

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

2019 Medical Expenditure Panel Survey
Insurance Component

HEALTH INSURANCE COST STUDY PLAN INFORMATION QUESTIONNAIRE

INSTRUCTIONS

REPORT FOR UP TO FOUR HEALTH INSURANCE PLANS OFFERED IN 2019 AT THE LOCATION LISTED ABOVE.

Please use photocopies of this MEPS-10(S) form if sufficient copies were not included in this reporting package.

GENERAL PLAN INFORMATION

If a plan name is preprinted in the Question 1 answer box below, answer for the plan specified. Otherwise, complete this Plan Information Questionnaire for the plan with the largest (or next largest) enrollment of active employees.

1 For 2019, what was the name of the health insurance plan with the largest (or next largest) enrollment of ACTIVE employees?

- Examples:
- Blue Cross Blue Shield, High Option
 - Option A
 - Aetna HMO

012 Name of plan

2 Which type of health care provider arrangement was available through this plan?

Exclusive providers - Enrollees must go to "in-network" providers associated with the plan for all non-emergency care in order for the costs to be covered.

Any providers - Enrollees may go to providers of their choice with no cost incentives to use a particular group of providers. This is also known as an indemnity plan.

Mixture of preferred and any providers - Enrollees may go to any provider, but there is a cost incentive to use a particular group of providers.

- 103
- 1 Exclusive providers
 - 2 Any providers
 - 3 Mixture of preferred providers and any providers

3 Did this plan REQUIRE that the enrollee see a gatekeeper or primary-care physician in order to be referred to a specialist?

For plans with multiple options, answer for the "in-network" option.

- 104
- 1 Yes
 - 2 No
 - 3 Don't know

4 Was this plan offered through a union (multi-employer health plan) or a trade or business association (Association Health Plan (AHP))?

Multi-employer Health Plan – An employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers.

Association Health Plan (AHP) – A group health plan that employer groups and associations offer to provide health coverage for their employees or members.

- 113
- 1 Union (multi-employer health plan)
 - 2 Trade or business association (AHP)
 - 3 Neither

Continue with 5

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ACTIVE ENROLLMENT

Estimates are acceptable for all enrollment figures.

For Questions 8a through 8d, if the answer is **NONE**, please enter "0".

Include:

- Full-time and part-time employees
- Temporary and seasonal employees

Exclude:

- Retirees
- Former employees
- Leased or contract workers

- 8** a. How many active employees were enrolled in this plan at this location during a typical pay period? 125 Active employees enrolled in plan
-
- b. How many of these active employees were enrolled in **SINGLE** coverage during a typical pay period? 129 Active employees enrolled in single coverage
-
- c. If this plan had **EMPLOYEE-PLUS-ONE** coverage, how many active employees were enrolled during a typical pay period? 571 Active employees enrolled in employee-plus-one coverage
- Include enrollment for both employee-plus-spouse and employee-plus-child coverage.*
-
- d. How many active employees were enrolled in **FAMILY** coverage during a typical pay period? 705 Active employees enrolled in family coverage

COBRA ENROLLMENT

- 9** How many **FORMER** employees were enrolled in this plan, excluding retirees, through **COBRA** or state continuation-of-benefits laws during a typical pay period? 126 Former employees enrolled in plan, excluding retirees

PLAN PREMIUMS

Report for **TYPICAL** situations and enrollees. If premiums varied, report for a **TYPICAL** employee.

If this was a self-insured plan, report the premium equivalent.

Report employer/employee contributions and total premium for the same period during 2019.

- 10** The following questions, 11a through 13e, refer to plan premium amounts. For which time period will you be reporting? 790
- Mark (X) only one.
- 1 Weekly
 - 2 Every 2 weeks
 - 3 Monthly
 - 5 Quarterly
 - 4 Yearly

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Continue with **11a**

GENERAL PREMIUM INFORMATION

14 a. Did the amount individual EMPLOYEES contributed toward their single coverage premium vary by any of these characteristics?

Do not include incentive programs that do not impact contributions.

| | Yes (1) | No (2) | Don't know (3) |
|--|--------------------------|--------------------------|--------------------------|
| 734 Participation in a fitness/weight loss program | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 735 Participation in a smoking cessation program | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 761 Wellness/Health monitoring | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 784 Age | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 785 Wage or Salary levels | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

b. Was the TOTAL PREMIUM for an employee with single coverage higher for older workers?

- 749
- 1 Yes
 - 2 No
 - 3 Don't know

DEDUCTIBLES

15 Did this plan have a deductible?

- 151
- 1 Yes - Continue with **16**
 - 2 No - **SKIP to 19a**

16 What were the annual deductibles in this plan for different levels of coverage?

Report "in-network" deductibles (if applicable).

If deductible was per overnight hospital stay, it is not an annual deductible and should be reported under Question 20b on Page 7.

If prescription drugs had a separate deductible, it should be reported under Question 22c on Page 7.

DO NOT report COPAYMENTS or individual or family out-of-pocket maximums here.

146 Individual annual deductible

786 Employee-plus-one annual deductible

791 Employee-plus-one coverage not offered

149 Family annual deductible

792 Family coverage not offered

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

- 224
- 1 Yes - Continue with **17b**
 - 2 No
 - 3 Family coverage not offered
- } **SKIP to 18a**

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

Report for a family of four.

150 Number of family members

Continue with 18a

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HEALTH SAVINGS ACCOUNT (HSA)

Complete only if the deductibles for this plan were \$1,350 or higher for single coverage and/or \$2,700 or higher for family coverage, otherwise skip to Question 19a.

- 18 a. Did your organization contribute to a Health Savings Account (HSA) for the plan enrollees?** 714
- | | | | |
|---|--------------------------|----------------------------------|----------------------|
| 1 | <input type="checkbox"/> | Yes, contributed to an HSA | } SKIP to 19a |
| 2 | <input type="checkbox"/> | No, did not contribute to an HSA | |
| 4 | <input type="checkbox"/> | Don't know | |

- b. What was the MONTHLY contribution your organization made to the HSA for a typical employee with single coverage for this plan?** 777
- | | | |
|--|--|--|
| | \$ <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> .00 | Monthly HSA contribution for single coverage |
|--|--|--|

This amount should NOT include the amount your organization contributed toward the plan premium.

- c. What was the MONTHLY contribution your organization made to the HSA for a typical employee with family coverage for this plan?** 778
- | | | |
|--|--|--|
| | \$ <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> .00 | Monthly HSA contribution for family coverage |
|--|--|--|

This amount should NOT include the amount your organization contributed toward the plan premium.

Report for a family of four.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

- 19 a. Did your organization offer a Health Reimbursement Arrangement (HRA) associated with this plan?** 710
- | | | | |
|---|--------------------------|----------------------------------|----------------------|
| 1 | <input type="checkbox"/> | Yes, contributed to an HRA | } SKIP to 20a |
| 2 | <input type="checkbox"/> | No, did not contribute to an HRA | |
| 3 | <input type="checkbox"/> | Don't know | |

An employer can offer an HRA by setting up an account to reimburse employees for medical expenses not covered by health insurance.

HRAs are NOT Flexible Spending Accounts (FSAs) or Health Savings Accounts (HSAs). See definition sheet MEPS-20(D) for more information.

- b. Up to what dollar amount did your organization contribute ANNUALLY to a typical employee's HRA for single coverage for this plan?** 779
- | | | |
|--|--|---|
| | \$ <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> .00 | Annual HRA contribution for single coverage |
|--|--|---|

This amount should NOT include the amount your organization contributed toward the plan premium.

- c. Up to what dollar amount did your organization contribute ANNUALLY to a typical employee's HRA for family coverage for this plan?** 780
- | | | |
|--|--|---|
| | \$ <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> <input style="border: 1px solid black;" type="text"/> .00 | Annual HRA contribution for family coverage |
|--|--|---|

This amount should NOT include the amount your organization contributed toward the plan premium.

Report for a family of four.

Continue with 20a



PAYMENTS

- 20 a. Was hospital care covered under this plan?** 155
- 1 Yes - Continue with **20b**
- 2 No - **SKIP to 21a**

- b. How much and/or what percentage of the total bill did an enrollee pay out-of-pocket for an inpatient hospital admission after any annual deductible was met?** 152
- Report for precertified hospital admissions (if applicable).*
- Report for an admission at an "in-network"/participating hospital (if applicable).*
- Do not include any physician charges incurred during the hospital admission.*
- 153 % Copayment paid by enrollee for hospital admission
- 154 1 Per day
- 2 Per stay
- AND/OR**
- 153 % Coinsurance paid by enrollee

- 21 a. Was physician care covered under this plan?** 218
- 1 Yes - Continue with **21b**
- 2 No - **SKIP to 22a**

- b. How much and/or what percentage of the total bill did an enrollee pay out-of-pocket for a General Practitioner office visit, with a participating physician, after any annual deductible was met?** 156
- Report for an "in-network"/participating general practitioner, excluding preventive care visits.*
- 156 .00 Copayment paid by enrollee for office visit
- AND/OR**
- 157 % Coinsurance paid by enrollee

- c. How much and/or what percentage of the total bill did an enrollee pay out-of-pocket for a Specialist Physician office visit after any annual deductible was met?** 771
- Report for an "in-network"/participating specialist, excluding preventive care visits.*
- 771 .00 Copayment paid by enrollee for Specialist Physician office visit
- AND/OR**
- 772 % Coinsurance paid by enrollee

- 22 a. Were prescription drugs covered under this health plan?** 673
- 1 Yes - Continue with **22b**
- 2 No
- 3 Don't know
- SKIP to 23**

- b. Did this plan have a SEPARATE ANNUAL deductible that applies only to prescription drugs?** 773
- 1 Yes - Continue with **22c**
- 2 No
- 3 Don't know
- SKIP to 22d**

- c. What was the SEPARATE ANNUAL deductible for prescription drugs for single coverage in this plan?** 774
- Report "in-network" prescription deductibles for participating pharmacies (if applicable).*
- 774 .00 Separate individual prescription drug deductible

Continue with **22d**

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PLAN CHARACTERISTICS

24 Which of the services listed were covered by this plan?

Yes (1) No (2) Don't know (3)

| | | | | |
|-----|---|--------------------------|--------------------------|--------------------------|
| 173 | Chiropractic care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 736 | Routine vision care for children. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 587 | Routine vision care for adults. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 737 | Routine dental care for children. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 176 | Routine dental care for adults. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 738 | Mental health care. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 182 | Substance abuse treatment | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 781 | Telemedicine. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Telemedicine is the delivery of health care through telecommunications to a patient from a provider who is at a remote location.

25 Was this a grandfathered health plan as defined by the Affordable Care Act?

See the definition sheet MEPS-20(D) included with this package for an explanation.

- 739
- 1 Yes
 - 2 No
 - 3 Don't know

***** PLEASE NOTE *****

If your organization offered only one health insurance plan, you have completed your response to this survey.

If your organization offered MORE THAN ONE health insurance plan, please complete a Plan Information Questionnaire for each plan that was offered, up to four plans.

Feel free to include any health insurance brochure information you may have in your return packet or fax to 1-800-447-4613.

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