MEPS Insurance Component

Glossary of Health Insurance Terms That Appear in the MEPS-IC Questionnaires and Tables

ACTIVE EMPLOYEE – A person who was employed full- or part-time during the year regardless of whether the employee was considered permanent, temporary, or seasonal. Includes owners and officers of the organization. Excludes individuals who were contract laborers, retirees, laid off, or those who left employment prior to the survey year.

ACTUARIAL VALUE – The percentage of medical expenses paid by the plan, rather than out-of-pocket, by a typical group of enrollees. As plans increase in actuarial value, they would cover a greater share of enrollees' medical expenses overall.

ASSOCIATION HEALTH PLAN (AHP) – A group health plan that employer groups and associations offer to provide health coverage for their employees or members.

ANY PROVIDER PLAN – A plan that allows covered persons to go to the providers of their choice with no cost incentives to use a particular subset of providers. Often referred to as a Conventional Indemnity Plan.

AVERAGE WAGE QUARTILES AVERAGE WAGE QUARTILES (1) – Quartiles are groups of establishments, each of which contains 25 percent of the total employment.

CIVILIAN – A combination of both private sector and state and local governments.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Part of this law requires employers to continue offering health coverage for enrollees and their dependents for a period of time after an enrollee leaves the firm. Typically, the enrollee pays the entire monthly premium when covered by COBRA. COBRA coverage for state and local governments was transmitted through the Public Health Service Act and may also be referred to as PHSA coverage.

COINSURANCE – A fixed percentage that an enrollee pays for medical expenses after the deductible amount, if any, was paid. Coinsurance rates may differ for different types of services. For example, an enrollee may pay a 10 percent rate for doctor fees, a 20 percent rate for hospital fees, and a 5 percent rate for prescription fees.

COMPOSITE PLAN – A composite plan is a plan where the premium and member contribution rates do not vary between single and family coverage.

CONVENTIONAL INDEMNITY PLAN – An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.

COPAYMENT – A fixed dollar amount that an enrollee pays when medical service is received, regardless of the total charge for service. The insurer is responsible for the rest of the total charge. For example, an enrollee may pay a $20 copay for each doctor's office visit, $150 for each day in the hospital, and $20 for each prescription.

COVERED PERSONS – An enrollee plus any dependents covered by a health insurance plan. The MEPS IC survey has no data on the number of dependents covered and therefore cannot estimate total number of covered persons.

COVERAGE RATE – The coverage rate is the percentage of all employees enrolled in their health insurance plan at establishments that offer health insurance. The coverage rate is equal to the eligibility rate (the percentage of employees eligible for health insurance at establishments that offer insurance) multiplied by the take-up rate (the percentage of eligible employees who enrolled).

CRITICAL ILLNESS INSURANCE – A special form of insurance that pays the policyholder a lump-sum, tax-free payment if they suffer from serious illnesses, including but not limited to cancer, heart attack, kidney failure, and stroke.

DEDUCTIBLE – A fixed dollar amount during the benefit period (usually a year) that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both individual and family deductibles.

DOMESTIC PARTNERS – Unmarried couples of the same or opposite sex who live together and share a common domestic life. People in a common-law marriage should not be considered domestic partners.

CENSUS DIVISION (2) – The States are grouped by Census in divisions.

ELIGIBLE EMPLOYEES – Eligible employees are those that are allowed to enroll in employer-sponsored coverage offered by their employer. Common eligibility criteria include a minimum number of hours worked per pay period or a minimum length of service with the employer.

EMPLOYEE – An employee is a person on the actual payroll. This definition excludes temporary and contract workers but includes the owner or manager if that person works at the firm.

EMPLOYEE-PLUS-ONE COVERAGE – Health insurance plan for an employee and the employee's spouse or an employee and the employee's child, at a lower premium level than family coverage. If premiums differed for employee-plus-spouse and employee-plus-child coverage, information for employee-plus-child coverage was collected.

EMPLOYEE CONTRIBUTION – The amount that the employee contributes to health plan premiums.

EMPLOYEE PRE-TAX CONTRIBUTION – An employee pays their share of the premium for employer-sponsored health insurance through a payroll deduction prior to taxes being withheld. This lowers the amount of income on which the employee must pay taxes.

EMPLOYER SPONSORED INSURANCE – ESI, Employer-sponsored health insurance is a common type of U.S. health coverage where employers offer health plans to their employees, often splitting the premium costs and providing access to broader networks and benefits than individual plans.

ENROLLMENT RATE – The enrollment rate is the percentage of all employees enrolled in their employers' health insurance at establishments both offering and not offering health insurance.

ESTABLISHMENT – A particular workplace or physical location where business is conducted, or services or industrial operations are performed. Also known as a site. The

sample is chosen at the establishment level, and the MEPS-IC data are collected at the establishment level whenever possible.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN – A restrictive type of preferred provider organization plan under which enrollees must use providers from the specified network of physicians and hospitals for all non-emergency care in order for costs to be covered.

FAMILY COVERAGE – A health insurance plan that covers the enrollee and members of the enrollee's immediate family (spouse and/or children). "Family coverage" is defined as any coverage other than single and employee-plus-one. Some plans offer more than one rate for family coverage, depending on family size and composition. If more than one rate is offered, MEPS-IC respondents are asked to report costs for a family of four.

FIRM – A business entity consisting of one or more establishments under common ownership or control. Also known as an enterprise. A firm represents the entire organization, including the company headquarters and all divisions, subsidiaries, and branches. A firm may consist of a single-location establishment or multiple establishments. In the case of a single-location firm, the firm and establishment are identical. Firm size is the total number of employees for the entire firm as reported on the sample frame.

FLEXIBLE BENEFITS PLAN/CAFETERIA PLAN – A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits which may include cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans, and childcare.

FLEXIBLE SPENDING ACCOUNT (FSA) – An account offered and administered by employers that provides a way for employees to set aside, out of their paycheck, pre-tax dollars to pay for the employee's share of medical expenses not covered by the employer's health plan. Typically, benefits or cash must be used within the given benefit year, or the employee loses the money.

FOR PROFIT, INCORPORATED – A private sector firm that is granted a charter recognizing it as a separate legal entity having its own privileges and liabilities, separate from those of its members.

FOR PROFIT, UNINCORPORATED – A private sector firm with a sole owner or a partnership where two or more persons join to carry on a trade or business with each having a shared financial interest in the business. The MEPS-IC survey does not include unincorporated, self-employed sole owners with no employees.

FULL-TIME EQUIVALENT (FTE) – An FTE is the number of working hours that represents one full-time employee during a specific time period, such as a week. An FTE is 30 hours per week for purposes of determining whether an employer is eligible to obtain health insurance through a SHOP exchange and 40 hours per week for purposes of determining whether an employer is eligible for the Small Business Healthcare Tax Credit. See https://www.healthcare.gov/ for details.

GATEKEEPER – A gatekeeper is responsible for coordinating all services, approving referrals and directing patients to specialists or health care facilities.

GRANDFATHERED HEALTH PLANS – Plans that existed before the Patient Protection and Affordable Care Act (PPACA) was enacted. Plans certified to be grandfathered plans are not subject to all of the PPACA requirements.

GROUP MODEL HMO – An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.

GROUP PURCHASING ARRANGEMENT – Any of a wide array of arrangements in which two or more small employers purchase health insurance collectively, often through a common intermediary **that** acts on their collective behalf. Such arrangements may go by many different names, including cooperatives, alliances, or business groups on health. They differ from one another along a number of dimensions, including governance, functions and status under federal and state laws. Some are set up or chartered by States while others are entirely private enterprises. Some centralize more of the purchasing functions than others, including functions such as risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks. Depending on their functions, they may be subject to different state and/or federal rules. For example, they may be regulated as Multiple Employer Welfare Arrangements (MEWAs).

HEALTH INSURANCE PLAN – An insurance contract that provides healthcare coverage to an employee for an agreed-upon fee (Premium) for a defined benefit period.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) – This federal law protects health insurance coverage for workers and their families when they change jobs by limiting exclusions for pre-existing conditions, prohibiting discrimination against employees and dependents based on their health status, and guaranteeing renewability and availability of health coverage to certain employers and individuals.

HEALTH MAINTENANCE ORGANIZATION (HMO) – A healthcare system in which plan participants obtain comprehensive healthcare services from a specified list of "in-network" providers who receive a fixed periodic prepayment from the insurer. Plan participants' access to "in-network" providers is controlled by a primary-care physician or gatekeeper. HMOs typically do not have a deductible.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) – An agreement where an employer funds a predetermined amount of expenses to pay an employee per benefit year for out-of-pocket medical costs, including health insurance premiums. The HRA funds may be carried over to the next benefit year. The HRA does not have to be used in conjunction with any health plan.

HEALTH SAVINGS ACCOUNT (HSA) – A trust account owned by the employee for the purpose of paying for medical expenses not covered by the employer's health plan. The employee must be enrolled in a high deductible health plan that is HSA-eligible in order to qualify for an HSA.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) – Health insurance plans are classified as "high deductible" if the deductibles meet or exceeded the Internal Revenue Service (IRS) threshold for a high deductible plan in a given year. Plans must also meet other requirements to be considered a high deductible plan by the IRS.

INDEMNITY PLAN – A type of medical plan that reimburses the patient and/or provider as expenses are incurred.

INDIVIDUAL COVERAGE HEALTH REIMBURSEMENT ARRANGEMENT (**ICHRA)** – A type of health reimbursement arrangement (HRA) that allows businesses of all sizes to provide tax-free reimbursement to employees for individually purchased health insurance premiums (or other medical care expenses) up to a maximum dollar amount set by the employer each year. Employers can offer an ICHRA and a traditional group health plan, but they have to be offered to different classes of employees (e.g. part-time versus full-time).

INDIVIDUAL PRACTICE ASSOCIATION (IPA) HMO – A type of healthcare provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

INDUSTRY CATEGORIES (3) – The primary business activity as reported by the respondent**.**

INDUSTRY GROUPING (4) – For data estimation and reporting purposes, groups of industry categories are constructed in the creation of MEPS-IC tables. Without grouping the industries, the cell sample sizes would be insufficient for producing estimates.

LEVEL-FUNDED PLAN – In this type of plan, employee's organization makes a set payment each month to an insurer or third-party administrator which funds a reserve account for claims, administrative costs, and premiums for stop-loss coverage. When claims are lower than expected, surplus payments may be refunded at the end of the contract. These arrangements may also be referred to as balanced funding or alternative funding. Legally, level-funded plans are self-insured plans coupled with stop-loss coverage with a low attachment point, but in practical implementation often resemble a fully insured plan.

LOW-WAGE EMPLOYEE (5) – Beginning in 2000, the definition of a low-wage employee was redefined as those earning at or below the 25th percentile for all hourly wages in the United States based on data from the Bureau of Labor Statistics.

MANAGED CARE PLAN – Managed care plans generally provide comprehensive health services to their members and offer financial incentives for patients to use the providers who belong to the plan.

MANAGED CARE PROVISIONS – Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members.

METROPOLITAN STATISTICAL AREA (MSA) – A geographical region with a relatively high population density at its core and close economic ties throughout the area. MSAs consist of one or more counties, are defined by the U.S. Office of Management and Budget, and are used by U.S. government agencies for statistical purposes.

MINIMUM PREMIUM PLAN (MPP) – A Minimum Premium Plan (MPP) is a type of self-funded health insurance arrangement where an employer pays a fixed premium for a specific level of coverage, and the insurance company manages claims and risk for claims exceeding that level.

MIXED-PROVIDER PLAN – A plan that allows covered persons to go to any provider but there is a cost incentive to use a particular subset of providers.

MULTI-EMPLOYER HEALTH PLAN – An employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers. These plans are also known as Taft-Hartley plans or jointly administered plans. They are subject to federal but not state law (although States may regulate any insurance policies that they buy). They often self-insure.

MULTIPLE EMPLOYER WELFARE ARRANGEMENT (MEWA) (6) – MEWA is a technical term under federal law that encompasses essentially any arrangement not maintained pursuant to a collective bargaining agreement (other than a State-licensed insurance company or HMO) that provides health insurance benefits to the employees of two or more private employers.

NETWORK MODEL HMO – An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multi-specialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.

NON-EMERGENCY WEEKEND ADMISSION RESTRICTION – A requirement that imposes limits on reimbursement to patients for non-emergency weekend hospital admissions.

NONPROFIT – A private sector firm that does not distribute surplus funds to its owners or shareholders, but instead uses surplus funds to help pursue its goals. Most nonprofits are exempt from taxes.

OFFER RATE – The offer rate is the percentage of employees who work at establishments that offer health insurance.

OPTIONAL COVERAGE (Single service plans) – Separate coverage for a limited area of medical care to supplement the basic health insurance plan. Often, these plans are offered through an insurance company/carrier separate from the one providing basic health coverage. An additional premium is paid by the enrollee and/or employer for this optional coverage (Example: Dental or Vision Plan).

OUT-OF-NETWORK – An out-of-network provider is a doctor, hospital, or other healthcare provider who does not have a contract with your health insurance company and will not accept negotiated rates. This would mean that patients will typically pay more out-of-pocket and be responsible for the difference between the provider's full charge and what your insurance deems the "allowed amount".

OUT-OF-POCKET MAXIMUM – The most an enrollee will have to pay during a policy period (usually a year) for healthcare services. Once an enrollee has reached the plan's out-of-pocket maximum, the plan begins to pay 100 percent of the allowed amount for covered services.

PERCENTILES – The value at or below which a certain percent of observations fall. For example, the 10th percentile is the value at or below which 10 percent of the observations are found. The 50th percentile is also referred to as the median.

PRIVATE EXCHANGE – Online platform where individuals and employers can shop for, compare, and enroll in health insurance plans. Private exchanges are Affordable Care Act (ACA) compliant but are not the same as the Federal exchange or marketplace (at healthcare.gov) or those run by individual states.

PRIVATE SECTOR – All economic activity other than that of government. In the MEPS-IC survey, the private sector excludes the unincorporated, self-employed with no employees. However, the self-employed with employees and the incorporated, self-employed with no employees are included.

PHYSICIAN-HOSPITAL ORGANIZATION (PHO) – Alliances between physicians and hospitals to help providers attain market share, improve bargaining power and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.

POINT-OF-SERVICE (POS) PLAN – A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

PREADMISSION CERTIFICATION – An authorization for hospital admission given by a healthcare provider to a group member prior to their hospitalization. Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the healthcare provider's obligation to pay for services rendered.

PREADMISSION TESTING – A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.

PREFERRED ("IN-NETWORK"/PARTICIPATION) PROVIDER – A medical provider (doctor, hospital, pharmacy) who is a member of a health plan's network. Enrollees generally pay lower or no copayment for services from a preferred provider.

PREFERRED PROVIDER ORGANIZATION (PPO) PLAN – An indemnity plan where coverage is provided to participants through a network of selected healthcare providers (such as hospitals and physicians). The enrollees may go outside the network but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

PREMIUM – Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured person and the plan sponsor.

PREMIUM EQUIVALENT – For self-insured plans, this is the cost per covered enrollee, or the amount the organization would expect to pay in premiums if the plan were insured by someone else. The premium equivalent is equal to the per-capita number of claims, administration, and stop-loss premiums for a self-insured plan.

PURCHASED PLAN (Also called a fully insured plan) – A health plan is considered purchased when the financial risk for the enrollee’s medical claims is assumed by a health insurance company/carrier.

QSEHRA – Qualified Small Employer Health Reimbursement Arrangement – also known as a Small Business HRA, allows businesses with fewer than 50 FTE employees to provide tax-free reimbursements to employees to help cover their medical expenses including insurance premiums for plans purchased on the individual market.

PUBLIC SECTOR (STATE AND LOCAL GOVERNMENTS) – The public sector is the portion of the economy consisting of various levels of government. The MEPS-IC survey only collects public sector data from state and local governments. The Federal government (including the postal system and the military) are not included in the MEPS-IC. Where possible, the term state and local government is used instead of public sector as it more accurately describes the coverage of the MEPS-IC survey.

SECOND SURGICAL OPINION – A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome.

SELF-INSURED PLAN – A health plan is self-insured when the financial risk for the enrollee's medical claims is assumed partially or entirely by the organization offering the plan. Organizations with self-insured plans commonly purchase stop-loss coverage (see definition).

SINGLE COVERAGE – A health insurance plan that covers the employee only.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) EXCHANGE – A marketplace where small businesses can purchase health insurance for their employees. It's a component of the Affordable Care Act (ACA) designed to make it easier for small businesses to offer and manage health coverage.

SPECIALIST PHYSICIAN – A doctor who has completed advanced education and training in a specific field of medicine. Depending on the type of health insurance plan, an enrollee may need a referral from a primary care physician to see a specialist. Some examples of specialist physicians include urologists, sleep disorder specialists, oncologists, and cardiologists.

SPECIALTY DRUGS – Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions.

STAFF MODEL HMO – A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.

STOP-LOSS COVERAGE – A form of reinsurance for organizations with self-insured health plans which limits the amount the firm will have to pay for each enrollee's healthcare (the specific (individual) stop-loss coverage amount) or for the total health expenses of the firm (the aggregate stop-loss coverage amount).

TAKE-UP RATE – The take-up rate is the percentage of eligible employees who enroll in health insurance coverage through their employer at establishments that offer insurance.

TELEMEDICINE – Provision of healthcare services through telecommunications to a patient from a provider who is at a remote location, including video chat and remote monitoring.

THIRD PARTY ADMINISTRATOR (TPA)/ADMINISTRATIVE SERVICES ONLY (ASO) – An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of a self-insured health plan.

TYPICAL PAY PERIOD – Any pay period during the calendar year in which employment was neither unusually high nor unusually low.

UNION PRESENCE – An establishment has a union presence if any of its employees are covered by a collective bargaining agreement.

USUAL, CUSTOMARY, AND REASONABLE (UCR) CHARGES – Conventional indemnity plans operate based on usual, customary, and reasonable (UCR) charges. UCR charges mean that the charge is the provider's usual fee for a service that does not exceed the customary fee in that geographic area and is reasonable based on the circumstances. Instead of UCR charges, PPO plans often operate based on a negotiated (fixed) schedule of fees that recognize charges for covered services up to a negotiated fixed dollar amount.

UTILIZATION REVIEW – The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.

(1) AVERAGE WAGE QUARTILES AVERAGE WAGE QUARTILES

Average wage quartiles: (Table VIII series) Quartiles are groups of establishments, each of which contains 25 percent of the total employment. The following process was used to determine the establishments within each of these employment quarters or quartiles:

1. The establishments were placed in order from lowest to highest average payroll per employee.
2. Starting with the lowest establishment, the employment was summed until the cumulative employment of the establishments on the list was 25 percent of the total employment of all establishments. The establishments on the list to that point are considered to be in the first quartile.
3. The second quartile begins with the next establishment on the list and includes all establishments from that point on the list until the cumulative employment reaches 50 percent.
4. The third quartile includes all establishments after the second quartile and ends with the establishment that brings the cumulative employment to 75 percent of the total.
5. The fourth quartile includes all establishments above the third quartile.

Using this process, the establishments were broken into groups of 25 percent of the employment, with each group having establishments that had a higher average payroll per employee than the previous set. Wage (average payroll) quartiles are constructed for each state individually and for the US at the national level. The average payroll data are taken from the Census Bureau's Business Register frame, which is the basis for the MEPS-IC sample. Because the frame is based in part on confidential IRS tax records, the average payroll value cutoff for each quartile cannot be disclosed.

(2) CENSUS DIVISION

The States are grouped in the tables by the following Census divisions:

New England	West North Central	West South Central
Connecticut	Iowa	Arkansas
Maine	Kansas	Louisiana
Massachusetts	Minnesota	Oklahoma
New Hampshire	Missouri	Texas
Rhode Island	Nebraska	
Vermont	North Dakota	
	South Dakota	
Middle Atlantic	**South Atlantic**	**Mountain**
New Jersey	Delaware	Arizona
New York	District of Columbia	Colorado
Pennsylvania	Florida	Idaho
	Georgia	Montana
	Maryland	Nevada
	North Carolina	New Mexico
	South Carolina	Utah
	Virginia	Wyoming
	West Virginia	
East North Central	**East South Central**	**Pacific**
Illinois	Alabama	Alaska
Indiana	Kentucky	California
Michigan	Mississippi	Hawaii
Ohio	Tennessee	Oregon
Wisconsin		Washington

(3) INDUSTRY CATEGORIES – The primary business activity as reported by the respondent. Some industry categories are abbreviated in the tables (as shown in the list below). From 1996 to 1999, the industries were based on SIC (Standard Industrial Classification) codes. Beginning in 2000, the industries were converted to NAICS (the North American Industry Classification System). Even categories that retained the same name are not comparable for the two coding systems, due to the reclassification of specific businesses from one industry category to another. Making year-to-year comparisons of MEPS data by industries across the 1999:2000 boundary is not recommended. For more information on NAICS, visit the Census Bureau's NAICS web site.

SIC industry categories used by MEPS IC for collection (1996-1999)	NAICS industry categories used by MEPS IC for collection (2000-current)	NAICS Sector
Agriculture (agric.)	Agriculture (agric.)	11
Fishing (fish.)	Fishing (fish.)	11
Forestry (forest.)	Forestry (forest.)	11
Mining	Mining	21
Manufacturing	Manufacturing	31,32,33
Construction	Construction	23
Retail trade	Retail trade	44,45
Wholesale trade	Wholesale trade	42
Transportation (transp.)	Transportation (transp.)	48,49
Utilities (util.)	Utilities (util.)	22
Communications (commu.)	Financial services (fin. svs.)	52,55
Finance (fin.)	Real estate (real est.)	53
Insurance (ins.)	Professional services	51,54,61,62
Real estate (real est.)	Other services	56,71,72,81
Services	(no data)	(no data)

(4) INDUSTRY GROUPING – For data estimation and reporting purposes, groups of industry categories are constructed in the creation of MEPS-IC tables. Without grouping the industries, the cell sample sizes would be insufficient for producing estimates.

TABLE I SERIES (NATIONAL ESTIMATES BY FIRM SIZE) – The industry groups are:

NAICS industry groups used by MEPS IC in Table I series	NAICS Sector
Agriculture (agric.), Fishing (fish.), Forestry (forest.)	11
Mining and Manufacturing	21,31,32,33
Construction	23
Utilities (util.) and Transportation (transp.)	22,48,49
Wholesale trade	42

Financial services (fin. svs.) and Real estate (real est.)	52,53,55
Retail trade	44,45
Professional services	51,54,61,62
Other services	56,71,72,81

TABLE V SERIES (STATE BY INDUSTRY GROUPINGS) – The industry groups are:

NAICS industry groups used by MEPS IC in Table V series	NAICS Sector
Agriculture (agric.), Fishing (fish.), Forestry (forest.) and Construction	11,23
Mining and Manufacturing	21,31,32,33
Retail trade, other services	44,45,56,71,72,81
Professional services	51,54,61,62
All other	22,42,48,49,52,53,55

(5) LOW-WAGE EMPLOYEE – From 1996 through 1999, a low-wage employee was defined as an employee making $6.50 per hour or less and that rate was not adjusted for increasing wage levels. Beginning in 2000, the definition of a low-wage employee was redefined as those earning at or below the 25th percentile for all hourly wages in the United States based on data from the Bureau of Labor Statistics. Using this new criterion, the dollar amount used to define this category is adjusted each year based on the most recent wage data available so that the wage level will remain constant relative to overall wages from year-to-year.

Year	Low-wage upper bound (in $/hours)
1996-1999	$6.50
2000-2003	$9.50
2004-2005	$10.00

2006	$10.50
2008-2009	$11.00
2010-2016	$11.50
2017-2018	$12.00
2019	$12.50
2020	$13.00
2021	$13.50
2022	$14.50
2023	$15.50
2024	$17.00

Making comparisons of changes across the 1999:2000 survey years regarding low-wage employees is not recommended due to the definition change.

(6) MULTIPLE EMPLOYER WELFARE ARRANGEMENT (MEWA) – MEWA is a technical term under federal law that encompasses essentially any arrangement not maintained pursuant to a collective bargaining agreement (other than a State-licensed insurance company or HMO) that provides health insurance benefits to the employees of two or more private employers.

Some MEWAs are sponsored by associations that are local, specific to a trade or industry, and exist for business purposes other than providing health insurance. Such MEWAs most often are regulated as employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), although States generally also retain the right to regulate them, much the way States regulate insurance companies. They can be funded through tax-exempt trusts known as Voluntary Employees Beneficiary Associations (VEBAs) and they can and often do use these trusts to self-insure rather than to purchase insurance policies. Other MEWAs are sponsored by Chambers of Commerce or similar organizations of relatively unrelated employers. These MEWAs are not considered to be health plans under ERISA. Instead, each participating employer's plan is regulated separately under ERISA. States are free to regulate the MEWAs themselves. These MEWAs tend to serve as vehicles for participating employers to buy insurance policies from State-licensed insurance companies or HMOs. They do not tend to self-insure.