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

FORM **MEPS-13**
(7-8-97)

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)

SELF-EMPLOYED QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Your report to the Census Bureau is **confidential** by law (Title 13, United States Code). It may be seen only by sworn Census employees and may be used only for statistical purposes.

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

If you have any questions concerning this survey, please call 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. For this survey, **a health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to the enrollee. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
2. Section C requests information on plans providing coverage for a single service, such as dental, drug, or vision coverage, at an additional cost.
3. **Estimates** are acceptable if you do not have this information readily available.
4. Provide information for the **period that included July 1, 1996**. However, **annual** costs should be reported for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A – HEALTH INSURANCE INFORMATION

A1. On July 1, 1996, did you operate a business or profession that produced self-employment income, with no paid employees other than yourself?

225 1 ☐ Yes 2 ☐ No – **If No, go to Section E on page 4.**

A2a. Were you covered by a public health insurance plan on July 1, 1996?

226 1 ☐ Yes 2 ☐ No – **If No, go to Question A3a.**

b. Indicate the type(s) of public health insurance by which you were covered on July 1, 1996.

Check all that apply.

227 ☐ Medicaid
228 ☐ Medicare
229 ☐ CHAMPUS/CHAMPVA
230 ☐ Other public health insurance

A3a. Were you covered by a private health insurance plan(s) that covered hospital and/or physician services on July 1, 1996?

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

b. Which of these categories **best** describes how you obtained (each of) your health insurance plans?

Check all that apply.

232 ☐ From your current or former spouse's employer plan
233 ☐ From your current or previous employer

Complete Section C on page 3.

234 ☐ From an insurance carrier or HMO
235 ☐ From a union
236 ☐ From a trade/ professional association
237 ☐ From a pooling arrangement (e.g., a small business group)
238 ☐ Other – *Specify*
098 [ ]

Complete Section B on page 2.

Section B – PLAN CHARACTERISTICS

Provide information for the hospital and/or physician plan(s) in which you were enrolled on **July 1, 1996**. Exclude any plan(s) in which you may have been covered through your or your spouse's current or former employer. If you have more than one hospital and/or physician plan, please make a copy of Section B and complete it for each plan.

B1. What was the name of the health insurance plan and its carrier, covering hospital and/or physician services, in which you were enrolled on July 1, 1996?

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 you see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the level of coverage purchased:

239

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

B5. What was the total premium paid for this hospital and/or physician plan?

361 $ .00 → 376

3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

B6. Did you receive a direct subsidy or contribution towards this plan's premium from another source, such as a government?

122 1 ☐ Yes 2 ☐ No

B7. Enter the **annual deductibles** required out of your pocket 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 B8a.

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

B8a. How much would you have paid 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 would you have paid 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

B9. What was the maximum amount this plan would have paid –

a. Over your lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

Control No.

Section B – HEALTH INSURANCE PLAN INFORMATION – Continued

B10. What was the maximum annual out-of-pocket amount you could have paid?

241 $ .00

163 ☐ No maximum

B11. 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

B12. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No 3 ☐ Don't know

B13a. Are you currently enrolled in the same health plan this year?

242 1 ☐ Yes – **If Yes, go to Question B13c.**
2 ☐ No

b. What type of health plan replaced the one you had in 1996?

243 1 ☐ Similar plan
2 ☐ Substantially different plan
3 ☐ No longer purchase a health plan – **Go to Section C.**

c. What is your 1997 premium for this plan or the one that took its place?

244 $ .00 → 245
3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

Section C – SINGLE-SERVICE PLAN INFORMATION

C1. Did you obtain any **optional** single-service coverage (not included in your basic hospital and/or physician coverage) at an additional premium?

246 1 ☐ Yes 2 ☐ No – **If No, go to Section D on page 4.**

C2. Which of the following single-service plans did you purchase?

Check all that apply.

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

C3. What was the total premium paid for your single-service plan(s)?

374 $ .00 → 380
3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

Section D – SELF-EMPLOYMENT INFORMATION

D1. How long have you operated this business/profession?

064 ☐ Years

D2. Which of these categories **best** describes your principal business activity (i.e., generates MOST of your revenue)?

Check only ONE.

060
1 ☐ Retail (sell to general public)
2 ☐ Personal services (e.g., beauty shops, dry cleaners)
3 ☐ Business services (e.g., advertising, computer processing)
4 ☐ Other services (e.g., legal and health services)
5 ☐ Manufacturing
6 ☐ Wholesale trade (sell to businesses and industry)
7 ☐ Finance, insurance, or real estate
8 ☐ Transportation, communications, electric, gas, or sanitary services
9 ☐ Construction
10 ☐ Agriculture or forestry

Section E – DEMOGRAPHIC INFORMATION

Unless otherwise directed, please answer the following demographic questions as they pertained to you on July 1, 1996. The following characteristics of business owners are being used for statistical purposes only.

E1. What is your sex?

248 1 ☐ Male 2 ☐ Female

E2. What was your age on July 1, 1996?

249
1 ☐ Under 24
2 ☐ 24–34
3 ☐ 35–44
4 ☐ 45–54
5 ☐ 55–64
6 ☐ 65 or over

E3. What is the highest level of education you have obtained?

250
1 ☐ Some high school
2 ☐ High school degree or G.E.D.
3 ☐ Some college
4 ☐ Undergraduate/Bachelor's degree (B.S., B.A., etc.)
5 ☐ Graduate studies

E4. What is your marital status?

251
1 ☐ Single, never married
2 ☐ Married, spouse employed
3 ☐ Married, spouse not employed
4 ☐ Separated
5 ☐ Divorced
6 ☐ Widowed

E5. Including yourself and your spouse, how many dependents do you have?

257 ☐ Number of dependents

E6a. Are you of Hispanic, Latino, or Spanish origin?

258 1 ☐ Yes 2 ☐ No

b. Which group best represents your race?

Check only ONE.

259
1 ☐ American Indian
2 ☐ Aleut, Eskimo
3 ☐ Asian or Pacific Islander
4 ☐ Black
5 ☐ White
6 ☐ Other

E7. What was your 1996 annual household income? **(Household income for all family members after business expenses.)**

260
1 ☐ Under $25,000
2 ☐ $25,000 – $44,999
3 ☐ $45,000 – $74,999
4 ☐ $75,000 – $99,999
5 ☐ $100,000 and over

500 Remarks

Section F – 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

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS