OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-10(P)**
(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)

PERSON-LEVEL QUESTIONNAIRE FOR ESTABLISHMENTS

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. In this questionnaire, "this person" refers to the individual named in the label area. A permission slip signed by the individual authorizing our collection of this information is included at the back of this reporting package.

2. "Your organization" refers to the location on the label of this questionnaire.

3. For this survey, **a health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Also included in Section C of this questionnaire are single-service plans, which provide optional coverage not included in the basic health insurance plan(s) for an additional premium.

Section A – PERSON–LEVEL INFORMATION

A1. Which category below **best** describes this person's status with your organization on July 1, 1996?

065 *Check only ONE.*

1 ☐ A full- or part-time employee
2 ☐ A retiree
3 ☐ A former employee
4 ☐ A relative/survivor of a former employee
5 ☐ A seasonal or temporary employee

Go to Section B on page 2.

6 ☐ An employee of a temporary agency
7 ☐ An independent contract worker
8 ☐ No record of this person

Go to Section D on page 3.

Section B – HOSPITAL OR PHYSICIAN PLAN

B1a. Was this person **eligible** for hospital/physician insurance coverage through your organization on July 1, 1996?

350 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section C on page 3.**

If more than one plan was offered through this organization, answer Part b below. If only one plan was offered, go to Question B2a.

b. Of the hospital/physician plans offered by your organization, for which plans was this person eligible?

Please enter plan name(s) exactly as entered in Question B1 of the Establishment Questionnaire (MEPS-10) or Supplemental Sheet (MEPS-10(S)).

351 ☐ All **OR** ↙

501
502
503
504

B2a. Was this person **enrolled** in a hospital/physician plan provided by your organization on July 1, 1996?

231 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section C on page 3.**

If more than one plan was offered through this organization, answer Part b below. If only one plan was offered, go to Question B3.

b. In which hospital/physician plan(s) was this person enrolled?

Please enter plan name(s) exactly as entered in Question B1 of the Establishment Questionnaire (MEPS-10) or Supplemental Sheet (MEPS-10(S)).

352 ☐ All **OR** ↙

021
505

B3. What level of coverage did this person choose?

239
1 ☐ Single
2 ☐ Two adults
3 ☐ One adult/one child
4 ☐ Family (3 or more people)

B4. For the pay period including July 1, 1996, provide the information below regarding premiums paid for this person's hospital/physician coverage.

a. What was the **total premium including both employer and employee contributions?**

If this plan was self-insured, *enter the monthly premium equivalent. If a premium equivalent was not calculated, enter the COBRA amount.*

361 $ .00 PER →

376
1 ☐ Week
2 ☐ 2 weeks
3 ☐ Month
4 ☐ Year

B4b. How much did **this person contribute** towards his/her coverage?

Report for the same premium period as in Question B4a.

362 $ .00

OR

353 ☐ Percent of insurance premium

c. How much did **your organization contribute** towards this person's coverage?

Report for the same premium period as in Question B4a.

363 $ .00

OR

354 ☐ Percent of insurance premium

d. How much did sources other than your organization, such as a union or government, contribute towards/subsidize this person's coverage?

Report for the same premium period as in Question B4a.

355 $ .00

OR

356 ☐ Percent of insurance premium

OR

357 ☐ No subsidy/contribution from other sources – **Go to Question B6.**

B5. What was the source of the outside subsidy or contribution reported in B4d?

Check only ONE.

358
1 ☐ Union
2 ☐ Government
3 ☐ Other

B6. Was this person's insurance provided through COBRA?

359 1 ☐ Yes 2 ☐ No

Control No.

Section C – SINGLE-SERVICE PLANS

C1. On July 1, 1996, did this person obtain through your organization any optional coverage (not included in his/her basic health plan reported in Section B above) at an additional premium?

246 1 ☐ Yes 2 ☐ No – **If No, go to Section D.**

C2. Which of the following single-service plans did this person obtain?

Check all that apply.

370 ☐ Dental
372 ☐ Vision
371 ☐ Prescription drugs
373 ☐ Long-term care

C3a. What was the total premium for all single-service plans obtained by this person, including both employer and employee contributions?

374 $ .00 PER →

380 1 ☐ Week
2 ☐ 2 weeks
3 ☐ Month
4 ☐ Year

b. How much did **this person contribute** towards his/her single-service plan coverage?

Report for the same premium period as in Question C3a.

375 $ .00

OR

360 ☐ Percent of insurance premium

500 Remarks

Section D – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title	
Signature		214 Date
215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address