MEPS-20(D)
(03-08-2013)

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 DEFINITIONS

ACTIVE EMPLOYEE – A person who was employed full- or part-time in 2013 regardless of whether the employee was considered permanent, temporary, or seasonal. Include owners and officers of the organization. Exclude individuals who were contract laborers, retirees, laid off, or left employment prior to 2013.

CAFETERIA PLAN – ***See Flexible Benefits Plan.***

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Part of this law requires employers to continue offering health coverage for enrollees and their dependents for a period of time after an enrollee leaves the firm. Typically, the enrollee pays the entire monthly premium when covered by COBRA. COBRA coverage for State and local governments was transmitted through the Public Health Service Act and may also be referred to as **PHSA** coverage or **PHSA (COBRA)** coverage.

COINSURANCE – A fixed percentage that an enrollee pays for medical expenses after the deductible amount, if any, was paid. Coinsurance rates may differ for different types of services. For example, an enrollee may pay a 10% rate for doctor fees, a 20% rate for hospital fees, and a 5% rate for prescription fees.

COPAYMENT – A fixed dollar amount that an enrollee pays when medical service is received, regardless of the total charge for service. The insurer is responsible for the rest of the total charge. For example, an enrollee may pay a $20 copay for each doctor's office visit, $150 for each day in the hospital, and $20 for each prescription.

DEDUCTIBLE – A fixed dollar amount during the benefit period (usually a year) that an insured person pays before the insurer starts to make payments for covered medical services. For example, if the plan has a $1000 deductible, the insured person would be responsible for the first $1000 of covered medical services. Plans may have both individual and family deductibles. Plans may have separate deductibles for specific services.

DOMESTIC PARTNERS – Unmarried couples of the same or opposite sex who live together and share a common domestic life.

EMPLOYEE-PLUS-ONE COVERAGE – Health insurance coverage for an employee-plus-spouse or an employee-plus-child(ren) AT A LOWER PREMIUM LEVEL than family coverage.

EMPLOYEE PRE-TAX CONTRIBUTIONS TO HEALTH INSURANCE – Also known as a Premium Only Plan (POP), this is the most basic type of Section 125 Plan. An employee pays his/her share of the premium for employer-sponsored health insurance through a payroll deduction prior to taxes being withheld. This lowers the amount of income on which the employee must pay taxes.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN – A restrictive type of preferred provider organization plan under which enrollees must use providers from the specified network of physicians and hospitals to receive coverage except in an emergency situation.

FAMILY COVERAGE – A health plan that covers the enrollee and members of his/her immediate family (spouse and/or children). For purposes of this survey, "family coverage" is any coverage other than single and employee-plus-one (see definitions). Some plans offer more than one rate for family coverage, depending on family size and composition. If more than one rate is offered, report costs for a family of four.

FLEXIBLE BENEFITS PLAN (Full Cafeteria Plan) – A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits which may include cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Employee contributions may be made for additional coverage.

FLEXIBLE SPENDING ACCOUNT (FSA) – An account offered and administered by employers that provides a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of medical expenses not covered by the employer's health plan. In 2013, the maximum amount allowed in an individual's FSA is $2,500. Typically, benefits or cash must be used within the given benefit year or the employee loses the money.

GATEKEEPER – A gatekeeper is responsible for coordinating (managing) all services, approving referrals and directing patients to specialists or health care facilities. Gatekeepers are associated with prepaid health plans. A gatekeeper may or may not be a physician.

GRANDFATHERED HEALTH PLANS – Plans that existed before the Patient Protection and Affordable Care Act (PPACA) was enacted. Plans certified to be grandfathered plans are not subject to all of the PPACA requirements.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – This federal law, enacted in 1996, protects health insurance coverage for workers and their families when they change jobs by limiting exclusions for pre-existing conditions, prohibiting discrimination against employees and dependents based on their health status, and guaranteeing renewability and availability of health coverage to certain employers and individuals.

Continued on reverse

HEALTH MAINTENANCE ORGANIZATION (HMO) – A health care system in which plan participants obtain comprehensive health care services from a specified list of "in-network" providers who receive a fixed periodic prepayment from the insurer. Plan participants' access to "in-network" providers is controlled by a primary-care physician or gatekeeper. HMOs typically do not have a deductible.

HEALTH SAVINGS ACCOUNT (HSA) – A trust account owned by the employee for the purpose of paying for medical expenses not covered by the employer's health plan. The employee must be enrolled in a high deductible health plan that is HSA-eligible in order to qualify for an HSA. Both employers and employees can contribute to an HSA. Unused funds are carried over to the following year.

LONG-TERM CARE INSURANCE – Covers all forms of health care (both institutional and non-institutional) required by the chronically ill or disabled. Normally provided as optional coverage.

OPTIONAL COVERAGE ***(Single service plans)*** – Separate coverage for a limited area of medical care to supplement the basic health insurance plan. Often, these plans are offered through an insurance company/carrier separate from the one providing basic health coverage. An additional premium is paid by the enrollee and/or employer for this optional coverage. (Example: Dental or Vision Plan)

POINT-OF-SERVICE PLAN (POS) ***(Also called open-ended HMO or HMO/PPO hybrid)*** – Plan participants' access to "in-network" providers is controlled by primary-care doctors or gatekeepers. Participants are covered when they seek care from out-of-network providers, but at reduced coverage levels.

PRE-EXISTING CONDITION LIMITATION – Restricts coverage for medical or health conditions which exist prior to enrollment in a health plan.

PREFERRED ("IN-NETWORK"/PARTICIPATING) PROVIDER – A medical provider (doctor, hospital, pharmacy) who is a member of a health plan's network. Enrollees generally pay lower or no copayment for services from a preferred provider.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN – A plan that provides coverage to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

PREMIUM – Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured person and the plan sponsor.

PREMIUM EQUIVALENT – For self-insured plans, this is the cost per covered enrollee, or the amount the organization would expect to pay in premiums if the plan were insured by someone else. The premium equivalent is equal to the per-capita amount of claims, administration, and stop-loss premiums for a self-insured plan.

PURCHASED PLAN ***(Also called a fully-insured plan)*** – A health plan is considered purchased when the financial risk for the enrollee's medical claims is assumed by a health insurance company/carrier.

SELF-INSURED PLAN – A health plan is self-insured when the financial risk for the enrollee's medical claims is assumed partially or entirely by the organization offering the plan. Organizations with self-insured plans commonly purchase stop-loss coverage from an insurer who agrees to bear the risk (or stop the loss) for those expenses exceeding a predetermined dollar amount.

SINGLE COVERAGE – A health plan that covers the employee only.

SMALL BUSINESS HEALTHCARE TAX CREDIT – A small employer may be eligible for this credit on its federal income taxes if 1.) it has fewer than 25 full-time equivalent employees, 2.) pays an average wage of less than $50,000 per year, and 3.) pays at least half of the health insurance premiums for its employees.

STATE CONTINUATION-OF-BENEFITS LAWS – Laws which vary by state mandating that organizations provide enrollees with the option of continuing to purchase insurance through the organization for a limited amount of time after they leave the organization.

STOP-LOSS COVERAGE – A form of reinsurance for organizations with self-insured health plans which limits the amount the firm will have to pay for each enrollee's healthcare (**the specific (individual) stop-loss coverage** amount) or for the total health expenses of the firm (the aggregate stop-loss coverage amount).

THIRD PARTY ADMINISTRATOR (TPA) / ADMINISTRATIVE SERVICES ONLY (ASO) – An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of a self-insured health plan. The TPA's and ASO's are not the policyholders or the insurers. The two terms are often used interchangeably with ASO more frequently used when an insurance company provides the service.

TYPICAL PAY PERIOD – Any pay period during calendar year 2013 in which employment was neither unusually high nor unusually low.

UNDERWRITER – The company that issues an insurance policy and assumes the financial risk for covered individuals.

If you would like more information on the Medical Expenditure Panel Survey – Insurance Component (MEPS–IC) or the survey sponsor, the Agency for Healthcare Research and Quality (AHRQ), please visit the AHRQ Website at <http://www.meps.ahrq.gov>.