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FORM **MEPS-10(S)**
(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)

SUPPLEMENTAL SHEET ESTABLISHMENT QUESTIONNAIRE

INSTRUCTIONS

This Supplemental Sheet is a reprint of the questions in Section B of the Establishment Questionnaire (MEPS-10). You may use it to report additional health plan information. You may use photocopies of this Supplemental Sheet if sufficient copies were not included in your reporting package. Refer to the instructions on the first page of the Establishment Questionnaire (MEPS-10) when completing this Supplemental Sheet.

Section B – PLAN CHARACTERISTICS

B1. Enter the name of the health insurance plan and the insurance carrier.

FOR CENSUS USE ONLY

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

c. 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 both employer and employee contributions.

108 $ .00

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 2.*

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 on page 2.

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

Section B – PLAN CHARACTERISTICS – Continued

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

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 1.

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 1.

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 ☐☐☐☐☐

b. 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

Control No.

Section B – PLAN CHARACTERISTICS – Continued

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

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

Section B – PLAN CHARACTERISTICS – Continued

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 – **END THIS FORM.**

B21c. 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 2.

188 _____ Single enrollment

189 _____ Family enrollment

190 $ _____.00 Single premium

191 $ _____.00 Family premium

500 Remarks

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS