

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

2021 Medical Expenditure Panel Survey  
Insurance Component

# HEALTH INSURANCE COST STUDY PLAN INFORMATION QUESTIONNAIRE

## INSTRUCTIONS

**REPORT FOR UP TO FOUR HEALTH INSURANCE PLANS OFFERED IN 2021 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 2021, 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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### GENERAL PLAN INFORMATION - Continued

**5 Was this plan purchased from an insurance underwriter or was it self-insured?**

- 105  1 Purchased - **SKIP to 7**
- 2 Self-insured - Continue with **6a**
- 3 Don't know - **SKIP to 7**

**Purchased from an insurance underwriter -** (Fully-insured) Coverage is purchased from an insurance company or other underwriter who assumes the risk for the enrollees' medical expenses.

**Self-insured -** Your organization assumes the risk for the enrollees' medical expenses and may charge a premium to employees. This plan may be administered by a third party and may employ supplemental stop-loss insurance to limit unanticipated losses.

### SELF-INSURED PLAN INFORMATION

**6 a. Did your organization employ a third party administrator (TPA) or purchase administrative services only (ASO) from an insurer for this self-insured plan?**

- 713  1 Yes - Used a TPA or ASO
- 2 No - Self-administered the plan

**b. Did your organization purchase stop-loss coverage for this plan?**

- 107  1 Yes - Continue with **6c**
- 2 No - **SKIP to 7**

See definition sheet MEPS-20(D) for more information.

**c. What was the stop-loss amount PER ENROLLEE?**

732   ,   ,   .00

### ACTUARIAL VALUE OR METAL LEVEL

**7 What was this plan's actuarial value OR metal level?**

**Actuarial Value** is the average percentage of total enrollee medical expenses for plan covered benefits **paid by the plan**, rather than by enrollee cost sharing, for a typical group of enrollees.

**Metal Levels** are labels for insurance plans that describe the level of benefits and cost-sharing provisions.

**Actuarial Value:**  
747    % of medical expenses paid by plan

**OR**

- Metal Level:**
- 746  1 Bronze
  - 2 Silver
  - 3 Gold
  - 4 Platinum

**OR**

- 739  Grandfathered Plan
- 776  Don't know

Continue with **8a**



## ACTIVE ENROLLMENT

*Estimates are acceptable for all enrollment figures.*

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

**Include:**

- Corporate officers and managers
- Employees on the payroll for this location, including:  
those who work off-site.  
those who are leased or contracted TO other organizations.
- Full-time and part-time employees
- Owners
- Temporary and seasonal employees

**Exclude:**

- Former employees
- Workers leased or contracted FROM other organizations
- Retirees

- |          |   |     |   |   |
|----------|---|-----|---|---|
| <b>8</b> | <p><b>a. How many active employees were enrolled in this plan at this location during a typical pay period?</b></p>   | 125 | <input style="width: 100%; height: 20px; border: 1px solid #ccc;" type="text" value="125"/> | Active employees enrolled in plan                       |
|          | <p><b>b. How many of these active employees were enrolled in SINGLE coverage during a typical pay period?</b></p>   | 129 | <input style="width: 100%; height: 20px; border: 1px solid #ccc;" type="text" value="129"/> | Active employees enrolled in single coverage            |
|          | <p><b>c. If this plan had EMPLOYEE-PLUS-ONE coverage, how many active employees were enrolled during a typical pay period?</b></p> <p><i>Include enrollment for both employee-plus-spouse and employee-plus-child coverage.</i></p> | 571 | <input style="width: 100%; height: 20px; border: 1px solid #ccc;" type="text" value="571"/> | Active employees enrolled in employee-plus-one coverage |
|          | <p><b>d. How many active employees were enrolled in FAMILY coverage during a typical pay period?</b></p>  | 705 | <input style="width: 100%; height: 20px; border: 1px solid #ccc;" type="text" value="705"/> | Active employees enrolled in family coverage            |

## COBRA ENROLLMENT

- |          |  |     |   |   |
|----------|--|-----|---|---|
| <b>9</b> | <p><b>How many FORMER employees were enrolled in this plan through COBRA or state continuation-of-benefits laws during a typical pay period? Exclude retirees.</b></p> | 126 | <input style="width: 100%; height: 20px; border: 1px solid #ccc;" type="text" value="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 2021.*

- |           |  |               |   |   |                          |        |   |                          |               |   |                          |         |   |                          |           |   |                          |        |
|-----------|--|---------------|---|---|--------------------------|--------|---|--------------------------|---------------|---|--------------------------|---------|---|--------------------------|-----------|---|--------------------------|--------|
| <b>10</b> | <p><b>The following questions, 11a through 13e, refer to plan premium amounts. For which time period will you be reporting?</b></p> <p><i>Mark (X) only one.</i></p> | 790           | <table border="0" style="width: 100%;"> <tr> <td style="width: 20px;">1</td> <td style="width: 20px;"><input type="checkbox"/></td> <td>Weekly</td> </tr> <tr> <td>2</td> <td><input type="checkbox"/></td> <td>Every 2 weeks</td> </tr> <tr> <td>3</td> <td><input type="checkbox"/></td> <td>Monthly</td> </tr> <tr> <td>5</td> <td><input type="checkbox"/></td> <td>Quarterly</td> </tr> <tr> <td>4</td> <td><input type="checkbox"/></td> <td>Yearly</td> </tr> </table> | 1 | <input type="checkbox"/> | Weekly | 2 | <input type="checkbox"/> | Every 2 weeks | 3 | <input type="checkbox"/> | Monthly | 5 | <input type="checkbox"/> | Quarterly | 4 | <input type="checkbox"/> | Yearly |
| 1         | <input type="checkbox"/>   | Weekly        |   |   |                          |        |   |                          |               |   |                          |         |   |                          |           |   |                          |        |
| 2         | <input type="checkbox"/>   | Every 2 weeks |   |   |                          |        |   |                          |               |   |                          |         |   |                          |           |   |                          |        |
| 3         | <input type="checkbox"/>   | Monthly       |   |   |                          |        |   |                          |               |   |                          |         |   |                          |           |   |                          |        |
| 5         | <input type="checkbox"/>   | Quarterly     |   |   |                          |        |   |                          |               |   |                          |         |   |                          |           |   |                          |        |
| 4         | <input type="checkbox"/>   | Yearly        |   |   |                          |        |   |                          |               |   |                          |         |   |                          |           |   |                          |        |

**Continue with 11a**



## PLAN PREMIUMS - Continued

### SINGLE COVERAGE

- 11 a. Was SINGLE coverage offered under this plan?** 552
- 1  Yes - Continue with **11b**
- 2  No - **SKIP to 12a**
- 
- b. For this plan, how much did the EMPLOYER contribute toward the plan premium of one typical employee with single coverage?** 131
- \$    ,    .00 Employer contribution for single premium
- 
- c. How much did this typical EMPLOYEE with single coverage contribute toward his/her own premium?** 132
- \$    ,    .00 Employee contribution for single premium
- 
- d. What was the TOTAL premium for this typical employee with single coverage?** 130
- \$    ,    .00 Total single premium

### EMPLOYEE-PLUS-ONE COVERAGE

*If employee-plus-one premiums were different for employee-plus-child and employee-plus-spouse coverage, report for employee-plus-one child. If premiums varied for other reasons, report for a TYPICAL employee.*

- 12 a. Was EMPLOYEE-PLUS-ONE coverage offered under this plan?** 570
- 1  Yes - Continue with **12b**
- 2  No - **SKIP to 13a**
- 
- b. For this plan, how much did the EMPLOYER contribute toward the plan premium of one typical employee with employee-plus-one coverage?** 636
- \$    ,    .00 Employer contribution for employee-plus-one premium
- 
- c. How much did this typical EMPLOYEE with employee-plus-one coverage contribute toward his/her own premium?** 637
- \$    ,    .00 Employee contribution for employee-plus-one premium
- 
- d. What was the TOTAL premium for this typical employee with employee-plus-one coverage?** 635
- \$    ,    .00 Total employee-plus-one premium

### FAMILY COVERAGE

*If premium varied by family size, report for a family of four.*

- 13 a. Was FAMILY coverage offered under this plan?** 137
- 1  Yes - Continue with **13b**
- 2  No - **SKIP to 14a**
- 
- b. For this plan, how much did the EMPLOYER contribute toward the plan premium of one typical employee with family coverage?** 135
- \$    ,    .00 Employer contribution for family premium
- 
- c. How much did this typical EMPLOYEE with family coverage contribute toward his/her own premium?** 136
- \$    ,    .00 Employee contribution for family premium
- 
- d. What was the TOTAL premium for this typical employee with family coverage?** 134
- \$    ,    .00 Total family premium
- 
- e. Did the TOTAL premium for family coverage vary depending on the number of family members covered by the plan?** 752
- 1  Yes
- 2  No
- 3  Don't know

**Continue with 14a**

### 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

### IN-NETWORK 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 22b on Page 7.*

*If prescription drugs had a separate deductible, it should be reported under Question 24c on Page 8.*

*DO NOT report copayments or 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 \$1,400 or higher for single coverage and/or \$2,800 or higher for employee-plus-one or family coverage, otherwise skip to Question 20.

**18** Did your organization contribute to a Health Savings Account (HSA) for the plan enrollees?

- 714
- 1  Yes, contributed to an HSA
- 2  No, did not contribute to an HSA
- 4  Don't know

} **SKIP to 20**

**19 a.** What was the MONTHLY contribution your organization made to the HSA for a typical employee with single coverage for this plan?

777

\$    ,    .00

Monthly HSA contribution for single coverage

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

**b.** What was the MONTHLY contribution your organization made to the HSA for a typical employee with employee-plus-one coverage for this plan?

799

\$    ,    .00

Monthly HSA contribution for employee-plus-one 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

\$    ,    .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)

**20** Did your organization contribute to a Health Reimbursement Arrangement (HRA) associated with this plan?

710

- 1  Yes, contributed to an HRA
- 2  No, did not contribute to an HRA
- 3  Don't know

} **SKIP to 22a**

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

DO NOT report ICHRA or QSEHRA here.

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

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Continue with **21a**

### HEALTH REIMBURSEMENT ARRANGEMENT (HRA) - Continued

**21 a. Up to what dollar amount did your organization contribute ANNUALLY to a typical employee's HRA for single coverage for this plan?**

779

\$    ,    .00

Annual HRA contribution for single coverage

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

**b. Up to what dollar amount did your organization contribute ANNUALLY to a typical employee's HRA for employee-plus-one coverage for this plan?**

800

\$    ,    .00

Annual HRA contribution for employee-plus-one 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

\$    ,    .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.*

### IN-NETWORK PAYMENTS

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

155

- 1  Yes - Continue with **22b**
- 2  No - **SKIP to 23a**

**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

\$    ,    .00

Copayment paid by enrollee for hospital admission

*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.*

154

- 1  Per day
- 2  Per stay

**AND/OR**

153

%

Coinsurance paid by enrollee

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Continue with **23a**

### IN-NETWORK PAYMENTS - Continued

- 23 a. Was physician care covered under this plan?** 218
- 1  Yes - Continue with **23b**
- 2  No - **SKIP to 24a**

**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

\$     .00 Copayment paid by enrollee for General Practitioner office visit

**AND/OR**

*Report for an "in-network"/participating general practitioner, excluding preventive care visits.*

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

\$     .00 Copayment paid by enrollee for Specialist Physician office visit

**AND/OR**

*Report for an "in-network"/participating specialist, excluding preventive care visits.*

772

% Coinsurance paid by enrollee

- 24 a. Were prescription drugs covered under this health plan?** 673
- 1  Yes - Continue with **24b**
- 2  No
- 3  Don't know
- } **SKIP to 25**

**b. Did this plan have a SEPARATE ANNUAL deductible that applies only to prescription drugs?** 773

1  Yes - Continue with **24c**

2  No

3  Don't know

} **SKIP to 24d**

**c. What was the SEPARATE ANNUAL deductible for prescription drugs for single coverage in this plan?** 774

\$   ,    .00 Separate individual prescription drug deductible

*Report "in-network" prescription deductibles for participating pharmacies (if applicable).*

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Continue with **24d**



IN-NETWORK PAYMENTS - Continued

24 d. How much and/or what percentage did an enrollee pay out-of-pocket for each type of prescription drug covered after any annual deductible was met?

Specialty drugs are prescription medications that are used to treat complex, chronic and often costly conditions. See definition sheet MEPS-20(D) for more information.

Generic

753 \$ [ ][ ][ ][ ] .00 Copayment

AND/OR

754 [ ][ ][ ] % Coinsurance

762  Generic not covered

Preferred brand name

755 \$ [ ][ ][ ][ ] .00 Copayment

AND/OR

756 [ ][ ][ ] % Coinsurance

763  Preferred brand name not covered

Non-preferred brand name

757 \$ [ ][ ][ ][ ] .00 Copayment

AND/OR

758 [ ][ ][ ] % Coinsurance

764  Non-preferred brand name not covered

Specialty

767 \$ [ ][ ][ ][ ] .00 Copayment

AND/OR

768 [ ][ ][ ] % Coinsurance

769  Specialty not covered

Include all copayments, coinsurance and deductibles.

25 What was the overall MAXIMUM ANNUAL out-of-pocket expense?

This is often referred to as a catastrophic limit.

Report "in-network" maximum out-of-pocket expense (if applicable).

161 \$ [ ][ ][ ][ ] , [ ][ ][ ] .00 Maximum out-of-pocket expense for an individual

OR

163  No individual maximum

788 \$ [ ][ ][ ][ ] , [ ][ ][ ] .00 Maximum out-of-pocket expense for employee-plus-one

OR

789  No employee-plus-one maximum

162 \$ [ ][ ][ ][ ] , [ ][ ][ ] .00 Maximum out-of-pocket expense for a family

OR

222  No family maximum

Continue with 26



## PLAN CHARACTERISTICS

### 26 Did this plan cover any of the services listed?

	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.*

## OUT-OF-NETWORK DEDUCTIBLES AND PAYMENTS

### 27 Does this plan cover any of the costs of non-emergency out-of-network care?

801

1  Yes

2  No

3  Don't know

**Skip to the bottom of page 11 for instructions.**

*If this plan had an out-of-network deductible, continue with Question 28, otherwise skip to Question 29.*

### 28 What was the annual deductible an enrollee paid out-of-pocket for care provided by an out-of-network provider for different levels of coverage?

*If deductible was per overnight hospital stay, it is not an annual deductible and should be reported under Question 29.*

*DO NOT report copayments or out-of-pocket maximums here.*

802   ,   .00 Out-of-network individual annual deductible

803   ,   .00 Out-of-network employee-plus-one annual deductible

804  Employee-plus-one coverage not offered.

805   ,   .00 Out-of-network family annual deductible

806  Family coverage not offered.

*If this plan offered hospital care, continue with Question 29, otherwise skip to Question 30.*

### 29 For an out-of-network provider, 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?

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

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

807   ,   .00 Copayment paid by enrollee for out-of-network hospital admission

808

1  Per day

2  Per stay

**AND/OR**

809   % Coinsurance paid by enrollee for out-of-network hospital admission

**Continue with 30**

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### OUT-OF-NETWORK DEDUCTIBLES AND PAYMENTS - Continued

Include all copayments, coinsurance and deductibles.

**30** What was the maximum annual out-of-pocket expense for care provided by an out-of-network provider?

*This is often referred to as a catastrophic limit.*

810         Out-of-network maximum out-of-pocket expense for an individual

**OR**

811  No **individual** maximum

812         Out-of-network maximum out-of-pocket expense for employee-plus-one

**OR**

813  No **employee-plus-one** maximum

814         Out-of-network maximum out-of-pocket expense for a family

**OR**

815  No **family** maximum

**\*\*\* 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.**

**To supplement your response, you may include Summary of Benefits and Coverage or other materials describing plan benefits and premiums in your return packet or fax to 1-800-447-4613.**

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