SESSION V:

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The Agency for Healthcare Research and Quality is part of the Department of Health and Human Services and is also responsible for the Medical Expenditure Panel Survey (MEPS) which I will talk about more during my talk. I was here for most of yesterday and before I begin talking about the paper I am summarizing I want to relate this work to some of the things that were discussed yesterday. You heard how controversial this topic is among the policy experts. You heard about the controversy and the lack of consensus in the U.S. surrounding the inclusion of health care needs into poverty measures. Why is it so controversial? Well, today's newspaper explains the issue; the number of uninsured in this country is growing and there are now 43.6 million people without health insurance coverage in this country, according to the latest estimates from the Census Bureau. This is one of the major policy issues in the U.S. In addition to people who are uninsured there are also people who are underinsured, that is, their insurance coverage is not very complete.

We have imperfect markets to purchase health insurance. Some people who are uninsured and would like to purchase a policy cannot find one in the non-group market. Insurance companies may turn them down because of pre-existing health conditions. As the newspaper said today, workers are increasingly turning down health insurance coverage from their employers because it is not affordable. Although public insurance comes in, our public insurance programs don't necessarily cover everyone who is in need. Among Medicaid and SCHIP there are a number of people who are eligible who do not enroll in the programs, partly because some of them are ignorant of their eligibility. There is also some stigma attached to these programs. So we have public policy failure and market failure surrounding this issue.

The issue of people without health insurance coverage is high on the political agenda. As a result of this inequity in access to affordable health insurance coverage it is very clear there are also inequities in the access to care and needed health services with resulting health disparities. Research has documented this. So, this is reason why in the United States we continue to argue about how to incorporate health care needs into poverty measures. We don't want to mask this public policy problem with a poverty

measure that fails to account for health care needs. On the other hand we don't want to manipulate the measure to do something unreasonable.

In some other countries lack of health insurance for a large segment of the population is not the primary health policy issue. Therefore, different poverty measurement issues may be more important in other countries. In countries where there is universal health insurance, for example, there is less concern about measuring health care needs. Colleagues from the U.K. and from Canada were asking questions about the non-medical care needs of disabled persons. That's an important issue. But in the U.S. we continue to focus on the best ways of incorporating medical care needs into poverty measures because of the large number of uninsured in our country. We have not yet moved on to other issues such as the non-medical care needs of the disabled that might put them into poverty. In Latin America there may be other important policy issues that differ from the U.S. focus on unevenness in access to insurance coverage. For example, significant inequities in income will complicate how best to measure medical care spending and spending on other basic needs in order to determine the minimum thresholds that can be used to define the poverty line. Income disparities can complicate issues of poverty measurement. So, it is important to put poverty measurement into a broader context before I begin to talk about my own paper.

The paper I am presenting was co-authored with Kathy Short from the Census Bureau and Thesia Garner from the Bureau of Labor Statistics. We look at different ways of incorporating health care into poverty measurement, specifically incorporating them into the thresholds as basic needs. Health care is certainly a basic need, but it is slightly different from food, shelter and clothing, because of the greater variation in needs, the greater uncertainty surrounding health care needs, and also because of the imperfect markets that exist for health insurance.

First, a quick review the National Academies of Sciences (NAS) recommendation which many of you heard yesterday. The NAS suggested subtracting MOOP from income. They make no adjustments to the thresholds and their methodology for subtracting medical out of pocket expenditures retains the skewed distribution. When you follow the NAS method they assume that reported levels of medical care are appropriate. They use age, race, family size, income and insurance status in their

imputation method. The ultimate poverty measures thus differ by the list of variables included in this step. The NAS method may misclassify people who consume less care than appropriate levels of medical care such as the uninsured, obviously. Some of the other policy relevant groups who may be misclassified by the NAS poverty measure include Hispanics, immigrants and non-working persons, because many of them are uninsured.

I just wanted to make a brief mention about the use of race in the imputation method. When you use race in the NAS imputation model you are implicitly defining race specific poverty measures. I don't believe the NAS intended to do that. It is easy to correct for this issue. Researchers can use as many variables as necessary to fit the model, including race and ethnicity. When the model is used to project or assign medical spending to the population, then it is advisable to use population averages for variables such as race and ethnicity. In this way racial differences are averaged out and final imputed levels of medical care spending are not specific to racial or ethnic categories.

In this paper we examine an alternative way of incorporating medical care needs into poverty measures. We add medical care out of pocket spending (MOOP) to poverty thresholds. Whether you subtract MOOP from income or add it to thresholds is conceptually equivalent. The differences lay in the imputation method. I should add that in the U.S. we use several sources of survey data to measure poverty. We always have to impute medical out of pocket spending to the Current Population Survey (CPS) which does not collect it directly. We must use other data sources to impute or match medical out of pocket spending to the CPS. When MOOP is added to thresholds, this allows you to produce what Gary Burtless calls "reasonable levels of medical out of pocket spending" and that's what we are trying to do in this paper.

I am not going to go into our methods in great detail but we followed the methods recommended by the NAS except for the subtraction of medical care from income. These methods are complicated; the first step requires you to identify a reference family which must be families consisting of two adults and two children and then adjust measures for every other type of family. In this paper we actually combined three sources of data. Bill Passero talked extensively yesterday about the Consumer Expenditure survey, that is abbreviated here as CE. What I am introducing in this paper

is the MEPS, the Medical Expenditure Panel Survey.

We also make an explicit adjustment in levels of medical care needs for the uninsured. We don't assume that their level of spending is appropriate; we believe they under-consume medical care because of their lack of insurance. To correct for this under-consumption we replace their expenditures with those of similar privately insured families. Then at the end we compare poverty measures with and without the adjustment of medical expenditures for the uninsured.

When we assign medical out of pocket spending amounts to families in the CPS we make use of several classification variables. Both the CPS and the MEPS include self reported health status, recorded as excellent, very good, good, fair, or poor. In addition to health status, we use family size, age of household head, and health insurance status.

Briefly, the Medical Expenditure Panel Survey supports nationally representative estimates of the U.S. civilian, non-institutionalized population on health insurance coverage, use and expenditures on medical care services, sources of payment, health status, medical conditions, family composition, employment, income and more. If you are interested in more information you can find it on our web site: www.meps.ahrq.gov

I will talk about a few of the main results. In this slide we see the reference family, two adults and two children. Not many of these family types are uninsured, and so when we make an adjustment to their MOOP expenditures it's not very large. The two bars on the left show their MOOP expenditures without any adjustments for uninsured families; two bars on the right show the adjustment. This slide also illustrates the differences between means and medians. When it is necessary to define a reasonable level of medical out of pocket spending the estimate must have face value legitimacy. Means, which are standard in statistics, are influenced by the highly skewed nature of the distribution and result in very large numbers. So in some measures we experimented by using medians. Yesterday, Gary Burtless did not mention that in his analysis he used means throughout but only after he cut off the top 5% of the distribution in order to make the mean a more reasonable number. So there are various methods you can use, but it is tricky and depends on consensus and what looks reasonable. The unadjusted mean is

very high.

The next slide illustrates the size of our adjustment to uninsured families, which is actually considerable and it also illustrates the means and medians. Because of sample size we could only define family size as either one person or two or more. Anyone in fair or poor health was labeled "sick" while others were labeled "well". You can see how out of pocket expenditures vary by these variables.

The next slide doesn't have any adjustment for whether a family is uninsured because uninsured families as seen here actually consume very low levels of medical care. In this slide we've added an adjustment that accounts for increased out of pocket expenditures plus the out of pocket premiums they would have had to pay. The adjustment is quite large because premiums are very high and we are making the assumption they would have to pay 100% of the premium. In future work, we may explore different adjustments for the uninsured. As the slides reveal, estimated levels of medical out of pocket spending are always lower in the CE survey than in the MEPS. We are not really sure why that is but there is clearly a difference in the level of out of pocket spending between the two surveys.

I am going to skip the next slide which examines the aggregate level of imputed MOOP in our paper. I no longer think this is an important issue.

The next slide shows the six overall poverty rates that we computed based on six different poverty measures. The first bar shows the current official poverty rate and the second bar is the NAS measure. I will compare the second bar to the remaining six bars for the next three slides. Our methods don't make a huge difference in the overall poverty rate; they are all much higher than the official rate as we know. The last two bars on the right (median-A and mean-A) reflect the adjustments for the uninsured and they are higher than the NAS method.

What do these alternative measures mean for certain populations? When we look at children, you can see the last two bars on the right are higher than the NAS bar, reflecting the fact that there are still uninsured children in the U.S. despite the expansions of Medicaid and the SCHIP program. When you make an adjustment for the

uninsured, their poverty rates are slightly higher even than the NAS method.

Among the elderly there is not much difference across the various measures. Most of the elderly in the U.S. are insured so any adjustments for the uninsured do not affect them. Although they have problems with being underinsured we didn't make any adjustment for people who might have inadequate insurance coverage.

And then we focus on the uninsured. This group was not broken out separately in any of the results presented yesterday. We see here that they have very high poverty rates, no matter how it is calculated. This population consists of many unemployed persons, disabled, young adults, immigrants and Hispanics. They have very high poverty rate to begin with but when you make an adjustment for their lack of insurance the poverty rate soars to over 40% and that's very, very high. We also looked at persons in poor health and there was very little change, only a slight increase when we adjusted for lack of insurance. People in poor health often manage to find coverage one way or another, and are more likely to have coverage than people in good or better health. We also looked at the working disabled. They had a slight increase in poverty rates due to our adjustment.

In conclusion, I want to say that it does matter which method you use to impute medical out of pocket spending. The uninsured in the U.S. are a huge policy problem; they are at risk for experiencing catastrophic expenditures due to serious illness and the current poverty measure and the recommended NAS poverty measure does not identify them. The reason that we argue so much about this in the U.S. is because our poverty measures are meant to guide public policy. We know this is an important policy issue in the U.S., and we want a measure that helps our policy makers understand this problem better. Thank you.