

HI. HEALTH INSURANCE
(BASELINE AND CORE)

BOX HIS1A	IF THIS IS SP'S EXIT INTERVIEW AND PREVIOUS INTERVIEW <u>NOT</u> SKIPPED, GO TO BOX UTS1A . OTHERWISE, GO TO BOX HIS4A IF NO PREVIOUS HEALTH INSURANCE DATA OR GO TO HISINTRO IF PREVIOUS HEALTH INSURANCE DATA.
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HISINTRO. Now I'd like to review with you the information we have about health insurance plans that (you/SP) had at the time of the last interview.

[HAND HEALTH INSURANCE SUMMARY PAGE TO R.]

[PRESS ENTER TO CONTINUE.]

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

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

PLANDVB1 _____
 PLANDVB2 _____
 PLANDVB3 _____
 PLANDVB4 _____

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

TEMP MEDICAID/MEDICAID MANAGED CARE PLAN 1 **BOX HIS2**
 PUBLIC PLAN OTHER THAN MEDICAID 2 **BOX HIS2**
 PRIVATE HEALTH INSURANCE PLAN 3 **BOX HIS2**
 MEDICARE MANAGED CARE PLAN 4 **BOX HIS2**

BOX HIS2	IF 1, ASK HIS6 – HIS10c, THEN RETURN TO HIS1. IF 2, ASK HIS12 – BOX HIS3 , THEN RETURN TO HIS1. IF 3, ASK HIS20 – HIS33c, THEN RETURN TO HIS1. IF 4, ASK HISMC1 – HISMC14, THEN RETURN TO HIS1.
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HISMC1. What is the name of the Medicare Managed Care Plan that covered (you/SP)?
[ENTER ONLY ONE PLAN.]

PLNAME

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

TEMP YES 1 **BOX HISMC1**
 NO 2 **BOX HISMC2**
 REFUSED -7 **BOX HISMC2**
 DON'T KNOW -8 **BOX HISMC2**

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

TEMP

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

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

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

MHMORX

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

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

MHMODENT

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

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

MHMOEYE

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

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

MHMOPCAR

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

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

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. In 2001, the first 20 days are paid in full and the next 80 days require a copayment of \$99 per day.]

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

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

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

MHMOPAY	YES	1 (HISMC10)
	NO	2 (HISMC13)
	REFUSED	-7 (HISMC13)
	DON'T KNOW	-8 (HISMC13)

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

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

AMOUNT \$ _____.

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

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

MHMOCOST	YES	1 (HISMC12)
	NO	2 (HISMC13)
	REFUSED	-7 (HISMC13)
	DON'T KNOW	-8 (HISMC13)

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

	(SP's) CURRENT EMPLOYER	1
	(SP's) FORMER EMPLOYER	2
	(SP's) UNION	3
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

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

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

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

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

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

HIS3a. OMITTED IN ROUND 23.

HIS4 AND HIS5 OMITTED.

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

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

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

COVNOW	YES	1 (HIS8)
	NO	2 (HIS9)
	REFUSED	-7 (HIS10a)
	DON'T KNOW	-8 (HIS10a)

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

COVBEGMM	_____ / _____ / _____	(HIS10a)
COVBEGDD	MM DD YY	
COVBEGYY		

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

COVENDMM	_____ / _____ / _____	(HIS10a)
COVENDDD	MM DD YY	
COVENDYY		

HIS10. OMITTED IN ROUND 30.

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

MCAIDHMO	YES	1 (HIS10b)
	NO	2 (HIS10c)
	REFUSED	-7 (HIS10c)
	DON'T KNOW	-8 (HIS10c)

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

CHOICHMO	GIVEN A CHOICE TO ENROLL	1
	HAD TO ENROLL	2
	DOESN'T REMEMBER	3
	REFUSED	-7
	DON'T KNOW	-8

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

MCDRXCov	YES	1 (HIS1)
	NO	2 (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 (HIS16a)
	PART OF THE TIME	2 (HIS14)
	REFUSED	-7 (HIS16a)
	DON'T KNOW	-8 (HIS14)

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

COVNOW	YES	1 (HIS15)
	NO	2 (HIS16)
	REFUSED	-7 (HIS16a)
	DON'T KNOW	-8 (HIS16a)

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

COVBEGMM	_____ / _____ / _____	(HIS16a)
COVBEGDD	MM DD YY	
COVBEGYY		

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	MM DD YY
COVENDYY	

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

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

HIS17/HIS18 OMITTED.

BOX HIS3	GO TO HIS13 FOR NEXT PUBLIC PLAN ADDED AT HIS12. IF NO OTHER PUBLIC PLAN, THEN GO TO HIS1.
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HIS20. What is the name of each of the (other) private plans that provided (your/SP's) medical insurance coverage between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)? [ENTER ALL PRIVATE PLANS.]

PLNAME
PLANSUMM

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

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

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

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

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

COVBEGMM	_____ / _____ / _____	(HIS25)
COVBEGDD	MM DD YY	
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	_____ / _____ / _____
COVENDDD	MM DD YY
COVENDYY	

HIS25. [CODE WITHOUT ASKING IF VOLUNTEERED.]

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

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

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

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

PLMIPNUM
MIPNUM
D_PHREL1
D_PHREL2
D_PHREL3
D_PHREL4
D_PHREL5

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

PRVGET	DIRECTLY	1 (HIS27a)
PPRVGET	(MIP's) CURRENT EMPLOYER	2 (HIS28)
D_OBTNP1	(MIP'S) FORMER EMPLOYER	3 (HIS28)
D_OBTNP2	(MIP'S) UNION	4 (HIS29)
D_OBTNP3	(MIP'S) FAMILY BUSINESS	5 (HIS27a)
D_OBTNP4	AARP.....	6 (HIS27a)
D_OBTNP5	DECEASED SPOUSE'S EMPLOYER	7 (HIS28)
	DECEASED SPOUSE'S UNION	8 (HIS29)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9 (HIS29)
	SOME OTHER WAY (SPECIFY)	91 (HIS29)
PRVGETOS	REFUSED	-7 (HIS29)
PPRVGTOS	DON'T KNOW	-8 (HIS29)

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

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

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

PLANLETR PLAN LETTER _____
D_PLLTR1
D_PLLTR2
D_PLLTR3
D_PLLTR4
D_PLLTR5

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

PRVBUS1 PRVBUS2 PRVBUS3 INDCODE D_INDUS1 D_INDUS2 D_INDUS3 D_INDUS4 D_INDUS5	<hr style="border: none; border-top: 1px dashed black;"/> <hr style="border: none; border-top: 1px dashed black;"/>	PPRVBUS1 PPRVBUS2 PPRVBUS3 PINDCODE
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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 D_COVNM1 D_COVNM2 D_COVNM3 D_COVNM4 D_COVNM5	NUMBER COVERED: _____
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HIS30. Did (your/MIP's) (HIS20 PLAN NAME) plan cover medicines prescribed by a doctor?

PRVRXCOV D_COVRX1 D_COVRX2 D_COVRX3 D_COVRX4 D_COVRX5	YES 1 NO 2 REFUSED -7 DON'T KNOW -8
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BOX HIS3A	IF PLAN IS A MANAGED CARE PLAN (HIS25 = 1), GO TO HIS30a. OTHERWISE, GO TO HIS31.
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HIS30a. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did (you/SP) have dental coverage through (HIS20 PLAN NAME)?

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

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

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

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

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
D_COVNH1	NO	2
D_COVNH2	REFUSED	-7
D_COVNH3	DON'T KNOW	-8
D_COVNH4		
D_COVNH5		

HIS32. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), 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)
D_PAYSP1	NO	2 (HIS33a)
D_PAYSP2	REFUSED	-7 (HIS33a)
D_PAYSP3	DON'T KNOW	-8 (HIS33a)

D_PAYSP4
D_PAYSP5

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?]

MIPPAMT	AMOUNT: \$	
MIPPUNIT	PER YEAR	1
D_ANAMT1	QUARTERLY/EVERY 3 MONTHS	2
D_ANAMT2	BIMONTHLY/EVERY 2 MONTHS	3
D_ANAMT3	PER MONTH	4
D_ANAMT4	PER WEEK	5
D_ANAMT5	SEMI-ANNUALLY/2 TIMES PER YEAR	6
	SEMI-MONTHLY/2 TIMES PER MONTH	7
MIPPUNOS	OTHER (SPECIFY)	91
	REFUSED	-7
	DON'T KNOW	-8

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

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

HIS33b. Who else paid all or some portion of the cost for (your/MIP's) (HIS20 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 A MANAGED CARE PLAN, GO TO HIS33c. OTHERWISE, GO TO BOX HIS4 .
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HIS33c. Some managed care plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), [were you/was (SP)] enrolled in a point-of-service option offered by (HIS20 PLAN NAME)?

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

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.
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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).

[PRESS ENTER TO CONTINUE.]

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

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

MHMOSAME
D_HMOCOV

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 MANAGED CARE PLAN NAME) [STOPHMO] coverage?

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

BOX HIS4C	IF THIS PLAN NOT "CURRENT" IN PREVIOUS ROUND <u>OR</u> IF THIS PLAN "CURRENT" AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HIMC6. OTHERWISE, GO TO BOX HIMC2 .
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HIMC1c. [Since (REF. DATE)/Between (REF. DATE) and (DATE OF DEATH/INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Managed Care Plans besides (MEDICARE MANAGED CARE PLAN CURRENT LAST ROUND)?

SHOW CARD HIMC1	MHMOOTHR	YES	1	(HIMC3)
	D_HMOCOV	NO	2	BOX HIMC4
		REFUSED	-7	BOX HIMC4
		DON'T KNOW	-8	BOX HIMC4

BOX MC1 OMITTED.

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

How is this information incorrect?

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

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

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

- DISENROL**
- TOO EXPENSIVE 1 **BOX MC1A**
 - SP DISSATISFIED WITH QUALITY OF CARE 2 **BOX MC1A**
 - DOCTOR LEFT PLAN/DIED/RETIRED 3 **BOX MC1A**
 - INCONVENIENT LOCATION 4 **BOX MC1A**
 - PLAN 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**
 - PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER MANAGED CARE PLAN 16 **BOX MC1A**
- DISENROS**
- 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 many Medicare Managed Care Plans, such as health maintenance organizations, the health plan gives the patient a list of doctors from which he chooses a primary care physician. This primary care physician provides the patient's usual medical care and can refer the patient to specialists, if necessary. (Do you/Does SP) have a primary care physician?

- 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 MANAGED CARE 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 Medicare 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 MANAGED CARE PLAN AS CURRENT MEDICARE MANAGED CARE PLAN OR THE PLAN ADDED AT MC5/MC12 AS CURRENT MEDICARE MANAGED CARE PLAN. THEN GO TO HIMC6.
------------	---

MC13 OMITTED.

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

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 <u>NEVER</u> ENROLLED IN MEDICARE MANAGED CARE PLAN (NO PLANTYPE = 5 ON PLAN ROSTER) AND SP NOT DECEASED, THEN GO TO HIMC1INT. OTHERWISE, GO TO BOX HIMC4 . 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 managed care plan provides all (your/SP's) care for a fixed fee, rather than billing Medicare for each service. In many Medicare Managed Care Plans, the primary care doctor authorizes, arranges, and coordinates all services for (you/SP).
[PRESS ENTER TO CONTINUE.]

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

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

HIMC1bb. Are there managed care plans 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) managed care plans offered in (your/his/her) area?

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

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

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

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 (for SP)?

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, REF, DK, GO TO HIMC1ff. IF HIMC1bb = 2, GO TO HIMC1hh. OTHERWISE, GO TO BOX HI1 .
---------------	---

HIMC1ff. (Have you/Has SP) considered joining a managed care plan 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 a managed care plan?
[RECORD RESPONSE VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

JOINHMO1	_____	VCJOIN1
JOINHMO2	_____	VCJOIN2
JOINHMO3	_____	VCJOIN3
	_____	VCJOIN4
		GO TO BOX HI1

HIMC1hh. If there were managed care plans 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 a managed care plan?
[RECORD RESPONSE VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

IFMHMO1	_____	VCIFMH1
IFMHMO2	_____	VCIFMH2
IFMHMO3	_____	VCIFMH3
	_____	VCIFMH4
		GO TO BOX HI1

HIMC2 OMITTED.

BOX HIMC1BB OMITTED.

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

MHMOCURR	YES	1 (HIMC5)
D_MCRHMO	NO	2 BOX HIMC1C
D_HMOCUR	REFUSED	-7 BOX HIMC1C
	DON'T KNOW	-8 BOX HIMC1C

BOX HIMC1C	IF COMING FROM CHARGE SERIES OR INTERRUPT, RETURN TO CHARGE SERIES OR INTERRUPT. OTHERWISE, GO TO HIMC17.
---------------	--

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

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

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

PLNAME

BOX HIMC1	IF THIS IS A SUPPLEMENTAL ROUND OR HIMC6 NEVER ASKED FOR THIS MEDICARE MANAGED CARE PLAN OR IF THIS MEDICARE MANAGED CARE PLAN WAS SELECTED (I.E., THE SP HAS RE-STARTED THIS PLAN), GO TO HIMC6. OTHERWISE, GO TO BOX H11 /ST/NS/CT/CPS.
--------------	---

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

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

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

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

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

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

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

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

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

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

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. In 2001, the first 20 days are paid in full and the next 80 days require a copayment of \$99 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 MANAGED CARE PLAN NAME) coverage? Please do not include any amount that (you/SP) may pay as a co-payment for an office visit or a prescribed medicine.

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

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 MANAGED CARE PLAN NAME) coverage? [Please do not include any copayments (or any amount that may be paid for (your/SP's) spouse's coverage).]

AMOUNT \$ PER ()

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

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

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

MHMOCAST	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 MANAGED CARE 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 MANAGED CARE PLAN OR IF THIS MEDICARE MANAGED CARE PLAN WAS SELECTED (I.E., THE SP HAS RE-STARTED THIS PLAN), GO TO HIMC14. OTHERWISE, GO TO HIMC15.
---------------	--

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

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

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

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

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

BOX HIMC2	IF COMING FROM CHARGE SERIES OR INTERRUPT, RETURN TO CHARGE SERIES OR INTERRUPT. IF CURRENT MEDICARE MANAGED CARE PLAN IS SAME PLAN AS PREVIOUS ROUND MEDICARE MANAGED CARE PLAN (HIMC1a=1), GO TO BOX HIMC4 . OTHERWISE, GO TO HIMC16.
--------------	--

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

SHOW CARD HIMC1	MHMOMORE	YES	1 (HIMC17)
		NO	2 BOX HIMC4
		REFUSED	-7 BOX HIMC4
		DON'T KNOW	-8 BOX HIMC4

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

[ENTER ALL PLAN NAMES.]
PLNAME

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

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

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

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

HIMC19. Would you recommend (CURRENT MEDICARE MANAGED CARE 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 managed care plans offered in (your/his/her) area?

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

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

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?

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> SHOW CARD HIMC2 </div>	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 (for SP)?

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

BOX HIMC5	GO TO BOX H11 IF SP NOT CURRENTLY IN A MEDICARE MANAGED CARE PLAN OR IF HIMC24 HAS BEEN ASKED AT ANY TIME. OTHERWISE, GO TO HIMC24.
--------------	---

HIMC23. OMITTED IN ROUND 28.

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

[ENTER 96 IF LESS THAN 1 YEAR.]

HMONUMYR	NUMBER OF YEARS _____	
	REFUSED	-7
	DON'T KNOW	-8

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

HIINTRO OMITTED IN ROUND 31.

HI1-HI4h OMITTED IN ROUND 31.

BOX HI1AA OMITTED IN ROUND 31.

BOX HI1A OMITTED IN ROUND 31.

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

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

SHOW CARD HI3

[PRESS ENTER TO CONTINUE.]

BOX HI1B	IF STATE IN WHICH INTERVIEW IS BEING CONDUCTED DOES NOT OFFER A MEDICAID MANAGED CARE PLAN, GO TO HI5. OTHERWISE, GO TO HI5INTRB.
-------------	--

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, REF OR DK AND SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF 2, REF OR DK 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 **BOX HI5A**
 PART OF THE TIME 2 (HI7)
 REFUSED -7 (HI10a)
 DON'T KNOW -8 (HI7)

BOX HI3 OMITTED IN ROUND 25.

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

COVNOW YES 1 **BOX HI4**
D_MCAID NO 2 (HI9)
 REFUSED -7 (HI10a)
 DON'T KNOW -8 (HI10a)

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

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

COVBEGMM _____ / _____ / _____
COVBEGDD MM DD YY
COVBEGYY

BOX HI5A	IF SP <u>NOT</u> DECEASED OR INSTITUTIONALIZED, GO TO HI10. 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	_____	/	_____	/	_____	(HI10a)
COVENDDD	MM		DD		YY	
COVENDYY						

BOX HI6 OMITTED IN R20.

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

AIDTYPE	CARD AVAILABLE, CURRENT	1
	CARD AVAILABLE, EXPIRED	2
	CARD NOT AVAILABLE OR NOT SEEN	3 (HI10a)
AIDTYPOS	OTHER CARD SEEN (SPECIFY)	91

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

AIDCARD	YES	1 (HI10aa)
	NO	2 (HI10a)
	CAN'T TELL	3 (HI10a)

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

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

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

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

MCAIDHMO YES 1 **BOX HI5B**
 NO 2 **BOX HI5C**
 REFUSED -7 **BOX HI5D**
 DON'T KNOW -8 **BOX HI5D**

BOX HI5B	IF MCAIDHMO ≠ 1 IN THE PREVIOUS ROUND OR THIS MEDICAID PLAN WAS NOT "CURRENT" AT THE TIME OF THE LAST INTERVIEW, GO TO HI10b. OTHERWISE, GO TO BOX HI5D .
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BOX HI5C	IF MCAIDHMO = 1 IN PREVIOUS ROUND, MEDICAID WAS "CURRENT" AT THE TIME OF THE LAST INTERVIEW AND HI6 = 1 FOR CURRENT ROUND, GO TO HI10c. OTHERWISE, GO TO BOX HI5D .
-------------	--

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

CHOICHMO GIVEN A CHOICE TO ENROLL 1 **BOX HI5D**
 HAD TO ENROLL 2 **BOX HI5D**
 DOESN'T REMEMBER 3 **BOX HI5D**
 REFUSED -7 **BOX HI5D**
 DON'T KNOW -8 **BOX HI5D**

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

[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

_____	MCAIDVB1
_____	MCAIDVB2
_____	MCAIDVB3

BOX HI5D	<p>(A) IF MEDICAID WAS NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI10d.</p> <p>(B) IF MEDICAID WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A SUPPLEMENTAL SAMPLE ROUND, GO TO HI10d.</p> <p>(C) OTHERWISE, GO TO BOX HI7.</p>
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HI10d. (Does/Did) [your/(SP's)] Medicaid plan cover medicines prescribed by a doctor?

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

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.
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HI11. At any time [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)], [(have you/has SP) been/was (SP)] covered by any other public program that pays for medical care, [for example, a public program that pays for prescribed medicines/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM), a public program that pays for prescribed medicines/ for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM1) or (STATE PHARMACEUTICAL ASSISTANCE PROGRAM2)/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM1), (STATE PHARMACEUTICAL ASSISTANCE PROGRAM2), or (STATE PHARMACEUTICAL ASSISTANCE PROGRAM3), public programs that pay for prescribed medicines?]

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

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

OTHER PUBLIC PROGRAM = XXXXXXXX

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

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

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

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

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

COVBEGMM _____ / _____ / _____ (HI16a)
COVBEGDD MM DD YY
COVBEGYY

BOX HI11 OMITTED IN ROUND 25.

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

COVENDMM
COVENDDD
COVENDYY

_____/_____/_____
MM DD YY

BOX HI11A	<p>(A) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI16a.</p> <p>IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A SUPPLEMENTAL SAMPLE ROUND, GO TO HI16a.</p> <p>OTHERWISE, (IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS <u>NOT</u> A SUPPLEMENTAL ROUND), GO TO (B).</p> <p>(B) IF THERE ARE MORE PUBLIC PLANS FROM PREVIOUS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN FROM PREVIOUS ROUND.</p> <p>IF NO MORE PUBLIC PLANS FROM PREVIOUS ROUND, GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND.</p>
--------------	---

HI16a. (Does/Did) [your/(SP's)] (PUBLIC PLAN NAME) plan cover medicines prescribed by a doctor?

PUBRXCov

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

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

[HI17A, HI17B]

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

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

PRVCOVER	YES	1 (HI20)
D_TYPPL1	NO	2 BOX HI13
D_TYPPL2	REFUSED	-7 BOX HI13
D_TYPPL3	DON'T KNOW	-8 BOX HI13
D_TYPPL4		
D_TYPPL5		

BOX HI13	<p>IF 2, REF OR DK AND SP WAS COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, AND SP SERVED IN THE ARMED FORCES (I.E., EN9 OR EN11=1), GO TO BOX HI20.</p> <p>IF 2, REF OR DK AND SP WAS COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, AND SP DID NOT SERVE IN THE ARMED FORCES (I.E., 1 EN9 OR EN11=2), GO TO BOX HI21. OTHERWISE, GO TO BOX HI13A.</p>
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HI18 OMITTED.

BOX HI13A	<p>IF 2, REF, DK AND SUPPLEMENTAL SAMPLE OR 1ST COMMUNITY INTERVIEW (INTERVIEW TYPE = 2), GO TO HI19. OTHERWISE, GO TO HI34.</p>
--------------	--

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.
-------------	---

HI21. PRIVATE INSURANCE PLAN = (PLAN NAME)

[HI21A, 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 = REF OR DK, 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
D_PHREL1
D_PHREL2
D_PHREL3
D_PHREL4
D_PHREL5

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

PRVGET	DIRECTLY	1 (HI22b1)
PPRVGET	(MIP'S) CURRENT EMPLOYER	2 (HI22c)
D_OBTNP1	(MIP'S) FORMER EMPLOYER	3 (HI22c)
D_OBTNP2	(MIP'S) UNION	4 (HI22d)
D_OBTNP3	(MIP'S) FAMILY BUSINESS	5 (HI22b1)
D_OBTNP4	AARP	6 (HI22b1)
D_OBTNP5	DECEASED SPOUSE'S EMPLOYER	7 (HI22c)
PRVGETOS	DECEASED SPOUSE'S UNION	8 (HI22d)
PPRVGTOS	PROFESSIONAL/FRATERNAL ORGANIZATION	9 (HI22d)
	SOME OTHER WAY (SPECIFY)	91 (HI22d)
	REFUSED	-7 (HI22d)
	DON'T KNOW	-8 (HI22d)

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

PRVLETR	YES	1 (HI22b2)
	NO	2 BOX HI16AA
	REFUSED	-7 BOX HI16AA
	DON'T KNOW	-8 BOX HI16AA

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

D_PLLTR1 PLAN LETTER _____
D_PLLTR2
D_PLLTR3
D_PLLTR4
D_PLLTR5

BOX HI16AA	IF HI22b = 5, GO TO HI22c. OTHERWISE, GO TO 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 _____
D_COVNM1	
D_COVNM2	
D_COVNM3	
D_COVNM4	
D_COVNM5	

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

PRVRXCOV	YES	1
D_COVRX1	NO	2
D_COVRX2	REFUSED	-7
D_COVRX3	DON'T KNOW	-8
D_COVRX4		
D_COVRX5		

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

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

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

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

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

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

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
D_COVNH1	NO	2
D_COVNH2	REFUSED	-7
D_COVNH3	DON'T KNOW	-8
D_COVNH4		
D_COVNH5		

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)
D_PAYSP1	NO	2 (HI22h1)
D_PAYSP2	REFUSED	-7 (HI22h1)
D_PAYSP3	DON'T KNOW	-8 (HI22h1)
D_PAYSP4		
D_PAYSP5		

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?]

MIPPAMT	AMOUNT: \$ _____	
MIPPUNIT	PER YEAR	1
D_ANAMT1	QUARTERLY/EVERY 3 MONTHS	2
D_ANAMT2	BIMONTHLY/EVERY 2 MONTHS	3
D_ANAMT3	PER MONTH	4
D_ANAMT4	PER WEEK	5
D_ANAMT5	SEMI-ANNUALLY/2 TIMES PER YEAR	6
	SEMI-MONTHLY/2 TIMES PER MONTH	7
MIPPUNOS	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 A MANAGED CARE PLAN, GO TO HI22h3. OTHERWISE, GO TO BOX HI16A .
---------------	--

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

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

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

BOX HI16A	GO TO HI21 FOR NEXT PREVIOUS ROUND PRIVATE PLAN OR GO TO HI17 TO COLLECT NEW PRIVATE PLANS FOR THIS ROUND.
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HI23. On what date did (your/SP's) coverage under (PLAN NAME) start between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

COVBEGMM _____/_____/_____ (HI25)
COVBEGDD MM DD YY
COVBEGYY

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

COVENDMM _____/_____/_____
COVENDDD MM DD YY
COVENDYY

BOX HI17	<p>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.</p> <p>IF HI24 BEING ASKED FOR PRIVATE PLAN COVERAGE FOR THIS ROUND, GO TO HI25.</p>
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HI25. [CODE WITHOUT ASKING IF VOLUNTEERED.]
(Is/Was) this a managed care plan, such as an HMO (Health Maintenance Organization)?
[EXPLAIN IF NECESSARY: Managed care plans generally provide a full range of health care services for a prepaid fee. The major types of managed care plans are health maintenance organizations (HMOs), HMOs with a point-of-service option, Provider-Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs).]

PRVHMO	YES	1
PLHMOERR	NO	2
PPRVHMO	REFUSED	-7
D_HMOPL1	DON'T KNOW	-8
D_HMOPL2		
D_HMOPL3		
D_HMOPL4		
D_HMOPL5		

HI26. Who (is/was) listed as the main insured person on the (PLAN NAME) policy or contract?
[ENTER ONLY ONE PERSON.]

PLMIPNUM
MIPNUM
D_PHREL1
D_PHREL2
D_PHREL3
D_PHREL4
D_PHREL5

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

PRVGET	DIRECTLY	1	(HI27a)
PPRVGET	(MIP'S) CURRENT EMPLOYER	2	(HI28)
D_OBTNP1(MIP'S) FORMER EMPLOYER	3	(HI28)
D_OBTNP2	(MIP'S) UNION	4	(HI29)
D_OBTNP3	(MIP'S) FAMILY BUSINESS	5	(HI27a)
D_OBTNP4	AARP	6	(HI27a)
D_OBTNP5	DECEASED SPOUSE'S EMPLOYER	7	(HI28)
	DECEASED SPOUSE'S UNION	8	(HI29)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9	(HI29)
	SOME OTHER WAY (SPECIFY) _____	91	(HI29)
PRVGETOS	REFUSED	-7	(HI29)
PPRVGTOS	DON'T KNOW	-8	(HI29)

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

PRVLETR	YES	1	(HI27b)
	NO	2	BOX HI17AA
	REFUSED	-7	BOX HI17AA
	DON'T KNOW	-8	BOX HI17AA

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

PLANLETR	PLAN LETTER _____
D_PLLTR1	
D_PLLTR2	
D_PLLTR3	
D_PLLTR4	
D_PLLTR5	

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

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

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 _____
D_COVNM1
D_COVNM2
D_COVNM3
D_COVNM4
D_COVNM5

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

PRVRXCOV YES 1
D_COVRX1 NO 2
D_COVRX2 REFUSED -7
D_COVRX3 DON'T KNOW -8
D_COVRX4
D_COVRX5

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

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

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

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

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

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

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

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

PRVNHCOV	YES	1
D_COVNH1	NO	2
D_COVNH2	REFUSED	-7
D_COVNH3	DON'T KNOW	-8
D_COVNH4		
D_COVNH5		

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)
D_PAYSP1	NO	2 (HI33a)
D_PAYSP2	REFUSED	-7 (HI33a)
D_PAYSP3	DON'T KNOW	-8 (HI33a)
D_PAYSP4		
D_PAYSP5		

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?]

MIPPAMT	AMOUNT \$	
MIPPUNIT	PER YEAR	1
D_ANAMT1	QUARTERLY/EVERY 3 MONTHS	2
D_ANAMT2	BIMONTHLY/EVERY 2 MONTHS	3
D_ANAMT3	PER MONTH	4
D_ANAMT4	PER WEEK	5
D_ANAMT5	SEMI-ANNUALLY/2 TIMES PER YEAR	6
	SEMI-MONTHLY/2 TIMES PER MONTH	7
MIPPUNOS	OTHER (SPECIFY)	91
	REFUSED	-7
	DON'T KNOW	-8

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

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

HI33b. Who else (pays/paid) 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 HI17B	IF PLAN IS A MANAGED CARE PLAN, GO TO HI33c. OTHERWISE, GO TO BOX HI19 .
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- HI33c. Some managed care plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Are you/Were you/Is (SP)/Was (SP)] enrolled in a point-of-service option offered by (PLAN NAME)?

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

MHMOPOS

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

BOX HI19	<p>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.</p> <p>IF HI34=2 OR MISSING (REF, DK, -9) IN PREVIOUS ROUND OR -1 (INAPPLICABLE) FOR THIS ROUND, GO TO HI34.</p>
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- 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	<p>IF SP SERVED IN THE ARMED FORCES (I.E., SP SERVED IN ARMED FORCES AND EN9 OR EN11=1) AND HI36 = 2, REF, DK, OR -9 IN PREVIOUS ROUND, OR THIS IS FIRST UTILIZATION INTERVIEW FOR SP, GO TO HI36.</p> <p>IF SP DID NOT SERVE IN THE ARMED FORCES (I.E., EN9 OR EN11=2, REF, DK, 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.</p>
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VACOVER	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

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