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FORM **MEPS-14(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)

INSURANCE PROVIDER QUESTIONNAIRE

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 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER street and number 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.
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. Did this company provide health insurance coverage on July 1, 1996, to the person named in the label area of this questionnaire?

310
1 ☐ Yes
2 ☐ No – **If No, go to Section D on page 3.**

A2a. Did your company provide a hospital and/or physician plan (including Medigap) to this person?

311
1 ☐ Yes – **If Yes, go to Section B on page 2.**
2 ☐ No

A2b. Did your company provide a single-service plan to this person?

312
1 ☐ Yes – **If Yes, go to Section C on page 3.**
2 ☐ No

c. Did your company provide a dread-disease or extra-cash plan to this person?

313
1 ☐ Yes – **If Yes, go to Section D on page 3.**
2 ☐ No – **If No, go to Section B on page 2.**

Section B – PLAN CHARACTERISTICS

Please provide information for the plan in which the person named in the label was enrolled on July 1, 1996.

Answer the questions only for the hospital/physician insurance plan which covered a set of benefits (including hospital stays and /or physician visits) for a single premium. Additional benefits such as dental, vision, or prescription drugs may be included in these plans.

B1. What was the name of the plan in which this person was enrolled on July 1, 1996?

012 Name of plan

B2a. Was this a Medigap plan?

275 1 ☐ Yes 2 ☐ No – **If No, go to Question B3.**

b. Which of the 10 common plans, identified by letters "A–J", is this Medigap plan?

276 ☐

OR

277 ☐ Not applicable

c. Is the premium for this Medigap plan issue-age rated or attained-age rated?

278
1 ☐ Issue-age rated
2 ☐ Attained-age rated
3 ☐ Neither

B3. Was this person's enrollment financed through Medicare or Medicaid?

279
1 ☐ Medicare
2 ☐ Medicaid
3 ☐ Neither

B4a. For the period including July 1, 1996, was this person's plan a group policy?

280 1 ☐ Yes ↙ 2 ☐ No

b. How many policyholders were in the group?

281 ☐

B5. What type of plan did your company provide to this person?

Check only ONE.

282
1 ☐ Conventional Health Insurance (Fee-for-Service)
2 ☐ PPO (Preferred Provider Organization)
3 ☐ HMO (Health Maintenance Organization)
4 ☐ EPO (Exclusive Provider Organization)
5 ☐ POS/Open Ended HMO (Point of Service)
6 ☐ Other – *Specify*

097 ☐

B6. What was this plan's premium for this person?

361 $ .00 → 376
3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

B7. What level of coverage did this person hold?

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

B8. Was there a waiting period for this person before his/her plan benefits began?

290 1 ☐ Yes 2 ☐ No

B9a. Was a summary of this person's recent health history required for enrollment in this plan?

291 1 ☐ Yes 2 ☐ No

b. Was a physical examination required for enrollment in this plan?

292 1 ☐ Yes 2 ☐ No

B10a. Is this plan community rated?

293 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Question B11 on page 3.**

b. How is this plan rated?

Check all that apply.

294 ☐ Age
295 ☐ Geographic area
296 ☐ Other

} **Go to Question B12a on page 3.**

Control No.

Section B – PLAN CHARACTERISTICS– Continued

B11. For this plan, which of the following characteristics affected the premium amount?

Check all that apply.

297 ☐ Age
298 ☐ Health enhancing habits
299 ☐ Smoking
300 ☐ Other health endangering habits/hobbies
301 ☐ Geographic area
302 ☐ Specific medical conditions
303 ☐ Other

B12a. Did any characteristics preclude enrollment in this plan?

304 1 ☐ Yes → 2 ☐ No – **If No, go to Section C.**

b. Which of the following characteristics precluded enrollment in this plan?

Check all that apply.

305 ☐ Age
306 ☐ Smoking
307 ☐ Other health endangering habits/hobbies
308 ☐ Specific medical conditions
309 ☐ Other

Section C – SINGLE-SERVICE PLANS

C1. Did your company provide single-service plan coverage to this person at an additional premium?

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

C2. Which of the following single-service plans did your company provide to this person?

Check all that apply.

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

C3. What was the total premium this person paid for his/her single-service plan(s)?

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

C4. What level of coverage did this person hold?

314 1 ☐ Single
2 ☐ Two adults
3 ☐ One adult, one child
4 ☐ Family (3 or more people)

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