MAIN STUDY - ROUND 16

COMMUNITY COMPONENT

HI. HEALTH INSURANCE

BOX HIS1A	IF THIS IS SP'S EXIT INTERVIEW AND PREVIOUS INTERVIEW NOT SKIPPED, GO TO BOX ***UTS1A***. OTHERWISE, GO TO HIINTRO IF NO PREVIOUS HEALTH INSURANCE DATA OR GO TO HISINTRO IF PREVIOUS HEALTH INSURANCE DATA.

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 the (PREVIOUS ROUND INTERVIEW DATE).] [(You/SP) had Medicare coverage (through an HMO 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 an HMO plan)] on (PREVIOUS ROUND INTERVIEW DATE). Is that correct?

TEMP

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	RETURN TO HIS1.

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

TEMP

MEDICAID	1	***BOX HIS2***
PUBLIC PLAN OTHER THAN MEDICAID	2	***BOX HIS2***
PRIVATE HEALTH INSURANCE PLAN.....	3	***BOX HIS2***
MEDICARE HMO PLAN	4	(HIS3a)

BOX HIS2	IF 1, ASK HIS6 - HIS10, THEN RETURN TO HIS1. IF 2, ASK HIS12 - HIS16, THEN RETURN TO HIS1. IF 3, ASK HIS20 - HIS33, THEN RETURN TO HIS1.

HIS3a. What is the name of each of the Medicare HMOs that covered (you/SP)? GO TO HIS1
[ENTER ALL MEDICARE HMOs.]

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?

COVTIME	THE WHOLE TIME	1	(HIS10)
	PART OF THE TIME	2	(HIS7)
	REFUSED	-7	(HIS1)
	DON'T KNOW	-8	(HIS1)

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

COVNOW	YES	1	(HIS8)
	NO	2	(HIS9)
	REFUSED	-7	(HIS1)
	DON'T KNOW	-8	(HIS1)

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

COVBEGMM **COVBEGDD** **COVBEGYY** _____/_____/_____ (HIS10)
MONTH DAY YEAR

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

COVENDMM **COVENDDD** **COVENDYY** _____/_____/_____ (HIS1)
MONTH DAY YEAR

HIS10. May I please see (your/SP's) MEDICAID card to verify the date of coverage?
[IF DATE NOT SHOWN, CODE AS "CURRENT."]

AIDTYPE	CARD AVAILABLE, CURRENT	1	(HIS1)
	CARD AVAILABLE, EXPIRED	2	(HIS1)
	CARD NOT AVAILABLE, OR NOT SEEN	3	(HIS1)
AIDTYPOS	OTHER CARD SEEN (SPECIFY) _____	91	(HIS1)

HIS11 OMITTED.

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?

COVTIME

THE WHOLE TIME	1	***BOX HIS3***
PART OF THE TIME	2	(HIS14)
REFUSED	-7	***BOX HIS3***
DON'T KNOW	-8	***BOX HIS3***

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

COVNOW

YES	1	(HIS15)
NO	2	(HIS16)
REFUSED	-7	***BOX HIS3***
DON'T KNOW	-8	***BOX HIS3***

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

COVBEGMM **COVBEGDD** **COVBEGYY**

_____/_____/_____ ***BOX HIS3***
MONTH DAY YEAR

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**

_____/_____/_____ ***BOX HIS3***
MONTH DAY YEAR

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 provide (your/SP's) medical insurance coverage? [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	(HIS25)

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

_____/_____/_____ (HIS25)
MONTH DAY YEAR

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

_____/_____/_____ (HIS25)
MONTH DAY YEAR

HIS25. [CODE WITHOUT ASKING IF VOLUNTEERED.]
(Is/Was) this an HMO (Health Maintenance Organization)?
[HMO stands for Health Maintenance Organization, an organization that, for a prepaid fee, provides a full range of health care services.]

PRVHMO
PLHMOERR

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

HIS26. Who (is/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/HMO), 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	(HIS29)
PPRVGET	(MIP's) CURRENT EMPLOYER	2	(HIS28)
	(MIP'S) FORMER EMPLOYER	3	(HIS28)
	(MIP'S) UNION	4	(HIS29)
	(MIP'S) FAMILY BUSINESS	5	(HIS28)
	AARP	6	(HIS29)
	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)

HIS28. What kind of business or industry is (RESPONSE IN HIS27)? That is, what does (RESPONSE IN HIS27) make or do?
RECORD VERBATIM.

PRVBUS1	_____	**PPRVBUS1**
PRVBUS2		**PPRVBUS2**
PRVBUS3	_____	**PPRVBUS3**
INDCODE		**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:	

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

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

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

HIS32. Did (you/MIP) pay any or all of the 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.]

MIPPINS	YES	1	(HIS33)
	NO	2	***BOX HIS4***
	REFUSED	-7	***BOX HIS4***
	DON'T KNOW	-8	***BOX HIS4***

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: $_____.____

MIPPAMT	PER YEAR	1	***BOX HIS4***
MIPPUNIT	QUARTERLY/EVERY 3 MONTHS	2	***BOX HIS4***
	BIMONTHLY/EVERY 2 MONTHS	3	***BOX HIS4***
	PER MONTH	4	***BOX HIS4***
	PER WEEK	5	***BOX HIS4***
	SEMI-ANNUALLY/2 TIMES PER YEAR	6	***BOX HIS4***
	SEMI-MONTHLY/2 TIMES PER MONTH	7	***BOX HIS4***
	REFUSED	-7	***BOX HIS4***
	DON'T KNOW	-8	***BOX HIS4***
MIPPUNOS	OTHER (SPECIFY)	91	***BOX HIS4***

BOX HIS4	CYCLE THROUGH QUESTIONS HIS21 - HIS33 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 the time between (PREVIOUS ROUND INTERVIEW DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION).

BOX HIS4A	ORD SAMPLE AND SUPPLEMENTAL SAMPLE CASES: IF ANY HCFA MEDICARE HMOs WERE LOADED AT HOME OFFICE, GO TO MC1. IF NO HCFA MEDICARE HMOs WERE LOADED AT HOME OFFICE, GO TO HIMC1. NON-SUPPLEMENTAL SAMPLE CASES, GO TO ***BOX HIS4B***.

BOX HIS4B	IF MEDICARE HMO CURRENT AS OF PREVIOUS INTERVIEW, GO TO HIMC1a. OTHERWISE, GO TO HIMC1.

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

MHMOSAME

YES	1	(HIMC13)
NO	2	(HIMC1b)
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	***BOX HIMC4***

HIMC1b. What is the most important reason (you/SP) stopped the (MEDICARE HMO PLAN NAME) coverage?

DISENROL
DISENROS

TOO EXPENSIVE	1
SP DISSATISFIED WITH QUALITY OF CARE	2
DOCTOR LEFT HMO/DIED/RETIRED	3
INCONVENIENT LOCATION	4
HMO 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
OTHER (SPECIFY)	91
REFUSED	-7
DON'T KNOW	-8

HIMC1c. Since (REFERENCE DATE) (have you/has SP) been covered by any other Medicare HMO plans besides (MEDICARE HMO PLAN CURRENT LAST ROUND)?

MHMOOTHR

YES	1	(HIMC3)
NO	2	***BOX HIMC4***
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	***BOX HIMC4***

BOX MC1 OMITTED.

MC1. As you may know, Medicare allows beneficiaries in certain parts of the country to enroll in HMO (health maintenance organization) or managed care programs to receive their Medicare-funded health care. According to Medicare records, (you are/SP is) currently enrolled in an HMO called (HCFA MEDICARE HMO PLAN NAME). Is this information correct?

LOADCORR	YES	1	(HIMC6)
	NO	2	(MC2)
	REFUSED	-7	***BOX HIMC4***
	DON'T KNOW	-8	(MC11)

MC2. (HCFA MEDICARE HMO PLAN NAME)

How is this information incorrect?
[CODE ONLY ONE. IF MORE THAN ONE CODE APPLICABLE, CODE THE LOWEST NUMBER CODE.]

WHATWRNG	SP NOW DISENROLLED FROM (HCFA MEDICARE HMO PLAN NAME), ENROLLED IN NEW MEDICARE HMO PLAN	1	(MC2a)
	SP HAS PLAN CALLED (HCFA MEDICARE HMO PLAN NAME), R DOESN'T THINK IT'S HMO	2	(MC3)
	SP NOW DISENROLLED FROM (HCFA MEDICARE HMO PLAN NAME), NO LONGER IN ANY MEDICARE HMO	3	(MC2a)
	SP ENROLLED IN MEDICARE HMO PLAN, BUT NEVER (HCFA MEDICARE HMO PLAN NAME)	4	(MC4)
	SP NEVER COVERED BY OR ENROLLED IN (HCFA MEDICARE HMO PLAN NAME)	5	(MC11)

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

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

BOX MC1A	IF MC2=1, GO TO MC5. IF MC2 = 3, GO TO HIMC16.

MC3. In a managed care or a health maintenance organization, 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?

PRIMPHYS

YES	1	(HIMC6)
NO	2	(HIMC6)
REFUSED	-7	(HIMC6)
DON'T KNOW	-8	(HIMC6)

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

SAMEPLAN

SAME PLANS	1	***BOX MC2***
NOT THE SAME PLANS	2	(MC5)
REFUSED	-7	(MC5)
DON'T KNOW	-8	(MC5)

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

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?

REFERMED

MEDICARE ONLY	1	***BOX HIMC4***
OTHER NAME	2	(MC12)
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	***BOX HIMC4***

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

BOX MC2	FLAG THE HCFA MEDICARE HMO PLAN AS CURRENT MEDICARE HMO PLAN OR THE PLAN ADDED AT MC5/MC12 AS CURRENT MEDICARE HMO PLAN. THEN GO TO HIMC6.

MC13 OMITTED.

HIMC1. As you (may) know, Medicare allows beneficiaries in certain parts of the country to enroll in HMO (health maintenance) or managed care organizations to receive their Medicare-funded health care.
(Please look at this card.) At any time since (REF. DATE), (have you/has SP) been enrolled in or covered by (one of these/any) Medicare HMO plans?

SHOW CARD HIMC1

MHMOCOV

YES	1	(HIMC3)
NO	2	***BOX HIMC1A***
REFUSED	-7	***BOX HIMC1A***
DON'T KNOW	-8	***BOX HIMC1A***

BOX HIMC1A	IF SP NEVER ENROLLED IN MEDICARE HMO PLAN (NO PLAN TYPE = 5 ON PLAN ROSTER) AND SP NOT DECEASED, THEN GO TO HIMC1INT. OTHERWISE, GO TO ***BOX HIMC4***.

HIMC1INT. [In some areas, Medicare beneficiaries like (yourself/SP) can join managed care plans such as health maintenance organizations (HMOs).] The HMO provides all (your/SP's) care for a fixed fee, rather than billing Medicare for each service. In an HMO, the primary care doctor authorizes, arranges, and coordinates all services for (you/SP).

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

HEARMHMO

YES	1	(HIMC1bb)
NO	2	***BOX HI1***
REFUSED	-7	***BOX HI1***
DON'T KNOW	-8	***BOX HI1***

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

AREAMHMO

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

HIMC1cc. Joining a managed care plan is a choice for many Medicare beneficiaries these days. How satisfied are you with the choices of managed care plans available to (you/SP) in (your/his/her) area?

SHOW CARD HIMC2

HICHOICE

VERY SATISFIED	1
SATISFIED	2
UNSATISFIED	3
VERY UNSATISFIED	4
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

HIINFO

VERY UNSATISFIED	1
SATISFIED	2
UNSATISFIED	3
VERY UNSATISFIED	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?

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

BOX HIMC1B

IF HIMC1bb = 1, -7, -8, GO TO HIMC1ff.
IF HIMC1bb = 2, GO TO HIMC1hh.

HIMC1ff. (Have you/Has SP) considered joining an HMO since (you/SP) became a Medicare beneficiary?

JOINMHMO

YES	1	***BOX HI1***
NO	2	(HIMC1gg)
REFUSED	-7	***BOX HI1***
DON'T KNOW	-8	***BOX HI1***

HIMC1gg. Why (haven't you/hasn't SP) considered joining an HMO?
[RECORD RESPONSE VERBATIM.]

JOINHMO1	_____	**VCJOIN1**
JOINHMO2	_____	**VCJOIN2**
JOINHMO3	_____	**VCJOIN3**
	_____	**VCJOIN4**

GO TO ***BOX HI1***

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

IFMHMO

YES	1	***BOX HI1***
NO	2	(HIMC1ii)
REFUSED	-7	***BOX HI1***
DON'T KNOW	-8	***BOX HI1***

HIMC1ii. Why wouldn't (you/SP) consider joining an HMO?
RECORD RESPONSE VERBATIM.

IFMHMO1	_____	**VCIFMH1**
IFMHMO2	_____	**VCIFMH2**
IFMHMO3	_____	**VCIFMH3**
	_____	**VCIFMH4**

GO TO ***BOX HI1***

HIMC2. What is the name of the plan?
[ENTER ALL MEDICARE HMO PLANS.]
PLNAME

BOX HIMC1BB	IF CURRENT MEDICARE HMO, GO TO HIMC4. IF NO CURRENT MEDICARE HMO, GO TO HIMC3.

HIMC3. (Are you/Is SP) currently covered by or enrolled in a Medicare HMO?

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 HMO PLAN NAME) was (your/SP's) current Medicare HMO 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 HMO that currently covers (you/SP)?]
[ENTER ONLY ONE PLAN.]
PLNAME

BOX HIMC1	IF HIMC6 ALREADY ASKED FOR PLAN SELECTED AT HIMC5, GO TO ST/NS/CT/CPS. OTHERWISE, GO TO HIMC6.

HIMC6. (Do you/Does SP) have prescribed medicine coverage through (CURRENT MEDICARE HMO 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.

MHMORX

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

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

MHMODENT

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

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

MHMOEYE

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

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

MHMOPCAR

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

HIMC10. Does (your/SP's) (CURRENT MEDICARE HMO PLAN NAME) coverage include nursing home care?

MHMONH

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

HIMC11. Other than the cost of (your/SP's) Medicare premium, (do you/does SP) pay anything additional for [(your/SP's) part only of the] (CURRENT MEDICARE HMO 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.

MHMOPAY	YES	1	(HIMC12)
	NO	2	(HIMC13)
	REFUSED	-7	(HIMC13)
	DON'T KNOW	-8	(HIMC13)

HIMC12. Besides the cost of (your/SP's) Medicare premium, how much is the <u>additional</u> amount (you pay/SP pays) for (CURRENT MEDICARE HMO PLAN NAME) coverage? [Please only give me the additional cost for (your/SP's) coverage, not including any amount that may be paid for (your/SP's) spouse's coverage.]

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

AMOUNT $ _____._____

MHMOAMT	PER YEAR	1
MHMOUNIT	QUARTERLY/EVERY 3 MONTHS	2
MHMOUNOS	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
	REFUSED	-7
	DON'T KNOW	-8
	OTHER (SPECIFY) _____	91

HIMC13. For the (CURRENT MEDICARE HMO PLAN NAME), did (you/SP) sign up directly through (CURRENT MEDICARE HMO PLAN NAME), or did (you/SP) get this plan through a current employer, a former employer, a union, or some other way?

MHMOGET	DIRECTLY THROUGH HMO	1
MHMOGTOS	(SP's) CURRENT EMPLOYER	2
	(SP's) FORMER EMPLOYER	3
	(SP's) UNION	4
	DECEASED SPOUSE'S EMPLOYER	5
	DECEASED SPOUSE'S UNION	6
	PROFESSIONAL/FRATERNAL ORGANIZATION	7
	SOME OTHER WAY (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

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

MHMOMEMB
MHMOMEOS

LOWER COST	1
BETTER BENEFITS OR COVERAGE	2
DOCTOR WAS MEMBER	3
CONVENIENT LOCATION	4
RECOMMENDATION OR REPUTATION	5
FORMER EMPLOYER PAYS PREMIUM	6
OTHER (SPECIFY) _____	91
REFUSED	-7
DON'T KNOW	-8

HIMC15. Some HMOs will pay all or part of the cost if you choose to go to a doctor who does not work for the HMO or that the HMO does not refer you to. Does (your/SP's) HMO plan pay all or part of the costs if (you/he/she) use(s) an out-of-plan doctor?

MHMOPOS

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 HMO IS SAME PLAN AS PREVIOUS ROUND MEDICARE HMO (HIMC1a=1), GO TO ***BOX HIMC4***. OTHERWISE, GO TO HIMC16.

HIMC16. Since (REFERENCE DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/ INSTITUTIONALIZATION), [have you/has (SP)] been covered by any other Medicare HMO plans besides (CURRENT MEDICARE HMO PLAN) [and (MEDICARE HMO PLAN)]?

MHMOMORE

YES	1	(HIMC17)
NO	-2	***BOX HIMC4***
REFUSED	-7	
DON'T KNOW	-8	

HIMC17. [Now I'd like to ask you about the managed care plans that did cover (you/SP)]. What are the names of the (other) managed care plans that 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 HMO PLAN NAME) coverage?

DISENROL
DISENROS

TOO EXPENSIVE	1
SP DISSATISFIED WITH QUALITY OF CARE	2
DOCTOR LEFT HMO/DIED/RETIRED	3
INCONVENIENT LOCATION	4
HMO 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
OTHER (SPECIFY) _____	91
REFUSED	-7
DON'T KNOW	-8

BOX HIMC4	IF SP IS DECEASED, GO TO ***BOX HI1***. NON-DECEASED SPS: GO TO HIMC20 IF SP NOT CURRENTLY IN A MEDICARE HMO. OTHERWISE, GO TO HIMC19.

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

RECMHMO

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

HIMC20. Joining a managed care plan is a choice for many Medicare beneficiaries these days. How satisfied are you with the choices of managed care plans available to (you/SP) in (your/his/her) area?

SHOW CARD HIMC2

HICHOICE

VERY SATISFIED	1
SATISFIED	2
UNSATISFIED	3
VERY UNSATISFIED	4
REFUSED	-7
DON'T KNOW	-8

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

SHOW CARD HIMC2	**HIINFO**	VERY SATISFIED	1
		SATISFIED	2
		UNSATISFIED	3
		VERY UNSATISFIED	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?

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

BOX HIMC5	GO TO ***BOX HI1*** IF SP NOT CURRENTLY IN A MEDICARE HMO. OTHERWISE, GO TO HIMC23.

HIMC23. How many years (have you/has SP) been enrolled in an HMO?

SHOW CARD HIMC3	**YEARSHMO**	Less than 1 year	1
		1 to 2 years	2
		3 to 5 years	3
		6 to 10 years	4
		11 to 15 years	5
		16 to 20 years	6
		More than 20 years	7
		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.

HIINTRO. **[PLEASE READ THIS INTRODUCTION SLOWLY AND CLEARLY:**]

In this study, we are asking the participants for their Medicare numbers, so that their Medicare records can be easily and accurately located and identified for statistical research purposes. Under the Privacy Act of 1974, providing us (your/SP's) number is a voluntary decision and the benefits (you/SP) may be receiving under this program will not be affected by your decision.
[PRESS ENTER TO CONTINUE.]

HI1. People covered by Medicare usually have a card that looks like this. (Do you/Does SP) have such a card?

SHOW CARD HI1

MCCARD

YES	1	(H14)
NO	2	(HI2)
(SP/PROXY) REPORTS THAT (HE/SHE/SP) IS NOT ELIGIBLE FOR MEDICARE	3	(HI2)
REFUSED	-7	***BOX HI1A***
DON'T KNOW	-8	(HI2)

HI2. (Are you/Is SP) eligible for benefits from the Railroad Retirement Board?

RRBELIG

YES	1	(HI3)
NO	2	***BOX HI1A***
REFUSED	-7	***BOX HI1A***
DON'T KNOW	-8	***BOX HI1A***

HI3. (Do you/Does SP) have an RRB card?

SHOW CARD HI2

RRBCARD

YES	1	(HI4)
NO	2	***BOX HI1A***
REFUSED	-7	***BOX HI1A***
DON'T KNOW	-8	***BOX HI1A***

HI4.

a. INTERVIEWER: IS (SP'S) CARD AVAILABLE?

CARDAVAL

YES	1	(b)
NO	2	***BOX HI1A***

b. NUMBER: (DISPLAY NUMBER FROM HCFA FILES.)
INTERVIEWER: VERIFY THE NUMBER AGAINST (SP'S) CARD. DO THE NUMBERS MATCH?

CARDMATC

YES	1	***BOX HI1A***
NO	2	(c)

c. DOES (SP'S) CARD NUMBER BEGIN WITH A LETTER OR A NUMBER?

CARDLN
CARDFORM

LETTER	1	(HI4d1)
NUMBER	2	(HI4d2: DISPLAY MEDICARE ENTRY FIELD)

d1. IS THE NUMBER ON THE CARD SEPARATED BY HYPHENS?
[DOES THE NUMBER LOOK SIMILAR TO THE SOCIAL SECURITY NUMBER?] I.E. (000-00-0000)

CARDSET

HYPHENS 1
NO HYPHENS 2

(HI4d2: DISPLAY APPROPRIATE RRB ENTRY FIELD)

d2. WHAT IS THE NUMBER ON THE CARD?

MEDICARE NUMBER: (__ __ __) - (__ __) - (__ __ __) - (__ __)

OR

RRB NUMBER: (__ __ __) - (__ __ __) - (__ __) - (__ __ __ __)

OR

(__ __ __ __ __ __ __ __ __)

NEWMCRRB

e. WHAT TYPE OF COVERAGE DOES (SP) HAVE?

CARDTYPE

HOSPITAL ONLY 1 (HI4h)
MEDICAL AND HOSPITAL 2 (HI4g)
MEDICAL ONLY 3 (HI4g)

HI4f OMITTED.

g. WHAT IS THE DATE OF MEDICAL (PART B) COVERAGE?

CARDBMM _____/_____/_____
CARDBDD MONTH DAY YEAR
CARDBYY

BOX HI1AA	IF HI4e = 3, GO TO ***BOX HI1A***. OTHERWISE, GO TO HI4h.

h. WHAT IS THE DATE OF HOSPITAL (PART A) COVERAGE?

CARDAMM _____/_____/_____
CARDADD MONTH DAY YEAR
CARDAYY

BOX HI1A	GO TO ***BOX HIS4A***.

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.]

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?

AIDCOVER

YES	1	(HI6)
NO	2	***BOX HI2***
REFUSED	-7	***BOX HI2***
DON'T KNOW	-8	***BOX HI2***

BOX HI2	IF 2, -7 OR -8 AND SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF 2, -7 OR -8 AND SP NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11 FOR THIS ROUND.

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?

COVTIME

THE WHOLE TIME	1	(HI10)
PART OF THE TIME	2	(HI7)
REFUSED	-7	***BOX HI3***
DON'T KNOW	-8	***BOX HI3***

BOX HI3	IF -7 OR -8 AND SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF -7 OR -8 AND SP NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11 FOR THIS ROUND.

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

COVNOW

YES	1	***BOX HI4***
NO	2	(HI9)
REFUSED	-7	***BOX HI4***
DON'T KNOW	-8	***BOX HI4***

BOX HI4	IF 1 AND SP COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI10. IF 1 AND SP NOT COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI8. IF -7 OR -8 AND SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13. IF -7 OR -8 AND SP NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11.

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

COVBEGMM **COVBEGDD** **COVBEGYY** _____/_____/_____ ***BOX HI5***
MONTH DAY YEAR

BOX HI5	IF SP IS DECEASED OR INSTITUTIONALIZED AND WAS COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF SP IS DECEASED OR INSTITUTIONALIZED AND WAS NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11 FOR THIS ROUND. IF SP IS NOT DECEASED OR INSTITUTIONALIZED, GO TO HI10.

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?

COVENDMM **COVENDDD** **COVENDYY** _____/_____/_____ ***BOX HI6***
MONTH DAY YEAR

BOX HI6	IF SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF SP NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11 FOR THIS ROUND.

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

AIDTYPE	CARD AVAILABLE, CURRENT	1	
	CARD AVAILABLE, EXPIRED	2	
	CARD NOT AVAILABLE, OR NOT SEEN	3	
AIDTYPOS	OTHER CARD SEEN (SPECIFY)	91	

BOX HI7	IF SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF SP NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11 FOR THIS ROUND.

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 <u>other</u> public program that pays for medical care [for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM), a public program that pays for prescribed medicine]?

PUBCOVER	YES	1	(HI12)
	NO	2	***BOX HI8***
	REFUSED	-7	***BOX HI8***
	DON'T KNOW	-8	***BOX HI8***

BOX HI8	IF 2, -7, OR -8 AND SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF 2, -7 OR -8 AND SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.

HI12. What is the name of the public program that covered (you/SP)?
[ENTER ALL PUBLIC PROGRAMS.]
PLNAME

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	***BOX HI9***

BOX HI9	IF 1, -7 OR -8 AND HI13 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. IF 1, -7 OR -8 AND HI13 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.

HI14. [(Are you/Is SP) now 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	IF 1, -7 OR -8 AND SP WAS COVERED BY THIS PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR NEXT PREVIOUS ROUND PUBLIC PLAN OR GO TO HI11 FOR THIS ROUND. IF 1 AND SP WAS NOT COVERED BY THIS PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI15. IF -7 OR -8 AND SP WAS NOT COVERED BY THIS PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI17.

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

_____/_____/_____ ***BOX HI11***
MONTH DAY YEAR

BOX HI11	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.

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 _____/_____/_____ ***BOX HI12***
COVENDDD MONTH DAY YEAR
COVENDYY

BOX HI12	IF HI16 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. IF HI16 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.

HI17. (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 HMO or managed care plan(s)?

[PROBE: A plan that pays hospital or doctor bills or covers the cost of prescribed medicines?]

PRVCOVER

YES	1	(HI20)
NO	2	***BOX HI13***
REFUSED	-7	***BOX HI13***
DON'T KNOW	-8	***BOX HI13***

BOX HI13	IF 2, -7 OR -8 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 ***BOX HI20***. IF 2, -7 OR -8 AND SP WAS COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, AND SP DID NOT SERVE IN THE ARMED FORCES (I.E., 1 EN9 OR EN11=2), GO TO ***BOX HI21***. OTHERWISE, GO TO ***BOX HI13A***.

HI18 OMITTED.

BOX HI13A	IF 2, -7, -8 AND SUPPLEMENTAL SAMPLE OR 1ST COMMUNITY INTERVIEW, GO TO HI19. OTHERWISE, GO TO HI34.

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 - HI33 FOR EACH PLAN COLLECTED IN HI20.

HI21. [At the time of the last interview (you were/SP was) covered by (PRIVATE PLAN NAME).] (Were you/Was SP) 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	***BOX HI15***
PART OF THE TIME	2	(HI22)
REFUSED	-7	***BOX HI15***
DON'T KNOW	-8	***BOX HI15***

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 ***BOX HI16A***.

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	***BOX HI16***
NO	2	(HI24)
REFUSED	-7	***BOX HI16***
DON'T KNOW	-8	***BOX HI16***

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 = -7 OR -8, GO TO HI25. IF THIS PLAN "CURRENT" AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HI22a. OTHERWISE, GO TO ***BOX HI16A***.

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 with the (insurance company/HMO), 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	(HI22d)
PPRVGET	(MIP'S) CURRENT EMPLOYER	2	(HI22c)
	(MIP'S) FORMER EMPLOYER	3	(HI22c)
	(MIP'S) UNION	4	(HI22d)
	(MIP'S) FAMILY BUSINESS	5	(HI22c)
	AARP	6	(HI22d)
	DECEASED SPOUSE'S EMPLOYER	7	(HI22c)
	DECEASED SPOUSE'S UNION	8	(HI22d)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9	(HI22d)
PRVGETOS	REFUSED	-7	(HI22d)
PPRVGTOS	DON'T KNOW	-8	(HI22d)
	SOME OTHER WAY (SPECIFY) _____	91	(HI22d)

HI22c. 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.]

PRVBUS1	_____	**PPRVBUS1**
PRVBUS2		**PPRVBUS2**
PRVBUS3	_____	**PPRVBUS3**
INDCODE		**PINDCODE**
	_____	

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

PRVNMCOV NUMBER COVERED _____

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

HI22f. 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

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.]

MIPPINS

YES	1	(HI22h)
NO	2	***BOX HI16A***
REFUSED	-7	***BOX HI16A***
DON'T KNOW	-8	***BOX HI16A***

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: $_____._____

MIPPAMT
MIPPUNIT
MIPPUNOS

PER YEAR	1
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
OTHER (SPECIFY)	91
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
COVBEGDD
COVBEGYY

_____/_____/_____ (HI25)
MONTH DAY YEAR

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
COVENDYY

_____/_____/_____
MONTH DAY YEAR

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 an HMO (Health Maintenance Organization)?
[HMO stands for Health Maintenance Organization, an organization that, for a prepaid fee, provides a full range of health care services.]

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

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 with the (insurance company/HMO), 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	(HI29)
PPRVGET	(MIP'S) CURRENT EMPLOYER	2	(HI28)
	(MIP'S) FORMER EMPLOYER	3	(HI28)
	(MIP'S) UNION	4	(HI29)
	(MIP'S) FAMILY BUSINESS	5	(HI28)
	AARP	6	(HI29)
	DECEASED SPOUSE'S EMPLOYER	7	(HI28)
	DECEASED SPOUSE'S UNION	8	(HI29)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9	(HI29)
PRVGETOS	REFUSED	-7	(HI29)
PPRVGTOS	DON'T KNOW	-8	(HI29)
	SOME OTHER WAY (SPECIFY) _____	91	(HI29)

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

PRVBUS1	_____	**PPRVBUS1**
PRVBUS2	_____	**PPRVBUS2**
PRVBUS3	_____	**PPRVBUS3**
INDCODE	_____	**PINDCODE**
	_____	

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

PRVNMCOV NUMBER COVERED _____

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

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	***BOX HI18***
REFUSED	-7	***BOX HI18***
DON'T KNOW	-8	***BOX HI18***

BOX HI18	IF 2, -7 OR -8, CYCLE THROUGH QUESTIONS HI21-HI33 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 (-7, -8, -9) IN PREVIOUS ROUND OR =-1 (INAPPLICABLE) FOR THIS ROUND, GO TO HI34.

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 $_____._____

MIPPAMT

PER YEAR	1
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
REFUSED	-7
DON'T KNOW	-8
OTHER (SPECIFY) _____	91

MIPPUNIT
MIPPUNOS

BOX HI19	CYCLE THROUGH QUESTIONS HI21-HI33 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 (-7, -8, -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 HI20***
REFUSED	-7	***BOX HI20***
DON'T KNOW	-8	***BOX HI20***

BOX HI20	IF SP SERVED IN THE ARMED FORCES (I.E., SP SERVED IN ARMED FORCES AND EN9 OR EN11=1) AND HI36 = 2, -7, -8, OR -9 IN PREVIOUS ROUND, OR THIS IS FIRST UTILIZATION INTERVIEW FOR SP, GO TO HI36. IF SP DID NOT SERVE IN THE ARMED FORCES (I.E., EN9 OR EN11=2, -7, -8, OR -9) OR SP SERVED IN THE ARMED FORCES AND HI36 = 1 IN PREVIOUS ROUND, OR SP SERVED IN ARMED FORCES AND THIS IS FIRST COMMUNITY INTERVIEW, GO TO ***BOX HI21***.

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 at a Veterans Administration facility?

VACOVER

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

BOX HI21	IF SUPPLEMENTAL SAMPLE, GO TO ACINTRO. IF NOT SUPPLEMENTAL SAMPLE AND PREVIOUS INTERVIEW WAS COMMUNITY, GO TO ***BOX UTS1A***. OTHERWISE, GO TO DUINTRO.