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DETAILED METHODS FOR THE MEDICAL EXPENDITURE PANEL SURVEY

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Background

The Medical Expenditure Panel Survey (MEPS) is designed to provide nationally representative estimates of healthcare use, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population. MEPS is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS). MEPS comprises three component surveys: the Household Component (HC), the Medical Provider Component (MPC), and the Insurance Component (IC). The HC is the core survey of MEPS.

The MEPS HC, a nationally representative survey of the U.S. civilian noninstitutionalized population, collects medical expenditure data at both the person and household levels. The HC collects detailed data on demographic characteristics; health conditions; health status, including adult disability status as measured by activity limitations; use of medical care services; charges and payments; access to care; satisfaction with care; health insurance coverage; income; and employment.

The HC uses an overlapping panel design in which data are collected through a preliminary contact followed by a series of five rounds of interviews over a 2½-year period. Through the use of computer-assisted personal interviewing technology, data on medical expenditures and use for 2 calendar years are collected from each household. This series of data collection rounds is launched each year on a new sample of households to provide overlapping panels of survey data and, when combined with other ongoing panels, will provide continuous and current estimates of healthcare expenditures. Typically, the MEPS HC collects information for all people in the family responding unit by asking questions of the family respondent.

The sample of households selected for the MEPS HC is drawn from respondents to the National Health Interview Survey (NHIS), conducted by NCHS. NHIS provides a nationally representative sample of the U.S. civilian noninstitutionalized population, with oversampling of Hispanics and Blacks and Asians starting in 2006.

Each new MEPS panel includes some oversampling in the NHIS sample of population groups of particular analytic interest. Since 2010 (Panel 15), the set of MEPS sample domains has included oversamples of Asians, Blacks, and Hispanics. White and other race households have been subsampled at varying rates across the years.

Beginning with the panel that began in 2011 (Panel 16), a new sample domain was created by dividing what in prior years had been a single domain, the “white/other” domain, into two domains, one consisting of NHIS “partial completes,” the other of NHIS “completes.” The “partial completes” were sampled at a lower rate than the “completes.”

For more detailed information about MEPS and the information discussed here, refer to documentation for the MEPS 2002-2016 Full Year Consolidated Data Files, available at <http://www.meps.ahrq.gov>.

Time Period and Data

National healthcare estimates from MEPS for the *2018 National Healthcare Quality and Disparities Report* (QDR) were derived from the 2002-2016 MEPS HC survey, including the Self-Administered Questionnaire (SAQ), the Child Health and Preventive Care section, and the Diabetes Care Survey (DCS).

The SAQ is a supplement to the MEPS HC that includes healthcare quality measures taken from the health plan version of CAHPS® (Consumer Assessment of Healthcare Providers and Systems), an AHRQ-sponsored family of survey instruments designed to measure quality of care from the consumer’s perspective; general health questions; attitudes about health questions; and health status questions as measured by the SF-12 and the EuroQol 5D.

The Child Health and Preventive Care section is part of the regular MEPS HC interview. It includes healthcare quality measures taken from the health plan version of CAHPS®; Children with Special Health Care Needs (CSHCN) Screener questions; children’s general health status as measured by several questions from the General Health Subscale of the Child Health Questionnaire; Columbia Impairment Scale questions about possible child behavioral problems; and child preventive care questions. Researchers should note that the CAHPS® and CSHCN questions changed from a self-administered parent questionnaire in 2000 to an interviewer-administered questionnaire starting in 2001.

Another supplement to the MEPS HC, the DCS, is a self-administered questionnaire given to people identified with diabetes. It questions respondents about the care they received in the treatment of their diabetes.

Population Characteristics

Estimates derived from MEPS are presented at both an aggregate level and for select subpopulations. Characteristics used to define subpopulations include: age, gender, race, ethnicity, family income, education, employment status, health insurance, Medicaid/CHIP for people under age 65, residence location, language spoken at home/language spoken most often at home, perceived health status, adult disability status as measured by activity limitations, children with special health care needs, number of chronic conditions, and whether U.S. born.

Information for selected measures that require more detail include usual primary care provider, CAHPS® composite measure (adults and children), adults age 65 and over who received potentially inappropriate prescription medications in the calendar year, dental visit in the calendar year, opioid prescription fills, health literacy measures, obesity, and financial burden of healthcare costs and underinsurance.

A brief description of how each of these subpopulation characteristics and selected measures that require more detail was defined is provided below.

Subpopulation Characteristics

Age—With the exception of analytic variables associated with round-specific questions noted below, age was defined as a person’s age on December 31 of the data year.

For measures using analytic variables associated with round-specific questions (e.g., questions from the SAQ, the Child Health and Preventive Care supplement, and access-to-care measures), corresponding round-specific age variables were used to determine age.

Gender—Male or female.

Race—MEPS tables are shown starting with 2002 data, the year MEPS transitioned to the Office of Management and Budget (OMB) standards issued in 1997 for collecting racial and ethnic data. The new standards allow respondents to identify more than one racial group (<https://www.gpo.gov/fdsys/pkg/FR-1997-10-30/pdf/97-28653.pdf>). For all tables, race is classified into five single race categories and a multiple-race category, as follows: (1) White, (2) Black, (3) Asian, (4) Native Hawaiian or Other Pacific Islander, (5) American Indian or Alaska Native, and (6) multiple races. Because of differences in the classification of race, racial estimates reported using MEPS data from 2002 and subsequent years is not directly comparable with estimates that use data prior to 2002.

Ethnicity—Ethnicity was designated as either Hispanic or non-Hispanic. People of Hispanic origin may be of any race. Estimates were derived for both Hispanic and non-Hispanic subpopulations. In addition, race was combined with ethnicity to enable estimation of data for categories that include non-Hispanic White, non-Hispanic Black, and non-Hispanic other. For 2002 and later years, non-Hispanic White and non-Hispanic Black categories excluded multiple-race individuals; estimates are not directly comparable with data from previous years.

Family income—MEPS includes a five-level categorical variable for family income as a percentage of the federal poverty level (FPL). For construction of this variable, definitions of income, family, and poverty are taken from the poverty statistics developed by the Current Population Survey. For the purposes of analysis and reporting in the QDR, the near-poor and low-income categories were combined. This resulted in a four-level categorical variable of poverty status: (1) negative or poor refers to household incomes below the Federal poverty level (FPL); (2) near poor/low income, from the FPL to just below 200 percent of the FPL; (3) middle income, 200 percent to just below 400 percent of the FPL; and (4) high income, 400 percent or more of the FPL.

Education—The education variable was constructed only for people age 18 years and over, and any measure presented for the education subpopulations includes only people in this age group. Reporting of educational attainment is based on the number of completed years of education when they first entered MEPS. For the QDR, this measure was grouped into three categories: (1) less than high school refers to people with less than 12 completed years of education; (2) high school graduate, people with exactly 12 completed years of education; and (3) at least some college, people with greater than 12 completed years of education. A different education question was asked in 2012-2014 and was used to produce estimates for the same three categories.

Employment status—MEPS includes four-level round-specific categorical variables for employment status for people age 16 years and over. For the MEPS tables, employment status variables were set for adults ages 18-64. For the QDR, employment status was grouped into two categories: Employed, which refers to adults who were (1) currently employed, (2) had a job to return to, or (3) had a job but did not work during the reference period; and Not employed.

Health insurance—Health insurance coverage was constructed in a hierarchical manner and in relation to a person's age. For the population under age 65, those who were uninsured for the entire year were classified as "uninsured"; those who had any private coverage at any time during the year (including TRICARE/CHAMPVA) were

classified as having “private insurance”; and those who had only public coverage (i.e., no private) at any time during the year were classified as “public only.”

The population age 65 and over was classified as “Medicare only,” “Medicare and private,” or “Medicare and other public assistance.” A small number of people age 65 and over were found to only have private insurance or to be uninsured. This residual group is not shown in the tables.

Medicaid/CHIP for people under age 65—The Medicaid coverage variable was constructed in a hierarchical manner based on yearly and monthly insurance variables for people under age 65. First, if a person had any Medicaid or CHIP coverage for at least 1 month, the person was classified as “Any Medicaid/CHIP.” If a person did not have any coverage in any month, the person was classified as “Uninsured all year.” If a person did not have Medicaid in any month but had other insurance in at least 1 month, the person was classified as “Other non-Medicaid/CHIP.”

Two additional subcategories were defined for people with Medicaid/CHIP coverage. “Only Medicaid/CHIP” included people with Medicaid/CHIP only, with no evidence of other types of insurance. “Medicaid/CHIP with other” included people who also had other types of insurance.

People with “Only Medicaid/CHIP” were further grouped into “full year” or “part year.” Full-year coverage included people whose number of months with Medicaid coverage was the same as with any type of coverage. Part-year coverage included people whose total coverage months were more than Medicaid/CHIP coverage.

Residence location—The MEPS tables in the 2018 QDR used the 2013 NCHS Urban-Rural Classification Scheme for Counties (URCSC) for the 2016 data and the 2006 NCHS URCSC for 2002-2015 data. Before the 2018 QDR, the 2006 NCHS URCSC was used for all years’ data.

The 2013 NCHS URCSC is based on the Office of Management and Budget’s (OMB) February 2013 delineation of metropolitan statistical areas (MSAs) and micropolitan statistical areas (MISAs) (derived according to the 2010 OMB standards for defining these areas) and Vintage 2012 postcensal estimates of the resident U.S. population;

The 2006 NCHS URCSC is based on OMB’s December 2005 delineation of MSAs and MISAs (derived according to the 2000 OMB standards for defining these areas) and Vintage 2004 postcensal estimates of the resident U.S. population).

The urban-rural categories are:

1. Large central metro (“central” counties of metropolitan area of 1 million or more population).
2. Large fringe metro (“fringe” counties of a metropolitan area of 1 million or more population).
3. Medium metro (counties in metropolitan areas of 250,000 to 999,999 population).
4. Small metro (counties in metropolitan areas of 50,000 to 249,999 population).
5. Micropolitan (counties with at least one urban cluster of at least 10,000 residents).
6. Noncore (counties without an urban cluster of at least 10,000 residents).

More information is available at http://www.cdc.gov/nchs/data_access/urban_rural.htm.

Language spoken at home/language spoken most often at home—From 2002 to 2013, families were asked what language was spoken in their home most of the time, with the categories English, Spanish, and Other. The categories were collapsed into two options: English; and Other (includes Spanish and Other).

In 2014, the questionnaire changed and families were asked whether anyone age 5 and above in their family spoke a language other than English at home. The two categories with this question are: Speak only English; and Speak language other than English. Therefore, only data beginning in 2014 are shown in the QDR tables since they are not comparable with data in previous years.

Perceived health status—MEPS includes five-level round-specific categorical variables for perceived health status; these categories are “excellent,” “very good,” “good,” “fair,” and “poor.” For purposes of analyzing data in the QDR, these five levels were collapsed into two: (1) excellent, very good, or good; and (2) fair or poor.

Adult disability status as measured by activity limitations—The MEPS disability measures used in the 2018 QDR are for adults and have been used in the QDR (and previously, the separate healthcare quality and healthcare disparities reports) since 2007. They were based on the work of an interagency Disability Working Group (DWG) convened by AHRQ whose purpose was to develop cross-survey comparable measures of disability to use with existing data of surveys included in the QDR (and previous iterations).

For the purposes of the QDR, adults with disabilities are defined as those with physical, sensory, and/or mental health conditions that can be associated with a decrease in functioning in such day-to-day activities as bathing, walking, doing everyday chores, and/or engaging in work or social activities.

The DWG recommended using paired measures in displaying disability data for adults to preserve the qualitative aspects of the data. The first measure, limitations in *basic activities*, represents problems with mobility and other basic functioning at the person level. The second measure, limitations in *complex activities*, represents limitations encountered when the person, in interaction with his or her environment, attempts to participate in community life.

Limitations in *Basic activities* include problems with mobility; self-care (activities of daily living); domestic life (instrumental activities of daily living); and activities dependent on sensory functioning (limited to people who are blind or deaf). Limitations in *Complex activities* include limitations experienced in work; and in community, social, and civic life. These two categories are not mutually exclusive; people may have limitations in basic activities *and* in complex activities. The residual category *neither* includes adults with neither basic nor complex activity limitations.

Children with special health care needs—The Child Health and Preventive Care section identifies children with special health care needs (CSHCN) based on the CSHCN Screener instrument developed through a national collaborative process as part of the Child and Adolescent Health Measurement Initiative under the coordination of the Foundation for Accountability. Children whose “special health care needs” status could not be determined were coded as “unknown.” Data for individuals classified as “unknown” are not shown in the QDR tables.

Number of chronic conditions—A person-level count was constructed for the number of chronic conditions reported for an office-based provider visit, a hospital outpatient visit, a hospital inpatient visit, an emergency room visit, a prescription, or a home health visit. The list of chronic conditions was developed by a working group on multiple chronic conditions of the Office of the Assistant Secretary for Health in the Department of Health and Human Services. Twenty chronic conditions were searched for: hypertension, hyperlipidemia, congestive heart failure, coronary artery disease, diabetes, stroke, cardiac arrhythmias, arthritis, cancer, depression, dementia, substance abuse disorders (drug and alcohol), chronic obstructive pulmonary disease, asthma, chronic kidney disease, HIV, hepatitis, autism spectrum disorder, schizophrenia, and osteoporosis (Goodman, 2013).

Whether U.S. born—The Access to Care section ascertains whether a person was born in the United States. This question was previously asked only if a language other than English was spoken in the home and only of those people uncomfortable speaking English. Beginning in 2007, the question is asked of all family members regardless of the language most often spoken in the home and regardless of whether all family members are comfortable speaking English. Therefore, only data beginning in 2007 are shown in the QDR tables.

Selected Measures That Require More Detail

Usual primary care provider—People are considered to have a usual primary care provider if they have a usual source of care not located in a hospital emergency room, to which they go for new health problems; preventive health care such as general checkups, examinations, and immunizations; and referrals to other professionals when needed.

CAHPS® composite measure (adults and children)—This measure identified people who had a doctor's office or clinic visit in the last 12 months whose health providers listened carefully, explained things clearly, showed respect for what they had to say, and spent enough time with them. For adults (children) who had a doctor's office or clinic visit in the last 12 months, percent distribution was determined of how often the response categories of Always, Usually, and Sometimes or Never were selected for the four CAHPS questions asking about health providers (1) listening carefully; (2) explaining things clearly; (3) showing respect for what they had to say; and (4) spending enough time with them. For example, if a person responded "Always" for each of the four questions, the composite measure would be 100% for Always, 0% for Usually, and 0% for Sometimes or Never. If a person did not complete all four questions, the percentage estimates were weighted by the percentage of the four questions that were completed.

Adults age 65 and over who received potentially inappropriate prescription medications in the calendar year—Prescription medications received includes all prescribed medications initially purchased or otherwise obtained during the calendar year, as well as any refills. Inappropriate medications are defined by the implementation of the Beers criteria in MEPS (Zahn, et al., 2001). According to this definition, the 11 drugs that should always be avoided for older patients include barbiturates, flurazepam, meprobamate, chlorpropamide, meperidine, pentazocine, trimethobenzamide, belladonna alkaloids, dicyclomine, hyoscyamine, and propantheline. The 22 drugs that should often be avoided for older patients include carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, methocarbamol, amitriptyline, chlorthalidone, diazepam, doxepin, indomethacin, dipyridamol, ticlopidine, methyl dopa, reserpine,

disopyramide, oxybutynin, chlorpheniramine, cyproheptadine, diphenhydramine, hydroxyzine, promethazine, and propoxyphene.

Dental visit in the calendar year—This measure refers to care by or visits in the calendar year to any type of dental care provider, including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists. This measure is consistent with but not exactly the same as the Healthy People 2020 Oral Health Objective OH-7, “Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year.” For example, Healthy People 2020 (HP2020) objective OH-7 includes people age 2 and over and the estimates are age adjusted. The QDR measure includes children ages 2-17 and adults age 18 and over, and the estimates are not age adjusted. Information and data for OH-7 are available at <https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health/objectives>.

Any preventive dental service in the calendar year—This measure includes preventive dental services in the calendar year during care by or visits to any type of dental care provider. Preventive dental service includes cleanings, fluoride, sealants, and periodontal recall visits. This measure is consistent with but not exactly the same as the *Healthy People 2020* Oral Health Objective OH-8 “Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year.” For example, OH-8 includes people ages 2-18 at or below 200 percent of the Federal poverty level. The QDR measure for children is for all people ages 2-17 and the measure for adults is for all people age 65 and over. Information and data for OH-8 are available at <https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health/objectives>.

Opioid prescription fills—This measure includes outpatient prescription fills of opioids commonly used to treat pain. These opioids are identified using generic drug names for narcotic analgesics and narcotic analgesic combinations in the Multum Lexicon database from Cerner Multum, Inc. We identify slightly more opioids commonly used for pain than one would find in the MEPS public use files due to methods used to preserve the confidentiality of sample members. Opioids excluded from our analysis include respiratory agents, antitussives, and drugs commonly used in medication-assisted treatment.

We examine the percentage of adults who filled an outpatient opioid prescription in the calendar year and the percentage of adults who filled four or more outpatient opioid prescriptions in the calendar year. The definition of opioid prescription is the same as the one used in MEPS Statistical Brief 515, *Any Use and Frequent Use of Opioids*

Among Elderly Adults in 2015–2016, by Socioeconomic Characteristics (https://meps.ahrq.gov/data_files/publications/st515/stat515.shtml), and MEPS Statistical Brief 516, *Any Use and Frequent Use of Opioids Among Non-Elderly Adults in 2015–2016, by Socioeconomic Characteristics* (https://meps.ahrq.gov/data_files/publications/st516/stat516.shtml). The differences are that the statistical briefs used pooled 2015-2016 data and stratified by elderly adults and nonelderly adults. This measure used 1-year data from 2103-2016 and includes adults age 18 and over.

Health literacy measures—The three measures are:

- Adults who had a doctor’s office or clinic visit in the last 12 months whose health providers always gave them easy-to-understand instructions about what to do for a specific illness or health condition,
- Adults who had a doctor’s office or clinic visit in the last 12 months whose health providers always asked them to describe how they will follow the instructions, and
- Adults who had a doctor’s office or clinic visit in the last 12 months whose health providers’ office always offered help in filling out a form.

The denominator includes adults who reported going to a doctor’s office or clinic in the last 12 months and were given instructions about their illness or health condition or had to fill out forms, excluding missing data. The possible answer categories were Never, Sometimes, Usually, and Always.

These measures refer to the health literate care received by those who had a doctor’s office or clinic visit in the last 12 months and were given instructions about what to do for a specific illness or health condition or those who had a doctor’s office or clinic visit in the last 12 months and had to fill out forms. These measures are consistent with HP2020 objectives HC/HIT 1.1 HC/HIT 1.2, and HC/HIT 1.3, respectively. Information and data for these HP2020 objectives are available at <https://www.healthypeople.gov/2020/topics-objectives/topic/health-communication-and-health-information-technology/objectives>.

Obesity—The obesity measures are:

- Adults with obesity who ever received advice from a health professional to exercise more,
- Adults with obesity who did not spend half an hour or more in moderate or vigorous physical activity at least five times a week, and

- Adults with obesity who ever received advice from a health professional about eating fewer high-fat or high cholesterol foods.

The measures exclude pregnant women from the denominator. Pregnant women were identified using CCCODEX codes $177 \leq \text{CCODEX} \leq 196$ in rounds 5/3 in the Medical Conditions file for data years 2002-2015. For the 2016 data year, pregnant women were identified using the PREGNT53 variable.

Financial burden of healthcare costs and underinsurance—Financial burden of healthcare costs and underinsurance are defined for people under age 65. Financial burden of healthcare costs is defined as a person’s family-level out-of-pocket health insurance premiums and medical expenditures being greater than 10 percent of total family income. Underinsurance is defined for people with private insurance as a person’s family-level out-of-pocket medical expenditures (excluding premiums) being greater than 10 percent of total family income (Bernard & Banthin, 2007).

The following family-level variables are defined for these measures:

Family. The definition of family is based on the MEPS health insurance eligibility unit (HIEU), which includes all members of the family who would typically be covered under a private insurance family plan. HIEUs include adults, their spouses, and their unmarried natural/adoptive children under age 18 and children under age 24 who are full-time students.

Nonelderly families include families in which at least one person is under age 65. In these cases, family-level expenditures include the expenditures for the elderly person as well. Elderly families in which all people are age 65 years or above are not included in this analysis.

Out-of-pocket expenditures on healthcare services. Out-of-pocket expenses include all out-of-pocket payments for deductibles, coinsurance, copayments, and payments for any noncovered services and supplies. Using the HIEU definition of family unit, we add out-of-pocket expenditures on healthcare services across all members of the family to calculate family-level out-of-pocket expenditures on healthcare services.

Out-of-pocket expenditures on health insurance premiums. MEPS collects out-of-pocket expenditures on premiums for private health insurance from household respondents. We add private out-of-pocket premium costs and (imputed) Medicare Part B premiums across all health insurance policies covering family members. For example, if there are two single policies covering the two adults of a childless couple unit, we add these together. Premiums are prorated to account for the number of months of coverage

during the year. For employer-sponsored group coverage, employer contributions toward premiums are not included in this analysis.

Person-level insurance status. Results are reported by individual health insurance status, which is defined hierarchically for the categories below:

- Private, employer sponsored: people who had at least 1 month of employer-sponsored insurance and no uninsured months in the year.
- Private, nongroup: people who had least 1 month of nongroup private insurance and no uninsured months in the year.
- Public only: people who had public insurance only for all available months in MEPS during the year.
- Part-year uninsured: people whose number of uninsured months is less than the number of available months in MEPS during the year.
- Full-year uninsured: people whose number of uninsured months is equal to the number of available months in MEPS during the year.

Total family income. Total family income is the sum of person-level pretax total income, refund income, and sales income.

Round-specific variables—For analytic data collected during specific rounds, age and other population variables were also defined using the round-specific variables. In some cases, missing values were replaced with the value from the closest prior round.

MEPS Estimates

MEPS estimates were generated for each year for 2002-2015, when appropriate. Standard errors of the estimates were provided to permit an assessment of sampling variability. All estimates and standard errors were derived using SUDAAN statistical software, which accounts for the complex survey design of MEPS.

All estimated proportions and ratios are weighted to reflect the experiences of the U.S. civilian noninstitutionalized population at the aggregate and subpopulation levels. Person-level weights, specific to the SAQ and DCS, were used for measures derived with data from these supplements. For other person-level measures, including those from the Child Health and Preventive Care section, the overall person-level weight was used. In analyzing data from the Child Health and Preventive Care section, the full file should be used subset to those cases eligible for this section. More information about these weights is available from the MEPS website: <http://www.meps.ahrq.gov>.

In analyzing data from the DCS, a “diabetes pseudo-weight” was used with the file subset to cases where the original DCS weight is positive in order to produce the same variance estimates using different statistical software. The “diabetes pseudo-weight” was defined to equal the diabetes weight when the diabetes weight is positive, to equal 1 when the diabetes weight is zero and the SAQ weight is positive; and is set as undefined when the SAQ weight is zero.

Some MEPS measures were age adjusted to the 2000 U.S. standard population. Among the measures that are age adjusted are the following pertaining to:

- Diabetes.
- Asthma.
- Adult current smokers.
- Adults with obesity.

Measures pertaining to children were not age adjusted. Table 1 lists measures that are age adjusted in the 2017 QDR and provides information about the age groups used for adjustment.

Table 1. Age-adjusted measures in the 2017 National Health Care Quality Report and National Health Care Disparities Report

Measure Title	Age Groups Used in Adjustment (Years)
Composite measure: Adults age 40 and over with diagnosed diabetes who received all four recommended services for diabetes in the calendar year (2 or more hemoglobin A1c measurements, dilated eye examination, foot examination, and flu vaccination)	40-59, 60+
Adults age 40 and over with diagnosed diabetes who received 2 or more hemoglobin A1c measurements in the calendar year	40-59, 60+
Adults age 40 and over with diagnosed diabetes who received a dilated eye examination in the calendar year	40-59, 60+
Adults age 40 and over with diagnosed diabetes who had their feet checked for sores or irritation in the calendar year	40-59, 60+
Adults age 40 and over with diagnosed diabetes who received a flu vaccination in the calendar year	40-59, 60+
People with current asthma who are now taking preventive medicine daily or almost daily (either oral or inhaler)	0-17, 18-44, 45-64, 65+
Adult current smokers with a checkup in the last 12 months who received advice to quit smoking	18-44, 45-64, 65+
Adults with obesity who ever received advice from a health professional to exercise more	18-44, 45-64, 65+

Measure Title	Age Groups Used in Adjustment (Years)
Adults with obesity who ever received advice from a health professional about eating fewer high-fat or high-cholesterol foods	18-44, 45-64, 65+
Adults with obesity who do not now spend half an hour or more in moderate or vigorous physical activity at least five times a week	18-44, 45-64, 65+

Tables containing estimates from MEPS are available from the Data Query Tool on the National Healthcare Quality and Disparities Reports' website at <https://nhqrnet.ahrq.gov/inhqrdr/>. Consistent with the established criteria for data reporting in the QDR (and NHQR and NHDR), MEPS estimates in the tables are suppressed when they are based on sample sizes of fewer than 100 or when their relative standard errors are 30% or more. In the tables, the cell value of these estimates is replaced with the notation DSU (data statistically unreliable). Records in which analytic variables have missing values were excluded for most analysis.

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