

U.S. DEPARTMENT OF COMMERCE  
 Economics and Statistics Administration  
 U.S. CENSUS BUREAU  
 ACTING AS COLLECTING AGENT FOR  
 U.S. DEPARTMENT OF  
 HEALTH AND HUMAN SERVICES  
 AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Medical Expenditure Panel Survey  
 Insurance Component

**HEALTH INSURANCE COST STUDY  
 PLAN INFORMATION QUESTIONNAIRE**

**INSTRUCTIONS**

The MEPS-10(S), Plan Information Questionnaire, is to be completed for the health insurance plans offered AT THIS LOCATION in 1999. Please respond for the plans indicated in the question 1a box of each MEPS-10(S). If no plan names are preprinted, complete a separate MEPS-10(S) for the 4 largest plans your organization offered. You may use photocopies of this MEPS-10(S) form if sufficient copies were not included in this reporting package.

**GENERAL PLAN INFORMATION**

		<b>FOR CENSUS USE ONLY</b>	
<p><i>If a plan name is preprinted in the question 1a answer box on the right, answer for the plan specified. Otherwise, complete this Plan Information Questionnaire for the plan with the largest (or next largest) enrollment of active employees.</i></p>		100	
<p><b>1a. For 1999, what was the name of the health insurance plan with the largest (or next largest) enrollment of active employees?</b></p> <p>Examples: • Blue Cross Blue Shield, High Option                  • Option A                  • Aetna HMO</p>		012 Name of plan	
<p><b>b. What was the name of the insurance company or carrier providing this plan?</b></p> <p>Examples: • Blue Cross Blue Shield                  • Alliance                  • Charter Health</p> <p><i>Enter your company name if self-insured.</i></p>		102 Name of insurance carrier	
<p><b>2. Which type of health care provider was available through this plan?</b></p> <p><b>Exclusive providers</b> – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit.</p> <p><b>Any providers</b> – Enrollees may go to providers of their choice on a fee-for-service basis. The plan does not have any associated providers.</p> <p><b>Mixture of preferred and any providers</b> – Enrollees may go to a set of "preferred" providers associated with the plan or providers of their choice. If they go to a non-preferred provider, they face higher costs.</p>		103 1 <input type="checkbox"/> Exclusive providers (Examples: Most HMO, IPA, and EPO-type plans) 2 <input type="checkbox"/> Any providers (Examples: Most conventional and indemnity plans) 3 <input type="checkbox"/> Mixture of preferred and any providers (Examples: Most PPO and POS-type plans)	
<p><b>3. Did this plan REQUIRE that the enrollee see a primary-care physician in order to be referred to a specialist?</b></p> <p><i>For plans with multiple options, answer for the "in-network" option.</i></p>		104 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
<p><b>4. Was this plan purchased through a pooling arrangement with other employers such as a multi-employer welfare arrangement (MEWA)?</b></p>		112 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	





## FAMILY COVERAGE PREMIUMS

*Report for typical situations and enrollees.  
If premium varies, report for an average employee.  
Report employer/employee contributions and total premium for the same period.  
Report for a family of four if cost varies by family size.*

**10a. Was family coverage offered under this plan?**

- 137 1  Yes – Continue with question 10b  
2  No – **SKIP to question 11a**

**b. For this plan, how much did the employer contribute toward the plan premium of ONE TYPICAL full-time employee with family coverage?**

135 \$     ,    .  0  0 Employer contribution

**c. How much did this typical employee with family coverage contribute toward his/her own premium?**

136 \$     ,    .  0  0 Employee contribution

**d. What was the total premium for this typical employee with family coverage?**

134 \$     ,    .  0  0 **Total family premium**  
*If this was a self-insured plan, this total should be the same as 6f on Page 2.*

**e. The amounts reported in questions 10b–d are based on which one of the following time periods?**

*Mark (X) only one.*

- 553 1  Weekly  
2  Every 2 weeks  
3  Monthly  
5  Quarterly  
4  Yearly

## GENERAL PREMIUM INFORMATION

**11a. Did the PREMIUMS charged by the insurance company or carrier vary by any of these characteristics?**

*Mark (X) all that apply.*

- 138  Age  
139  Sex (Gender)  
140  Number of persons covered by a family plan  
141  Wage or salary levels  
142  Other – *Specify* ↴  
099   
567  None of the above

**b. Did the amount an EMPLOYEE CONTRIBUTED toward his/her own coverage vary by different employee categories?**

Examples: Full-time, part-time, union status, wage or salary levels

- 143 1  Yes  
2  No

**12. Did the plan premium include life and/or disability insurance?**

*Mark (X) all that apply.*

- 144  Life insurance  
145  Disability insurance  
565  No life and/or disability insurance covered by the premium

## INDIVIDUAL DEDUCTIBLES

**13a. Did this plan have a deductible?**

**Deductible** – Predetermined amount which must be met by an individual before the plan will pay for covered services.

Many HMOs do not have a deductible.

- 151 1  Yes – Continue with question 13b  
 2  No – **SKIP to Page 6, question 15a**

**b. What was the annual deductible an individual paid?**

Report deductibles for care received "in-network" from preferred providers, if applicable.

Enter physician care and hospital care amounts in appropriate boxes if separate deductibles apply.

If deductible is per overnight hospital stay, it is not an annual deductible and should be reported under 15b on Page 6.

146 

\$		,								.	0	0
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 Individual annual deductible

**OR**

Separate deductibles for:

147 

\$		,								.	0	0
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 Physician care

148 

\$		,								.	0	0
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 Hospital care

## FAMILY DEDUCTIBLES

**14a. Did this plan require that a specific number of family members must meet their individual deductibles before the family deductible was met?**

- 224 1  Yes – Continue with question 14b  
 2  No – **SKIP to question 14c**  
 3  Family coverage not offered – **SKIP to Page 6, question 15a**

**b. How many family members were required to meet their individual deductibles before the family deductible was met?**

Report for typical situations and enrollees.

150 



 Number of family members

**c. What was the total annual deductible a family paid?**

Report for a family of four.

149 

\$		,								.	0	0
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 Total annual family deductible

## PAYMENTS

**15a. Was hospital care covered under this plan?**

- 155 1  Yes – Continue with question 15b  
 2  No – **SKIP to question 15c**

**b. How much and/or what percentage of the total bill did an enrollee pay out-of-pocket for an inpatient hospital stay after any annual deductible was met?**

Some plans may have both a dollar amount and a percentage copayment.

**Out-of-pocket expense** – Those costs paid directly by the enrollee.

*Report for precertified hospital stays (if applicable).*

*Report the copayment for stays at "in-network"/participating hospitals (if applicable).*

*Do not include any physician charges incurred during the hospital stay.*

152 

\$	,							.	0	0
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 Amount paid by enrollee for hospital care

- 154 1  Per day  
 2  Per stay

**AND/OR**

153 

	%
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 Paid by enrollee

**c. Was physician care covered under this plan?**

- 218 1  Yes – Continue with question 15d  
 2  No – **SKIP to question 16a**

**d. How much and/or what percentage of the total bill did an enrollee pay out-of-pocket for an office visit after any annual deductible was met?**

Some plans may have both a dollar amount and a percentage copayment.

**Out-of-pocket expense** – Those costs paid directly by the enrollee.

*Report the copayment for an "in-network"/participating general practitioner during normal office hours.*

156 

\$								.	0	0
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 Amount paid by enrollee for office visit

**AND/OR**

157 

	%
--	---

 Paid by enrollee

**16a. What was the maximum amount this plan would have paid for an enrollee over his/her lifetime?**

159 

\$	,										.	0	0
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**OR**

158  No lifetime maximum

**b. What was the maximum amount this plan would have paid for an enrollee in one year?**

160 

\$	,										.	0	0
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**OR**

221  No annual maximum

**17a. What was the maximum annual out-of-pocket expense for an individual?**

**Out-of-pocket expense** – Those costs paid directly by the enrollee.

This is often referred to as a catastrophic limit.

*Include all copayments and deductibles.*

161 

\$	,							.	0	0
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**OR**

163  No individual maximum

**b. What was the maximum annual out-of-pocket expense for a family of four?**

162 

\$	,							.	0	0
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**OR**

222  No family maximum

## PLAN CHARACTERISTICS

**18a. Could this plan have refused to cover persons with certain pre-existing medical or health conditions?**

- 183 1  Yes – Continue with question 18b  
 2  No – SKIP to question 19

**b. Did this happen in 1999?**

- 184 1  Yes  
 2  No

**19. Did this plan have a policy requiring a waiting period before covering pre-existing conditions?**

- 185 1  Yes  
 2  No

**20. In what month did the plan year begin?**

Enter a two-digit numeric response.  
 Example: January = 01; May = 05

123   Month

**21. Which of the services listed were covered by this plan?**

		Yes (1)	No (2)	Don't know (3)
164	Routine mammograms . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
165	Adult routine physical exams . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
166	Routine pap smears . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
167	Office visits for prenatal care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
168	Adult immunizations . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
169	Child immunizations . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
170	Well-baby care, under 1 year . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
171	Well-child care, 1–4 years . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
173	Chiropractic care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
174	Other non-physician providers (such as physical therapists, podiatrists, and midwives) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
175	Outpatient prescriptions . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
176	Routine dental care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
177	Orthodontic care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
178	Skilled nursing facility (convalescent care) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
179	Home health care . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
180	Inpatient mental illness . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
181	Outpatient mental illness . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
182	Alcohol/substance abuse treatment . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**\*\*\* PLEASE NOTE \*\*\***

**If your organization offered only one health insurance plan, please end the form.**

**If your organization offered more than one health insurance plan, please complete a General Plan Information Questionnaire for each plan that was offered, up to four plans.**