2026 Medical Expenditure Panel Survey
Insurance Component

HEALTH INSURANCE COST STUDY DEFINITIONS

U.S. DEPARTMENT OF COMMERCE
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
AGENCY FOR HEALTHCARE
RESEARCH AND QUALITY

ACTIVE EMPLOYEE – A person who was employed full- or part-time in 2026 regardless of whether the employee was considered permanent, temporary, or seasonal. Include owners and officers of the organization. Exclude individuals who were contract laborers, retirees, laid off, or left employment prior to 2026.

ACTUARIAL VALUE – The average percentage of total enrollee medical expenses for plan covered benefits paid by the plan, rather than by enrollee cost sharing, for a typical group of enrollees. A higher actuarial value means the plan pays for 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.

CAFETERIA PLAN – *See Flexible Benefits Plan.*

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 or PHSA (COBRA) 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.

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.

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. For example, if the plan has a $1000 deductible, the insured person would be responsible for the first $1000 of covered medical services. Plans may have individual, employee-plus-one, 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.

EMPLOYEE-PLUS-ONE COVERAGE – Health insurance coverage for an employee-plus-spouse or an employee-plus-child.

EMPLOYEE PRE-TAX CONTRIBUTIONS TO HEALTH INSURANCE – Also known as a Premium Only Plan (POP), this is the most basic type of Section 125 Plan. An employee pays his/her 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.

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 to receive coverage except in an emergency situation.

FAMILY COVERAGE – A health plan that covers the enrollee and members of his/her immediate family (spouse and/or children). For purposes of this survey, "family coverage" is any coverage other than single and employee-plus-one (see definitions). Some plans offer more than one rate for family coverage, depending on family size and composition. If more than one rate is offered, report costs for a family of four.

FLEXIBLE BENEFITS PLAN (Full 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 child care.

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. In 2026, the maximum amount allowed in an individual's FSA is $3,400. Typically, benefits or cash must be used within the given benefit year or the employee loses the money.

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.

GATEKEEPER – A gatekeeper is responsible for coordinating (managing) 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.

HEALTH MAINTENANCE ORGANIZATION (HMO) – A health care system in which plan participants obtain comprehensive health care 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.

For Informational Purposes Only

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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. The HSA funds may be carried over to the next benefit year.

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.

ICHRA – Individual Coverage Health Reimbursement Arrangement is a new 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).

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

LEVEL-FUNDED PLAN – In a level-funded plan, your 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**.

LONG-TERM INSURANCE – Insurance that helps cover the cost of institutional and home care required by the chronically ill or disabled.

MULTI-EMPLOYER HEALTH PLAN – An employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers.

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 – Refers to a medical provider (doctor, hospital, pharmacy) who is not a member of a health plan's network. Enrollees generally incur larger costs for services from an out-of-network provider.

PREFERRED ("IN-NETWORK"/PARTICIPATING) 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 – A plan that provides coverage to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside of 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 amount of claims, administration, and stop-loss premiums for a self-insured plan.

PRIVATE EXCHANGE – An employer may choose to contract with a private exchange to provide a set of health insurance plans to be offered to its employees. 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.

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 up to a maximum dollar amount to employees to help cover their medical expenses including insurance premiums for plans purchased on the individual market.

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 plan that covers the employee only.

SPECIALTY DRUGS – Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. Additionally, specialty drugs include specifically identified types of drugs, such as lifestyle drugs and biologics.

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)**.

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 calendar year 2026, in which employment was neither unusually high nor unusually low.

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If you would like more information on the Medical Expenditure Panel Survey – Insurance Component (MEPS-IC) or the survey sponsor, the Agency for Healthcare Research and Quality (AHRQ), please visit the AHRQ Website at <https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp>.