

**MEPS HC-188B:
2016 Dental Visits
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**Agency for Healthcare Research and Quality
Center for Financing, Access, and Cost Trends
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A. Data Use Agreement

Individual identifiers have been removed from the micro-data contained in these files. Nevertheless, under sections 308 (d) and 903 (c) of the Public Health Service Act (42 U.S.C. 242m and 42 U.S.C. 299 a-1), data collected by the Agency for Healthcare Research and Quality (AHRQ) and/or the National Center for Health Statistics (NCHS) may not be used for any purpose other than for the purpose for which they were supplied; any effort to determine the identity of any reported cases is prohibited by law.

Therefore in accordance with the above referenced Federal Statute, it is understood that:

1. No one is to use the data in this data set in any way except for statistical reporting and analysis; and
2. If the identity of any person or establishment should be discovered inadvertently, then (a) no use will be made of this knowledge, (b) the Director Office of Management AHRQ will be advised of this incident, (c) the information that would identify any individual or establishment will be safeguarded or destroyed, as requested by AHRQ, and (d) no one else will be informed of the discovered identity; and
3. No one will attempt to link this data set with individually identifiable records from any data sets other than the Medical Expenditure Panel Survey or the National Health Interview Survey. Furthermore, linkage of the Medical Expenditure Panel Survey and the National Health Interview Survey may not occur outside the AHRQ Data Center, NCHS Research Data Center (RDC) or the U.S. Census RDC network.

By using these data you signify your agreement to comply with the above stated statutorily based requirements with the knowledge that deliberately making a false statement in any matter within the jurisdiction of any department or agency of the Federal Government violates Title 18 part 1 Chapter 47 Section 1001 and is punishable by a fine of up to \$10,000 or up to 5 years in prison.

The Agency for Healthcare Research and Quality requests that users cite AHRQ and the Medical Expenditure Panel Survey as the data source in any publications or research based upon these data.

B. Background

1.0 Household Component

The Medical Expenditure Panel Survey (MEPS) provides nationally representative estimates of health care use, expenditures, sources of payment, and health insurance coverage for the U.S. civilian noninstitutionalized population. The MEPS Household Component (HC) also provides estimates of respondents' health status, demographic and socio-economic characteristics, employment, access to care, and satisfaction with health care. Estimates can be produced for individuals, families, and selected population subgroups. The panel design of the survey, which includes 5 Rounds of interviews covering 2 full calendar years, provides data for examining person level changes in selected variables such as expenditures, health insurance coverage, and health status. Using computer assisted personal interviewing (CAPI) technology, information about each household member is collected, and the survey builds on this information from interview to interview. All data for a sampled household are reported by a single household respondent.

The MEPS-HC was initiated in 1996. Each year a new panel of sample households is selected. Because the data collected are comparable to those from earlier medical expenditure surveys conducted in 1977 and 1987, it is possible to analyze long-term trends. Each annual MEPS-HC sample size is about 15,000 households. Data can be analyzed at either the person or event level. Data must be weighted to produce national estimates.

The set of households selected for each panel of the MEPS HC is a subsample of households participating in the previous year's National Health Interview Survey (NHIS) conducted by the National Center for Health Statistics. The NHIS sampling frame provides a nationally representative sample of the U.S. civilian noninstitutionalized population and reflects an oversample of Blacks and Hispanics. In 2006, the NHIS implemented a new sample design, which included Asian persons in addition to households with Black and Hispanic persons in the oversampling of minority populations. The linkage of the MEPS to the previous year's NHIS provides additional data for longitudinal analytic purposes.

2.0 Medical Provider Component

Upon completion of the household CAPI interview and obtaining permission from the household survey respondents, a sample of medical providers are contacted by telephone to obtain information that household respondents cannot accurately provide. This part of the MEPS is called the Medical Provider Component (MPC) and information is collected on dates of visits, diagnosis and procedure codes, charges and payments. The Pharmacy Component (PC), a subcomponent of the MPC, does not collect charges or diagnosis and procedure codes but does collect drug detail information, including National Drug Code (NDC) and medicine name, as well as date filled and sources and amounts of payment. The MPC is not designed to yield national estimates. It is primarily used as an imputation source to supplement/replace household reported expenditure information.

3.0 Survey Management and Data Collection

MEPS HC and MPC data are collected under the authority of the Public Health Service Act. Data are collected under contract with Westat, Inc. (MEPS HC) and Research Triangle Institute (MEPS MPC). Data sets and summary statistics are edited and published in accordance with the confidentiality provisions of the Public Health Service Act and the Privacy Act. The National Center for Health Statistics (NCHS) provides consultation and technical assistance.

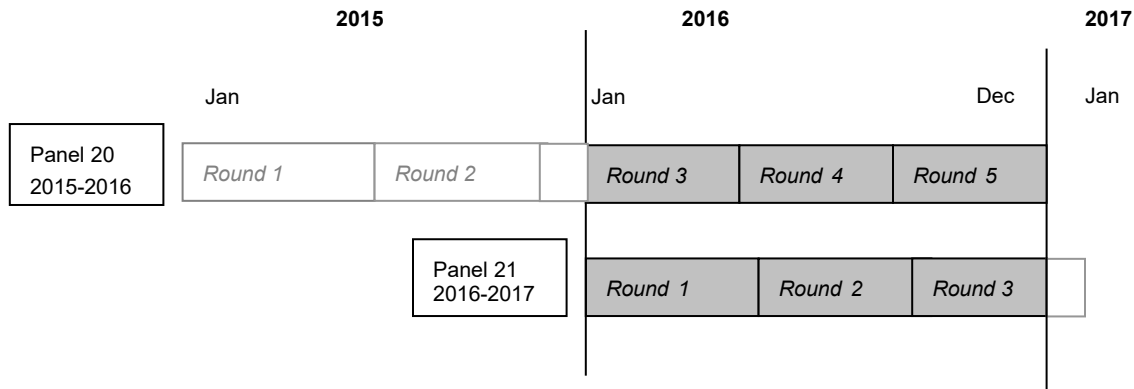
As soon as data collection and editing are completed, the MEPS survey data are released to the public in staged releases of summary reports, micro data files, and tables via the [MEPS website](#). Selected data can be analyzed through MEPSnet, an on-line interactive tool designed to give data users the capability to statistically analyze MEPS data in a menu-driven environment.

Additional information on MEPS is available from the MEPS project manager or the MEPS public use data manager at the Center for Financing, Access, and Cost Trends, Agency for Healthcare Research and Quality, 5600 Fishers Lane, Rockville, MD 20857 (301-427-1406).

C. Technical and Programming Information

1.0 General Information

This documentation describes one in a series of public use event files from the 2016 Medical Expenditure Panel Survey (MEPS) Household Component (HC). Released as an ASCII data file (with related SAS, SPSS, and Stata programming statements) and a SAS transport file, the 2016 Dental public use file provides detailed information on dental events for a nationally representative sample of the civilian noninstitutionalized population of the United States. Data from the Dental file can be used to make estimates of dental event utilization and expenditures for calendar year 2016. The file contains 76 variables and has a logical record length of 289 with an additional 2-byte carriage return/line feed at the end of each record. As illustrated below, this file consists of MEPS survey data obtained in the 2016 portion of Round 3 and Rounds 4 and 5 for Panel 20, as well as Rounds 1, 2 and the 2016 portion of Round 3 for Panel 21 (i.e., the rounds for the MEPS panels covering calendar year 2016).



Each record on this event file represents a unique dental event; that is, a dental event reported by the household respondent. Counts of dental event utilization are based entirely on household reports. Dental events were not included in the Medical Provider Component (MPC); therefore, all expenditure and payment data on the Dental event file are reported by the household.

Data from this event file can be merged with other 2016 MEPS HC data files for the purposes of appending person-level data such as demographic characteristics or health insurance coverage to each dental record.

This file can also be used to construct summary variables of expenditures, sources of payment, and related aspects of the dental event. Aggregate annual person-level information on the use of dental events and other health services is provided on the MEPS 2016 Full Year Consolidated Data File where each record represents a MEPS sampled person.

This document offers a brief overview of the types and levels of data provided, and the content and structure of the file and the codebook. It contains the following sections:

Data File Information
Sample Weight
Strategies for Estimation
Merging/Linking MEPS Data Files
References
Variable - Source Crosswalk

For more information on MEPS HC survey design, see T. Ezzati-Rice, et al. (1998-2007) and S. Cohen (1996). A copy of the MEPS HC survey instrument used to collect the information on the Dental file is available on the [MEPS website](#).

2.0 Data File Information

The 2016 Dental public use data set consists of one event-level data file. The file contains characteristics associated with the dental event and imputed expenditure data.

The 2016 Dental public use data set contains 27,306 dental event records; of these records, 26,873 are associated with persons having a positive person-level weight (PERWT16F). This file includes dental event (DV) records for all household members who resided in eligible responding households and reported at least one dental event. Each record represents one household-reported dental event that occurred during calendar year 2016. Dental visits known to have occurred before January 1, 2016 and after December 31, 2016 are not included on this file. Some household members may have multiple dental events and thus will be represented in multiple records on this file. Other household members may have had reported no dental events and thus will have no records on this file. These data were collected during the 2016 portion of Round 3, and Rounds 4 and 5 for Panel 20, as well as Rounds 1, 2, and the 2016 portion of Round 3 for Panel 21 of the MEPS HC. The persons represented on this file had to meet either (a) or (b) below:

- a) Be classified as a key in-scope person who responded for his or her entire period of 2016 eligibility (i.e., persons with a positive 2016 full-year person-level weight (PERWT16F > 0)), or
- b) Be an eligible member of a family all of whose key in-scope members have a positive person-level weight (PERWT16F > 0). (Such a family consists of all persons with the same value for FAMIDYR.) That is, the person must have a positive full-year family-level weight (FAMWT16F > 0). Note that FAMIDYR and FAMWT16F are variables on the 2016 Full Year Consolidated Data File.

Persons with no dental events for 2016 are not included on this event-level DV file but are represented on the person-level 2016 Full Year Population Characteristics file.

Each dental event record includes the following: date of the dental event; type of provider seen; procedure(s) associated with the dental event; whether or not medicines were prescribed; flat fee information; imputed sources of payment; total payment and total charge of the dental event expenditure; and a full-year person-level weight.

To append person-level information such as demographic or health insurance coverage to each event record, data from this file can be merged with 2016 MEPS HC person-level data (e.g. Full Year Consolidated or Full Year Population Characteristics files) using the person identifier, DUPERSID. Dental events can also be linked to the MEPS 2016 Prescribed Medicines File. Please see Section 5.0 or the 2016 Appendix for details on how to merge MEPS data files.

2.1 Codebook Structure

For most variables on the Dental event file, both weighted and unweighted frequencies are provided in the accompanying codebook. The exceptions to this are weight variables and variance estimation variables. Only unweighted frequencies of these variables are included in the accompanying codebook file. See the Weights Variables list in Section D, Variable-Source Crosswalk.

The codebook and data file sequence list variables in the following order:

- Unique person identifier
- Unique dental event identifier
- Dental characteristic variables
- Imputed expenditure variables
- Weight and variance estimation variables

Note that the person identifier is unique within this data year.

2.2 Reserved Codes

The following reserved code values are used:

Value	Definition
-1 INAPPLICABLE	Question was not asked due to skip pattern
-7 REFUSED	Question was asked and respondent refused to answer question
-8 DK	Question was asked and respondent did not know answer
-9 NOT ASCERTAINED	Interviewer did not record the data

Generally, values of -1, -7, -8, and -9 for non-expenditure variables have not been edited on this file. The values of -1 and -9 can be edited by the data users/analysts by following the skip patterns in the [HC survey questionnaire](#) located on the MEPS website.

2.3 Codebook Format

The codebook describes an ASCII data set (although the data are also being provided in a SAS transport file).

The following codebook items are provided for each variable:

Identifier	Description
Name	Variable name (maximum of 8 characters)
Description	Variable descriptor (maximum of 40 characters)
Format	Number of bytes
Type	Type of data: numeric (indicated by NUM) or character (indicated by CHAR)
Start	Beginning column position of variable in record
End	Ending column position of variable in record

2.4 Variable Source and Naming Conventions

In general, variable names reflect the content of the variable, with an eight-character limitation. All imputed/edited variables end with an “X”.

2.4.1 Variable - Source Crosswalk

Variables were derived from the HC survey questionnaire or from the CAPI. The source of each variable is identified in Section D Variable-Source Crosswalk in one of four ways:

1. Variables derived from CAPI or assigned in sampling are so indicated as “CAPI derived” or “Assigned in sampling,” respectively;
2. Variables which come from one or more specific questions have those questionnaire sections and question numbers indicated in the “Source” column; questionnaire sections are identified as:
 - FF - Flat Fee section
 - DN - Dental Event section
 - CP - Charge Payment section
3. Variables constructed from multiple questions using complex algorithms are labeled “Constructed” in the “Source” column; and
4. Variables that have been edited or imputed are so indicated.

2.4.2 Expenditure and Source of Payment Variables

The names of the expenditure and source of payment variables follow a standard convention, are seven characters in length, and end in an “X” indicating edited/imputed. Please note that imputed means that a series of logical edits, as well as an imputation process to account for missing data, have been performed on the variable.

The total sum of payments and 12 source of payment variables are named in the following way:

The first two characters indicate the type of event:

IP - inpatient stay	OB - office-based visit
ER - emergency room visit	OP - outpatient visit
HH - home health visit	DV - dental visit
OM - other medical equipment	RX - prescribed medicine

In the case of the source of payment variables, the third and fourth characters indicate:

SF - self or family	OF - other federal government
MR - Medicare	SL - state/local government
MD - Medicaid	WC - Workers' Compensation
PV - private insurance	OT - other insurance
VA - Veterans Administration/CHAMPVA	OR - other private
TR - TRICARE	OU - other public
	XP - sum of payments

In addition, the total charge variable is indicated by TC in the variable name.

The fifth and sixth characters indicate the year (16). The seventh character, "X", indicates the variable is edited/imputed.

For example, DVSF16X is the edited/imputed amount paid by self or family for 2016 dental expenditures.

2.5 File Contents

2.5.1 Survey Administration Variables

2.5.1.1 Person Identifiers (DUID, PID, DUPERSID)

The dwelling unit ID (DUID) is a five-digit random number assigned after the case was sampled for MEPS. The three-digit person number (PID) uniquely identifies each person within the dwelling unit. The eight-character variable DUPERSID uniquely identifies each person represented on the file and is the combination of the variables DUID and PID. For detailed information on dwelling units and families, please refer to the documentation for the 2016 Full Year Population Characteristics File.

2.5.1.2 Record Identifiers (EVNTIDX, FFEEIDX)

EVNTIDX uniquely identifies each dental event (i.e., each record on the Dental file) and is the variable required to link dental events to data files containing details on prescribed medicines (MEPS 2016 Prescribed Medicines File). For details on linking see Section 5.0 or the MEPS 2016 Appendix File, HC-188I.

FFEEIDX is a constructed variable that uniquely identifies a flat fee group, that is, all events that were part of a flat fee payment. For example, a charge for orthodontia is typically covered in a flat fee arrangement where all visits are covered under one flat fee dollar amount. These events

would have the same value for FFEEIDX. FFEEIDX identifies a flat fee payment that was identified using information from the Household Component.

2.5.1.3 Round Indicator (EVENTRN)

EVENTRN indicates the round in which the dental event was reported. Please note: Rounds 3 (partial), 4, and 5 are associated with MEPS survey data collected from Panel 20. Likewise, Rounds 1, 2, and 3 (partial) are associated with data collected from Panel 21.

2.5.1.4 Panel Indicator (PANEL)

PANEL is a constructed variable used to specify the panel number for the person. PANEL will indicate either Panel 20 or Panel 21 for each person on the file. Panel 20 is the panel that started in 2015, and Panel 21 is the panel that started in 2016.

2.5.2 Dental Event Variables

This file contains variables describing dental events reported by household respondents in the Dental Section of the MEPS HC survey questionnaire.

2.5.2.1 Date of Visit (DVDATEYR – DVDATEMM)

There are variables that indicate the month and year a dental event occurred (DVDATEMM and DVDATEYR, respectively). These variables have not been edited or imputed.

2.5.2.2 Type of Provider Seen (GENDENT - DENTYPE)

Respondents were asked about the type of provider seen during the dental visit (e.g., general dentist, dental hygienist, or orthodontist). More than one type of provider may have been identified on an event record.

2.5.2.3 Treatment, Procedures, and Services (EXAMINE - DENTMED)

Respondents were asked about the types of services or treatments received during the visit (EXAMINE - TMDTMJ), such as root canal or x-rays. More than one type of service or treatment may have been identified on an event record. Some procedures or services identified in DENTOTHX as “Other specify dental procedures edited” have been edited to appropriate procedure and service categories. While the unedited versions of these variables are included in the dental event file every year, an edited version of a particular variable is included only if editing was done for that category. In FY15, DENTOTHR was dropped from the file, but the edited version of this variable (DENTOTHX, “Other specify dental procedures edited”) is still included. Please note that the crosswalk in this document lists all possible edited procedure and service category variables; the edited variables in the data file will differ by year. The DENTMED variable indicates whether or not the household member received a prescription medication during the dental visit.

2.5.3 Flat Fee Variables (FFEEIDX, FFDVTYPE, FFBEF16, FFTOT17)

2.5.3.1 Definition of Flat Fee Payments

A flat fee is the fixed dollar amount a person is charged for a package of services provided during a defined period of time. Examples would be an orthodontist's fee, which covers multiple visits; or a dental surgeon's fee, which covers surgical procedure and post-surgical care. A flat fee group is the set of medical services that are covered under the same flat fee payment. The flat fee groups represented on the dental file include flat fee groups where at least one of the health care events, as reported by the HC respondent, occurred during 2016. By definition, a flat fee group can span multiple years. Furthermore, a single person can have multiple flat fee groups.

2.5.3.2 Flat Fee Variable Descriptions

2.5.3.2.1 Flat Fee ID (FFEEIDX)

As noted earlier in Section 2.5.1.2 "Record Identifiers," the variable FFEEIDX uniquely identifies all events that are part of the same flat fee group for a person. On any 2016 MEPS event file, every event that is part of a specific flat fee group will have the same value for FFEEIDX. Note that prescribed medicine and home health events are never included in a flat fee group and none of the flat fee variables is on those event files.

2.5.3.2.2 Flat Fee Type (FFDVTYPE)

FFDVTYPE indicates whether the 2016 dental event is the "stem" or "leaf" of a flat fee group. A stem (records with FFDVTYPE = 1) is the initial dental service (event) which is followed by other dental events that are covered under the same flat fee payment. The leaves of the flat fee group (records with FFDVTYPE = 2) are those dental events that are tied back to the initial medical event (the stem) in the flat fee group. These "leaf" records have their expenditure variables set to zero. For the dental visits that are not part of a flat fee payment, the FFDVTYPE is set to -1, "INAPPLICABLE".

2.5.3.2.3 Counts of Flat Fee Events that Cross Years (FFBEF16, FFTOT17)

As described in Section 2.5.3.1, a flat fee payment covers multiple events and the multiple events could span multiple years. For situations where a 2016 dental visit is part of a group of events, and some of the events occurred before or after 2016, counts of the known events are provided on the dental record. Variables that indicate events occurring before or after 2016 are the following:

FFBEF16 – indicates total number of pre-2016 events in the same flat fee group as the 2016 dental event. This count would not include 2016 dental events.

FFTOT17 – indicates the number of 2017 medical events expected to be in the same flat fee group as the 2016 dental event record.

2.5.3.3 Caveats of Flat Fee Groups

Data users/analysts should note that flat fee payments are common on the dental file. There are 3,283 dental events that are identified as being part of a flat fee payment group. In general, every flat fee group should have an initial visit (stem) and at least one subsequent visit (leaf). There are some situations where this is not true. For some of these flat fee groups, the initial visit reported occurred in 2016, but the remaining visits that were part of this flat fee group occurred in 2017. In this case, the 2016 flat fee group represented on this file would consist of one event (the stem). The 2017 “leaf” events that are part of this flat fee group are not represented on the file. Similarly, the household respondent may have reported a flat fee group where the initial visit began in 2015 but subsequent visits occurred during 2016. In this case, the initial visit would not be represented on the file. This 2016 flat fee group would then only consist of one or more leaf records and no stem. Please note that the crosswalk in this document lists all possible flat fee variables.

2.5.4 Condition Codes

Conditions data are not collected for dental events; therefore, this file cannot be linked to the Conditions File.

2.5.5 Expenditure Data

2.5.5.1 Definition of Expenditures

Expenditures on this file refer to what is paid for dental services. More specifically, expenditures in MEPS are defined as the sum of payments for care received, including out-of-pocket payments and payments made by private insurance, Medicaid, Medicare, and other sources. The definition of expenditures used in MEPS differs slightly from its predecessors, the 1987 NMES and 1977 NMCES surveys, where “charges” rather than sum of payments were used to measure expenditures. This change was adopted because charges became a less appropriate proxy for medical expenditures during the 1990s due to the increasingly common practice of discounting. Although measuring expenditures as the sum of payments incorporates discounts in the MEPS expenditure estimates, the estimates do not incorporate any payment not directly tied to specific medical care visits, such as bonuses or retrospective payment adjustments paid by third party payers. Another general change from the two prior surveys is that charges associated with uncollected liability, bad debt, and charitable care (unless provided by a public clinic or hospital) are not counted as expenditures because there are no payments associated with those classifications. While charge data are provided on this file, data users/analysts should use caution when working with these data because a charge does not typically represent actual dollars exchanged for services or the resource costs of those services, nor are they directly comparable to the resource costs of those services, nor are they directly comparable to the expenditures defined in the 1987 NMES. For details on expenditure definitions, please reference the following, “Informing American Health Care Policy” (Monheit et al., 1999). AHRQ has developed factors to apply to the 1987 NMES expenditure data to facilitate longitudinal analysis. These factors can be accessed via the CFACT data center. For more information see the [Data Center section of the MEPS website](#). If examining trends in MEPS expenditures, please refer to Section 3.3 for more information.

2.5.5.2 Data Editing and Imputation Methodologies of Expenditure Variables

The general methodology used for editing and imputing expenditure data is described below. The MPC did not include either the dental events or other medical expenditures (such as glasses, contact lenses, and hearing devices). Therefore, although the general procedures remain the same for dental and other medical expenditures, editing and imputation methodologies were applied only to household-reported data. Please see below for details on the differences between these editing/imputation methodologies. Separate imputations were performed for flat fee and simple events as well.

2.5.5.2.1 General Data Editing Methodology

Logical edits were used to resolve internal inconsistencies and other problems in the HC survey-reported data. The edits were designed to preserve partial payment data from households and providers, and to identify actual and potential sources of payment for each household-reported event. In general, these edits accounted for outliers, copayments or charges reported as total payments, and reimbursed amounts that were reported as out-of-pocket payments. In addition, edits were implemented to correct for misclassifications between Medicare and Medicaid, and between Medicare HMOs and private HMOs as payment sources. These edits produced a complete vector of expenditures for some events, and provided the starting point for imputing missing expenditures in the remaining events.

2.5.5.2.2 Imputation Methodologies

The predictive mean matching imputation method was used to impute missing expenditures. This procedure uses regression models (based on events with completely reported expenditure data) to predict total expenses for each event. Then, for each event with missing payment information, a donor event with the closest predicted payment with the same pattern of expected payment sources as the event with missing payment was used to impute the missing payment value. The imputations for the flat fee events were carried out separately from the simple events.

The weighted sequential hot-deck procedure was used to impute the missing total charges. This procedure uses survey data from respondents to replace missing data while taking into account the persons' weighted distribution in the imputation process.

2.5.5.2.3 Dental Data Editing and Imputation

Expenditures on visits to dentists were developed in a sequence of logical edits and imputations. The household edits were used to correct obvious errors in the reporting of expenditures, and to identify actual and potential sources of payments. Some of the edits were global (i.e., applied to all events); others were hierarchical and mutually exclusive. One of the more important edits separated flat fee events from simple events. This edit was necessary because groups of events covered by a flat fee (i.e., a flat fee bundle) were edited and imputed separately from individual events each covered by a single charge (i.e., simple events). Dental services were imputed as flat fee events if the charges covered a package of health care services (e.g., orthodontia), and all of the services were part of the same event type (i.e., a pure bundle). If a bundle contained more than one type of event, the services were treated as simple events in the imputations (See Section 2.5.3 for more detail on the definition and imputation of events in flat fee bundles.)

Logical edits were also used to sort each event into a specific category for the imputations. Events with complete expenditures were flagged as potential donors for the predictive mean matching imputations, while events with missing expenditure data were assigned to various recipient categories. Each event with missing expenditure data was assigned to a recipient category based on the extent of its missing charge and expenditure data. For example, an event with a known total charge but no expenditure information was assigned to one category, while an event with a known total charge and partial expenditure information was assigned to a different category. Similarly, events without a known total charge and no or partial expenditure information were assigned to various recipient categories.

The logical edits produced nine recipient categories for events with missing data. Eight of the categories were for events with a common pattern of missing data and a primary payer other than Medicaid. Medicaid events were imputed separately because persons on Medicaid rarely know the provider's charge for services or the amount paid by the state Medicaid program. As a result, the total charge for Medicaid-covered services was imputed and discounted to reflect the amount that a state program would pay for the care.

Separate predictive mean matching imputations were used to impute missing data in each of the eight recipient categories. The donor pool included "free events" because, in some instances, providers are not paid for their services. These events represent charity care, bad debt, provider failure to bill, and third party payer restrictions on reimbursement in certain circumstances. If free events were excluded from the donor pool, total expenditures would be over-counted because the distribution of free event among complete events (donors) is not represented among incomplete events (recipients).

2.5.5.3 Imputation Flag Variable (IMPFLAG)

IMPFLAG is a six-category variable that indicates if the event contains complete Household Component (HC) or Medical Provider Component (MPC) data, was fully or partially imputed, or was imputed in the capitated imputation process (for OP and MV events only). The following list identifies how the imputation flag is coded; the categories are mutually exclusive.

IMPFLAG = 0 not eligible for imputation (includes zeroed-out and flat fee leaf events)

IMPFLAG = 1 complete HC data

IMPFLAG = 2 complete MPC data (not applicable to DV events)

IMPFLAG = 3 fully imputed

IMPFLAG = 4 partially imputed

IMPFLAG = 5 complete MPC data through capitation imputation (not applicable to DV events)

2.5.5.4 Flat Fee Expenditures

The approach used to count expenditures for flat fees was to place the expenditure on the first visit of the flat fee group. The remaining visits have zero payments. Thus, if the first visit in the flat fee group occurred prior to 2016, all of the events that occurred in 2016 will have zero payments. Conversely, if the first event in the flat fee group occurred at the end of 2015, the total expenditure for the entire flat fee group will be on that event, regardless of the number of events it covered after 2016. See Section 2.5.3 for details on the flat fee variables.

2.5.5.5 Zero Expenditures

As noted above, there are some dental events reported by respondents where the payments were zero. This could occur for several reasons including (1) the visit was covered under a flat fee arrangement (flat fee payments are included only on the first event covered by the arrangement), (2) there was no charge for a follow-up visit, (3) the provider was never paid directly for services provided by an individual, insurance plan, or other source, (4) the charges were included in another bill, or (5) the event was paid through government or privately funded research or clinical trial. If all of the medical events for a person fell into one of these categories, then the total annual expenditures for that person would be zero.

2.5.5.6 Sources of Payment

In addition to total expenditures, variables are provided which itemize expenditures according to major source of payment categories. These categories are:

1. Out-of-pocket by User or Family,
2. Medicare,
3. Medicaid,
4. Private Insurance,
5. Veterans Administration/CHAMPVA, excluding TRICARE,
6. TRICARE,
7. Other Federal Sources - includes Indian Health Service, military treatment facilities, and other care by the federal government,
8. Other State and Local Source - includes community and neighborhood clinics, state and local health departments, and state programs other than Medicaid,
9. Workers' Compensation, and
10. Other Unclassified Sources - includes sources such as automobile, homeowner's, and liability insurance, and other miscellaneous or unknown sources.

Two additional source of payment variables were created to classify payments for events with apparent inconsistencies between insurance coverage and sources of payment based on data collected in the survey. These variables include:

11. Other Private - any type of private insurance payments reported for persons not reported to have any private health insurance coverage during the year as defined in MEPS, and
12. Other Public - Medicare/Medicaid payments reported for persons who were not reported to be enrolled in the Medicare/Medicaid program at any time during the year.

Though relatively small in magnitude, data users/analysts should exercise caution when interpreting the expenditures associated with these two additional sources of payment. While these payments stem from apparent inconsistent responses to health insurance and source of payment questions in the survey, some of these inconsistencies may have logical explanations. For example, private insurance coverage in MEPS is defined as having a major medical plan covering hospital and physician services. If a MEPS sampled person did not have such coverage but had a single service type insurance plan (e.g., dental insurance) that paid for a particular episode of care, those payments may be classified as “other private.” Some of the “other public” payments may stem from confusion between Medicaid and other state and local programs or may be from persons who were not enrolled in Medicaid, but were presumed eligible by a provider who ultimately received payments from the public payer.

2.5.5.7 Dental Expenditure Variables (DVSF16X - DVTC16X)

DVSF16X - DVOT16X are the 12 sources of payment. DVXP16X is the sum of the 12 sources of payment for the dental expenditures, and DVTC16X is the total charge. The 12 sources of payment are: self/family (DVSF16X), Medicare (DVMR16X), Medicaid (DVMD16X), private insurance (DVPV16X), Veterans Administration/CHAMPVA (DVVA16X), TRICARE (DVTR16X), other Federal sources (DVOF16X), State and Local (non-federal) government sources (DVSL16X), Workers’ Compensation (DVWC16X), other private insurance (DVOR16X), other public insurance (DVOU16X), and other insurance (DVOT16X).

2.5.5.8 Rounding

Expenditure variables on the 2016 dental file have been rounded to the nearest penny. Person-level expenditure information to be released on the MEPS 2016 Full Year Consolidated File will be rounded to the nearest dollar. It should be noted that using the MEPS event files to create person-level totals will yield slightly different totals than those found on the full-year consolidated file. These differences are due to rounding only. Moreover, in some instances, the number of persons having expenditures on the event files for a particular source of payment may differ from the number of persons with expenditures on the person-level expenditure file for that source of payment. This difference is also an artifact of rounding only.

3.0 Sample Weight (PERWT16F)

3.1 Overview

There is a single full year person-level weight (PERWT16F) assigned to each record for each key, in-scope person who responded to MEPS for the full period of time that he or she was in-scope during 2016. A key person was either a member of a responding NHIS household at the time of interview or joined a family associated with such a household after being out-of-scope at the time of the NHIS (the latter circumstance includes newborns as well as those returning from military service, an institution, or residence in a foreign country). A person is in-scope whenever he or she is a member of the civilian noninstitutionalized portion of the U.S. population.

3.2 Details on Person Weight Construction

The person-level weight PERWT16F was developed in several stages. Person-level weights for Panel 20 and Panel 21 were created separately. The weighting process for each panel included an adjustment for nonresponse over time and calibration to independent population figures. The calibration was initially accomplished separately for each panel by raking the corresponding sample weights for those in-scope at the end of the calendar year to Current Population Survey (CPS) population estimates based on five variables. The five variables used in the establishment of the initial person-level control figures were: census region (Northeast, Midwest, South, West); MSA status (MSA, non-MSA); race/ethnicity (Hispanic; Black, non-Hispanic; Asian, non-Hispanic; and other); sex; and age. A 2016 composite weight was then formed by multiplying each weight from Panel 20 by the factor .510 and each weight from Panel 21 by the factor .490. The choice of factors reflected the relative sample sizes of the two panels, helping to limit the variance of estimates obtained from pooling the two samples. The composite weight was raked to the same set of CPS-based control totals. When the poverty status information derived from income variables became available, a final raking was undertaken on the previously established weight variable. Control totals were established using poverty status (five categories: below poverty, from 100 to 125 percent of poverty, from 125 to 200 percent of poverty, from 200 to 400 percent of poverty, at least 400 percent of poverty) as well as the other five variables previously used in the weight calibration.

In developing the final person-level weight for 2016 (PERWT16F), an additional raking dimension was included beyond those based on the usual six variables. This dimension was added to adjust the distribution of inpatient hospital utilization among the elderly to reflect trends in other data sources. The table below shows ratios of weighted numbers for those 65 and older that were used to establish this additional raking dimension, modifying the corresponding estimates obtained without the additional dimension.

Ratio of Adjusted to Unadjusted Weights (Cases where AGE16X \geq 65 and INSC1231=1)

# of Inpatient Discharges (IPDIS16)	# of Nights in Hospital for Discharges (IPNGTD16)	Ratio
0	0	0.9746
1+	0 - 4	1.1227
1+	5 - 9	1.1548
1+	10+	1.3597

3.2.1 MEPS Panel 20 Weight Development Process

The person-level weight for MEPS Panel 20 was developed using the 2015 full year weight for an individual as a “base” weight for survey participants present in 2015. For key, in-scope members who joined an RU some time in 2016 after being out-of-scope in 2015, the initially assigned person-level weight was the corresponding 2015 family weight. The weighting process included an adjustment for person-level nonresponse over Rounds 4 and 5 as well as raking to population control totals for December 2016 for key, responding persons in-scope on December 31, 2016. These control figures were derived by scaling back the population distribution obtained from the March 2017 CPS to reflect the December 31, 2016 estimated population total (estimated based on Census projections for January 1, 2017). Variables used for person-level raking included: census region (Northeast, Midwest, South, West); MSA status (MSA, non-MSA); race/ethnicity (Hispanic; Black, non-Hispanic; Asian, non-Hispanic; and other); sex; and age. (Poverty status is not included in this version of the MEPS full year database because of the time required to process the income data collected and then assign persons to a poverty status category). The final weight for key, responding persons who were not in-scope on December 31, 2016 but were in-scope earlier in the year was the person weight after the nonresponse adjustment.

3.2.2 MEPS Panel 21 Weight Development Process

The person-level weight for MEPS Panel 21 was developed using the 2016 MEPS Round 1 person-level weight as a “base” weight. For key, in-scope members who joined an RU after Round 1, the Round 1 family weight served as a “base” weight. The weighting process included an adjustment for nonresponse over the remaining data collection rounds in 2016 as well as raking to the same population control figures for December 2016 used for the MEPS Panel 20 weights for key, responding persons in-scope on December 31, 2016. The same five variables employed for Panel 20 raking (census region, MSA status, race/ethnicity, sex, and age) were used for Panel 21 raking. Again, the final weight for key, responding persons who were not in-scope on December 31, 2016 but were in-scope earlier in the year was the person weight after the nonresponse adjustment.

Note that the MEPS Round 1 weights for both panels incorporated the following components: a weight reflecting the original household probability of selection for the NHIS and an adjustment for NHIS nonresponse; a factor representing the proportion of the 16 NHIS panel-quarter combinations eligible for MEPS; the oversampling of certain subgroups for MEPS among the NHIS household respondents eligible for MEPS; ratio-adjustment to NHIS-based national population estimates at the household (occupied DU) level; adjustment for nonresponse at the DU level for Round 1; and poststratification to U.S. civilian noninstitutionalized population estimates at the family and person level obtained from the corresponding March CPS databases.

3.2.3 The Final Weight for 2016

The final raking of those in-scope at the end of the year has been described above. In addition, the composite weights of two groups of persons who were out-of-scope on December 31, 2016 were poststratified. Specifically, the weights of those who were in-scope some time during the year, out-of-scope on December 31, and entered a nursing home during the year were poststratified to a corresponding control total obtained from the 1996 MEPS Nursing Home Component. The weights of persons who died while in-scope during 2016 were poststratified to corresponding estimates derived using data obtained from the Medicare Current Beneficiary Survey (MCBS) and Vital Statistics information provided by the National Center for Health Statistics (NCHS). Separate decedent control totals were developed for the “65 and older” and “under 65” civilian noninstitutionalized populations.

Overall, the weighted population estimate for the civilian noninstitutionalized population for December 31, 2016 is 319,197,609 (PERWT16F>0 and INSC1231=1). The sum of person-level weights across all persons assigned a positive person-level weight is 323,141,687.

3.2.4 Coverage

The target population for MEPS in this file is the 2016 U.S. civilian noninstitutionalized population. However, the MEPS sampled households are a subsample of the NHIS households interviewed in 2014 (Panel 20) and 2015 (Panel 21). New households created after the NHIS interviews for the respective Panels and consisting exclusively of persons who entered the target population after 2014 (Panel 20) or after 2015 (Panel 21) are not covered by MEPS. Neither are previously out-of-scope persons who join an existing household but are unrelated to the current household residents. Persons not covered by a given MEPS panel thus include some members of the following groups: immigrants; persons leaving the military; U.S. citizens returning from residence in another country; and persons leaving institutions. The set of uncovered persons constitutes only a small segment of the MEPS target population.

3.3 Using MEPS Data for Trend Analysis

MEPS began in 1996, and the utility of the survey for analyzing health care trends expands with each additional year of data; however, there are a variety of methodological and statistical considerations when examining trends over time using MEPS. Tests of statistical significance should be conducted to assess the likelihood that observed trends may be attributable to sampling variation. The length of time being analyzed should also be considered. In particular, large shifts in survey estimates over short periods of time (e.g. from one year to the next) that are statistically

significant should be interpreted with caution unless they are attributable to known factors such as changes in public policy, economic conditions, or MEPS survey methodology.

With respect to methodological considerations, in 2013 MEPS introduced an effort to obtain more complete information about health care utilization from MEPS respondents with full implementation in 2014. This effort likely resulted in improved data quality and a reduction in underreporting starting in FY 2014 and could have some modest impact on analyses involving trends in utilization across years.

There are also statistical factors to consider in interpreting trend analyses. Looking at changes over longer periods of time can provide a more complete picture of underlying trends. Analysts may wish to consider using techniques to evaluate, smooth, or stabilize analyses of trends using MEPS data such as comparing pooled time periods (e.g. 1996-97 versus 2011-13), working with moving averages, or using modeling techniques with several consecutive years of MEPS data to test the fit of specified patterns over time. Finally, researchers should be aware of the impact of multiple comparisons on Type I error. Without making appropriate allowance for multiple comparisons, undertaking numerous statistical significance tests of trends increases the likelihood of concluding that a change has taken place when one has not.

4.0 Strategies for Estimation

4.1 Developing Event-Level Estimates

The data in this file can be used to develop national 2016 event-level estimates for the U.S. civilian noninstitutionalized population on dental visits as well as expenditures, and sources of payment for these visits. The weight assigned to each dental visit reported is the person-level weight of the person who visited the dentist. If a person reported several visits, each visit is assigned that individual's person-level weight. Estimates of total visits are the sum of the weight variable (PERWT16F) across relevant event records while estimates of other variables must be weighted by PERWT16F to be nationally representative. For example, the appropriate estimate for the mean out-of-pocket payment per dental visit can be represented as follows (the subscript 'j' identifies each event and represents a numbering of events from 1 through the total number of events in the file):

$$(\sum W_j X_j) / (\sum W_j), \text{ where,}$$

$$W_j = \text{PERWT16F}_j \quad (\text{full year person weight for the person associated with event } j), \text{ and}$$

$$X_j = \text{DVSF16X}_j \quad (\text{amount paid by self/family for event } j)$$

Estimates and corresponding [standard errors \(SE\)](#) can be derived using an appropriate computer software package for complex survey analysis such as SAS, Stata, SUDAAN or SPSS. The tables below contain the event-level estimates for several key variables on this file.

Selected Event-Level Estimates

Visits

Estimate of Interest	Variable Name	Estimate (SE)	Estimate Excluding Zero Payment Events (SE)
Total number of dental visits (in millions)	PERWT16F	302.2 (9.73)	261.6 (7.85)
Proportion of dental visits with expenditures > 0*	DVXP16X	0.866 (0.0059)	-----

*Zero payment events can occur in MEPS for the following reasons: (1) the visit was covered under a flat fee arrangement (flat fee payments are included only on the first event covered by the arrangement), (2) there was no charge for a follow-up visit, (3) the provider was never paid directly for services provided by an individual, insurance plan, or other source, (4) the charges were included in another bill, or (5) the event was paid through government or privately funded research or clinical trial.

Expenditures

Estimate of Interest	Variable Name	Estimate (SE)	Estimate Excluding Zero Payment Events (SE)
Mean total payments per visit	DVXP16X	\$335 (\$8.8)	\$387 (\$10.7)
Mean out-of-pocket payment per visit	DVSF16X	\$150 (\$5.6)	\$174 (\$6.9)
Mean proportion of total expenditures paid by private insurance per visit	DVPV16X/ DVXP16X	-----	0.481 (0.0078)

Expenditures: Dental Hygienist Visits (DENTHYG = 1)

Estimate of Interest	Variable Name	Estimate (SE)	Estimate Excluding Zero Payment Events (SE)
Mean total payments per visit where person saw hygienist	DVXP16X	\$201 (\$5.7)	\$208 (\$6.0)
Mean out-of-pocket payment per visit where person saw hygienist	DVSF16X	\$68 (\$3.3)	\$71 (\$3.5)
Mean proportion of total expenditures per visit paid by private insurance where person saw hygienist	DVPV16X/ DVXP16X	-----	0.560 (0.0102)

4.2 Person-Based Estimates for Dental Care

To enhance analyses of dental care, analysts may link information about dental visits by sample persons in this file to the annual full year consolidated file (which has data for all MEPS sample persons), or conversely, link person-level information from the full year consolidated file to this event-level file (see Section 5 below for more details). Both this file and the full year consolidated file may be used to derive estimates for persons with dental care and annual estimates of total expenditures. However, if the estimate relates to the entire population, this file cannot be used to calculate the denominator, as only those persons with at least one dental visit are represented on this data file. Therefore, the full year consolidated file must be used for person-level analyses that include both persons with and without dental care.

4.3 Variables with Missing Values

It is essential that the analyst examine all variables for the presence of negative values used to represent missing values. For continuous or discrete variables, where means or totals may be estimated, it may be necessary to set negative values to values appropriate to the analytic needs. That is, the analyst should either impute a value or set the value to one that will be interpreted as missing by the software package used. For categorical and dichotomous variables, the analyst may want to consider whether to recode or impute a value for cases with negative values or whether to include or exclude such cases in the numerator and/or denominator when calculating proportions.

Methodologies used for the editing/imputation of expenditure variables (e.g., sources of payment, flat fee, and zero expenditures) are described in Section 2.5.5.2.

4.4 Variance Estimation (VARPSU, VARSTR)

MEPS has a complex sample design. To obtain estimates of variability (such as the standard error of sample estimates or corresponding confidence intervals) for MEPS estimates, analysts need to take into account the complex sample design of MEPS for both person-level and

family-level analyses. Several methodologies have been developed for estimating standard errors for surveys with a complex sample design, including the Taylor-series linearization method, balanced repeated replication, and jackknife replication. Various software packages provide analysts with the capability of implementing these methodologies. Replicate weights have not been developed for the MEPS data. Instead, the variables needed to calculate appropriate standard errors based on the Taylor-series linearization method are included on this file as well as all other MEPS public use files. Software packages that permit the use of the Taylor-series linearization method include SUDAAN, Stata, SAS (version 8.2 and higher), and SPSS (version 12.0 and higher). For complete information on the capabilities of each package, analysts should refer to the corresponding software user documentation.

Using the Taylor-series linearization method, variance estimation strata and the variance estimation PSUs within these strata must be specified. The variables VARSTR and VARPSU on this MEPS data file serve to identify the sampling strata and primary sampling units required by the variance estimation programs. Specifying a “with replacement” design in one of the previously mentioned computer software packages will provide estimated standard errors appropriate for assessing the variability of MEPS survey estimates. It should be noted that the number of degrees of freedom associated with estimates of variability indicated by such a package may not appropriately reflect the number available. For variables of interest distributed throughout the country (and thus the MEPS sample PSUs), one can generally expect to have at least 100 degrees of freedom associated with the estimated standard errors for national estimates based on this MEPS database.

Prior to 2002, MEPS variance strata and PSUs were developed independently from year to year, and the last two characters of the strata and PSU variable names denoted the year. However, beginning with the 2002 Point-in-Time PUF, the variance strata and PSUs were developed to be compatible with all future PUFs until the NHIS design changed. Thus, when pooling data across years 2002 through the Panel 11 component of the 2007 files, the variance strata and PSU variables provided can be used without modification for variance estimation purposes for estimates covering multiple years of data. There were 203 variance estimation strata, each stratum with either two or three variance estimation PSUs.

From Panel 12 of the 2007 files, a new set of variance strata and PSUs were developed because of the introduction of a new NHIS design. There are 165 variance strata with either two or three variance estimation PSUs per stratum, starting from Panel 12. Therefore, there are a total of 368 (203+165) variance strata in the 2007 Full Year file as it consists of two panels that were selected under two independent NHIS sample designs. Since both MEPS panels in the Full Year 2008 file and beyond are based on the new NHIS design, there are only 165 variance strata. These variance strata (VARSTR values) have been numbered from 1001 to 1165 so that they can be readily distinguished from those developed under the former NHIS sample design in the event that data are pooled for several years.

If analyses call for pooling MEPS data across several years, in order to ensure that variance strata are identified appropriately for variance estimation purposes, one can proceed as follows:

1. When pooling any year from 2002 or later, one can use the variance strata numbering as is.

2. When pooling any year from 1996 to 2001 with any year from 2002 or later, use the H36 file.
3. A new H36 file was constructed to allow pooling of 2007 and later years with 1996 to 2006.

5.0 Merging/Linking MEPS Data Files

Data from this file can be used alone or in conjunction with other files for different analytic purposes. This section summarizes various scenarios for merging/linking MEPS event files. The set of households selected for MEPS is a subsample of those participating in the National Health Interview Survey (NHIS), thus, each MEPS panel can also be linked back to the previous year's NHIS public use data files. For information on obtaining MEPS/NHIS link files please see the [MEPS website](#).

5.1 Linking to the Person-Level File

Merging characteristics of interest from other MEPS files (e.g., 2016 Full Year Consolidated File or 2016 Prescribed Medicines File) expands the scope of potential estimates. For example, to estimate the total number of dental events of persons with specific demographic characteristics (such as age, race, and sex), population characteristics from a person-level file need to be merged onto the Dental file. This procedure is shown below. The MEPS 2016 Appendix File, HC-188I, provides additional details of how to merge other MEPS data files.

1. Create data set PERSX by sorting the 2016 Full Year Consolidated File, by the person identifier, DUPERSID. Keep only variables to be merged onto the Dental file and DUPERSID.
2. Create data set DENT by sorting the dental event file by person identifier, DUPERSID.
3. Create final data set NEWDENT by merging these two files by DUPERSID, keeping only records on the dental event file.

The following is an example of SAS code which completes these steps:

```
PROC SORT DATA=HCXXX (KEEP=DUPERSID AGE31X AGE42X AGE53X
SEX RACEV1X EDUCYR HIDEG) OUT=PERSX;
    BY DUPERSID;
RUN;

PROC SORT DATA=DENT;
    BY DUPERSID;
RUN;
```

```
DATA NEWDENT;  
    MERGE DENT (IN=A) PERSX (IN=B);  
    BY DUPERSID;  
IF A;  
RUN;
```

The MEPS 2016 Appendix File, HC-188I, provides examples of how to merge other MEPS data files.

5.2 Linking to the Prescribed Medicines File

The RXLK file provides a link from the MEPS event files to the 2016 Prescribed Medicines Event File. When using RXLK, data users/analysts should keep in mind that one dental visit can link to more than one prescribed medicine record. Conversely, a prescribed medicine event may link to more than one dental visit or different types of events. When this occurs, it is up to the data user/analyst to determine how the prescribed medicine expenditures should be allocated among those medical events. For detailed linking examples, including SAS code, data users/analysts should refer to the MEPS 2016 Appendix File, HC-188I.

5.3 Linking to the Medical Conditions File

Conditions data are not collected for dental events; therefore, this file cannot be linked to the Conditions File.

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D. Variable-Source Crosswalk

VARIABLE-SOURCE CROSSWALK

FOR MEPS HC-188B: 2016 DENTAL VISITS

Survey Administration Variables

Variable	Description	Source
DUID	Dwelling unit ID	Assigned in sampling
PID	Person number	Assigned in sampling
DUPERSID	Person ID (DUID + PID)	Assigned in sampling
EVNTIDX	Event ID	Assigned in sampling
EVENTRN	Event round number	CAPI derived
FFEEIDX	Flat fee ID	CAPI derived
PANEL	Panel Number	Constructed

Dental Events Variables

Variable	Description	Source
DVDATEYR	Event date – year	CAPI derived
DVDATEMM	Event date – month	CAPI derived
GENDENT	General dentist seen	DN03
DENTHYG	Dental hygienist seen	DN03
DENTTECH	Dental technician seen	DN03
DENTSURG	Dental surgeon seen	DN03
ORTHODNT	Orthodontist seen	DN03
ENDODENT	Endodontist seen	DN03
PERIODNT	Periodontist seen	DN03
DENTYPE	Other dental specialist seen	DN03
EXAMINE	General exam or consultation	DN04
CLENTETX	Edited CLENTETH	DN04 (Edited)
CLENTETH	Cleaning, prophylaxis, or polishing	DN04
JUSTXRYX	Edited JUSTXRAY	DN04 (Edited)
JUSTXRAY	X-rays, radiographs or bitewings	DN04
FLUORIDE	Fluoride treatment	DN04
SEALANTX	Edited SEALANT	DN04 (Edited)
SEALANT	Sealant application	DN04

Dental Events Variables

Variable	Description	Source
FILLINGX	Edited FILLING	DN04 (Edited)
FILLING	Fillings	DN04
INLAY	Inlays	DN04
CROWNSX	Edited CROWNS	DN04 (Edited)
CROWNS	Crowns or caps	DN04
ROOTCANX	Edited ROOTCANL	DN04 (Edited)
ROOTCANL	Root canal	DN04
GUMSURGX	Edited GUMSURG	DN04 (Edited)
GUMSURG	Periodontal scaling, root planing or gum	DN04
RECLVISX	Edited RECLVIS	DN04 (Edited)
RECLVIS	Periodontal recall visit	DN04
EXTRACT	Extraction, tooth pulled	DN04
IMPLANTX	Edited IMPLANT	DN04 (Edited)
IMPLANT	Implants	DN04
ABCESS	Abscess or infection treatment	DN04
ORALSURX	Edited ORALSURG	DN04 (Edited)
ORALSURG	Oral surgery	DN04
BRIDGESX	Edited BRIDGES	DN04 (Edited)
BRIDGES	Bridges	DN04
DENTUREX	Edited DENTURES	DN04 (Edited)
DENTURES	Dentures or partial dentures	DN04
REPAIRX	Edited REPAIR	DN04 (Edited)
REPAIR	Repair of bridges/dentures or relining	DN04
ORTHDONX	Edited ORTHDONT	DN04 (Edited)
ORTHDONT	Orthodontia, braces or retainers	DN04
WHITENX	Edited WHITEN	DN04 (Edited)
WHITEN	Bonding, whitening or bleaching	DN04
TMDTMJ	Treatment for TMD or TMJ	DN04
DENTPROX	Edited DENTPROC	DN04OV (Edited)
DENTPROC	Other dental procedures	DN04OV
DENTOTHX	Other specify dental procedures edited	DN04OV (Edited)
DENTMED	Received medicine including free sample	DN05

Flat Fee Variables

Variable	Description	Source
FFDVTYPE	Flat fee bundle	Constructed
FFBEF16	Total # of visits in FF before 2016	FF05
FFTOT17	Total # of visits in FF after 2016	FF10

Imputed Expenditure Variables

Variable	Description	Source
DVSF16X	Amount paid, self/family (Imputed)	CP Section (Edited)
DVMR16X	Amount paid, Medicare (Imputed)	CP Section (Edited)
DVMD16X	Amount paid, Medicaid (Imputed)	CP Section (Edited)
DVPV16X	Amount paid, private insurance (Imputed)	CP Section (Edited)
DVVA16X	Amount paid, Veterans/CHAMPVA (Imputed)	CP Section (Edited)
DVTR16X	Amount paid, TRICARE (Imputed)	CP Section (Edited)
DVOF16X	Amount paid, other federal (Imputed)	CP Section (Edited)
DVSL16X	Amount paid, state & local government (Imputed)	CP Section (Edited)
DVWC16X	Amount paid, workers' comp (Imputed)	CP Section (Edited)
DVOR16X	Amount paid, other private (Imputed)	Constructed
DVOU16X	Amount paid, other public (Imputed)	Constructed
DVOT16X	Amount paid, other insurance (Imputed)	CP Section (Edited)
DVXP16X	Sum of DVSF16X – DVOT16X (Imputed)	Constructed
DVTC16X	Household reported total charge (Imputed)	CP Section (Edited)
IMPFLAG	Imputation status	Constructed

Weights Variables

Variable	Description	Source
PERWT16F	Expenditure File Person Weight, 2016	Constructed
VARSTR	Variance estimation stratum, 2016	Constructed
VARPSU	Variance estimation PSU, 2016	Constructed