MAIN STUDY - ROUND 22

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/MEDICAID HMO ..... | 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 - HIS10b, THEN RETURN TO HIS1.<br>IF 2, ASK HIS12 - HIS16, THEN RETURN TO HIS1.<br>IF 3, ASK HIS20 - HIS33c, 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 | (HIS7) |

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**

_____/_____/_____ (HIS10a)
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 |
| CARD AVAILABLE, EXPIRED | 2 |
| CARD NOT AVAILABLE, OR NOT SEEN | 3 |

**AIDTYPOS** OTHER CARD SEEN (SPECIFY) _____ 91

HIS10a. Some states now use HMOs (health maintenance organizations) to provide some or all health care for Medicaid beneficiaries. (Were you/Was SP) enrolled in a Medicaid HMO on (PREVIOUS ROUND INTERVIEW DATE/MEDICAID COVERAGE STOP DATE)?

**MCAIDHMO**

| | | |
|---|---|---|
| YES | 1 | (HIS10b) |
| NO | 2 | (HIS1) |
| REFUSED | -7 | (HIS1) |
| DON'T KNOW | -8 | (HIS1) |

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

**CHOICHMO**

| | | |
|---|---|---|
| GIVEN A CHOICE TO ENROLL | 1 | (HIS1) |
| HAD TO ENROLL | 2 | (HIS1) |
| DOESN'T REMEMBER | 3 | (HIS1) |
| REFUSED | -7 | (HIS1) |
| DON'T KNOW | -8 | (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 | (HIS14) |

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

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 | (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** _____/_____/_____ (HIS25)
**COVBEGDD** MONTH DAY YEAR
**COVBEGYY**

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** _____/_____/_____ (HIS25)
**COVENDDD** MONTH DAY YEAR
**COVENDYY**

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** | YES | 1 | |
| **PLHMOERR** | 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. PRESS ENTER TO LEAVE SCREEN.]

| | | |
|---|---|---|
| **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 |

| BOX HIS3A | IF PLAN IS AN HMO (HIS25 = 1), GO TO HIS30a.<br>OTHERWISE, GO TO HIS31. |
|---|---|

HIS30a. (Do/Does/Did) (you/SP) have dental coverage through (HMO PLAN NAME)?

**MHMODENT**

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

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

**MHMOEYE**

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

HIS30c. (Do/Does/Did) (you/SP) have coverage for preventive care such as routine annual physicals through (HMO PLAN NAME)?

**MHMOPCAR**

| | |
|---|---|
| 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 | (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: $_____._____ | |
| **MIPPAMT** | PER YEAR | 1 |
| **MIPPUNIT** | 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 |
| **MIPPUNOS** | OTHER (SPECIFY) _____ | 91 |

HIS33a. 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?

| | | | |
|---|---|---|---|
| **MHMOCOST** | YES | 1 | (HIS33b) |
| | NO | 2 | ***BOX HIS3B*** |
| | REFUSED | -7 | ***BOX HIS3B*** |
| | DON'T KNOW | -8 | ***BOX HIS3B*** |

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

| | | |
|---|---|---|
| **MHMOWHO** | (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 |
| **MHMOWHOS** | OTHER (SPECIFY) _____ | 91 |
| | REFUSED | -7 |
| | DON'T KNOW | -8 |

| | |
|---|---|
| BOX HIS3B | IF PLAN IS AN HMO PLAN, GO TO HIS33c.<br>OTHERWISE, GO TO ***BOX HIS4***. |

HIS33c. Some HMO plans offer a point-of-service option which allows members to receive services from non-plan providers even in non-emergency situations. [Are you/Is (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 he/she sees an out-of-plan provider. For example, if a member sees an in-plan provider, she may only have to make a $10 copayment. However, if she receives the same service from an out-of-plan provider, she may have to pay 20 percent of the cost and the HMO will pay 80 percent of the cost.]

**MHMOPOS**

| | |
|---|---|
| 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 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. |

MEDICARE HMO PLAN = XXXXXXX

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 | ***BOX HIS4C*** |
| 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 | (HIMC1c) |
| SP DISSATISFIED WITH QUALITY OF CARE | 2 | (HIMC1c) |
| DOCTOR LEFT HMO/DIED/RETIRED | 3 | (HIMC1c) |
| INCONVENIENT LOCATION | 4 | (HIMC1c) |
| HMO 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) |
| HMO NAME CHANGED OR HMO WAS BOUGHT BY/ MERGED WITH ANOTHER HMO | 16 | (HIMC3) |
| OTHER (SPECIFY) _____ | 91 | (HIMC1c) |
| REFUSED | -7 | (HIMC1c) |
| DON'T KNOW | -8 | (HIMC1c) |

| | |
|---|---|
| BOX HIS4C | IF THIS IS A SUPPLEMENTAL ROUND OR HIMC6 HAS NEVER BEEN ASKED FOR THIS MEDICARE HMO, GO TO HIMC6. OTHERWISE, GO TO ***BOX HIMC2***. |

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) <u>currently</u> 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*** |
| | 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*** |
| | HMO NAME CHANGED OR HMO WAS BOUGHT BY/ MERGED WITH ANOTHER HMO | 16 | ***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 | SKIP PATTERN FOR SUPPLEMENTAL SAMPLE ROUNDS: IF SP NEVER ENROLLED IN MEDICARE HMO PLAN (NO PLANTYPE = 5 ON PLAN ROSTER) AND SP NOT DECEASED, THEN GO TO HIMC1INT. OTHERWISE, GO TO ***BOX HIMC4***.<br>SKIP PATTERN FOR ALL OTHER ROUNDS: GO TO ***BOX HI1***. |

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. OMITTED IN ROUND 20.

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

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

| | |
|---|---|
| BOX HIMC1AA | IF HIMC1bb = 2 OR -8, GO TO HIMC1dd. OTHERWISE, GO TO HIMC1cc2. |

HIMC1cc2. Would (you/SP) prefer to have HMOs in (your/his/her) area that offer different services or features than those currently available?

| | | |
|---|---|---|
| **DIFFSRVC** | 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 | **HIINFO** | 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?

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

| | |
|---|---|
| BOX HIMC1B | IF FIRST-TIME COMMUNITY CASE AND: IF HIMC1bb = 1, -7, -8, GO TO HIMC1ff.<br>IF HIMC1bb = 2, GO TO HIMC1hh.<br>OTHERWISE, GO TO ***BOX HI1***. |

HIMC1ff. (Have you/Has SP) considered joining an HMO since becoming 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 OMITTED.

BOX HIMC1BB OMITTED.

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 THIS IS A SUPPLEMENTAL ROUND OR HIMC6 NEVER ASKED FOR THIS MEDICARE HMO OR IF THIS MEDICARE HMO 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) have prescribed medicine coverage through (CURRENT MEDICARE HMO PLAN NAME)?

[PROBE: I am asking about the type of insurance coverage that (<u>you</u> personally have/<u>SP</u> 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 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 of $95 per day.]

**MHMONH**

| | |
|---|---|
| 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 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.

[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.]

**MHMOPAY**

| | | |
|---|---|---|
| YES | 1 | (HIMC12) |
| NO | 2 | (BOX HIMC1D) |
| REFUSED | -7 | (BOX HIMC1D) |
| DON'T KNOW | -8 | (BOX HIMC1D) |

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 HMO 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: 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 |
| | 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 HMO PLAN NAME) coverage?

| | | | |
|---|---|---|---|
| **MHMOCOST** | YES | 1 | (HIMC12b) |
| | NO | 2 | (BOX HIMC1D) |
| | REFUSED | -7 | (BOX HIMC1D) |
| | DON'T KNOW | -8 | (BOX HIMC1D) |

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

| | | |
|---|---|---|
| | (SP's) CURRENT EMPLOYER | 1 |
| | (SP's) FORMER EMPLOYER | 2 |
| | (SP's) UNION | 3 |
| **MHMOWHO** | SPOUSE'S CURRENT EMPLOYER | 4 |
| | SPOUSE'S FORMER EMPLOYER | 5 |
| | PROFESSIONAL/FRATERNAL ORGANIZATION | 6 |
| **MHMOWHOS** | 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 HMO OR IF THIS MEDICARE HMO 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 HMO PLAN NAME)?

SHOW CARD HIMC2A

**MHMOMEMB**
**MHMOMEOS**

| | |
|---|---|
| LOWER COST | 1 |
| 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 HMO 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 HMO 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)] enrolled in a point-of-service option?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when he/she sees an out-of-plan provider. For example, if a member sees an in-plan provider, she may only have to make a $10 copayment. However, if she receives the same service from an out-of-plan provider, she may have to pay 20 percent of the cost and the HMO will pay 80 percent of the cost.]

**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. [[Besides (CURRENT MEDICARE HMO PLAN) [and (MEDICARE HMO PLAN)]], what (other) 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 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 |
| HMO NAME CHANGED OR HMO WAS BOUGHT BY/ MERGED WITH ANOTHER HMO | 16 |
| OTHER (SPECIFY) _____ | 91 |
| REFUSED | -7 |
| DON'T KNOW | -8 |

| | |
|---|---|
| BOX HIMC4 | SKIP PATTERN FOR SUPPLEMENTAL SAMPLE ROUND: IF SP IS DECEASED, GO TO ***BOX HI1***. NON-DECEASED SPS: GO TO HIMC20a IF SP NOT CURRENTLY IN A MEDICARE HMO. OTHERWISE, GO TO HIMC19.<br>SKIP PATTERN FOR ALL OTHER ROUNDS: GO TO ***BOX HI1***. |

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. OMITTED IN ROUND 20.

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

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

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

| | | |
|---|---|---|
| **DIFFSRVC** | 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?

| | | | |
|---|---|---|---|
| SHOW CARD HIMC2 | **HIINFO** | 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?

| | | | |
|---|---|---|---|
| **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 OR HIMC23 HAS BEEN ASKED AT ANY TIME. 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.<br>OTHERWISE: IF SP COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI6 FOR THIS ROUND.<br>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 | (HI4) |
| 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 | (HI4d2: DISPLAY APPROPRIATE RRB ENTRY FIELD) |
| NO HYPHENS | 2 | |

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**
**CARDBYY**

_____/_____/_____
MONTH DAY YEAR

| | |
|---|---|
| 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**
**CARDAYY**

_____/_____/_____
MONTH DAY YEAR

| | |
|---|---|
| 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.]

| | |
|---|---|
| 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. |

HI5INTRB. Some people receive their Medicaid benefits from plans that have names like those listed on this card.

SHOW CARD HI4

[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.<br>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 | (HI7) |

| | |
|---|---|
| BOX HI3 | IF -7 AND SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND.<br>IF -7 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.<br>IF 1 AND SP NOT COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI8.<br>IF -7 OR -8 AND SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13.<br>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**

_____/_____/_____
MONTH DAY YEAR

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

BOX HI5 OMITTED IN R20.

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**

_____/_____/_____ (HI10a)
MONTH DAY YEAR

BOX HI6 OMITTED IN R20.

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 | |

HI10a. [Some states now use 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 HMO.] (Are you now/Is SP now/Were you/Was SP) enrolled in a Medicaid HMO [as of (DATE OF DEATH/DATE OF INSTITUTIONALIZATION/MEDICAID COVERAGE STOP DATE)]?

**MCAIDHMO**

| | | |
|---|---|---|
| YES ..... | 1 | ***BOX HI5B*** |
| NO ..... | 2 | ***BOX HI5C*** |
| REFUSED ..... | -7 | ***BOX HI7*** |
| DON'T KNOW ..... | -8 | ***BOX HI7*** |

| 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.<br>OTHERWISE, GO TO ***BOX HI7***. |
|---|---|

| | |
|---|---|
| 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.<br>OTHERWISE, GO TO ***BOX HI7***. |

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

**CHOICHMO**

| | | |
|---|---|---|
| GIVEN A CHOICE TO ENROLL..... | 1 | ***BOX HI7*** |
| HAD TO ENROLL ..... | 2 | ***BOX HI7*** |
| DOESN'T REMEMBER ..... | 3 | ***BOX HI7*** |
| REFUSED ..... | -7 | ***BOX HI7*** |
| DON'T KNOW ..... | -8 | ***BOX HI7*** |

HI10c. Why (do you/does SP) no longer receive (your/his/her) Medicaid benefits through an HMO?

[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

_____ **MCAIDVB1**

_____ **MCAIDVB2**

_____ **MCAIDVB3**

| | |
|---|---|
| BOX HI7 | IF SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND.<br>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.<br>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**

OTHER PUBLIC PROGRAM = XXXXXXX

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 | 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.<br>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.<br>IF 1 AND SP WAS <u>NOT</u> COVERED BY THIS PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI15.<br>IF -7 OR -8 AND SP WAS <u>NOT</u> 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**
**COVENDDD**
**COVENDYY**

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

| | |
|---|---|
| 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.<br>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 covers the cost of hospital or doctor visits, prescribed medicines, or dental care?]

**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***.<br>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 - HI33c FOR EACH PLAN COLLECTED IN HI20. |

PRIVATE INSURANCE PLAN = XXXXXX

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 | (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 ***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**
**PPRVGET**

| | | |
|---|---|---|
| DIRECTLY | 1 | (HI22d) |
| (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) |
| SOME OTHER WAY (SPECIFY) _____ | 91 | (HI22d) |

**PRVGETOS**
**PPRVGTOS**

| | | |
|---|---|---|
| REFUSED | -7 | (HI22d) |
| DON'T KNOW | -8 | (HI22d) |

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** | _____ | **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 |

| | |
|---|---|
| BOX HI16A1 | IF PLAN IS AN HMO PLAN, GO TO HI22e1.<br>OTHERWISE, GO TO HI22f. |

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

**MHMODENT**

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

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

**MHMOEYE**

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

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

**MHMOPCAR**

| | |
|---|---|
| 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 | (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: $_____._____ | |
| **MIPPAMT** | PER YEAR | 1 |
| | QUARTERLY/EVERY 3 MONTHS | 2 |
| | BIMONTHLY/EVERY 2 MONTHS | 3 |
| | PER MONTH | 4 |
| | PER WEEK | 5 |
| **MIPPUNIT** | SEMI-ANNUALLY/2 TIMES PER YEAR | 6 |
| **MIPPUNOS** | 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?

| | | | |
|---|---|---|---|
| **MHMOCOST** | YES | 1 | (HI22h2) |
| | NO | 2 | ***BOX HI16A2*** |
| | REFUSED | -7 | ***BOX HI16A2*** |
| | DON'T KNOW | -8 | ***BOX HI16A2*** |

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

| | | |
|---|---|---|
| **MHMOWHO** | (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 |
| **MHMOWHOS** | OTHER (SPECIFY) _____ | 91 |
| | REFUSED | -7 |
| | DON'T KNOW | -8 |

| | |
|---|---|
| BOX HI16A2 | IF PLAN IS AN HMO PLAN, GO TO HI22h3.<br>OTHERWISE, GO TO ***BOX HI16A***. |

HI22h3. Some HMO plans offer a point-of-service option which allows members to receive services from non-plan providers even in non-emergency situations. [Are you/Is (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 he/she sees an out-of-plan provider. For example, if a member sees an in-plan provider, she may only have to make a $10 copayment. However, if she receives the same service from an out-of-plan provider, she may have to pay 20 percent of the cost and the HMO will pay 80 percent of the cost.]

**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**
**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.<br>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 |

| BOX HI17A | IF PLAN IS AN HMO (HI25 = 1), GO TO HI30a.<br>OTHERWISE, GO TO HI31. |
|---|---|

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

**MHMODENT**

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

HI30b. (Do/Does/Did) (you/SP) have optical coverage through (HMO 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 (HMO 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 $_____._____

**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 |
| REFUSED | -7 |
| DON'T KNOW | -8 |
| OTHER (SPECIFY) _____ | 91 |

HI33a. 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?

**MHMOCOST**

| | | |
|---|---|---|
| YES | 1 | (HI33b) |
| NO | 2 | ***BOX HI17B*** |
| REFUSED | -7 | ***BOX HI17B*** |
| DON'T KNOW | -8 | ***BOX HI17B*** |

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

**MHMOWHO**
**MHMOWHOS**

| | |
|---|---|
| (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 |
| OTHER (SPECIFY) _____ | 91 |
| REFUSED | -7 |
| DON'T KNOW | -8 |

| | |
|---|---|
| BOX HI17B | IF PLAN IS AN HMO PLAN, GO TO HI33c.<br>OTHERWISE, GO TO ***BOX HI19***. |

HI33c. Some HMO plans offer a point-of-service option which allows members to receive services from non-plan providers even in non-emergency situations. [Are you/Is (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 he/she sees an out-of-plan provider. For example, if a member sees an in-plan provider, she may only have to make a $10 copayment. However, if she receives the same service from an out-of-plan provider, she may have to pay 20 percent of the cost and the HMO will pay 80 percent of the cost.]

**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.<br>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.<br>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 Department of Veterans Affairs, or V.A., facility?

**VACOVER**

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

| | |
|---|---|
| BOX HI21 | IF SUPPLEMENTAL SAMPLE, GO TO ACINTRO.<br>IF NOT SUPPLEMENTAL SAMPLE AND PREVIOUS INTERVIEW WAS COMMUNITY, GO TO ***BOX UTS1A***.<br><br>OTHERWISE, GO TO ***BOX DU1A***. |