

Appendix C

2000 MINNESOTA DISABILITY AND ELDERLY CARE PROVIDERS HEALTH INSURANCE SURVEY

SECTION A - General Employer Information	
1. Which of the following provider types describes your establishment? (check all that apply)	
<input type="checkbox"/> Nursing Facility	<input type="checkbox"/> Day Training & Habilitation Center
<input type="checkbox"/> Hospice	<input type="checkbox"/> Personal Care Provider
<input type="checkbox"/> Institution for Mental Disease (IMD)	<input type="checkbox"/> Approved Day Treatment Center
<input type="checkbox"/> ICF/MR	<input type="checkbox"/> Home Health Agency
<input type="checkbox"/> Rehabilitation Agency	<input type="checkbox"/> Public Health Nursing Organization
<input type="checkbox"/> Home & Community Based Service Provider	<input type="checkbox"/> Other _____
2. What is your operating budget for your current fiscal year?	\$ _____
3. How many years has your establishment been in operation?	\$ _____
4. How many permanent employees did you employ as of October 1, 2000? (excluding temporary or seasonal workers)?	Part-time _____ + Full-time _____ = Total _____
5. How many temporary or seasonal employees did you employ as of October 1, 2000?	Part-time _____ + Full-time _____ = Total _____
6. How many permanent employees earned the following hourly wage on October 1, 2000?	
Less than \$7 per hour	Part-time _____ + Full-time _____ = Total _____
Between \$7 & \$9.99 per hour	Part-time _____ + Full-time _____ = Total _____
More than \$10 per hour	Part-time _____ + Full-time _____ = Total _____
7. In the past 12 months, how many permanent employees have joined your establishment?	_____
8. In the past 12 months, how many permanent employees left your establishment?	_____
9. How many of your employees are members of a union?	_____
10. What percentage of your patients are?	Disabled _____ Elderly _____ Other _____
11. Do you offer health insurance to any of your employees? Yes___ No___ (If no, skip to SECTION C)	
SECTION B - Health Insurance Benefits	
12. Do you offer family coverage?	Yes _____ No _____
13. How many of each of the following types of plans do you offer your employees? (Definitions on opposite side of page)	
<input type="checkbox"/> A health maintenance organization (HMO)	<input type="checkbox"/> A preferred provider organization (PPO)
<input type="checkbox"/> A point of service plan (POS)	<input type="checkbox"/> A traditional indemnity plan
14. Do you require new employees to work for a certain length of time before they are eligible for health insurance?	No___ Yes___ If yes, indicate number of days _____
15. Number of permanent employees eligible for coverage on October 1, 2000?	Part-time _____ + Full-time _____ = Total _____
16. Number of permanent employees enrolled in individual coverage on October 1, 2000?	Part-time _____ + Full-time _____ = Total _____
17. Number of permanent employees enrolled in family coverage?	Part-time _____ + Full-time _____ = Total _____
18. Typical monthly premium for individual coverage?	\$ _____ % paid by employer _____
19. Typical monthly premium for family coverage?	\$ _____ % paid by employer _____
20. What was the percentage change in premiums from the previous year?	_____
21. How much is the annual deductible for individual coverage?	_____
22. How much do employees with individual coverage pay when they receive services (co-pay)?	_____
SECTION C - No Health Insurance Benefits	
23. What was the last year you offered health insurance to any employees?	Year _____ Never _____

SURVEY ID#

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Instructions for completing the survey:

- Please provide the contact information requested on this page and answer each of the questions on the opposite side of the page.
- All questions on this survey apply to employees at your physical location of business, i.e. your establishment, except for QUESTION #3. Where applicable, Question #3 applies to your firm, which may consist of more than one establishment.
- If you do not know the exact answer to a question, please provide an approximate answer.
- **SECTION B** If your company offers more than one plan, please answer the questions in SECTION B based on the plan with the largest number of employees from your company enrolled.
- **Question # 13.** For this question, the following definitions apply:
 - HMO - only pays for care when members receive it from a specified list or network of physicians and hospitals.
 - POS - uses a primary care physician, sometimes called a "gatekeeper", to control access to a specified network of physicians and hospitals, but leaves members free to use physicians and hospitals not in the network at a higher cost.
 - PPO - is a plan in which patients receive a list of "preferred" providers. Patients pay less when they use physicians or hospitals on the list. They remain free to seek care from a physician or hospital not on the list but they pay more.
 - Traditional Indemnity plan - this is a plan with no list of physicians or hospitals and no restrictions on choice of physicians or hospitals.
- **Question #21.** If your plan includes multiple deductibles, please provide the deductible for *physician services* provided by in-plan providers. If no deductible, please indicate zero.
- **Question #22.** If your plan includes multiple co-pays (or multiple forms of coinsurance) please provide the co-pay amount for *office visits* provided by in-plan providers. If no co-pay, please indicate zero.
- After you have completed the survey, you may wish to make a photocopy of your questionnaire for your own files. Your file copy will be an important reference in case we need to call you to clarify any of your responses.
- If you have questions about this survey or need help completing it, please contact Jennifer Gillespie, Senior Policy Analyst, Health Economics Program, Minnesota Department of Health at 651.282.6324 or jennifer.gillespie@health.state.mn.us.
- When the survey is complete, please mail your questionnaire in the enclosed self-addressed stamped envelope to:
Minnesota Department of Health - Att. Jennifer Gillespie
P.O. Box 64975
St. Paul, MN 55164-0975

PLEASE RETURN YOUR SURVEY BY NOVEMBER 3, 2000

Contact Information: Please complete this section thoroughly and accurately

Name of person completing the survey: _____

Your title: _____

Your telephone: (____) _____ Fax: (____) _____ Email: _____