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FORM **MEPS-10**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

ESTABLISHMENT QUESTIONNAIRE

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
2. Coverage could have been purchased from an insurance company, provided by a union or trade association, or self-insured by your company.
3. **Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
4. **High and low** options of a plan offered by the same insurance company count as **two plans**.
5. An **HMO** and a **conventional** plan offered by the same insurance company count as **two plans**.
6. If your company operates at more than one location, provide information for the **location on the label** unless otherwise directed.
7. Count **owners and officers** as employees in the enrollment questions if they were eligible for coverage along with the other employees at this location.
8. For the deductibles, copayments, and premiums, **report for typical situations and enrollees**. If cost varies by family size, use a **family of four**. If cost varies by age, provide the information for the average age of your workers.
9. **Estimates** are acceptable if you do not have this information readily available.
10. Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A – NUMBER OF PLANS

A1. Did you make available or contribute to the cost of any health insurance plans for your employees or retirees on July 1, 1996? *See instructions 1–5 above for a description of health insurance plans.*

001 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section D on page 5.**

How many? 003 ☐ ↙

Continue with Section B on page 2.

Section B – PLAN CHARACTERISTICS

B1. On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier?

If you have received Supplemental Sheets (Form MEPS-10(S)) with plan names preprinted in Question B1, answer only for the preprinted plans. Otherwise, provide data for your 4 largest plans. You may make a copy of the Supplemental Sheet, or Section B of this form, if necessary.

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100

012 Name of plan

102 Name of insurance carrier

B2. Indicate the type of providers in this plan.

103
1 ☐ **Exclusive providers** – 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. (For example, HMOs, IPAs, EPOs)

2 ☐ **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)

3 ☐ **Mixture of preferred and any providers** – Enrollees can 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. (For example, PPOs, POSs)

B3. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the type of indemnification of this plan.

105
1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

If purchased, go to Question B6.

2 ☐ **Self-insured** – Your company pays the claims from its resources and may charge a premium to employees. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

For self-insured plans only:

B5a. Indicate if you administered the plan or if you employed a third party.

106
1 ☐ Self-administered
2 ☐ Insurance company or other administrator

b. Did you purchase stop-loss coverage?

107 1 ☐ Yes 2 ☐ No

B5c. Enter this establishment's **total annual cost** of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include employer and employee contributions.

108 $ .00 *If this is the only plan you offered, also enter this amount in Question C3 on page 4.*

d. Enter the **monthly premium equivalents** (or the COBRA amount if premium equivalents were not calculated) for single and family (of four) coverage for a typical full-time employee. Include the costs entered in B5c. *Also enter this information in Question B11a (single) and B11b (family) – Total premium on page 3.*

109 $ .00 Single coverage

110 $ .00 Family coverage

e. Is the amount entered in B5d –

111
1 ☐ A premium equivalent?
2 ☐ A COBRA amount?

If self-insured, go to Question B7.

B6. Was this plan purchased through a pooling arrangement with other employers such as a multi-employer trust (MET) or a multi-employer welfare arrangement (MEWA)?

112 1 ☐ Yes 2 ☐ No

B7. Was this plan operated by a –

113 1 ☐ Union ↙ 2 ☐ Trade Association ↙ 3 ☐ Neither

114 Name of union or trade association | 115 Local number, if a union

116 Name of insurance representative

117 Address *(Number and street)*

118 City | 119 State | 120 ZIP Code

121 Telephone number

( )

B8. Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a union or government)?

122 1 ☐ Yes 2 ☐ No

B9. In what month did the plan year begin?

Enter a numeric response (e.g., Jan = 01, May = 05). 123 ☐☐ Month

Control No.

Section B – PLAN CHARACTERISTICS – Continued

B10a. For this plan, enter the total number of enrollees excluding dependents for this establishment on July 1, 1996.

124 ☐

b. Enter the total number of active employees enrolled.

125 ☐

c. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.

126 ☐

d. Enter the number of retirees enrolled.

127 ☐ Total 128 ☐ 65 and older

e. Enter the **total** number of enrollees with **single** coverage.

129 ☐

B11a. Enter this plan's **total** premium, employer contribution, and employee contribution for a typical full-time employee with **single** coverage.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

130 $ .00 Total premium

131 $ .00 Employer contribution

132 $ .00 Employee contribution

Indicate the premium period ↙

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

b. Enter this plan's **total** premium, employer contribution, and employee contribution for an enrolled **family** (of four).

Report for the same premium period as in Question B11a.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

134 $ .00 Total premium

135 $ .00 Employer contribution

136 $ .00 Employee contribution

137 ☐ Family coverage was not offered

B12a. Did the **premiums** (not contributions) vary by –

Check all that apply.

138 ☐ Age?
139 ☐ Sex?
140 ☐ Number of persons (within family coverage)?
141 ☐ Wage or salary levels?
142 ☐ Other? – *Specify*
099 ☐

B12b. Did the **amount of the employee contribution** (not premium) vary for different employee categories (e.g., full-time, part-time, retiree)?

143 1 ☐ Yes 2 ☐ No

B13. Did this plan's **premium** include either of these services?

Check all that apply.

144 ☐ Life insurance 145 ☐ Disability insurance

B14. Enter the **annual deductibles** that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 $ .00 **Total individual annual deductible OR** ↙

Separate deductibles for:

147 $ .00 Physician care

148 $ .00 Hospital care

If the deductible is per overnight hospital stay, report under B15a.

149 $ .00 **Total family annual deductible** *(if applicable)* ↙

150 ☐ Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 ☐ Plan did not have a deductible

B15a. How much did an **enrollee** pay for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 $ .00 → 154 1 ☐ Per day 2 ☐ Per stay

OR

153 ☐ Percent **OR**

155 ☐ Hospital care was not covered

b. How much did an **enrollee** pay for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 $ .00

OR

157 ☐ Percent **OR**

218 ☐ Physician care was not covered

B16. What was the maximum amount this plan would have paid for an individual –

a. Over the enrollee's lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

Section B – PLAN CHARACTERISTICS – Continued

B17. What was the maximum annual out-of-pocket amount for –

a. An individual?

161 $ .00

b. A family (of four)?

162 $ .00

163 ☐ No maximum

B18. Indicate which of these services were included in the plan.

Check all that apply.

164 ☐ Routine mammograms
165 ☐ Adult routine physical exams
166 ☐ Routine pap smears

167 ☐ Office visits for prenatal care

168 ☐ Adult immunizations
169 ☐ Child immunizations

170 ☐ Well-baby care, under 1 year
171 ☐ Well-child care, 1–4 years
172 ☐ 100% well-baby care

173 ☐ Chiropractic care
174 ☐ Other non-physician providers
175 ☐ Outpatient prescriptions

176 ☐ Routine dental care
177 ☐ Orthodontic care

178 ☐ Nursing home care
179 ☐ Home health care

180 ☐ Inpatient mental illness
181 ☐ Outpatient mental illness
182 ☐ Alcohol/substance abuse treatment

B19. Could this plan have refused to cover persons with certain preexisting conditions?

183 1 ☐ Yes ↙ 2 ☐ No

Did this happen in 1996?

184 1 ☐ Yes 2 ☐ No

B20. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No

B21a. Is this plan offered in 1997?

186 1 ☐ Yes – **If Yes, go to Question B21c.**
2 ☐ No

b. If it is not still offered, indicate if it has been –

187 1 ☐ Replaced with a similar plan
2 ☐ Replaced by a substantially different plan
3 ☐ Dropped without offering a replacement – **Go to Section C.**

c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B11a on page 3.

188 ☐ Single enrollment

189 ☐ Family enrollment

190 $ .00 Single premium

191 $ .00 Family premium

Please complete one Supplemental Sheet for each additional hospital/physician plan you offered your employees and retirees on July 1, 1996. You may use photocopies of the Supplemental Sheet or Section B of this form, if necessary.

Section C – GENERAL HEALTH COVERAGE CHARACTERISTICS

C1a. Did you offer **optional** coverage (not included in the basic health coverage) for any of these services in 1996 at an additional premium to the employee?

Check all that apply.

192 ☐ Dental
193 ☐ Vision
194 ☐ Prescription drugs
195 ☐ Long-term care

b. What was the total amount paid for these coverages in 1996? *Include employer and employee contributions.*

196 $ .00

C2a. Did you impose a waiting period before new employees could be covered by health insurance?

197 1 ☐ Yes ↙ 2 ☐ No

b. What was the typical waiting period?

198 1 ☐ Less than 2 weeks
2 ☐ 2 weeks to less than 1 month
3 ☐ 1–3 months
4 ☐ More than 3 months

C3. Enter the total annual cost of coverage for the plan year that included July 1, 1996 for **ALL** hospital/physician plans that you offered **at this location**. *Include employer and employee contributions.*

199 $ .00

Control No.

Section D – EMPLOYMENT CHARACTERISTICS

D1. Enter the number of employees on your payroll at the location printed on the label for each of the categories below. Report for the pay period that included July 1, 1996. **If you offered health insurance**, also enter the number of employees eligible and enrolled for coverage through your organization. *Include officers and owners. Exclude leased, contract or agency workers.*

a. All employees

Total	Eligible	Enrolled
200	201	202

b. Part-time employees

Total	Eligible	Enrolled
203	204	205

c. Temporary (seasonal) employees

Total	Eligible	Enrolled
206	207	208

d. Were retirees eligible to receive health insurance (other than through COBRA or other continuation-of-benefits laws) on July 1, 1996?

219 1 ☐ Yes – *Check all that apply* 2 ☐ No

209 ☐ Retirees under 65 years
210 ☐ Retirees 65 years and over

D2. For the pay period that included July 1, 1996 –

a. Enter the number of women employees . . . . . 038 ☐

b. Enter the number of employees 50 years old or older . . . . . 039 ☐

c. Enter the number of employees who were union members . . . . . 040 ☐

d. Enter the number of employees who earned –

(1) Less than $6.50 per hour . . . . . 042 ☐

(2) Between $6.50 and $15.00 per hour . . . 043 ☐

(3) More than $15.00 per hour . . . . . 044 ☐

D3. How many hours per week must an employee work to be considered full time at your establishment?

041 ☐ Hours

Section E – COMPANY CHARACTERISTICS

E1. Do you offer any of these fringe benefits?

Check all that apply.

050 ☐ Paid vacation
051 ☐ Paid sick leave
052 ☐ Life insurance
053 ☐ Disability insurance
054 ☐ Retirement/pension plans
055 ☐ Medical Savings Accounts (MSAs)
056 ☐ Flexible spending accounts

057 ☐ Cafeteria plan –
Enter the average annual value per employee → 058 $ .00

E2. Which of these categories **best** describes your type of ownership?

Check only ONE.

062 1 ☐ S Corporation
2 ☐ Corporation
3 ☐ Partnership
4 ☐ Sole Proprietorship
5 ☐ Government (Federal, state, or local)
6 ☐ Joint venture or cooperative

E3. Is this a nonprofit business?

063 1 ☐ Yes 2 ☐ No

E4. Which of these categories **best** describes your principal business activity?

Check only ONE.

060 1 ☐ Retail trade
2 ☐ Personal services (e.g., beauty shops, dry cleaners)
3 ☐ Business services (e.g., advertising, computer processing)
4 ☐ Other services (e.g., legal and health services)
5 ☐ Manufacturing
6 ☐ Wholesale trade
7 ☐ Finance, insurance, or real estate
8 ☐ Transportation, communications, electric, gas, or sanitary services
9 ☐ Construction
10 ☐ Agriculture or forestry
11 ☐ Mining
12 ☐ Public administration

E5. How many years has your company been in business? *If you operate at multiple locations, enter the number of years in business for the entire enterprise.*

064 ☐ Years

E6. Enter the total number of employees your business has at all locations.

034 ☐ Employees

Section F – TO BE COMPLETED IF YOU DID NOT OFFER HEALTH INSURANCE COVERAGE

F1a. Has your business offered any health insurance as a benefit to the employees or retirees of this location since January 1, 1991?

031 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Question F2.**

b. In what year did your business last offer health insurance coverage to the employees of this location?

032 | 1 | 9 | 9 | | Last year offered

F2. Did you pay the medical or hospital bills of your employees directly, other than for workers' compensation and/or injuries suffered on the job?

049 1 ☐ Yes 2 ☐ No

F3a. Instead of providing a health plan in 1996, did you provide a voucher or stipend to your employees which could be used to purchase health insurance?

045 1 ☐ Yes 2 ☐ No – **If No, go to Section G.**

b. Could this voucher or stipend be used for –

046 1 ☐ Health insurance/health care only?
2 ☐ Other purposes as well?

c. What was the average value per employee of this voucher or stipend?

047 $ .00 PER → 048 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

500 Remarks

Section G – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title	
Signature		214 Date
215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS