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CNSTAT Panel on Evaluation and Improvements to the Supplemental Poverty Measure

AGENDA

June 28, 2021 (2 – 5 PM EDT)

MEETING GOALS: The charge to the panel is to assist the Census Bureau in making modifications to the SPM to ensure that it is providing information on the levels of economic need in a way that optimally informs public understanding of economic conditions and trends affecting people with lower incomes. The panel plans to focus much of its attention on factors affecting economic wellbeing for which conceptual and measurement questions have proven most difficult to resolve. Treatment of medical care is one such area—presenting challenges in establishing what constitutes people's "basic needs" and in determining the resources on hand to meet those needs. This meeting is intended to help inform the panel's deliberations on this crucial topic.

2:00 PM Welcome, Introductions, Meeting Plan (*10 minutes*)
– **Jim Ziliak**, *University of Kentucky, Panel Chair*

2:10 Introductory presentations: Three approaches which cover many, although not all, options potentially on the table for handling medical care expenditures and resources in poverty measurement (*10 minutes* each)

Current treatment of medical care expenditures in the SPM; feasibility of implementing a HIPM-style measure at Census
– **John Creamer**, *U.S. Census Bureau*

A health inclusive SPM
– **Sanders Korenman**, *Panel Member*; **Dahlia Remler**, *CUNY*

The full income poverty measure method of incorporating health benefits into poverty measures, implications for the SPM
– **Jeff Larrimore**, *Federal Reserve Board*

2:40 Roundtable discussion of key questions circulated to participants prior to the meeting (see list below). Moderated by the panel's medical care subgroup—**Sanders Korenman**, **Helen Levy**, **Barbara Wolfe**, **David Johnson**, **Indi Dutta-Gupta**—invited

guests, including statistical agency experts, will be encouraged to weigh in during this open-ended conversation. **Janet Currie** [*Princeton University* and current CNSTAT member who and has written extensively on public insurance and health care plans/policies in the poverty context] and **Mustafa Hussein** [*University of Wisconsin-Milwaukee,* who is working on a project that compare ex post medical expenditures with risk] will be among the invited guests.

3:30 ***BREAK***

3:40 Roundtable discussion (cont'd)

5:00 PM ***ADJOURN***

Questions/topics to be addressed during the roundtable discussion

Top level

1. To what extent should the SPM be a health inclusive poverty measure?
   - Should there be a separate poverty measure for this purpose?
   - Are the hurdles more conceptual or more practical (data limitations)?

Estimating Thresholds

2. How should the high variability of medical care needs across the population be reflected/captured?
   - How should differences in health that are tied to differences in required expenditures be handled? (A person who has a disability that requires an aide, or weekly infusions, or specialized equipment as examples).
   - Should differences in the cost of care across health care geographic markets be considered? If so, how?
3. How could health insurance be treated as a basic need in the SPM? The ACA essential benefits package may make this easier, but how do changes in that package get captured?
4. Despite the variability of usage, should medical/health care be explicitly added as a category to FCSU?
5. How, or to what extent, should nondiscretionary out-of-pocket medical care and insurance needs be included in threshold estimates?
6. What should happen to the poverty thresholds when health care costs rise for different reasons—e.g., increasing profit or waste vs. valuable care (improved health and life expectancy outcomes)?

Estimating Resources/Income

7. Should changes be made to the SPM approach of subtracting medical expenses, such as contributions toward the cost of medical care and health insurance premiums, from the income/available resource of families?

- Which MOOP categories should be included in the SPM?
- Should MOOP expenses be capped (as proposed, but not adopted, for 2021) and, if so, at what level(s)?
- How are MOOP categories being handled in other sub-national measures—e.g., the California or NYC SPMs.

8. How should medical care benefits be valued, distinguishing among insurance benefits, the full insurance premium (e.g., actuarial value), premiums required of the insured as the price to obtain insurance, cost-sharing expenses, OTC spending (not all "medical insurance" is an out-of-pocket expense)?
   - What are some solutions to the lack of fungibility problem in valuing health insurance?
   - SPM underestimates the poverty-reducing effects of medical care coverage provided through Medicaid and Medicare. How should the value of public plans be measured and incorporated?
   - How should SPM handle (and how sensitive should it be to) changes in public policy toward health care, such as those in ACA?
   - How should employer provided health care benefits be treated?
   - How should various kinds of "free care" be valued?
9. What is the relationship between health status and health resources? [this concern is reflected above for thresholds in point 2 "variability of healthcare needs"]
   - What does the role of choice in medical care spending play in estimating resources (or in setting thresholds)?
   - How can the SPM be specified to avoid making the injured and sick or those with greater medical needs look less poor, which is a concern with an alternate approach of simply including as a resource all medical spending incurred on behalf of an individual through insurance?

<u>Other</u>

10. Price indexing issues (e.g., should the CPI use a disease-based or cost of treatment approach), which are especially impactful for medical care expenditure category. Perhaps this is a problem one analytic level adrift of what the panel can address, and hence one that should be left for BLS-CPI to figure out? [This is important but not a concern with all approaches to including health; for example, the HIPM thresholds, like the SPM thresholds, are not directly price indexed. SPM is FCSU expenditure-indexed and the HIPM threshold health insurance need is indexed with the full price of the basic plan.]
11. Is the ability to compare poverty measures across countries (including those with nationalized medical care) a concern/priority? Or does the uniqueness of the U.S. system make it a nonstarter?
12. Promising data sources for increasing accuracy of medical care cost estimates. Strengths/limitations of CPS-ASEC (see Caswell and O'Hara, 2011), MEPS, CEX, etc. in their current roles. Where are the most glaring data gaps?

Meeting reading materials (see the last item in this list for a more comprehensive listing of relevant resources)**.**

- The Supplemental Poverty Measure: 2019, by Liana Fox, September 2020. https://www.census.gov/content/dam/Census/library/publications/2020/demo/p60-272.pdf
- Measuring Poverty: A New Approach (chapter 4, Defining Resources). https://www.nap.edu/download/4759#
- Accounting for the Impact of Medicaid on Child Poverty, by Sanders Korenman, Dahlia K. Remler & Rosemary T. Hyson. https://www.nber.org/papers/w25973
- The Supplemental Poverty Measure Under Alternate Treatments of Medical Out-of-Pocket Expenditures, by Thesia I. Garner. https://www.bls.gov/pir/spm/assa-2014-spmmit.pdf
- Connie's tables listing resources for estimating medical care components of the SPM