MEPS-20(D)
(03-29-2017)

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 2017 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 2017.

ACTUARIAL VALUE – The percentage of medical expenses paid by the plan, rather than out-of-pocket by a typical group of enrollees. As plans increase in actuarial value, they would cover a greater share of enrollees' medical expenses overall.

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.

DOMESTIC PARTNERS – Unmarried couples of the same or opposite sex who live together and share a common domestic life. People in a common-law marriage should not be considered domestic partners.

EMPLOYEE-PLUS-ONE COVERAGE – Health insurance coverage for an employee-plus-spouse or an employee-plus-child 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.

FLEXIBLE SPENDING ACCOUNT (FSA) – An account offered and administered by employers that provides a way for employees to set aside, out of their paycheck, pre-tax dollars to pay for the employee's share of medical expenses not covered by the employer's health plan. In 2017, the maximum amount allowed in an individual's FSA is $2,600. Typically, benefits or cash must be used within the given benefit year or the employee loses the money.

FULL-TIME EQUIVALENT (FTE) – An FTE is the number of working hours that represents one full-time employee during a specific time period, such as a week. A FTE is 30 hours per week for purposes of determining whether an employer is eligible to obtain health insurance through a SHOP exchange and 40 hours per week for purposes of determining whether an employer is eligible for the Small Business Healthcare Tax Credit. See healthcare.gov for details.

GATEKEEPER – A gatekeeper is responsible for coordinating (managing) all services, approving referrals and directing patients to specialists or health care facilities.

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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 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.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) – An agreement where an employer funds a predetermined amount of expenses to pay an employee per benefit year for out-of-pocket medical costs, including health insurance premiums. The HRA funds may be carried over to the next benefit year. The HRA does not have to be used in conjunction with any health plan.

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.

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 of 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.

PRIVATE EXCHANGE – An employer may choose to contract with a private exchange to provide a set of health insurance plans to be offered to its employees. Private exchanges are Affordable Care Act (ACA) compliant but are not the same as the Federal exchange or marketplace (at healthcare.gov) or those run by individual states.

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 (see definition).

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 (FTE) 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. Effective in 2014, small businesses obtaining coverage for their employees through a Small Business Health Options Program (SHOP) exchange are eligible for a tax credit.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) – SHOP exchanges are health insurance marketplaces that provide a variety of health insurance plans which small businesses can purchase for their employees. Each State has its own SHOP exchange that is administered by either the State or federal government. Coverage through an exchange is provided by private-sector insurance companies who choose to offer plans in the exchange. SHOP exchanges were created under the federal Patient Protection and Affordable Care Act of 2010. Effective in 2016, SHOP exchanges are available to employers with 100 or fewer full-time-equivalent (FTEs) employees. See healthcare.gov for details.

SPECIALTY DRUGS – Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. Additionally, specialty drugs include specifically identified types of drugs, such as lifestyle drugs and biologics.

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.

TYPICAL PAY PERIOD – Any pay period during calendar year 2017 in which employment was neither unusually high nor unusually low.

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>.