

## MCBS MAIN STUDY - ROUND 37, FALL 2003

## COMMUNITY COMPONENT

## HI. HEALTH INSURANCE

BOX HIS1A	IF THIS IS SP'S EXIT INTERVIEW AND PREVIOUS INTERVIEW <u>NOT</u> SKIPPED, GO TO <b>BOX DM1</b> . OTHERWISE, GO TO <b>BOX HIS4A</b> IF NO PREVIOUS HEALTH INSURANCE DATA (INTTYPE = 3) OR GO TO HISINTRO IF PREVIOUS HEALTH INSURANCE DATA.
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HISINTRO. Now I'd like to review with you the information we have about health insurance plans that (you/SP) had at the time of the last interview.

[HAND HEALTH INSURANCE SUMMARY PAGE TO R.]

[PRESS ENTER TO CONTINUE.]

HIS1. [Let's see if there are any other changes we need to make to the health insurance coverage (you/SP) had as of (PREVIOUS ROUND INTERVIEW DATE).] [(You/SP) had Medicare coverage (through a managed care plan) and (you were/he was/she was) also covered by [READ PLAN NAMES BELOW]/The only health insurance coverage (you/SP) had was Medicare (through a managed care plan)] on (PREVIOUS ROUND INTERVIEW DATE). Is that correct?

YES, ALL CORRECT AS SHOWN .....	1 (HISCLOSE)
NO, PLAN MISSING .....	2 (HIS3)
NO, PLAN NAME INCORRECT .....	3 (HIS2)
NO, PLAN NEEDS DELETION .....	4 (HIS2)
DON'T KNOW .....	-8 (HISCLOSE)

HIS2. [What is the name of the plan that (is incorrect/needs deletion)?]

BOX HIS1	IF HIS1 = 4 (PLAN DELETED), GO TO HIS2a. OTHERWISE, GO TO HIS1.
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HIS2a. INTERVIEWER: BRIEFLY EXPLAIN WHY (PLAN NEEDS/PLANS NEED) DELETION.

PLANDVB1 \_\_\_\_\_

PLANDVB2 \_\_\_\_\_

PLANDVB3 \_\_\_\_\_

PLANDVB4 \_\_\_\_\_

HIS3. [What type of insurance plan needs to be added?]

## MEDICAID/MEDICAID MANAGED CARE

PLAN.....	1	<b>BOX HIS2</b>
PUBLIC PLAN OTHER THAN MEDICAID ....	2	<b>BOX HIS2</b>
PRIVATE HEALTH INSURANCE PLAN.....	3	<b>BOX HIS2</b>
MEDICARE MANAGED CARE PLAN .....	4	<b>BOX HIS2</b>
TRICARE.....	5	<b>BOX HIS2</b>

BOX HIS2	<p>IF 1, ASK HIS6 – HIS10c, THEN RETURN TO HIS1.</p> <p>IF 2, ASK HIS12 – <b>BOX HIS3</b>, THEN RETURN TO HIS1.</p> <p>IF 3, ASK HIS20 – HIS33c, THEN RETURN TO HIS1.</p> <p>IF 4, ASK HISMC1 – HISMC14, THEN RETURN TO HIS1.</p> <p>IF 5, ASK HIST1 – HIST9, THEN RETURN TO HIS1.</p>
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HISMC1. What is the name of the Medicare Managed Care Plan that covered (you/SP)?

[ENTER ONLY ONE PLAN.]

HISMC2. (Were you/Was SP) covered by or enrolled in (HISMC1 PLAN NAME) on (PREVIOUS ROUND INTERVIEW DATE)?

YES .....	1	<b>BOX HISMC1</b>
NO .....	2	<b>BOX HISMC2</b>
REFUSED .....	-7	<b>BOX HISMC2</b>
DON'T KNOW .....	-8	<b>BOX HISMC2</b>

BOX HISMC1	<p>IF NO OTHER MEDICARE MANAGED CARE PLAN IS CURRENT, GO TO HISMC4.</p> <p>OTHERWISE, GO TO HISMC3.</p>
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HISMC3. I recorded previously that (CURRENT MEDICARE MANAGED CARE PLAN NAME) was (your/SP's) current Medicare Managed Care Plan on (PREVIOUS ROUND INTERVIEW DATE). Has this information changed?

YES .....	1
NO .....	2
REFUSED .....	-7
DON'T KNOW .....	-8

BOX HISMC2	<p>IF HISMC2 OR HISMC3 = 2, REF OR DK, THEN MARK PLAN ADDED/SELECTED AT HISMC1 AS "STOPPED" AND RETURN TO HIS1. OTHERWISE, GO TO HISMC4.</p>
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HISMC4. Did (you/SP) have prescribed medicine coverage through (HISMC1 PLAN NAME)?

[PROBE: I am asking about the type of insurance coverage that (you/SP) personally had, not what the plan offers everyone.]

<b>MHMORX</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HISMC5. Did (you/SP) have dental coverage through (HISMC1 PLAN NAME)?

<b>MHMODENT</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HISMC6. Did (you/SP) have optical coverage through (HISMC1 PLAN NAME), that is, for eyeglasses or contact lenses?

<b>MHMOEYE</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HISMC7. Did (you/SP) have coverage for preventive care such as routine annual physicals through (HISMC1 PLAN NAME)?

<b>MHMOPCAR</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HISMC8. Did (your/SP's) (HISMC1 PLAN NAME) coverage include nursing home care over and beyond what Medicare normally covers?

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. The first 20 days are paid in full and the next 80 days require a copayment, which in 2003 was up to \$105.00 per day.]

<b>MHMONH</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

- HISMC9. Besides the cost of (your/SP's) Medicare Part B premium, was there an additional cost for (your/SP's) (HISMC1 PLAN NAME) coverage? Please do not include any amount that (you/SP) may have paid as a co-payment for an office visit or a prescribed medicine.

[EXPLAIN IF NECESSARY: Some managed care plans may charge a monthly premium to cover the cost of the deductibles and coinsurance for normal Medicare services or because they provide services that are not covered by Medicare such as prescribed medicines, routine exams, and dental, eye, or hearing. Plans that have premiums typically charge from \$50 to \$75 per month.]

<b>MHMOPAY</b>	YES .....	1 (HISMC10)
	NO .....	2 (HISMC13)
	REFUSED .....	-7 (HISMC13)
	DON'T KNOW .....	-8 (HISMC13)

- HISMC10. Not including the cost of (your/SP's) Medicare Part B premium, what was the additional amount that [you/(SP)] paid for (your/his/her) (HISMC1 PLAN NAME) coverage? [Please do not include any copayments (or any amount that may be paid for (your/SP's) spouse's coverage).]

[PROBE IF NECESSARY: Was that per year, per month, per week, or what?]

AMOUNT \$ \_\_\_\_\_.

<b>MHMOAMT</b>	PER YEAR .....	1
<b>MHMOUNIT</b>	QUARTERLY/EVERY 3 MONTHS .....	2
<b>MHMOUNOS</b>	BIMONTHLY/EVERY 2 MONTHS .....	3
	PER MONTH .....	4
	PER WEEK .....	5
	SEMI-ANNUALLY/2 TIMES PER YEAR .....	6
	SEMI-MONTHLY/2 TIMES PER MONTH ....	7
	OTHER (SPECIFY) _____	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

- HISMC11. Did anyone else, such as an employer, a union or professional organization pay all or some portion of the additional cost for (your/SP's) (HISMC1 PLAN NAME) coverage?

<b>MHMOCOST</b>	YES .....	1 (HISMC12)
	NO .....	2 (HISMC13)
	REFUSED .....	-7 (HISMC13)
	DON'T KNOW .....	-8 (HISMC13)

HISMC12. Who else paid all or some portion of the additional cost for (your/SP's) (HISMC1 PLAN NAME) coverage?

	(SP's) CURRENT EMPLOYER .....	1
	(SP's) FORMER EMPLOYER .....	2
	(SP's) UNION .....	3
<b>MHMOWHO</b>	SPOUSE'S CURRENT EMPLOYER.....	4
	SPOUSE'S FORMER EMPLOYER.....	5
	PROFESSIONAL/FRATERNAL ORGANIZATION .....	6
<b>MHMOWHOS</b>	MEDICAID/MEDICAL ASSISTANCE .....	7
	OTHER (SPECIFY) .....	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

HISMC13. What is the most important reason (you/SP) decided to become a member of (HISMC1 PLAN NAME)?

SHOW CARD HIMC2A
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<b>MHMOMEMB</b>	LOWER COST .....	1
<b>MHMOMEOS</b>	BETTER BENEFITS OR COVERAGE .....	2
	DOCTOR WAS MEMBER .....	3
	CONVENIENT LOCATION .....	4
	RECOMMENDATION OR REPUTATION ....	5
	SP's CURRENT/FORMER EMPLOYER PAYS PREMIUM .....	6
	SPOUSE'S CURRENT/FORMER EMPLOYER PAYS PREMIUM .....	7
	LESS PAPERWORK .....	8
	PREVIOUS MANAGED CARE PLAN NAME CHANGED OR WAS BOUGHT BY/ MERGED WITH CURRENT PLAN .....	9
	BETTER SELECTION OF PROVIDERS .....	10
	BETTER QUALITY OF CARE .....	11
	COULDN'T GET MEDICARE SUPPLEMENTAL INSURANCE (MEDIGAP) .....	12
	OTHER (SPECIFY) .....	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

HISMC14. Some Medicare Managed Care Plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Were you/Was (SP)] enrolled in a point-of-service option?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a \$10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

<b>MHMOPOS</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIS3a. OMITTED IN ROUND 23.

**HIS4 AND HIS5 OMITTED.**

HIS6. (Were you/Was SP) covered by MEDICAID the whole time between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), or only part of the time?

<b>COVTIME</b>	THE WHOLE TIME .....	1 (HIS10a)
	PART OF THE TIME .....	2 (HIS7)
	REFUSED .....	-7 (HIS10a)
	DON'T KNOW .....	-8 (HIS7)

HIS7. (Were you/Was SP) covered by MEDICAID on (PREVIOUS ROUND INTERVIEW DATE)?

<b>COVNOW</b>	YES .....	1 (HIS8)
	NO .....	2 (HIS9)
	REFUSED .....	-7 (HIS10a)
	DON'T KNOW .....	-8 (HIS10a)

HIS8. On what date did (your/SP's) MEDICAID start between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)?

<b>COVBEGMM</b>	_____ / _____ / _____	(HIS10a)
<b>COVBEGDD</b>	MM DD YY	
<b>COVBEGYY</b>		

HIS9. On what date between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE) did (your/SP's) MEDICAID coverage stop?

<b>COVENDMM</b>	_____ / _____ / _____	(HIS10a)
<b>COVENDDD</b>	MM DD YY	
<b>COVENDYY</b>		

HIS10. OMITTED IN ROUND 30.

HIS10a. Some states now use managed care plans, such as HMOs (health maintenance organizations), to provide some or all health care for Medicaid beneficiaries. (Were you/Was SP) enrolled in a Medicaid Managed Care Plan on [(PREVIOUS ROUND INTERVIEW DATE)/(MEDICAID COVERAGE STOP DATE)/the date (your/SP's) Medicaid coverage stopped]?

<b>MCAIDHMO</b>	YES .....	1 (HIS10b)
	NO .....	2 (HIS10c)
	REFUSED .....	-7 (HIS10c)
	DON'T KNOW .....	-8 (HIS10c)

HIS10b. As far as you can recall, (were you/was SP) given a choice to enroll in a Medicaid Managed Care Plan, or did (you/he/she) have to enroll to receive Medicaid benefits?

<b>CHOICHMO</b>	GIVEN A CHOICE TO ENROLL .....	1
	HAD TO ENROLL .....	2
	DOESN'T REMEMBER .....	3
	REFUSED .....	-7

HIS10c. Did [your/(SP's)] Medicaid plan cover medicines prescribed by a doctor?

<b>MCDRXCOV</b>	YES .....	1 (HIS1)
	NO .....	2 (HIS1)
	REFUSED .....	-7 (HIS1)
	DON'T KNOW .....	-8 (HIS1)

HIS11 OMITTED.
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HIST1. (Were you/Was SP) covered by TRICARE the whole time between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), or only part of the time?

<b>COVTIME</b>	THE WHOLE TIME .....	1 (HIST3)
	PART OF THE TIME .....	2 (HIST2)
	REFUSED .....	-7 (HIST3)
	DON'T KNOW .....	-8 (HIST2)

HIST2. (Were you/Was SP) covered by TRICARE on (PREVIOUS ROUND INTERVIEW DATE)?

<b>COVNOW</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIST3. Did [your/(SP's)] TRICARE plan cover medicines prescribed by a doctor?

[PROBE: I am asking about the type of insurance coverage that you/SP personally had, not what the plan offers everyone.]

<b>TRIRXCOV</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIST4. Between (PREVIOUS ROUND REF. DATA) and (PREVIOUS ROUND INTERVIEW DATE) did (you/SP) have dental coverage through TRICARE?

<b>TRIDENT</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIST5. Did (you/SP) have optical coverage through TRICARE, that is, for eyeglasses or contact lenses?

<b>TRIEYE</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIST6. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE) did (you/SP) have coverage for preventive care such as routine annual physicals through TRICARE?

<b>TRIPCAR</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIST7. Did (your/SP's) TRICARE coverage include nursing home care over and beyond what Medicare normally covers?

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. The first 20 days are paid in full and the next 80 days require a copayment, which in 2003 was up to \$105.00 per day.]

<b>TRINHCOV</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIST8. Besides the cost of (your/SP's) Medicare Part B premium, was there an additional cost for (your/his/her) TRICARE coverage? Please do not include any amount that [you/(SP)] may have paid as a co-payment for an office visit or a prescribed medicine.

[EXPLAIN IF NECESSARY: Some plans may charge a monthly premium to cover the cost of the deductibles and coinsurance for normal Medicare services or because they provide services that are not covered by Medicare, such as prescribed medicines, routine exams, and dental, eye, or hearing. Plans that have premiums typically charge from \$50 to \$75 per month.]

<b>TRIINS</b>	YES .....	1 (HIST9)
	NO .....	2 (HIS1)
	REFUSED .....	-7 (HIS1)
	DON'T KNOW .....	-8 (HIS1)



- HIST9. Not including the cost of (your/SP's) Medicare Part B premium, what was the additional amount that (you paid/SP paid) for (your/his/her) TRICARE coverage? [Please do not include any copayments (or any amount that may be paid for [your/(SP's)] spouse's coverage.)]

AMOUNT \$ \_\_\_\_\_ PER ( )

[PROBE IF NECESSARY: (Is/Was) that per year, per month, per week, or what?]

<b>TRIAMT</b>	PER YEAR .....	1
<b>TRIUNIT</b>	QUARTERLY/EVERY 3 MONTHS .....	2
<b>TRIUNOS</b>	BIMONTHLY/EVERY 2 MONTHS .....	3
	PER MONTH .....	4
	PER WEEK .....	5
	SEMI-ANNUALLY/2 TIMES PER YEAR .....	6
	SEMI-MONTHLY/2 TIMES PER MONTH ....	7
	OTHER (SPECIFY) .....	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

- HIS12. What is the name of the public program that covered (you/SP)?  
[ENTER ALL PUBLIC PROGRAMS.]

**PLNAME**

- HIS13. (Were you/Was SP) covered by (HIS12 PUBLIC PLAN NAME) the whole time between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), or only part of the time?

<b>COVTIME</b>	THE WHOLE TIME .....	1 (HIS16a)
	PART OF THE TIME .....	2 (HIS14)
	REFUSED .....	-7 (HIS16a)
	DON'T KNOW .....	-8 (HIS14)

- HIS14. (Were you/Was SP) covered by (HIS12 PUBLIC PLAN NAME) on (PREVIOUS ROUND INTERVIEW DATE)?

<b>COVNOW</b>	YES .....	1 (HIS15)
	NO .....	2 (HIS16)
	REFUSED .....	-7 (HIS16a)
	DON'T KNOW .....	-8 (HIS16a)

- HIS15. On what date did (your/SP's) (HIS12 PUBLIC PLAN NAME) coverage start between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)?

<b>COVBEGMM</b>	_____ / _____ / _____	(HIS16a)
<b>COVBEGDD</b>	MM DD YY	
<b>COVBEGYY</b>		

HIS16. On what date between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE) did (your/SP's) (HIS12 PUBLIC PLAN NAME) coverage stop?

**COVENDMM**  
**COVENDDD**  
**COVENDYY**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YY

HIS16a. Did [your/(SP's)] (HIS12 PUBLIC PLAN NAME) plan cover medicines prescribed by a doctor?

**PUBRXCov**

YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

HIS17/HIS18 OMITTED.

BOX  
HIS3

GO TO HIS13 FOR NEXT PUBLIC PLAN ADDED AT HIS12. IF NO OTHER PUBLIC PLAN, THEN GO TO HIS1.

HIS20. What is the name of each of the (other) private plans that provided (your/SP's) medical insurance coverage between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)? [ENTER ALL PRIVATE PLANS.]

**PLNAME**  
**PLANSUMM**

HIS21. (Were you/Was SP) covered by (HIS20 PLAN NAME) the whole time between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), or only part of the time?

**COVTIME**

THE WHOLE TIME ..... 1 (HIS25)  
PART OF THE TIME ..... 2 (HIS22)  
REFUSED ..... -7 (HIS25)  
DON'T KNOW ..... -8 (HIS22)

HIS22. (Were you/Was SP) covered by (HIS20 PLAN NAME) on (PREVIOUS ROUND INTERVIEW DATE)?

**COVNOW**

YES ..... 1 (HIS23)  
NO ..... 2 (HIS24)  
REFUSED ..... -7 (HIS25)  
DON'T KNOW ..... -8 (HIS25)

HIS23. On what date did (your/SP's) coverage under (HIS20 PLAN NAME) start between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)?

**COVBEGMM**  
**COVBEGDD**  
**COVBEGYY**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YY (HIS25)

- HIS24. On what date between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE) did (your/SP's) coverage under (HIS20 PLAN NAME) stop?

**COVENDMM**  
**COVENDDD**  
**COVENDYY**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YY

- HIS25. [CODE WITHOUT ASKING IF VOLUNTEERED.]

Was this a managed care plan, such as an HMO (Health Maintenance Organization)?

[EXPLAIN IF NECESSARY: Managed care plans generally provide a full range of health care services for a prepaid fee. The major types of managed care plans are health maintenance organizations (HMOs), HMOs with a point-of-service option, Provider-Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs).]

**PRVHMO** YES ..... 1  
**PLHMOERR** NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

- HIS26. Who was listed as the main insured person on the (HIS20 PLAN NAME) policy or contract?  
[ENTER ONLY ONE PERSON.]

**PLMIPNUM**  
**MIPNUM**

- HIS27. For the (HIS20 PLAN NAME) plan, did (you/MIP) sign up directly with the (insurance company/managed care plan), or did (you/MIP) get this insurance through a current employer, a former employer, a union, a family business, AARP, or some other way?

**PRVGET** DIRECTLY ..... 1 (HIS27a)  
**PPRVGET** (MIP's) CURRENT EMPLOYER ..... 2 (HIS28)  
(MIP'S) FORMER EMPLOYER ..... 3 (HIS28)  
(MIP'S) UNION ..... 4 (HIS29)  
(MIP'S) FAMILY BUSINESS ..... 5 (HIS27a)  
AARP..... 6 (HIS27a)  
DECEASED SPOUSE'S EMPLOYER ..... 7 (HIS28)  
DECEASED SPOUSE'S UNION ..... 8 (HIS29)  
PROFESSIONAL/FRATERNAL  
ORGANIZATION ..... 9 (HIS29)  
SOME OTHER WAY (SPECIFY) \_\_\_\_\_ 91 (HIS29)  
**PRVGETOS** REFUSED ..... -7 (HIS29)  
**PPRVGTOS** DON'T KNOW ..... -8 (HIS29)

- HIS27a. Many Medicare Supplemental or Medigap plans are referred to by a plan letter. There are ten standardized policies, labeled **Plan "A" through Plan "J"**. Did (your/MIP's) (HIS20 PLAN NAME) have a plan letter?

**PRVLETR** YES ..... 1 (HIS27b)  
NO ..... 2 **BOX HIS3AA**  
REFUSED ..... -7 **BOX HIS3AA**  
DON'T KNOW ..... -8 **BOX HIS3AA**

- HIS27b. What was the plan letter for (your/MIP's) (HIS20 PLAN NAME)?

**PLANLETR** PLAN LETTER \_\_\_\_\_

BOX HIS3AA	IF HIS27 = 5, GO TO HIS28. OTHERWISE, GO TO HIS29.
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HIS28. What kind of business or industry is (RESPONSE IN HIS27)? That is, what does (RESPONSE IN HIS27) make or do?  
[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

**PRVBUS1**  
**PRVBUS2**  
**PRVBUS3**  
**INDCODE**

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**PPRVBUS1**  
**PPRVBUS2**  
**PPRVBUS3**  
**PINDCODE**

HIS29. How many family members, including (yourself/SP), were covered by (your/MIP's) (HIS20 PLAN NAME) between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)?

**PRVNMCOV** NUMBER COVERED: \_\_\_\_\_

HIS29a. Did (your/MIP's) (PLAN NAME) plan cover any portion of the cost of a visit to a doctor or a lab?

[EXPLAIN IF NECESSARY: For example, if (you/MIP) went to the doctor because (you/MIP) felt sick or if (you/MIP) had blood drawn at a lab, did (your/MIP's) (PLAN NAME) plan pay for any of the cost of these services?]

**PRVMSCOV** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

HIS29b. Did (your/MIP's) (PLAN NAME) plan cover any portion of the cost if (you were/MIP was) admitted to the hospital as an inpatient?

[EXPLAIN IF NECESSARY: For example, in 2003, Medicare beneficiaries are responsible for an \$840 deductible when admitted to a hospital and Medicare pays for most of the rest of the costs. Did (your/MIP's) (PLAN NAME) plan pay any portion of the hospital deductible or other cost?]

**PRVIPCOV** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

HIS30. Did (your/MIP's) (HIS20 PLAN NAME) plan cover medicines prescribed by a doctor?

**PRVRXCOV** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

BOX HIS3A	IF PLAN IS A MANAGED CARE PLAN (HIS25 = 1), GO TO HIS30a. OTHERWISE, GO TO HIS31.
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HIS30a. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did (you/SP) have dental coverage through (HIS20 PLAN NAME)?

<b>MHMODENT</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIS30b. Did (you/SP) have optical coverage through (HIS20 PLAN NAME), that is, for eyeglasses or contact lenses?

<b>MHMOEYE</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIS30c. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did (you/SP) have coverage for preventive care such as routine annual physicals through (HIS20 PLAN NAME)?

<b>MHMOPCAR</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIS31. Would (your/MIP's) (HIS20 PLAN NAME) plan have covered any part of a stay in a nursing home?

<b>PRVNHCOV</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIS32. Was there a premium or cost for the (HIS20 PLAN NAME) coverage?  
[Do not include the cost of any deductibles (you/SP) or (your/SP's) family may have had to pay.]

<b>MIPPINS</b>	YES .....	1 (HIS33)
	NO .....	2 (HIS33a)
	REFUSED .....	-7 (HIS33a)
	DON'T KNOW .....	-8 (HIS33a)

HIS33. How much did (you/MIP) pay for the (HIS20 PLAN NAME) coverage?  
[PROBE IF NECESSARY: Was that per year, per month, per week, or what?]

	AMOUNT: \$ _____	
<b>MIPPAMT</b>	PER YEAR .....	1
<b>MIPPUNIT</b>	QUARTERLY/EVERY 3 MONTHS .....	2
	BIMONTHLY/EVERY 2 MONTHS .....	3
	PER MONTH .....	4
	PER WEEK .....	5
	SEMI-ANNUALLY/2 TIMES PER YEAR .....	6
	SEMI-MONTHLY/2 TIMES PER MONTH ....	7
<b>MIPPUNOS</b>	OTHER (SPECIFY) _____	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIS33a. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did anyone else, such as an employer, a union or professional organization pay all or some portion of the premium or cost for (your/MIP's) (HIS20 PLAN NAME) coverage?

<b>MHMOCCOST</b>	YES .....	1 (HIS33b)
	NO .....	2 <b>BOX HIS3B</b>
	REFUSED .....	-7 <b>BOX HIS3B</b>
	DON'T KNOW .....	-8 <b>BOX HIS3B</b>

HIS33b. Who else paid all or some portion of the cost for (your/MIP's) (HIS20 PLAN NAME) coverage?

<b>MHMOWHO</b>	(MIP's) CURRENT EMPLOYER .....	1
	(MIP's) FORMER EMPLOYER .....	2
	(MIP's) UNION .....	3
	SPOUSE'S CURRENT EMPLOYER .....	4
	SPOUSE'S FORMER EMPLOYER .....	5
	PROFESSIONAL/FRATERNAL ORGANIZATION .....	6
	MEDICAID/MEDICAL ASSISTANCE .....	7
<b>MHMOWHOS</b>	OTHER (SPECIFY) _____	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HIS3B	IF PLAN IS A MANAGED CARE PLAN, GO TO HIS33c. OTHERWISE, GO TO <b>BOX HIS4</b> .
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HIS33c. Some managed care plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), [were you/was (SP)] enrolled in a point-of-service option offered by (HIS20 PLAN NAME)?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a \$10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

<b>MHMOPOS</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HIS4	CYCLE THROUGH QUESTIONS HIS21 - HIS33c FOR EACH PRIVATE PLAN REPORTED AT HIS20. WHEN ALL PLANS ADDED HAVE BEEN DISCUSSED RETURN TO HIS1, LISTING EACH PLAN NAME REPORTED IN HIS20.
-------------	--

HISCLOSE. That covers the health insurance (you/SP) had at the time of the last interview. The next questions are about (your/SP's) insurance coverage between (PREVIOUS ROUND INTERVIEW DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION).

[PRESS ENTER TO CONTINUE.]

BOX HIS4A	ORD AND DUAL ELIGIBLE SAMPLES AND SUPPLEMENTAL SAMPLE CASES: IF ANY CMS MEDICARE MANAGED CARE PLANS WERE LOADED AT HOME OFFICE, GO TO MC1. IF NO CMS MEDICARE MANAGED CARE PLANS WERE LOADED AT HOME OFFICE, GO TO HIMC1. NON-SUPPLEMENTAL SAMPLE CASES, GO TO <b>BOX HIS4B</b> .
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BOX HIS4B	IF MEDICARE MANAGED CARE PLAN CURRENT AS OF PREVIOUS INTERVIEW, GO TO HIMC1a. OTHERWISE, GO TO HIMC1.
--------------	---

MEDICARE MANAGED CARE PLAN = XXXXXXXX

HIMC1a. At the time of the last interview (you were/SP was) covered by (MEDICARE MANAGED CARE PLAN NAME). [(Are you/Is SP) now covered by (MEDICARE MANAGED CARE PLAN NAME)?] [Was (SP) covered by (MEDICARE MANAGED CARE PLAN NAME) on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]

<b>MHMOSAME</b>	YES .....	1	<b>BOX HIS4C</b>
	NO .....	2	(HIMC1b)
	REFUSED .....	-7	<b>BOX HIMC4</b>
	DON'T KNOW .....	-8	<b>BOX HIMC4</b>

HIMC1b. What is the most important reason (you/SP) stopped the (MEDICARE MANAGED CARE PLAN NAME) [STOPHMO] coverage?

<b>DISENROL</b>	TOO EXPENSIVE .....	1 (HIMC1c)
<b>DISENROS</b>	SP DISSATISFIED WITH QUALITY OF CARE .....	2 (HIMC1c)
	DOCTOR LEFT PLAN/DIED/RETIRED .....	3 (HIMC1c)
	INCONVENIENT LOCATION .....	4 (HIMC1c)
	PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE .....	5 (HIMC1c)
	DIFFICULTIES GETTING APPOINTMENTS .....	6 (HIMC1c)
	DIFFICULTY SEEING PROVIDERS SP WANTED TO SEE .....	7 (HIMC1c)
	COULDN'T GET NEEDED CARE .....	8 (HIMC1c)
	DOCTOR DID NOT SPEAK SP'S LANGUAGE .....	9 (HIMC1c)
	SP MOVED .....	10 (HIMC1c)
	SP WANTED OR NEEDED DIFFERENT HEALTH CARE BENEFITS ....	11 (HIMC1c)
	SP COULD NOT AFFORD THE PLAN'S PREMIUMS, DEDUCTIBLES, AND/OR COPAYMENTS .....	12 (HIMC1c)
	SP DIDN'T LIKE CHOICE OF DOCTORS .....	13 (HIMC1c)
	SP WANTED CHOICE OF DOCTORS .....	14 (HIMC1c)
	REACHED BENEFIT LIMIT .....	15 (HIMC1c)
	PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER MANAGED CARE PLAN .....	16 (HIMC3)
	OTHER (SPECIFY) .....	91 (HIMC1c)
	REFUSED .....	-7 (HIMC1c)
	DON'T KNOW .....	-8 (HIMC1c)

BOX HIS4C	IF THIS PLAN NOT "CURRENT" IN PREVIOUS ROUND <u>OR</u> IF THIS PLAN "CURRENT" AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HIMC6. OTHERWISE, GO TO <b>BOX HIMC2</b> .
--------------	--

HIMC1c. [Since (REF. DATE)/Between (REF. DATE) and (DATE OF DEATH/INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Managed Care Plans besides (MEDICARE MANAGED CARE PLAN CURRENT LAST ROUND)?

SHOW CARD HIMC1	<b>MHMOOTH</b>	YES .....	1 (HIMC3)
		NO .....	2 <b>BOX HIMC4</b>
		REFUSED .....	-7 <b>BOX HIMC4</b>
		DON'T KNOW .....	-8 <b>BOX HIMC4</b>

BOX MC1 OMITTED.



MC1. [The next questions are about health insurance.] As you may know, Medicare allows beneficiaries in certain parts of the country to enroll in managed care plans, such as HMOs (health maintenance organizations), to receive their Medicare-funded health care. According to Medicare records, (you are/SP is) currently enrolled in a Medicare Managed Care Plan called (CMS MEDICARE MANAGED CARE PLAN NAME). Is this information correct?

<b>LOADCORR</b>	YES .....	1 (HIMC6)
	NO .....	2 (MC2)
	REFUSED .....	-7 <b>BOX HIMC4</b>
	DON'T KNOW .....	-8 (MC11)

MC2. (CMS MEDICARE MANAGED CARE PLAN NAME)

How is this information incorrect?

[CODE ONLY ONE. IF MORE THAN ONE CODE APPLICABLE, ENTER THE LOWEST NUMBER CODE.]

<b>WHATWRNG</b>	SP NOW DISENROLLED FROM (CMS MEDICARE MANAGED CARE PLAN NAME), ENROLLED IN NEW MEDICARE MANAGED CARE PLAN .....	1 (MC2a)
	SP HAS PLAN CALLED (CMS MEDICARE MANAGED CARE PLAN NAME), R DOESN'T THINK IT'S A MEDICARE MANAGED CARE PLAN .....	2 (MC3)
	SP NOW DISENROLLED FROM (CMS MEDICARE MANAGED CARE PLAN NAME), NO LONGER IN ANY MEDICARE MANAGED CARE PLAN .....	3 (MC2a)
	SP ENROLLED IN MEDICARE MANAGED CARE PLAN, BUT NEVER (CMS MEDICARE MANAGED CARE PLAN NAME) .....	4 (MC4)
	SP NEVER COVERED BY OR ENROLLED IN (CMS MEDICARE MANAGED CARE PLAN NAME) .....	5 (MC11)

MC2a. What is the most important reason (you/SP) stopped the (CMS MEDICARE MANAGED CARE PLAN NAME) coverage?

<b>DISENROL</b>	TOO EXPENSIVE .....	1	<b>BOX MC1A</b>
<b>DISENROS</b>	SP DISSATISFIED WITH QUALITY OF CARE .....	2	<b>BOX MC1A</b>
	DOCTOR LEFT PLAN/DIED/RETIRED .....	3	<b>BOX MC1A</b>
	INCONVENIENT LOCATION .....	4	<b>BOX MC1A</b>
	PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE .....	5	<b>BOX MC1A</b>
	DIFFICULTIES GETTING APPOINTMENTS .....	6	<b>BOX MC1A</b>
	DIFFICULTY SEEING PROVIDERS SP WANTED TO SEE .....	7	<b>BOX MC1A</b>
	COULDN'T GET NEEDED CARE .....	8	<b>BOX MC1A</b>
	DOCTOR DID NOT SPEAK SP'S LANGUAGE .....	9	<b>BOX MC1A</b>
	SP MOVED .....	10	<b>BOX MC1A</b>
	SP WANTED OR NEEDED DIFFERENT HEALTH CARE BENEFITS ....	11	<b>BOX MC1A</b>
	SP COULD NOT AFFORD THE PLAN'S PREMIUMS, DEDUCTIBLES, AND/OR COPAYMENTS .....	12	<b>BOX MC1A</b>
	SP DIDN'T LIKE CHOICE OF DOCTORS .....	13	<b>BOX MC1A</b>
	SP WANTED CHOICE OF DOCTORS .....	14	<b>BOX MC1A</b>
	REACHED BENEFIT LIMIT .....	15	<b>BOX MC1A</b>
	PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER MANAGED CARE PLAN .....	16	<b>BOX MC1A</b>
	OTHER (SPECIFY) .....	91	<b>BOX MC1A</b>
	REFUSED .....	-7	<b>BOX MC1A</b>
	DON'T KNOW .....	-8	<b>BOX MC1A</b>

BOX MC1A	IF MC2=1, GO TO MC5. IF MC2 = 3, GO TO H1MC16.
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MC3. In many Medicare Managed Care Plans, such as health maintenance organizations, the health plan gives the patient a list of doctors from which he chooses a primary care physician. This primary care physician provides the patient's usual medical care and can refer the patient to specialists, if necessary. (Do you/Does SP) have a primary care physician?

<b>PRIMPHYS</b>	YES .....	1	(H1MC6)
	NO .....	2	(H1MC6)
	REFUSED .....	-7	(H1MC6)
	DON'T KNOW .....	-8	(H1MC6)

MC4. Is it possible that (your/SP's) current insurance plan is just another name for (CMS MEDICARE MANAGED CARE PLAN NAME), or are they not the same plans?

<b>SAMEPLAN</b>	SAME PLANS .....	1	<b>BOX MC2</b>
	NOT THE SAME PLANS .....	2	(MC5)
	REFUSED .....	-7	(MC5)
	DON'T KNOW .....	-8	(MC5)

MC5.      What is the name of the Medicare Managed Care Plan that provides (your/SP's) health care?  
[ENTER ONLY ONE PLAN.]  
**PLNAME** GO TO **BOX MC2**.

MC6-MC7 OMITTED.

BOX MC3 OMITTED.

MC8-MC9 OMITTED.

BOX MC4 OMITTED.

MC10 OMITTED.

MC11.      Do you refer to (your/SP's) Medicare coverage by any name besides Medicare?

<b>REFERMED</b>	MEDICARE ONLY .....	1	<b>BOX HIMC4</b>
	OTHER NAME .....	2	(MC12)
	REFUSED .....	-7	<b>BOX HIMC4</b>
	DON'T KNOW .....	-8	<b>BOX HIMC4</b>

MC12.      What do you call (your/SP's) coverage?  
[ENTER ONLY ONE PLAN.]  
**PLNAME**

BOX MC2	FLAG THE CMS MEDICARE MANAGED CARE PLAN AS CURRENT MEDICARE MANAGED CARE PLAN OR THE PLAN ADDED AT MC5/MC12 AS CURRENT MEDICARE MANAGED CARE PLAN. THEN GO TO HIMC6.
------------	--

MC13 OMITTED.

HIMC1.      [The next questions are about health insurance.] As you (may) know, Medicare allows beneficiaries in certain parts of the country to enroll in managed care plans, such as HMOs (health maintenance organizations), to receive their Medicare-funded health care.  
(Please look at this card.) At any time since (REF. DATE), (have you/has SP/had SP) been enrolled in or covered by (one of these/any) Medicare Managed Care Plans?

<div>SHOW CARD HIMC1</div>	<b>MHMOCOV</b>	YES .....	1	(HIMC3)
		NO .....	2	<b>BOX HIMC1A</b>
		REFUSED .....	-7	<b>BOX HIMC1A</b>
		DON'T KNOW .....	-8	<b>BOX HIMC1A</b>

BOX HIMC1A	<p>SKIP PATTERN FOR FALL “SUPPLEMENTAL” SAMPLE ROUNDS: IF SP <u>NEVER</u> ENROLLED IN MEDICARE MANAGED CARE PLAN (NO PLANTYPE = 5 ON PLAN ROSTER) AND SP NOT DECEASED, THEN GO TO HIMC1INT. OTHERWISE, GO TO <b>BOX HIMC4</b>.</p> <p>SKIP PATTERN FOR ALL OTHER ROUNDS: GO TO <b>BOX HI1</b>.</p>
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HIMC1INT. [In some areas, Medicare beneficiaries like (yourself/SP) can join managed care plans, such as health maintenance organizations (HMOs).] The managed care plan provides all (your/SP's) care for a fixed fee, rather than billing Medicare for each service. In many Medicare Managed Care Plans, the primary care doctor authorizes, arranges, and coordinates all services for (you/SP).  
[PRESS ENTER TO CONTINUE.]

HIMC1aa. Before today, had you ever heard of managed care plans that Medicare beneficiaries can join?

<b>HEARMHMO</b>	YES .....	1 (HIMC1bb)
	NO .....	2 <b>BOX HI1</b>
	REFUSED .....	-7 <b>BOX HI1</b>
	DON'T KNOW .....	-8 <b>BOX HI1</b>

HIMC1bb. Are there managed care plans in (your/SP's) area that Medicare beneficiaries can join?

<b>AREAMHMO</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC1cc. OMITTED IN ROUND 20.

HIMC1cc1. Would (you/SP) prefer to have (more) managed care plans offered in (your/his/her) area?

<b>OFFRAREA</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HIMC1AA	IF HIMC1bb = 2 OR DK, GO TO HIMC1dd. OTHERWISE, GO TO HIMC1cc2.
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HIMC1cc2. Would (you/SP) prefer to have managed care plans in (your/his/her) area that offer different services or features than those currently available?

<b>DIFFSRVC</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC1dd. How satisfied are you with the information available to (you/SP) to make health coverage choices?

SHOW CARD HIMC2	<b>HIINFO</b>	VERY SATISFIED .....	1
		SATISFIED .....	2
		DISSATISFIED .....	3
		VERY DISSATISFIED .....	4
		REFUSED .....	-7
		DON'T KNOW .....	-8

HIMC1ee. What additional kinds of information would you like to have to be able to make health coverage choices (for SP)?

<b>HIADDINF</b>	NO ADDITIONAL INFORMATION NEEDED/WANTED .....	1	<b>VCHIADD1</b>
<b>HIADDVB1</b>	RECORD ALL OTHER RESPONSES VERBATIM BELOW .....	91	<b>VCHIADD2</b>
<b>HIADDVB2</b>	_____		<b>VCHIADD3</b>
<b>HIADDVB3</b>	_____		<b>VCHIADD4</b>

BOX HIMC1B	IF FIRST-TIME COMMUNITY CASE AND: IF HIMC1bb = 1, REF, DK, GO TO HIMC1ff. IF HIMC1bb = 2, GO TO HIMC1hh. OTHERWISE, GO TO <b>BOX HI1</b> .
---------------	---

HIMC1ff. (Have you/Has SP) considered joining a managed care plan since becoming a Medicare beneficiary?

<b>JOINMHMO</b>	YES .....	1	<b>BOX HI1</b>
	NO .....	2	(HIMC1gg)
	REFUSED .....	-7	<b>BOX HI1</b>
	DON'T KNOW .....	-8	<b>BOX HI1</b>

HIMC1gg. Why (haven't you/hasn't SP) considered joining a managed care plan?  
[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

<b>JOINHMO1</b>	_____	<b>VCJOIN1</b>
<b>JOINHMO2</b>	_____	<b>VCJOIN2</b>
<b>JOINHMO3</b>	_____	<b>VCJOIN3</b>
	_____	<b>VCJOIN4</b>
		GO TO <b>BOX HI1</b>

HIMC1hh. If there were managed care plans in (your/SP's) area that Medicare beneficiaries could join, would [you/(SP)] consider joining?

<b>IFMHMO</b>	YES .....	1	<b>BOX HI1</b>
	NO .....	2	(HIMC1ii)
	REFUSED .....	-7	<b>BOX HI1</b>
	DON'T KNOW .....	-8	<b>BOX HI1</b>

HIMC1ii. Why wouldn't (you/SP) consider joining a managed care plan?  
[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

IFMHMO1

VCIFMH1

IFMHMO2

VCIFMH2

IFMHMO3

VCIFMH3

VCIFMH4

GO TO **BOX HI1**

HIMC2 OMITTED.

BOX HIMC1BB OMITTED.

HIMC3. (Are you/Is SP/Was SP) (currently) covered by or enrolled in a Medicare Managed Care Plan (on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

MHMOCURR

YES ..... 1 (HIMC5)  
NO ..... 2 **BOX HIMC1C**  
REFUSED ..... -7 **BOX HIMC1C**  
DON'T KNOW ..... -8 **BOX HIMC1C**

BOX  
HIMC1C

IF COMING FROM CHARGE SERIES OR INTERRUPT, RETURN TO CHARGE  
SERIES OR INTERRUPT. OTHERWISE, GO TO HIMC17.

HIMC4. I recorded previously that (CURRENT MEDICARE MANAGED CARE PLAN NAME) was (your/SP's) current Medicare Managed Care Plan. Has this information changed?

MHMOCHNG

YES ..... 1 (HIMC5)  
NO ..... 2 (ST/NS/CT/CPS)  
REFUSED ..... -7 (ST/NS/CT/CPS)  
DON'T KNOW ..... -8 (ST/NS/CT/CPS)

HIMC5. [What is the name of the Medicare Managed Care Plan that (currently covers/covered) (you/SP) (on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]  
[ENTER ONLY ONE PLAN.]

PLNAME

BOX  
HIMC1

IF THIS IS THE FALL "SUPPLEMENTAL" ROUND OR HIMC6 NEVER ASKED FOR  
THIS MEDICARE MANAGED CARE PLAN OR IF THIS MEDICARE MANAGED CARE  
PLAN WAS SELECTED (I.E., THE SP HAS RE-STARTED THIS PLAN), GO TO  
HIMC6. OTHERWISE, GO TO **BOX HI1/ST/NS/CT/CPS**.

HIMC6. (Do you/Does SP/Did SP) have prescribed medicine coverage through (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

[PROBE: I am asking about the type of insurance coverage that (you personally have/SP personally has), not what the plan offers everyone.]

<b>MHMORX</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC7. (Do you/Does SP/Did SP) have dental coverage through (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

<b>MHMODENT</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC8. (Do you/Does SP/Did SP) have optical coverage through (CURRENT MEDICARE MANAGED CARE PLAN NAME), that is, for eyeglasses or contact lenses?

<b>MHMOEYE</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC9. (Do you/Does SP/Did SP) have coverage for preventive care such as routine annual physicals through (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

<b>MHMOPCAR</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC10. (Does your/Does SP's/Did SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage include nursing home care over and beyond what Medicare normally covers?

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. In 2003, the first 20 days are paid in full and the next 80 days require a copayment of up to \$105.00 per day.]

<b>MHMONH</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

- HIMC11. Besides the cost of (your/SP's) Medicare Part B premium, is there an additional cost for (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage? Please do not include any amount that (you/SP) may pay as a co-payment for an office visit or a prescribed medicine.

[EXPLAIN IF NECESSARY: Some managed care plans may charge a monthly premium to cover the cost of the deductibles and coinsurance for normal Medicare services or because they provide services that are not covered by Medicare such as prescribed medicines, routine exams, and dental, eye, or hearing. Plans that have premiums typically charge from \$50 to \$75 per month.]

<b>MHMOPAY</b>	YES .....	1 (HIMC12)
	NO .....	2 <b>BOX HIMC1D</b>
	REFUSED .....	-7 <b>BOX HIMC1D</b>
	DON'T KNOW .....	-8 <b>BOX HIMC1D</b>

- HIMC12. Not including the cost of (your/SP's) Medicare Part B premium, what is the additional amount that [you pay/(SP) pays] for (your/his/her) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage? [Please do not include any copayments (or any amount that may be paid for (your/SP's) spouse's coverage).]

AMOUNT \$ \_\_\_\_\_ PER ( )

[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

<b>MHMOAMT</b>	PER YEAR .....	1
<b>MHMOUNIT</b>	QUARTERLY/EVERY 3 MONTHS .....	2
<b>MHMOUNOS</b>	BIMONTHLY/EVERY 2 MONTHS .....	3
	PER MONTH .....	4
	PER WEEK .....	5
	SEMI-ANNUALLY/2 TIMES PER YEAR .....	6
	SEMI-MONTHLY/2 TIMES PER MONTH ....	7
	OTHER (SPECIFY) _____	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

- HIMC12a. Does anyone else, such as an employer, a union or professional organization pay all or some portion of the additional cost for (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage?

<b>MHMOCAST</b>	YES .....	1 (HIMC12b)
	NO .....	2 <b>BOX HIMC1D</b>
	REFUSED .....	-7 <b>BOX HIMC1D</b>
	DON'T KNOW .....	-8 <b>BOX HIMC1D</b>



HIMC12b. Who else pays all or some portion of the additional cost for (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage?

	(SP'S) CURRENT EMPLOYER.....	1
	(SP'S) FORMER EMPLOYER.....	2
	(SP'S) UNION .....	3
<b>MHMOWHO</b>	SPOUSE'S CURRENT EMPLOYER.....	4
	SPOUSE'S FORMER EMPLOYER.....	5
	PROFESSIONAL/FRATERNAL ORGANIZATION .....	6
<b>MHMOWHOS</b>	MEDICAID/MEDICAL ASSISTANCE .....	7
	OTHER (SPECIFY) .....	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC13. OMITTED IN ROUND 18.

BOX HIMC1D	IF HIMC14 NEVER ASKED FOR THIS MEDICARE MANAGED CARE PLAN OR IF THIS MEDICARE MANAGED CARE PLAN WAS SELECTED (I.E., THE SP HAS RE-STARTED THIS PLAN), GO TO HIMC14. OTHERWISE, GO TO HIMC15.
---------------	--

HIMC14. What is the most important reason (you/SP) decided to become a member of (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

SHOW CARD HIMC2A	<b>MHMOMEMB</b>	LOWER COST .....	1
	<b>MHMOMEOS</b>	BETTER BENEFITS OR COVERAGE .....	2
		DOCTOR WAS MEMBER .....	3
		CONVENIENT LOCATION .....	4
		RECOMMENDATION OR REPUTATION ....	5
		SP'S CURRENT/FORMER EMPLOYER PAYS PREMIUM .....	6
		SPOUSE'S CURRENT/FORMER EMPLOYER PAYS PREMIUM .....	7
		LESS PAPERWORK .....	8
		PREVIOUS MANAGED CARE PLAN NAME CHANGED OR WAS BOUGHT BY/ MERGED WITH CURRENT PLAN .....	9
		BETTER SELECTION OF PROVIDERS .....	10
		BETTER QUALITY OF CARE .....	11
		COULDN'T GET MEDICARE SUPPLEMENTAL INSURANCE (MEDIGAP) .....	12
		OTHER (SPECIFY) .....	91
		REFUSED .....	-7
		DON'T KNOW .....	-8

HIMC15. Some Medicare Managed Care Plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Are you/Is (SP)/Was (SP)] enrolled in a point-of-service option offered by (CURRENT MEDICARE MANAGED CARE PLAN)?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a \$10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

<b>MHMOPOS</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HIMC2	IF COMING FROM CHARGE SERIES OR INTERRUPT, RETURN TO CHARGE SERIES OR INTERRUPT. IF CURRENT MEDICARE MANAGED CARE PLAN IS SAME PLAN AS PREVIOUS ROUND MEDICARE MANAGED CARE PLAN (HIMC1a=1), GO TO <b>BOX HIMC4</b> . OTHERWISE, GO TO HIMC16.
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HIMC16. [Since (REFERENCE DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/ INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Managed Care Plans besides (CURRENT MEDICARE MANAGED CARE PLAN) [and (MEDICARE MANAGED CARE PLAN)]?

<div>SHOW CARD HIMC1</div>	<b>MHMOMORE</b>	YES .....	1 (HIMC17)
		NO .....	2 <b>BOX HIMC4</b>
		REFUSED .....	-7 <b>BOX HIMC4</b>
		DON'T KNOW .....	-8 <b>BOX HIMC4</b>

HIMC17. [Besides (CURRENT MEDICARE MANAGED CARE PLAN) [and (MEDICARE MANAGED CARE PLAN)]]], what (other) Medicare Managed Care Plans provided (your/SP's) health care since (REFERENCE DATE)?

[ENTER ALL PLAN NAMES.]  
**PLNAME**

BOX HIMC3	FOR EACH PLAN ADDED OR SELECTED AT HIMC17, GO TO HIMC18.
--------------	--

HIMC18. What is the most important reason (you/SP) stopped the (MEDICARE MANAGED CARE PLAN NAME) [STOPHMO] coverage?

<b>DISENROL</b>	TOO EXPENSIVE .....	1
<b>DISENROS</b>	SP DISSATISFIED WITH QUALITY OF CARE .....	2
	DOCTOR LEFT PLAN/DIED/RETIRED .....	3
	INCONVENIENT LOCATION .....	4
	PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE .....	5
	DIFFICULTIES GETTING APPOINTMENTS .....	6
	DIFFICULTY SEEING PROVIDERS SP WANTED TO SEE .....	7
	COULDN'T GET NEEDED CARE .....	8
	DOCTOR DID NOT SPEAK SP'S LANGUAGE .....	9
	SP MOVED .....	10
	SP WANTED OR NEEDED DIFFERENT HEALTH CARE BENEFITS ....	11
	SP COULD NOT AFFORD THE PLAN'S PREMIUMS, DEDUCTIBLES, AND/OR COPAYMENTS .....	12
	SP DIDN'T LIKE CHOICE OF DOCTORS .....	13
	SP WANTED CHOICE OF DOCTORS .....	14
	REACHED BENEFIT LIMIT .....	15
	PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER MANAGED CARE PLAN .....	16
	OTHER (SPECIFY) .....	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HIMC4	<p>SKIP PATTERN FOR FALL "SUPPLEMENTAL" SAMPLE ROUND: IF SP IS DECEASED, GO TO <b>BOX H11</b>. NON-DECEASED SPS: GO TO HIMC20a IF SP NOT CURRENTLY IN A MEDICARE MANAGED CARE PLAN. OTHERWISE, GO TO HIMC19.</p> <p>SKIP PATTERN FOR ALL OTHER ROUNDS: GO TO <b>BOX H11</b>.</p>
--------------	--

HIMC19. Would you recommend (CURRENT MEDICARE MANAGED CARE PLAN NAME) to your family or friends?

<b>RECMHMO</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC20. OMITTED IN ROUND 20.

HIMC20a. Would (you/SP) prefer to have more managed care plans offered in (your/his/her) area?

<b>OFFRAREA</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC20b. Would (you/SP) prefer to have managed care plans in (your/his/her) area that offer different services or features than those currently available?

<b>DIFFSRVC</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIMC21. How satisfied are you with the information available to (you/SP) to make health coverage choices?

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> SHOW CARD HIMC2 </div>	<b>HIINFO</b>	VERY SATISFIED .....	1
		SATISFIED .....	2
		DISSATISFIED .....	3
		VERY DISSATISFIED .....	4
		REFUSED .....	-7
		DON'T KNOW .....	-8

HIMC22. What additional kinds of information would you like to have to be able to make health coverage choices (for SP)?

<b>HIADDINF</b>	NO ADDITIONAL INFORMATION NEEDED/WANTED .....	1	<b>VCHIADD1</b>
	RECORD ALL OTHER RESPONSES VERBATIM BELOW .....	91	<b>VCHIADD2</b>
<b>HIADDVB1</b>	_____		<b>VCHIADD3</b>
<b>HIADDVB2</b>	_____		<b>VCHIADD4</b>
<b>HIADDVB3</b>	_____		

BOX HIMC5	GO TO <b>BOX HI1</b> IF SP NOT CURRENTLY IN A MEDICARE MANAGED CARE PLAN OR IF HIMC24 HAS BEEN ASKED AT ANY TIME. OTHERWISE, GO TO HIMC24.
--------------	--

HIMC23. OMITTED IN ROUND 28.

HIMC24. How many years (have you/has SP) been enrolled in a managed care plan?

[ENTER 96 IF LESS THAN 1 YEAR.]

<b>HMONUMYR</b>	NUMBER OF YEARS _____	
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HI1	IF PLAN ADDED IN ST/NS/CT/CPS, RETURN TO ST/NS/CT/CPS. OTHERWISE: IF SP COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI6 FOR THIS ROUND. IF SP NOT COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI5INTRO.
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HIINTRO OMITTED IN ROUND 31.

HI1-HI4h OMITTED IN ROUND 31.

BOX HI1AA OMITTED IN ROUND 31.

BOX HI1A OMITTED IN ROUND 31.

HI5INTRO.    [MEDICAID PROGRAM NAME]  
                 [PLEASE READ THIS INTRODUCTION SLOWLY AND CLEARLY:]

MEDICAID (,also known as [READ FROM ABOVE],) is a state program for low income persons or for persons on public assistance. Sometimes persons with very large medical bills are also covered by MEDICAID. People covered by MEDICAID usually have a card that looks like this.

SHOW CARD HI3
---------------------

[PRESS ENTER TO CONTINUE.]

BOX HI1B	IF STATE IN WHICH INTERVIEW IS BEING CONDUCTED DOES NOT OFFER A MEDICAID MANAGED CARE PLAN, GO TO HI5. OTHERWISE, GO TO HI5INTRB.
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HI5INTRB.    Some people receive their Medicaid benefits from plans that have names like those listed on this card.

SHOW CARD HI4
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[PRESS ENTER TO CONTINUE.]

HI5.            At any time [since (REF. DATE), (have you/has SP) been/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION) was (SP)] covered by MEDICAID?

<b>AIDCOVER</b>	YES .....	1 (HI6)
	NO .....	2 <b>BOX HIT1</b>
	REFUSED .....	-7 <b>BOX HIT1</b>
	DON'T KNOW .....	-8 <b>BOX HIT1</b>

BOX HI2 OMITTED IN ROUND 35.
------------------------------

HI6. [MEDICAID PROGRAM NAME]

(At the time of the last interview (you were/SP was) covered by MEDICAID(, also known as [READ FROM ABOVE].) (Were you/Was SP) covered by MEDICAID the whole time between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION), or only part of the time?

<b>COVTIME</b>	THE WHOLE TIME .....	1	<b>BOX HI5A</b>
	PART OF THE TIME .....	2	(HI7)
	REFUSED .....	-7	(HI10a)
	DON'T KNOW .....	-8	(HI7)

BOX HI3 OMITTED IN ROUND 25.
------------------------------

HI7. [(Are you/Is SP) now covered by MEDICAID?]/  
[Was (SP) covered by MEDICAID on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]

<b>COVNOW</b>	YES .....	1	<b>BOX HI4</b>
	NO .....	2	(HI9)
	REFUSED .....	-7	(HI10a)
	DON'T KNOW .....	-8	(HI10a)

BOX HI4	IF SP COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO <b>BOX HI5A</b> . IF SP NOT COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI8.
------------	---

HI8. On what date did (your/SP's) MEDICAID start between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

<b>COVBEGMM</b>	_____ / _____ / _____
<b>COVBEGDD</b>	MM DD YY
<b>COVBEGYY</b>	

BOX HI5A	IF SP NOT DECEASED OR INSTITUTIONALIZED, GO TO HI10. OTHERWISE, GO TO HI10a.
-------------	---

BOX HI5 OMITTED IN R20.
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HI9. On what date [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], did (your/SP's) Medicaid coverage (most recently/last) stop?

<b>COVENDMM</b>	_____ / _____ / _____	(HI10a)
<b>COVENDDD</b>	MM DD YY	
<b>COVENDYY</b>		

BOX HI6 OMITTED IN R20.
-------------------------

HI10. May I please see (your/SP's) MEDICAID card to verify the date and type of coverage?  
[IF DATE NOT SHOWN, CODE AS "CURRENT".]

<b>AIDTYPE</b>	CARD AVAILABLE, CURRENT .....	1
	CARD AVAILABLE, EXPIRED .....	2
	CARD NOT AVAILABLE OR NOT SEEN .....	3 (HI10a)
<b>AIDTYPOS</b>	OTHER CARD SEEN (SPECIFY) .....	91

(DOES THE CARD INDICATE SP'S PARTICIPATION IN MEDICAID PROGRAMS SUCH AS QMB, SLMB, OR QI?)

<b>AIDCARD</b>	YES .....	1 (HI10aa)
	NO .....	2 (HI10a)
	CAN'T TELL .....	3 (HI10a)

HI10aa. SELECT MEDICAID PROGRAMS AS LISTED ON SP'S MEDICAID CARD. (DO NOT INCLUDE THE STATE NAME: [MEDICAID PROGRAM NAME].)

[SELECT ALL THAT APPLY. PRESS CTRL/L TO LEAVE THE SCREEN. DO NOT PROBE FOR ADDITIONAL MEDICAID PROGRAMS.]

<b>AIDQMB</b>	QMB (QUALIFIED MEDICARE BENEFICIARY PROGRAM).....	1
<b>AIDSLMB</b>	SLMB (SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM)....	2
<b>AIDQI</b>	QI (QUALIFYING INDIVIDUAL PROGRAM).	3
<b>AIDOTHR</b>	OTHER PROGRAM (SPECIFY) .....	91
<b>AIDOTHOS</b>		

HI10a. [Some states now use managed care plans, such as HMOs (health maintenance organizations), to provide some or all health care for Medicaid beneficiaries.] [At the time of the last interview (you were/SP was) enrolled in a Medicaid Managed Care Plan.] (Are you now/Is SP now/Were you/Was SP) enrolled in a Medicaid Managed Care Plan [as of (DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)/(MEDICAID COVERAGE STOP DATE)/the date (your/SP's) Medicaid coverage stopped]?

<b>MCAIDHMO</b>	YES .....	1 <b>BOX HI5B</b>
	NO .....	2 <b>BOX HI5C</b>
	REFUSED .....	-7 <b>BOX HI5D</b>
	DON'T KNOW .....	-8 <b>BOX HI5D</b>

BOX HI5B	IF MCAIDHMO ≠ 1 IN THE PREVIOUS ROUND OR THIS MEDICAID PLAN WAS NOT "CURRENT" AT THE TIME OF THE LAST INTERVIEW, GO TO HI10b. OTHERWISE, GO TO <b>BOX HI5D</b> .
-------------	--

BOX HI5C	IF MCAIDHMO = 1 IN PREVIOUS ROUND, MEDICAID WAS “CURRENT” AT THE TIME OF THE LAST INTERVIEW AND HI6 = 1 FOR CURRENT ROUND, GO TO HI10c. OTHERWISE, GO TO <b>BOX HI5D</b> .
-------------	---

HI10b. As far as you can recall, (were you/was SP) given a choice to enroll in a Medicaid Managed Care Plan, or did (you/he/she) have to enroll to receive Medicaid benefits?

<b>CHOICHMO</b>	GIVEN A CHOICE TO ENROLL.....	1	<b>BOX HI5D</b>
	HAD TO ENROLL .....	2	<b>BOX HI5D</b>
	DOESN'T REMEMBER .....	3	<b>BOX HI5D</b>
	REFUSED .....	-7	<b>BOX HI5D</b>

HI10c. Why (do you/does SP) no longer receive (your/his/her) Medicaid benefits through a managed care plan?

[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

_____	<b>MCAIDVB1</b>
_____	<b>MCAIDVB2</b>
_____	<b>MCAIDVB3</b>

BOX HI5D	(A) IF MEDICAID WAS NOT “CURRENT” IN PREVIOUS ROUND, GO TO HI10d. (B) IF MEDICAID WAS “CURRENT” IN PREVIOUS ROUND AND IT IS A FALL “SUPPLEMENTAL” SAMPLE ROUND, GO TO HI10d. (C) OTHERWISE, GO TO <b>BOX HIT1</b> .
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HI10d. (Does/Did) [your/(SP's)] Medicaid plan cover medicines prescribed by a doctor?

<b>MCDRXCov</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HIT1	IF SP NOT COVERED BY TRICARE IN THE PREVIOUS ROUND, GO TO HIT1. IF TRICARE WAS CURRENT (HIT2=1 OR REF OR HIT3=1) IN THE PREVIOUS ROUND, GO TO HIT2 FOR THIS ROUND. IF TRICARE WAS NOT CURRENT (HIT3=2, REF, OR DK) IN THE PREVIOUS ROUND, GO TO HIT1.
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HIT1. As you (may) know, the Department of Defense sponsors a regionally managed health care program called TRICARE for active duty and retired members of the uniformed Armed Forces, their families, and survivors.

Please look at this card. At any time [since (REF. DATE)/ between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], [(have you/has SP) been/was SP]] enrolled in or covered by any of these TRICARE plans?

[EXPLAIN IF NECESSARY: You may have received a reference card that looks like this (BACK OF SHOWCARD HIT1).]

<div style="border: 1px solid black; padding: 5px; text-align: center;"> SHOW CARD HIT1 </div>	<b>TRICOVER</b>	YES .....	1 (HIT2)
		NO .....	2 <b>BOX HIT3</b>
		REFUSED .....	-7 <b>BOX HIT3</b>
		DON'T KNOW .....	-8 <b>BOX HIT3</b>

HIT2. [At the time of the last interview (you were/SP was) covered by TRICARE.] (Were you/Was SP) covered by TRICARE the whole time between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION), or only part of the time?

<b>COVTIME</b>	THE WHOLE TIME .....	1 <b>BOX HIT2</b>
	PART OF THE TIME .....	2 (HIT3)
	REFUSED .....	-7 <b>BOX HIT2</b>
	DON'T KNOW .....	-8 (HIT3)

HIT3. [(Are you/Is SP) now covered by TRICARE?] [Was (SP) covered by TRICARE on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]

<b>COVNOW</b>	YES .....	1 <b>BOX HIT2</b>
	NO .....	2 <b>BOX HIT2</b>
	REFUSED .....	-7 <b>BOX HIT2</b>
	DON'T KNOW .....	-8 <b>BOX HIT2</b>

<div style="border: 1px solid black; padding: 10px; text-align: center;"> BOX HIT2 </div>	(A) IF SP NOT COVERED BY TRICARE IN THE PREVIOUS ROUND, GO TO HIT4.
	(B) IF TRICARE WAS NOT CURRENT (HIT3=2, REF, OR DK) IN THE PREVIOUS ROUND, GO TO HIT4.
	(C) IF TRICARE WAS CURRENT (HIT2=1 OR REF OR HIT3=1) IN THE PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HIT4.
	(D) IF TRICARE WAS CURRENT (HIT2=1 OR REF OR HIT3=1) IN THE PREVIOUS ROUND AND IT IS NOT A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO <b>BOX HIT3</b> .

HIT4. (Does/Did) [your/(SP's)] TRICARE plan cover medicines prescribed by a doctor?

[PROBE: I am asking about the type of insurance coverage that you personally have/(SP) personally has], not what the plan offers everyone.]

<b>TRIRXCOV</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIT5. [Do you/Does (SP)/Did (SP)] have dental coverage through TRICARE?

<b>TRIDENT</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIT6. [Do you/Does (SP)/Did (SP)] have optical coverage through TRICARE, that is, for eyeglasses or contact lenses?

<b>TRIEYE</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIT7. [Do you/Does (SP)/Did (SP)] have coverage for preventive care such as routine annual physicals through TRICARE?

<b>TRIPCAR</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIT8. [Does your/Does (SP's)/Did (SP's)] TRICARE coverage include nursing home care over and beyond what Medicare normally covers?

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. In 2003, the first 20 days are paid in full and the next 80 days require a copayment of up to \$105.00 per day.]

<b>TRINHCOV</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HIT9. Besides the cost of [your/(SP's)] Medicare Part B premium, (is/was) there an additional cost for (your/his/her) TRICARE coverage? Please do not include any amount that [you/(SP)] may (pay/have paid) as a co-payment for an office visit or a prescribed medicine.

[EXPLAIN IF NECESSARY: Some plans may charge a monthly premium to cover the cost of the deductibles and coinsurance for normal Medicare services or because they provide services that are not covered by Medicare,

such as prescribed medicines, routine exams, and dental, eye, or hearing. Plans that have premiums typically charge from \$50 to \$75 per month.]

**TRIINS** YES ..... 1 (HIT10)  
NO ..... 2 **BOX HIT3**  
REFUSED ..... -7 **BOX HIT3**  
DON'T KNOW ..... -8 **BOX HIT3**

HIT10. Not including the cost of [your/(SP's)] Medicare Part B premium, what (is/was) the additional amount that [(you pay/SP pays)/(you paid/SP paid)] for (your/his/her) TRICARE coverage? [Please do not include any copayments (or any amount that may be paid for [your/(SP's)] spouse's coverage.)]

AMOUNT \$ ..... PER ( )

[PROBE IF NECESSARY: (Is/Was) that per year, per month, per week, or what?]

**TRIAMT** PER YEAR ..... 1  
**TRIUNIT** QUARTERLY/EVERY 3 MONTHS ..... 2  
**TRIUNOS** BIMONTHLY/EVERY 2 MONTHS ..... 3  
PER MONTH ..... 4  
PER WEEK ..... 5  
SEMI-ANNUALLY/2 TIMES PER YEAR ..... 6  
SEMI-MONTHLY/2 TIMES PER MONTH .... 7  
OTHER (SPECIFY) ..... 91  
REFUSED ..... -7  
DON'T KNOW ..... -8

BOX HIT3	<p>IF INTTYPE = 3, GO TO <b>BOX HIT7</b>. IF MTFCOVER ≠ 1 IN ANY PREVIOUS ROUND AND</p> <ul style="list-style-type: none"> <li>■ SP COVERED BY TRICARE IN THE CURRENT OR THE PREVIOUS ROUND, OR</li> <li>■ SP SERVED IN THE ARMED FORCES (EN9 OR EN11 = 1),</li> </ul> <p>GO TO HIT11. OTHERWISE, GO TO <b>BOX HIT20</b>.</p>
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HIT11. [We recorded that (you/SP) served in the Armed Forces of the United States.] Since (REF. DATE), [(have you/has SP) received/did (SP) receive] health care or health services or prescribed medicines at a Military Treatment Facility or MTF?

[EXPLAIN IF NECESSARY: A Military Treatment Facility is any military hospital, clinic, or NAVCARE clinic.]

**MTFCOVER** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

BOX HI20	<p>IF SP SERVED IN THE ARMED FORCES (I.E., EN9 OR EN11=1) AND HI36 = 2, REF, DK, OR -9 IN PREVIOUS ROUND, OR THIS IS FIRST UTILIZATION INTERVIEW FOR SP, GO TO HI36.</p> <p>IF SP DID NOT SERVE IN THE ARMED FORCES (I.E., EN9 AND EN11=2, REF, DK, OR -9) OR SP SERVED IN THE ARMED FORCES AND HI36 = 1 IN PREVIOUS ROUND, GO TO <b>BOX HI7</b>.</p>
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HI36. We recorded that (you/SP) served in the Armed Forces of the United States. Since (REF. DATE), [(have you/has SP) received/did (SP) receive] health care or health services or prescribed medicines through the Department of Veterans Affairs or V.A.?

**VACOVER** YES ..... 1  
 NO ..... 2  
 REFUSED ..... -7  
 DON'T KNOW ..... -8

BOX HI7	<p>IF SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND.</p> <p>IF SP NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11 FOR THIS ROUND.</p>
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HI11. At any time [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], [(have you/has SP) been/was (SP)] covered by any public program other than Medicaid that pays for medical care, [for example, a public program that pays for prescribed medicines/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM), a public program that pays for prescribed medicines/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM1) or (STATE PHARMACEUTICAL ASSISTANCE PROGRAM2)/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM1), (STATE PHARMACEUTICAL ASSISTANCE PROGRAM2), or (STATE PHARMACEUTICAL ASSISTANCE PROGRAM3), public programs that pay for prescribed medicines]?

**D\_PUBLIC** YES ..... 1 (HI12)  
 NO ..... 2 **BOX HI8**  
 REFUSED ..... -7 **BOX HI8**  
 DON'T KNOW ..... -8 **BOX HI8**

BOX HI8	<p>IF 2, REF, OR DK AND SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND.</p> <p>IF 2, REF OR DK AND SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.</p>
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HI12. What is the name of the public program that covered (you/SP)?  
 [ENTER ALL PUBLIC PROGRAMS.]  
**PLNAME**

OTHER PUBLIC PROGRAM = XXXXXXXX

HI13. [At the time of the last interview (you were/SP was) covered by (PUBLIC PLAN NAME).] (Were you/Was SP) covered by (PUBLIC PLAN NAME) the whole time between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION), or only part of the time?

- COVTIME**
- THE WHOLE TIME ..... 1 **BOX HI9**
  - PART OF THE TIME ..... 2 (HI14)
  - REFUSED ..... -7 **BOX HI9**
  - DON'T KNOW ..... -8 (HI14)

BOX HI9	<p>(A) IF THIS PLAN WAS NOT “CURRENT” IN PREVIOUS ROUND, GO TO HI16a.</p> <p>(B) IF THIS PLAN WAS “CURRENT” IN PREVIOUS ROUND AND IT IS A FALL “SUPPLEMENTAL” SAMPLE ROUND, GO TO HI16a.</p> <p>(C) OTHERWISE, ASK HI13 FOR NEXT PREVIOUS ROUND PUBLIC PLAN OR GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND.</p> <p>(D) ASK HI13 FOR EACH NEW PUBLIC PLAN COLLECTED IN HI12.</p> <p>(E) IF SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.</p>
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HI14. [(Are you now/Is (SP) now/Was (SP)) covered by (PUBLIC PLAN NAME)?] [Was (SP) covered by (PUBLIC PLAN NAME) on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]

- COVNOW**
- YES ..... 1 **BOX HI10**
  - NO ..... 2 (HI16)
  - REFUSED ..... -7 **BOX HI10**
  - DON'T KNOW ..... -8 **BOX HI10**

BOX HI10	<p>(A) IF THIS PLAN WAS NOT “CURRENT” IN PREVIOUS ROUND AND HI14 = 1, GO TO HI15.</p> <p>(B) IF THIS PLAN WAS NOT “CURRENT” IN PREVIOUS ROUND AND HI14 = REF OR DK, GO TO HI16a.</p> <p>(C) IF THIS PLAN WAS “CURRENT” IN PREVIOUS ROUND AND IT IS A FALL “SUPPLEMENTAL” SAMPLE ROUND, GO TO HI16a.</p> <p>(D) OTHERWISE, ASK HI13 FOR NEXT PREVIOUS ROUND PUBLIC PLAN OR GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND.</p> <p>(E) ASK HI13 FOR EACH NEW PUBLIC PLAN COLLECTED IN HI12.</p> <p>(F) IF SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.</p>
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HI15. On what date did (your/SP's) (PUBLIC PLAN NAME) coverage start between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

**COVBEGMM**  
**COVBEGDD**  
**COVBEGYY**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_(HI16a)  
MM DD YY

BOX HI11 OMITTED IN ROUND 25.

HI16. On what date [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and [DATE OF DEATH/DATE OF INSTITUTIONALIZATION)] did (your/SP's) (PUBLIC PLAN NAME) coverage (most recently/last) stop?

**COVENDMM**  
**COVENDDD**  
**COVENDYY**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YY

BOX HI11A	<p>(A) IF THIS PLAN WAS NOT “CURRENT” IN PREVIOUS ROUND, GO TO HI16a.</p> <p>IF THIS PLAN WAS “CURRENT” IN PREVIOUS ROUND AND IT IS A FALL “SUPPLEMENTAL” SAMPLE ROUND, GO TO HI16a.</p> <p>OTHERWISE, (IF THIS PLAN WAS “CURRENT” IN PREVIOUS ROUND AND IT IS <u>NOT</u> A FALL “SUPPLEMENTAL” ROUND), GO TO (B).</p> <p>(B) IF THERE ARE MORE PUBLIC PLANS FROM PREVIOUS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN FROM PREVIOUS ROUND.</p> <p>IF NO MORE PUBLIC PLANS FROM PREVIOUS ROUND, GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND.</p>
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HI16a. (Does/Did) [your/(SP's)] (PUBLIC PLAN NAME) plan cover medicines prescribed by a doctor?

<b>PUBRXCOV</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HI12	<p>IF HI16a BEING ASKED FOR PUBLIC PLAN FROM PREVIOUS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN FROM PREVIOUS ROUND. IF NO MORE PUBLIC PLANS FROM PREVIOUS ROUND, GO TO HI11 TO COLLECT ANY NEW PUBLIC PLANS FOR THIS ROUND.</p> <p>IF HI16a BEING ASKED FOR PUBLIC PLAN COVERAGE FOR THIS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN ADDED THIS ROUND. IF NO MORE PUBLIC PLAN COVERAGE FOR THIS ROUND, FOLLOW THESE SKIP PATTERNS: (1) IF SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR FIRST PRIVATE PLAN. (2) IF SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17.</p>
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HI17. We've talked about [READ PLAN(S) LISTED BELOW].

[HI17A, HI17B]

(Now, I would like to ask about other types of health insurance.) At any time [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], [(have you/has SP) been/was (SP)] covered by (any other) private health insurance or private managed care plan(s)?

[PROBE: A plan that covers the cost of hospital or doctor visits, prescribed medicines, or dental care?]

<b>D_TYPPL1</b>	YES .....	1 (HI20)
<b>D_TYPPL2</b>	NO .....	2 <b>BOX HI13</b>
<b>D_TYPPL3</b>	REFUSED .....	-7 <b>BOX HI13</b>
<b>D_TYPPL4</b>	DON'T KNOW .....	-8 <b>BOX HI13</b>
<b>D_TYPPL5</b>		

BOX HI13	<p>IF 2, REF OR DK AND SP WAS COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, AND SP SERVED IN THE ARMED FORCES (I.E., EN9 OR EN11=1), GO TO <b>BOX HI20</b>.</p> <p>IF 2, REF OR DK AND SP WAS COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, AND SP DID NOT SERVE IN THE ARMED FORCES (I.E., EN9 AND EN11=2, REF, DK, OR -9), GO TO <b>BOX HI21A</b>. OTHERWISE, GO TO <b>BOX HI13A</b>.</p>
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HI18 OMITTED.

BOX HI13A	IF 2, REF, DK AND SUPPLEMENTAL SAMPLE OR 1ST COMMUNITY INTERVIEW (INTERVIEW TYPE = 2), GO TO HI19. OTHERWISE, GO TO HI34.
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HI19. Some people who are eligible for Medicare have additional coverage through a private insurance carrier. This is sometimes referred to as Medigap or Medicare Supplement. At any time since (REF. DATE) did (you/SP) have this type of health insurance coverage?

**GAPCOVER**

YES .....	1 (HI20)
NO .....	2 (HI34)
REFUSED .....	-7 (HI34)
DON'T KNOW .....	-8 (HI34)

HI20. What is the name of each of the (other) private plans that provide(d) (your/SP's) medical insurance coverage?  
[ENTER ALL PRIVATE PLANS.]

**PLNAME**

BOX HI14	ASK HI21 - HI33c FOR EACH PLAN COLLECTED IN HI20.
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HI21. PRIVATE INSURANCE PLAN = (PLAN NAME)  
[HI21A, [At the time of the last interview (you were/SP was) covered by (PRIVATE PLAN NAME).] (Were you/Was SP)  
HI21] covered by (PLAN NAME) the whole time between (REF. DATE) and (today/ DATE OF DEATH/DATE OF INSTITUTIONALIZATION), or only part of the time?

**COVTIME**

THE WHOLE TIME .....	1 <b>BOX HI15</b>
PART OF THE TIME .....	2 (HI22)
REFUSED .....	-7 <b>BOX HI15</b>
DON'T KNOW .....	-8 (HI22)

BOX HI14A OMITTED.

BOX HI15	IF THIS PLAN NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI25. IF THIS PLAN "CURRENT," AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HI22a. OTHERWISE, GO TO <b>BOX HI16A</b> .
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HI22. [(Are you/Is SP) now covered by (PLAN NAME)?] [Was (SP) covered by (PLAN NAME) on (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)?]

**COVNOW**

YES .....	1 <b>BOX HI16</b>
NO .....	2 (HI24)
REFUSED .....	-7 <b>BOX HI16</b>
DON'T KNOW .....	-8 <b>BOX HI16</b>



BOX HI16	IF THIS PLAN NOT “CURRENT” IN PREVIOUS ROUND AND HI22 = 1, GO TO HI23. IF THIS PLAN NOT “CURRENT” IN PREVIOUS ROUND AND HI22 = REF OR DK, GO TO HI25. IF THIS PLAN “CURRENT” AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HI22a. OTHERWISE, GO TO <b>BOX HI16A</b> .
-------------	--

HI22a. Who (is/was) listed as the main insured person on the (PLAN NAME) policy or contract?  
[ENTER ONLY ONE PERSON.]

**MIPNUM**  
**PLMIPNUM**

HI22b. For the (PLAN NAME) plan, did (you/MIP) sign up directly, or did (you/MIP) get this insurance through a current employer, a former employer, a union, a family business, AARP, or some other way?

<b>PRVGET</b>	DIRECTLY .....	1 (HI22b1)
<b>PPRVGET</b>	(MIP’S) CURRENT EMPLOYER .....	2 (HI22c)
	(MIP’S) FORMER EMPLOYER .....	3 (HI22c)
	(MIP’S) UNION .....	4 (HI22d)
	(MIP’S) FAMILY BUSINESS .....	5 (HI22b1)
	AARP .....	6 (HI22b1)
	DECEASED SPOUSE’S EMPLOYER .....	7 (HI22c)
	DECEASED SPOUSE’S UNION .....	8 (HI22d)
	PROFESSIONAL/FRATERNAL ORGANIZATION .....	9 (HI22d)
	SOME OTHER WAY (SPECIFY) _____	91 (HI22d)
<b>PRVGETOS</b>	REFUSED .....	-7 (HI22d)
<b>PPRVGTOS</b>	DON’T KNOW .....	-8 (HI22d)

HI22b1. Many Medicare Supplemental or Medigap plans are referred to by a plan letter. There are ten standardized policies, labeled **Plan “A” through Plan “J”**. (Does/Did) (your/MIP’s) (PLAN NAME) have a plan letter?

<b>PRVLETR</b>	YES .....	1 (HI22b2)
	NO .....	2 <b>BOX HI16AA</b>
	REFUSED .....	-7 <b>BOX HI16AA</b>
	DON’T KNOW .....	-8 <b>BOX HI16AA</b>

HI22b2. What (is/was) the plan letter for (your/MIP’s) (PLAN NAME)?

**PLANLETR** PLAN LETTER \_\_\_\_\_

BOX HI16AA	IF HI22b = 5, GO TO HI22c. OTHERWISE, GO TO HI22d.
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- HI22c. What kind of business or industry is (RESPONSE IN HI22b)? That is, what does (RESPONSE IN HI22b) make or do? [RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

**PRVBUS1**  
**PRVBUS2**  
**PRVBUS3**  
**INDCODE**

**PPRVBUS1**  
**PPRVBUS2**  
**PPRVBUS3**  
**PINDCODE**

- HI22d. How many family members, including (yourself/SP), (are/were) covered by (your/MIP's) (PLAN NAME)?

**PRVNMCOV** NUMBER COVERED \_\_\_\_\_

- HI22d1. (Does/Did) (your/MIP's) (PLAN NAME) plan cover any portion of the cost of a visit to a doctor or a lab?

[EXPLAIN IF NECESSARY: For example, if (you/MIP) (go/goes/went) to the doctor because (you/MIP) (feel/feels/felt) sick or if (you/MIP) (have/has/had) blood drawn at a lab, (does/did) (your/MIP's) (PLAN NAME) plan pay for any of the cost of these services?]

**PRVMSCOV** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

- HI22d2. (Does/Did) (your/MIP's) (PLAN NAME) plan cover any portion of the cost if (you/MIP) (are/is/were/was) admitted to the hospital as an inpatient?

[EXPLAIN IF NECESSARY: For example, in 2003, Medicare beneficiaries are responsible for an \$840 deductible when admitted to a hospital and Medicare pays for most of the rest of the costs. (Does/Did) (your/MIP's) (PLAN NAME) plan pay any portion of the hospital deductible or other cost?]

**PRVPCOV** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

- HI22e. (Does/Did) (your/MIP's) (PLAN NAME) plan cover medicines prescribed by a doctor?

**PRVRXCOV** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

BOX HI16A1	IF PLAN IS A MANAGED CARE PLAN, GO TO HI22e1. OTHERWISE, GO TO HI22f.
---------------	--

HI22e1. [Do you/Does (SP)/Did (SP)] have dental coverage through (PLAN NAME)?

<b>MHMODENT</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HI22e2. [Do you/Does (SP)/Did (SP)] have optical coverage through (PLAN NAME), that is, for eyeglasses or contact lenses?

<b>MHMOEYE</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HI22e3. [Do you/Does (SP)/Did (SP)] have coverage for preventive care such as routine annual physicals through (PLAN NAME)?

<b>MHMOPCAR</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HI22f. Would (your/MIP's) (PLAN NAME) plan (cover/have covered) any part of a stay in a nursing home?

<b>PRVNHCOV</b>	YES .....	1
	NO .....	2
	REFUSED .....	-7
	DON'T KNOW .....	-8

HI22g. [Do you/Does (MIP)/Did (SP)/Did (MIP)] pay any or all of the premium or cost for the (PLAN NAME) coverage?  
[Do not include the cost of any deductibles (you/SP) or (your/SP's) family may (have/have had) to pay.]

<b>MIPPINS</b>	YES .....	1 (HI22h)
	NO .....	2 (HI22h1)
	REFUSED .....	-7 (HI22h1)
	DON'T KNOW .....	-8 (HI22h1)

HI22h. How much [(do you/does (MIP)/did (SP)/did (MIP)] pay for the (PLAN NAME) coverage?  
[PROBE IF NECESSARY: (Is/Was) that per year, per month, per week, or what?]

	AMOUNT: \$ _____	
<b>MIPPAMT</b>	PER YEAR .....	1
	QUARTERLY/EVERY 3 MONTHS .....	2
	BIMONTHLY/EVERY 2 MONTHS .....	3
	PER MONTH .....	4
	PER WEEK .....	5
<b>MIPPUNIT</b>	SEMI-ANNUALLY/2 TIMES PER YEAR .....	6
<b>MIPPUNOS</b>	SEMI-MONTHLY/2 TIMES PER MONTH ....	7
	OTHER (SPECIFY) _____	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

HI22h1. Does anyone else, such as an employer, a union or professional organization pay all or some portion of the premium or cost for (your/MIP's) (PLAN NAME) coverage?

<b>MHMOCOST</b>	YES .....	1 (HI22h2)
	NO .....	2 <b>BOX HI16A2</b>
	REFUSED .....	-7 <b>BOX HI16A2</b>
	DON'T KNOW .....	-8 <b>BOX HI16A2</b>

HI22h2. Who else pays all or some portion of the cost for (your/MIP's) (PLAN NAME) coverage?

<b>MHMOWHO</b>	(MIP's) CURRENT EMPLOYER .....	1
	(MIP's) FORMER EMPLOYER .....	2
	(MIP's) UNION .....	3
	SPOUSE'S CURRENT EMPLOYER .....	4
	SPOUSE'S FORMER EMPLOYER .....	5
	PROFESSIONAL/FRATERNAL ORGANIZATION .....	6
	MEDICAID/MEDICAL ASSISTANCE .....	7
<b>MHMOWHOS</b>	OTHER (SPECIFY) _____	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HI16A2	IF PLAN IS A MANAGED CARE PLAN, GO TO HI22h3. OTHERWISE, GO TO <b>BOX HI16A</b> .
---------------	--

HI22h3. Some managed care plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Are you/Is (SP)/Was (SP)] enrolled in a point-of-service option offered by (PLAN NAME)?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a \$10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

**MHMOPOS**                      YES ..... 1  
                                     NO ..... 2  
                                     REFUSED ..... -7  
                                     DON'T KNOW ..... -8

BOX HI16A	GO TO HI21 FOR NEXT PREVIOUS ROUND PRIVATE PLAN OR GO TO HI17 TO COLLECT NEW PRIVATE PLANS FOR THIS ROUND.
--------------	--

HI23. On what date did (your/SP's) coverage under (PLAN NAME) start between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

**COVBEGMM**                      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (HI25)  
**COVBEGDD**                      MM                      DD                      YY  
**COVBEGYY**

HI24. On what date since [(REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)] did (your/SP's) coverage under (PLAN NAME) stop?

**COVENDMM**                      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**COVENDDD**                      MM                      DD                      YY  
**COVENDYY**

BOX HI17	IF HI24 BEING ASKED FOR PRIVATE PLAN FROM PREVIOUS ROUND, GO TO HI21 FOR NEXT PRIVATE PLAN FROM PREVIOUS ROUND. IF NO MORE PRIVATE PLANS FROM PREVIOUS ROUND, GO TO HI17 TO COLLECT ANY NEW PRIVATE PLANS FOR THIS ROUND. IF HI24 BEING ASKED FOR PRIVATE PLAN COVERAGE FOR THIS ROUND, GO TO HI25.
-------------	--

HI25. [CODE WITHOUT ASKING IF VOLUNTEERED.]

(Is/Was) this a managed care plan, such as an HMO (Health Maintenance Organization)?

[EXPLAIN IF NECESSARY: Managed care plans generally provide a full range of health care services for a prepaid fee. The major types of managed care plans are health maintenance organizations (HMOs), HMOs with a point-of-service option, Provider-Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs).]

<b>D_HMOPL1</b>	YES .....	1
<b>D_HMOPL2</b>	NO .....	2
<b>D_HMOPL3</b>	REFUSED .....	-7
<b>D_HMOPL4</b>	DON'T KNOW .....	-8
<b>D_HMOPL5</b>		

HI26. Who (is/was) listed as the main insured person on the (PLAN NAME) policy or contract?

[ENTER ONLY ONE PERSON.]

**PLMIPNUM**

**MIPNUM**

HI27. For the (PLAN NAME) plan, did (you/MIP) sign up directly, or did (you/MIP) get this insurance through a current employer, a former employer, a union, a family business, AARP, or some other way?

<b>PRVGET</b>	DIRECTLY .....	1 (HI27a)
<b>PPRVGET</b>	(MIP'S) CURRENT EMPLOYER .....	2 (HI28)
	(MIP'S) FORMER EMPLOYER .....	3 (HI28)
	(MIP'S) UNION .....	4 (HI29)
	(MIP'S) FAMILY BUSINESS .....	5 (HI27a)
	AARP .....	6 (HI27a)
	DECEASED SPOUSE'S EMPLOYER .....	7 (HI28)
	DECEASED SPOUSE'S UNION .....	8 (HI29)
	PROFESSIONAL/FRATERNAL ORGANIZATION .....	9 (HI29)
	SOME OTHER WAY (SPECIFY) _____	91 (HI29)
<b>PRVGETOS</b>	REFUSED .....	-7 (HI29)
<b>PPRVGTOS</b>	DON'T KNOW .....	-8 (HI29)

HI27a. Many Medicare Supplemental or Medigap plans are referred to by a plan letter. There are ten standardized policies, labeled **Plan "A" through Plan "J"**. (Does/Did) (your/MIP's) (PLAN NAME) have a plan letter?

<b>PRVLETR</b>	YES .....	1 (HI27b)
	NO .....	2 <b>BOX HI17AA</b>
	REFUSED .....	-7 <b>BOX HI17AA</b>
	DON'T KNOW .....	-8 <b>BOX HI17AA</b>

HI27b. What (is/was) the plan letter for (your/MIP's) (PLAN NAME)?

**PLANLETR** PLAN LETTER \_\_\_\_\_

BOX HI17AA	IF HI27 = 5, GO TO HI28. OTHERWISE, GO TO HI29.
---------------	--

HI28. What kind of business or industry is (RESPONSE IN HI27)? That is, what does (RESPONSE IN HI27) make or do? [RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

<b>PRVBUS1</b>		<b>PPRVBUS1</b>
<b>PRVBUS2</b>		<b>PPRVBUS2</b>
<b>PRVBUS3</b>		<b>PPRVBUS3</b>
<b>INDCODE</b>		<b>PINDCODE</b>

HI29. How many family members, including (yourself/SP), (are/were) covered by (your/MIP's) (PLAN NAME)?

**PRVNMCOV**                      NUMBER COVERED \_\_\_\_\_

HI29a. (Does/Did) (your/MIP's) (PLAN NAME) plan cover any portion of the cost of a visit to a doctor or a lab?

[EXPLAIN IF NECESSARY: For example, if (you/MIP) (go/goes/went) to the doctor because (you/MIP) (feel/feels/felt) sick or if (you/MIP) (have/has/had) blood drawn at a lab, (does/did) (your/MIP's) (PLAN NAME) plan pay for any of the cost of these services?]

**PRVMSCOV**                      YES ..... 1  
    NO ..... 2  
    REFUSED ..... -7  
    DON'T KNOW ..... -8

HI29b. (Does/Did) (your/MIP's) (PLAN NAME) plan cover any portion of the cost if (you/MIP) (are/is/were/was) admitted to the hospital as an inpatient?

[EXPLAIN IF NECESSARY: For example, in 2003, Medicare beneficiaries are responsible for an \$840 deductible when admitted to a hospital and Medicare pays for most of the rest of the costs. (Does/Did) (your/MIP's) (PLAN NAME) plan pay any portion of the hospital deductible or other cost?]

**PRVIPCOV**                      YES ..... 1  
    NO ..... 2  
    REFUSED ..... -7  
    DON'T KNOW ..... -8

HI30. (Does/Did) (your/MIP's) (PLAN NAME) plan cover medicines prescribed by a doctor?

**PRVRXCOV**                      YES ..... 1  
    NO ..... 2  
    REFUSED ..... -7  
    DON'T KNOW ..... -8

BOX HI17A	IF PLAN IS A MANAGED CARE PLAN (HI25 = 1), GO TO HI30a. OTHERWISE, GO TO HI31.
--------------	---

HI30a. (Do/Does/Did) (you/SP) have dental coverage through (PLAN NAME)?

**MHMODENT** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

HI30b. (Do/Does/Did) (you/SP) have optical coverage through (PLAN NAME), that is, for eyeglasses or contact lenses?

**MHMOEYE** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

HI30c. (Do/Does/Did) (you/SP) have coverage for preventive care such as routine annual physicals through (PLAN NAME)?

**MHMOPCAR** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

HI31. Would (your/MIP's) (PLAN NAME) plan (cover/have covered) any part of a stay in a nursing home?

**PRVNHCOV** YES ..... 1  
NO ..... 2  
REFUSED ..... -7  
DON'T KNOW ..... -8

HI32. [Do you/Does (MIP)/Did (you/MIP)/Did (MIP)] pay any or all of the premium or cost for the (PLAN NAME) coverage?

[Do not include the cost of any deductibles (you/SP) or (your/SP's) family may (have/have had) to pay.]

**MIPPINS** YES ..... 1 (HI33)  
NO ..... 2 (HI33a)  
REFUSED ..... -7 (HI33a)  
DON'T KNOW ..... -8 (HI33a)

BOX HI18 OMITTED IN R20.



- HI33. How much [do you/does (MIP)/did (you/MIP)/did (MIP)] pay for the (PLAN NAME) coverage?  
[PROBE IF NECESSARY: (Is/Was) that per year, per month, per week, or what?]

AMOUNT \$\_\_\_\_\_.

<b>MIPPAMT</b>	PER YEAR .....	1
	QUARTERLY/EVERY 3 MONTHS .....	2
	BIMONTHLY/EVERY 2 MONTHS .....	3
	PER MONTH .....	4
	PER WEEK .....	5
<b>MIPPUNIT</b>	SEMI-ANNUALLY/2 TIMES PER YEAR .....	6
	SEMI-MONTHLY/2 TIMES PER MONTH ....	7
<b>MIPPUNOS</b>	OTHER (SPECIFY) _____	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

- HI33a. (Does/Did) anyone else, such as an employer, a union or professional organization pay all or some portion of the premium or cost for (your/MIP's) (PLAN NAME) coverage?

<b>MHMOCOST</b>	YES .....	1	(HI33b)
	NO .....	2	<b>BOX HI17B</b>
	REFUSED .....	-7	<b>BOX HI17B</b>
	DON'T KNOW .....	-8	<b>BOX HI17B</b>

- HI33b. Who else (pays/paid) all or some portion of the cost for (your/MIP's) (PLAN NAME) coverage?

<b>MHMOWHO</b>	(MIP's) CURRENT EMPLOYER .....	1
	(MIP's) FORMER EMPLOYER .....	2
	(MIP's) UNION .....	3
	SPOUSE'S CURRENT EMPLOYER .....	4
	SPOUSE'S FORMER EMPLOYER .....	5
	PROFESSIONAL/FRATERNAL ORGANIZATION .....	6
	MEDICAID/MEDICAL ASSISTANCE .....	7
<b>MHMOWHOS</b>	OTHER (SPECIFY) _____	91
	REFUSED .....	-7
	DON'T KNOW .....	-8

BOX HI17B	IF PLAN IS A MANAGED CARE PLAN, GO TO HI33c. OTHERWISE, GO TO <b>BOX HI19</b> .
--------------	--

HI33c. Some managed care plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Are you/Were you/Is (SP)/Was (SP)] enrolled in a point-of-service option offered by (PLAN NAME)?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a \$10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

**MHMOPOS**                      YES ..... 1  
   NO ..... 2  
   REFUSED ..... -7  
   DON'T KNOW ..... -8

BOX HI19	CYCLE THROUGH QUESTIONS HI21-HI33c FOR EACH PRIVATE PLAN REPORTED IN HI20. IF HI34=1 IN PREVIOUS ROUND OR IF HI34=1 or 2 OR MISSING FOR THIS ROUND, GO TO HI35. IF HI34=2 OR MISSING (REF, DK, -9) IN PREVIOUS ROUND OR -1 (INAPPLICABLE) FOR THIS ROUND, GO TO HI34.
-------------	--

HI34. (Other than the plans you have already told me about,) (do you/does SP/did SP) have any insurance that (pays/paid) **just** for **nursing home** care or other long term care?

**OTHNHCOV**                      YES ..... 1 (HI20)  
   NO ..... 2 (HI35)  
   REFUSED ..... -7 (HI35)  
   DON'T KNOW ..... -8 (HI35)

HI35. We've talked about [READ PLANS LISTED BELOW]. (Do you/Does SP/Did SP) have medical coverage under any (other) private insurance plans we haven't talked about?

**PRVOCOV**                      YES ..... 1 (HI20)  
   NO ..... 2 **BOX HI21A**  
   REFUSED ..... -7 **BOX HI21A**  
   DON'T KNOW ..... -8 **BOX HI21A**

BOX HI20 MOVED TO FOLLOW HIT11 IN ROUND 36.

QUESTION HI36 MOVED TO FOLLOW HIT11 IN ROUND 36.

BOX HI21 OMITTED IN ROUND 33.

BOX HI21A	GO TO <b>BOX DM1</b> .
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ATTACHMENT HI1  
STATE MEDICAID PROGRAMS

STATE	PROGRAM NAME
Alaska (AK)	Medical Assistance
Alabama (AL)	Medicaid
Arkansas (AR)	Medical Services
Arizona (AZ)	Health Care Cost Containment System (AHCCCS)
California (CA)	Medi-Cal
Colorado (CO)	Medicaid
Connecticut (CT)	Medical Assistance
District of Columbia (DC)	Medical Assistance
Delaware (DE)	Medical Assistance
Florida (FL)	Medicaid
Georgia (GA)	Medical Assistance
Hawaii (HI)	Medical Assistance
Iowa (IA)	Medical Assistance
Idaho (ID)	Medicaid
Illinois (IL)	Medical Assistance
Indiana (IN)	Medicaid
Kansas (KS)	Medical Assistance, Title XIX or MediKan
Kentucky (KY)	Medicaid
Louisiana (LA)	Medicaid
Maine (ME)	MaineCare
Massachusetts (MA)	MassHealth or Medical Assistance
Maryland (MD)	Medical Assistance
Michigan (MI)	Medicaid
Minnesota (MN)	Medical Assistance
Missouri (MO)	Medical Services
Mississippi (MS)	Medicaid
Montana (MT)	Medicaid
North Carolina (NC)	Medical Assistance

ATTACHMENT HI1 (continued)  
STATE MEDICAID PROGRAMS

STATE	PROGRAM NAME
North Dakota (ND)	Medical Services
Nebraska (NE)	Medical Assistance or Medicaid
New Hampshire (NH)	Medicaid
New Jersey (NJ)	Medicaid
New Mexico (NM)	Medical Assistance
Nevada (NV)	Medicaid
New York (NY)	Medicaid
Ohio (OH)	Medicaid
Oklahoma (OK)	Medicaid
Oregon (OR)	Medical Assistance
Pennsylvania (PA)	Medical Assistance
Puerto Rico (PR)	Asistencia Médica or La Reforma
Rhode Island (RI)	Medical Assistance
South Carolina (SC)	Medicaid
South Dakota (SD)	Medical Services
Tennessee (TN)	TennCare
Texas (TX)	Medicaid
Utah (UT)	Medicaid
Vermont (VT)	Medicaid
Virginia (VA)	Medical Assistance
Washington (WA)	Medical Assistance
Wisconsin (WI)	Medical Assistance or Title 19
West Virginia (WV)	Medical Services
Wyoming (WY)	Medicaid

ATTACHMENT HI2  
STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
<b>California Prescription Drug Discount Program for Medicare Recipients</b>	Department of Health Services	California	(916) 657-4302 HICAP: (800) 434-0222
<b>CT Pharmaceutical Assistance Contract to the Elderly and Disabled Prog. (ConnPACE)</b>	Connecticut Dept. of Social Services P.O. Box 5011	Hartford, CT 06102	(860) 832-9265 (800) 423-5026
<b>Delaware Prescription Drug Payment Assistance Program (DPAP)</b>	Division of Social Services EDS DPAP P.O. Box 950	New Castle, DE 19720-9914	(800) 996-9969, x 17 (302) 577-4900
<b>Delaware Nemours Health Clinic Pharmaceutical Assistance Program</b>	1801 Rockland Road	Wilmington, DE 19803	(302) 651-4405 (800) 292-9538
<b>Florida Medicare Prescription Discount Program</b>	Agency for Health Care Administration	Tallahassee, FL 32999	(800) 963-5337 (888) 419-3456 (850) 487-4441
<b>Florida Silver SaveRx/Ron Silver Senior Drug Program</b>	Agency for Health Care Administration	Tallahassee, FL 32399	(888) 419-3456 (850) 414-8306
<b>Illinois Pharmaceutical Assistance Program</b>	Dept. of Revenue P.O. Box 19021	Springfield, IL 62794	(217) 524-0084 (800) 624-2459
<b>Illinois Rx Senior Care</b>	Dept. of Revenue	Springfield, IL 62794	(800) 252-8966
<b>Indiana Prescription Drug Fund (Hoosier Rx)</b>	P.O. Box 6224	Indianapolis, IN 46206-6224	(317) 234-1381 (866) 267-4679
<b>Iowa Priority Prescription Savings Program</b>	Dept. of Public Health 1231 8th St. Suite 232	West Des Moines, IA 50265	(515) 281-4343 (866) 282-5817
<b>Kansas Senior Pharmacy Assistance Program</b>	Dept. of Aging	Kansas	(785) 368-7327
<b>Healthy Maine Prescription Program</b>	Department of Human Services 13 Prescott Drive	Machias, ME 04654	(888) 600-2466 (207) 287-2674
<b>Maryland Pharmacy Assistance Program (MPAP)</b>	Secretary of Health and Mental Hygiene P.O. Box 386	Baltimore, MD 21203	(410) 767-5394 (800) 492-1974
<b>Maryland Care First Plan/Short-Term Prescription Drug Subsidy Program</b>	Secretary of Health and Mental Hygiene P.O. Box 386	Baltimore, MD 21203	(410) 767-5394 (800) 492-1974

ATTACHMENT HI2 (continued)  
STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
<b>Maryland Pharmacy Discount Program</b>	Dept. of Health and Mental Hygiene P.O. Box 386	Baltimore, MD 21203-0386	(410) 767-5394 (800) 492-1974
<b>Massachusetts Prescription Advantage Plan</b>	Exec. Office of Elder Affairs 1 Ashburton Place, 5th Floor	Boston, MA 02108	(800) 243-4636 (617) 727-7750
<b>Michigan Elder Prescription Insurance Coverage (EPIC) Program</b>	Dept. of Community Health, Lewis Cass Bldg., 6 <sup>th</sup> Fl., 320 South Walnut St.	Lansing, MI 48913	(517) 373-2559 (866) 747-5844
<b>Minnesota Prescription Drug Program</b>	Minnesota Department of Human Services 444 Lafayette Rd. North	Saint Paul, MN 55155	(651) 297-5404 (800) 333-2433
<b>Missouri SeniorRx</b>	Dept. of Health and Senior Services P.O. Box 570	Jefferson City, MO 65102	(866) 556-9316
<b>Nevada Senior Rx Insurance Subsidy for Prescription Drugs</b>	Aging Services Division, 3416 Goni Rd, Bldg. D, Suite 132	Carson City, NV 89710	(800) 262-7726
<b>New Hampshire Prescription Drug Discount Program</b>	Division of Elderly and Adult Services 129 Pleasant Street	Concord, NH 03301	(800) 351-1888
<b>New Jersey Pharmaceutical Assistance for the Aged and Disabled (PAAD)</b>	Department of Health and Senior Services	Trenton, NJ 08625	(609) 588-7048 In NJ: (800) 792-9745
<b>New Jersey Senior Gold Prescription Drug Discount</b>	Department of Health and Senior Services	Trenton, NJ 08625	(609) 588-7048 (800) 792-9745
<b>New York State Elderly Pharmaceutical Insurance Coverage (EPIC)</b>	P.O. Box 15018	Albany, NY 12212-5018	(518) 452-6828 In NY: (800) 332-3742
<b>North Carolina Prescription Drug Assistance Program</b>	Public Health Dept.	Raleigh, NC 27699	(919) 715-3338 (800) 662-7030
<b>North Carolina Senior Care Health Plan</b>	Dept. of Health and Human Services	Raleigh, NC 27699	(866) 226-1388
<b>Pennsylvania Pharmacy Assistance Contract for the Elderly (PACE)</b>	P.A. Dept. of Aging 555 Walnut St. 5th Floor	Harrisburg, PA 17101	(717) 652-9028, In PA: (800) 225-7223
<b>Pennsylvania PACE Needs Enhancement Tier (PACENET)</b>	P.A. Dept. of Aging 555 Walnut St. 5th Floor	Harrisburg, PA 17101	(717) 652-9028, In PA: (800) 225-7223
<b>Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)</b>	Dept. of Elderly Affairs 160 Pine Street	Providence, RI 02903	(401) 222-2880 (800) 222-2880

ATTACHMENT HI2 (continued)  
STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
<b>South Carolina SilverRxCard – Seniors' Prescription Drug Program</b>	Office of Insurance Services		(877) 239-5277 (803) 734-1061
<b>Vermont Health Access Program (VHAP)</b>	103 S. Main Street	Waterbury, VT 05671	(800) 529-4060 (800) 250-8427
<b>VT State Pharmaceutical Assistance Prog. for Elderly &amp; Disabled (VSCRIPT)/VSCRIPT Expanded</b>	103 S. Main Street	Waterbury, VT 05671	(800) 529-4060 (800) 250-8427
<b>West Virginia Golden Mountaineer Discount Card</b>	Bureau of Senior Services 1900 Kanawha Blvd. East Holly Grove Bldg. #10	Charleston, WV 25305	(304) 558-3317 (877) 987-3646
<b>Wisconsin SENIORCARxE</b>	Dept. of Health and Family Services 1 West Wilson Street	Madison, WI 53702	(800) 657-2038
<b>Wyoming Prescription Drug Assistance Program</b>	Healthcare Access and Resources Division, Hathaway Bldg, Rm. 154	Cheyenne, WY 82002	(307) 777-7531 (800) 442-2766

ATTACHMENT HI3  
STATES THAT DO NOT HAVE MEDICARE HMOs

AK  
AR  
DE  
ME  
MT  
SC  
SD  
UT  
VT  
WY



## HI Addendum

HIS1: “covered/current as of previous round interview date” includes the following

- Medicare HMO:  
MHMODFLG ≠ 1 and PLANHIDE ≠ 1 and ((COVANYTM = 1 and COVCURNT = 1) or COVANYTM = 2)
- Medicaid, Public, Private:  
PLANDFLG ≠ 1 and PLANHIDE ≠ 1 and (COVTIME = 1, -7, -8, -9 or COVNOW = 1, -7, -8, -9)
- TRICARE:  
PLANDFLG ≠ 1 and (COVTIME = 1, -7 or COVNOW = 1)

HIS3: “had Medicaid/TRICARE as of previous round interview date” includes the following

- Medicaid:  
PLANDFLG ≠ 1 and PLANHIDE ≠ 1 and (COVTIME = 1, -7, -8, -9 or COVNOW = 1, -7, -8, -9)
- TRICARE:  
PLANDFLG ≠ 1 and (COVTIME = 1, -7 or COVNOW = 1)

BOX HIT3: HIT11 = MTFCOVER  
EN9 = SPAFEVER  
EN11 = SPNGEVER  
“COVERED” = HIT2 ≠ -1 and PLANDFLG ≠ 1