institute of Medicine (IOM) report, *Health Insurance Is a Family Matter*, "the most comprehensive data on who uses what health care service and how much is paid for those services comes from the Medical Expenditure Panel Survey" (IOM 2002, 71). MEPS-related analyses were prominently used to inform components of this IOM report, which focused on issues of insurance coverage and cost.

Recently, greater attention and priority have been given to data collection procedures, predictive modeling, and estimation strategies that help improve the precision and quality of the survey estimates that characterize the policy- relevant population subgroup of individuals with high levels of medical expenditures (S. Cohen, Ezzati-Rice, and Yu 2006). Research findings from the MEPS also provide clear evidence of the utility and appropriateness of probabilistic models as prediction tools for identifying individuals likely to incur high levels of medical expenditures in future years. To the extent that this policy-relevant subset of the population is amenable to successful prediction through the application of well-developed models, the methodology continues to find several appropriate venues. Prominent examples ripe for application include adoption of oversampling strategies for national health care surveys, and the identification of individuals whose health status improvements through disease management programs could most significantly result in potential reductions in overall future-year health care expenditures.

Given the growing attention to achieving a better understanding of the impact of rising prescription drug costs on health and the consumption of health services, it is also important to note the utility of the MEPS to inform studies examining the association between the use of newer medicines and morbidity, mortality, and health spending. Using this data resource, researchers have been able to determine the direction of the association between the use of newer drugs and all other types of nondrug medical spending. Attention has also been focused on studies that identify inappropriate medication use, which is a major patient safety concern and has significant consequences with respect to health care costs. With its wealth of data on health conditions, prescription drug use and expenditures, and associated therapeutic drug classifications, the MEPS data have also been helpful to researchers attempting to identify potentially inappropriate medication use in the community (Zuvekas and Vitiello 2012).

Longitudinal Capacity

Research efforts build upon the analytical strengths of the MEPS to support longitudinal analyses and take advantage of its integrated survey design linked to the NHIS to expand the time period and analytical profiles of the sample respondents. With the MEPS longitudinal design, analysts have assessed the persistence of high health care expenditures by examining whether individuals in high percentiles of the health care expenditure distribution in a particular year remain in the upper percentiles in the following year or shift to a higher or lower percentile. The overlapping panel design of the MEPS has also been used to assess the impact of survey attrition on the resultant survey estimates by comparing the national health care estimates produced by the first year of a sample panel (with a higher response rate) with the estimates derived from the second year of a MEPS sample panel covering the same time period. In addition, with the linkage of MEPS and NHIS files, longitudinal analyses of transitions in health insurance coverage and health status characteristics have been examined over a three-year period. All the survey estimates and analyses conducted with the MEPS adjust for survey design complexities and include adjustments for survey nonresponse and post-stratification. The survey and resulting analyses have also benefited from ongoing statistical and methodological research initiatives to improve the accuracy, precision, efficiency, timeliness, and overall data quality and analytical capacity of the survey.

State-level Capacity

Because of the importance of state regulatory and coverage policies to health insurance markets, the MEPS-IC is designed to provide estimates of employment-related insurance both for the nation and for every state. The ability to track employers' offers of coverage, numbers of employees enrolled, and the costs of insurance to both the employer and employee by employer characteristics, particularly firm size, will be critical to evaluating the effects of the ACA on this segment of the market. The IC annually posts comprehensive sets of tables on national estimates of insurance coverage for the private sector by firm size, industry group, census regions, and other characteristics; public sector data by state and local government types, government size, and census division; civilian estimates that incorporate both the private and state and local government sectors; and national totals for enrollees and costs of health insurance coverage for both the private and public sectors. At the state and local levels, the IC tables provide state-level estimates for the private sector by firm size, industry groupings, ownership type, age of firm, employee characteristics, and average wage quartiles, and metropolitan area private sector estimates of premiums, employee contributions, enrollments, and take-up rates by firm size.

The MEPS household survey, although not optimized for state estimates, can support such estimates for the larger states and metro areas (Sommers 2005). Data from the household survey have been used to make estimates of medical expenditures in the ten largest states (Rohde 2011) and ten large metropolitan areas (Machlin, Nixon, and Sommers 2004). However, sample size restrictions and the survey's complex sample design, which can have a significant impact on the precision of estimates, do limit the extent to which the MEPS-HC can be used for these types of estimates.

MEPS and Implementation of the ACA

This section describes the current capacity of the MEPS to inform program planning, implementation, and evaluations of program performance for several components of the ACA.

Use of the MEPS to Determine the Amount of the Small Employer Health Insurance Tax Credit

The ACA provides tax credits for small employers that purchase health insurance for their employees. To receive these credits, the employer must contribute at least 50 percent of the total premium cost. The first phase, which was implemented in 2010, provided a tax credit of up to 35 percent of the employer's contribution toward the employee's health insurance premium. The full credit is available to employers with ten or fewer employees and average annual wages of less than $25,000; it phases out as firm size increases (to a limit of twenty-five) and as average wage increases (to a limit of $50,000). When fully implemented in 2014, the tax credit will pay for up to 50 percent of employers' contributions toward employees' health insurance premiums in the state exchanges.

In collaboration with the DHHS Office of the Secretary, and the Department of Treasury, AHRQ staff have provided MEPS-IC national and state-level estimates of average premiums that were used to determine the small business tax credits for 2010 and subsequent years. Most recently, data from the 2012 MEPS-IC were used to provide estimates of health insurance premiums by state for employer-sponsored coverage provided by small employers with fifty or fewer workers. The small employer health insurance tax credit was then determined based on the MEPS-derived estimates of the average premium for the small group market in each state for the taxable year. For illustrative purposes, the average insurance premiums in the small group market in each state based on the MEPS-IC data are accessible at the following Internal Revenue Service (IRS) website http://www.irs.gov/pub/irs-drop/rr-10-13.pdf

The secretary of health and human services also determines whether separate average premiums will apply for areas within a state ("substate areas") and also determines the average premium for a state or substate area. Data from the MEPS-IC have also been used to inform ongoing analyses of average premiums at the substate rating area level.

Use of the MEPS to Evaluate the Health Insurance Status of Young Adults, Ages Twenty-Two to Twenty-Five

Health insurance helps people get timely access to medical care and protects them against the risk of expensive and unanticipated medical events. Young adults are less likely to be covered by health insurance than their older counterparts. Effective September 2010, one component of the ACA permits adult dependents to remain on their parents' insurance plans until their twenty-sixth birthday. This coverage provision also applies to adult dependents under age twenty-six who no longer live with their parents, are not dependents on their parents' tax returns, or are no longer students.

Using information from the MEPS-HC, analyses have been conducted to obtain detailed estimates for the U.S. civilian noninstitutionalized population between the ages of twenty-two and twenty-five, a group typically ineligible for continuance of coverage under their parents' insurance plans prior to 2010 (Cohen and Rhoades 2010). The MEPS will continue to be used to discern changes in health insurance coverage take-up by this vulnerable population that are attributable to the fall 2010 enactment of the ACA. In addition, the MEPS will be employed to assess changes in health care access, related health care utilization, and out-of-pocket and total expenditures incurred by these young adults as a consequence of this legislation and its impact on health status.

Use of the MEPS to Inform the Excise Tax on High Cost "Cadillac" Health Plans

Based on requests from the White House in summer 2009, AHRQ staff provided detailed estimates of the distribution of employer-sponsored health insurance premiums as of 2008. These estimates were derived from the MEPS-IC private coverage data. Particular attention was given to the cost of premiums at the ninetieth, ninety-fifth, and ninety-ninth percentiles. Based on similar requests from the House Ways and Means Committee in early 2010, AHRQ staff provided distributional estimates of employer-sponsored premiums, with a focus on premiums above the eightieth percentile in the cost distribution, further disaggregated by industry type. These estimates were also derived from the MEPS-IC private coverage data. Findings from the MEPS thus helped to inform the excise tax provisions of the ACA on the most expensive employer-sponsored health plans.

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

Use of the MEPS to Evaluate the Health Insurance Status of High-risk Individuals

The ACA now provides eligible uninsured individuals access to coverage with no exclusions for preexisting health conditions. In the past, many high-risk individuals with multiple chronic conditions were virtually uninsurable. Using information from the HC of the MEPS, analyses are underway to determine the scale and characteristics of individuals under age sixty-five with multiple chronic conditions who were without health insurance coverage prior to enactment of the ACA.

MEPS data also will be used to discern changes in health insurance coverage take-up by this vulnerable population that are attributable to enactment of the ACA. In addition, the MEPS will be employed to assess changes in health care access, health care utilization, out-of-pocket expenses, and total expenditures incurred by high-risk, chronically ill individuals as a consequence of this legislation, as well as the

subsequent impact these changes have on the health status of this vulnerable population.

Use of the MEPS to Inform Projections of the Allocation of Federal Medical Assistance Percentages (FMAP) Matching Funds for State Medicaid Programs

The ACA simplifies Medicaid eligibility rules and unifies them across all States by expanding Medicaid eligibility to 133 percent of the federal poverty line (FPL) beginning in 2014. The federal government's share of a state's expenditures for most Medicaid services is called the FMAP. The remainder is referred to as the nonfederal share, or state and local share. Generally determined annually, the FMAP is designed so that the federal government pays a larger portion of Medicaid costs in states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes) (Peterson 2010). The new eligibility rules eliminate asset tests and require less information to be collected from Medicaid applicants. A complication arises, however, in determining which federal match rate applies to the enrolled population. Beginning in 2014, allocations for the portion of the Medicaid-enrolled population eligible under "old" state-specific rules will follow the existing FMAP, which ranges from 50 to 75 percent depending on the state. Allocations for the proportion of the enrolled population eligible under the "new" rules will be 100 percent FMAP. This means the federal government will pay 100 percent of the costs of the newly eligible population under the expanded eligibility rules, which translates into billions of federal dollars (Peterson 2010). Clearly, states are concerned about receiving the appropriate level of FMAP dollars.

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

Discussion

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

To date, the MEPS has been used to determine the tax credit amount for the small employer health insurance, to evaluate the health insurance status of young adults up to age twenty-six, to inform the excise tax on high-cost employer-sponsored health plans, to evaluate the health insurance status of high-risk individuals and their health care experiences, and to inform the allocation of FMAPs, the matching funds for state Medicaid programs. Since 2011, several content enhancements have also been incorporated into the MEPS-HC to further enhance its capacity to inform provisions of the ACA. With respect to monitoring the take-up of coverage by individuals with chronic conditions, questions have been added to the survey to explicitly determine whether anyone in the family has purchased

coverage directly from a "high-risk pool" and to obtain the name of the high-risk pool. More questions have been added on the topic of health savings accounts to discern the level of the plan deductible and whether there is a special account or fund associated with the plan that can be used to pay for medical expenses. The MEPS-HC has also added questions on flexible spending accounts (FSAs) to determine whether anyone in the family has a FSA for health expenses, who that individual is, and what amount the family asked to have placed in the medical FSA for the respective calendar year.

The MEPS was originally designed as a general purpose survey that collected the information necessary to support a flexible research agenda related to questions revolving around health insurance coverage and health care access, use, and expenditures. As such, it serves as a solid framework for evaluating the effects of the ACA on the American health care system. Nonetheless, to evaluate some of the specific provisions mandated in the act a few modest changes are planned for both the insurance and the HC survey questionnaires. Most of these changes relate to the mandate for employers with fifty or more full-time equivalent employees to offer health insurance and the establishment of the new health insurance exchanges.

Several content enhancements are planned for the MEPS-IC, beginning in 2013. For self-insured health plans that purchase stop-loss coverage, questions have been added to determine the specific stop-loss coverage amount per employee. Information will be obtained as to whether the premiums for specific insurance plans vary by smoker/nonsmoker status, in addition to age, gender, and wage or salary levels. Questions have been added to discern whether specific health plans are "grandfathered" health plans as defined by the ACA. Also, participation in a fitness/weight-loss program and participation in a smoking cessation program will be added to the current list of response options, which include hours worked, union status, wage or salary level, occupation and length of employment. In terms of the list of potential responses to the question, "Which of the services listed were covered by the plan?" additions coming are routine vision care for children, routine dental care for children, mental health care, and substance abuse treatment; routine vision care for adults and routine dental care for adults will replace routine vision care and routine dental care, respectively.

In another enhancement unrelated to the ACA but relevant to current policy discussions, all establishment-level questionnaires will feature the following questions for employers who offer health insurance: "Did your organization offer health insurance to unmarried domestic partners of the same sex?" and "Did your organization offer health insurance to unmarried domestic partners of the opposite sex?"

For the household survey, enhancements are being explored to help ascertain whether insurance was purchased through an exchange, and if so, whether the insurance was subsidized. The initial proposals for questionnaire additions focus on three potential questions: (1) Is the coverage purchased through a state portal or insurance exchange? (2) Is there a monthly premium for the plan? and (3) Is the cost of the premium subsidized? Their specification have been informed by work done at the Census Bureau in Massachusetts, which has an insurance mandate similar to that being implemented in the ACA (see Pascale et al. 2013).

The implementation of health insurance exchanges in 2014 and other changes in the U.S. health care system due to the ACA have the potential to affect employer decisions about health insurance offerings and the behavior of individuals in signing up for insurance plans. Thus, it is critical that we ensure that the MEPS-Insurance and HC designs are optimized to permit the necessary evaluations of the effects of those changes. Employers may respond to the new laws in a variety of ways such as applying for tax credits, instituting vouchers for their employees, offering or discontinuing insurance coverage, instituting wellness programs that affect premiums, and varying employee contributions by wage or other characteristics. Households may also alter their decisions with respect to whether and how they sign up for insurance. As noted, the current MEPS-IC design provides estimates of employer decisions about health insurance offerings for periods both before and after full implementation of the ACA coverage provisions, both at the

national and state levels. The household survey also provides a solid framework for estimating the impact of the act on individual's and family's behavior. To further enhance the analytic capacity of this part of the survey, design research efforts are underway to assess the costs and benefits of the inclusion of a longitudinal arm to the MEPS-IC to permit time-dependent analyses of direct changes in employer behavior over time, and parallel assessment efforts are underway to consider extending the longitudinal capacity of the HC.

As a consequence of its representativeness, scope, content, and breadth, the MEPS is well positioned to continue to serve as a vital resource to inform provisions of the ACA. Its capacity to measure the impact of changes in health insurance coverage on access to care, service utilization, and related expenditures, health outcomes, and quality coincides with several evaluative needs of the ACA legislation. Ongoing enhancements to the MEPS in these areas will continue to help optimize its alignment with departmental, national, and state-specific needs.

Authors' Note

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