MCBS MAIN STUDY - ROUND 43, FALL 2005

COMMUNITY COMPONENT

HI. HEALTH INSURANCE

BOX HIS1A	IF THIS IS SP'S EXIT INTERVIEW AND PREVIOUS INTERVIEW NOT SKIPPED (INTERVIEW TYPE = 8), GO TO ***BOX DM1***. IF PREVIOUS ROUND WAS FACILITY INTERVIEW (INTERVIEW TYPE = 2, 5, OR 6), GO TO HIMC1. IF SUPPLEMENTAL SAMPLE (INTERVIEW TYPE = 3), GO TO ***BOX HIS4A***. OTHERWISE, GO TO HISINTRO.

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.

HIS2a. INTERVIEWER: BRIEFLY EXPLAIN WHY (PLAN NEEDS/PLANS NEED) DELETION.

PLANDVB1 _____

PLANDVB2 _____

PLANDVB3 _____

PLANDVB4 _____

BOX	GO TO HIS1.

OMB # 0938-0568
Exp. 3/31/07

HIS1b	

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***
TRICARE	5	***BOX HIS2***

BOX HIS2	IF HIS3 = 1, ASK HIS6 – HIS10c, THEN RETURN TO HIS1. IF HIS3 = 2, ASK HIS12 – ***BOX HIS3***, THEN RETURN TO HIS1. IF HIS3 = 3, ASK HIS20 – HIS33c, THEN RETURN TO HIS1. IF HIS3 = 4, ASK HISMC1 – HISMC14, THEN RETURN TO HIS1. IF HIS3 = 5, ASK HIST1 – HIST9, THEN RETURN TO HIS1.

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.

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, -7, OR -8, THEN MARK PLAN ADDED/SELECTED AT HISMC1 AS "STOPPED" AND RETURN TO HIS1. OTHERWISE, GO TO HISMC4.

HISMC4. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), 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	***BOX HISMC3***
	NO	2	(HISMC5)
	REFUSED	-7	(HISMC5)
	DON'T KNOW	-8	(HISMC5)

BOX HISMC3	IF INS1 = 1, GO TO HISMC4a. OTHERWISE, GO TO HISMC5.

HISMC4a. Did (your/SP's) (HISMC1 PLAN NAME) plan require (you/him/her) to pay a deductible before (HISMC1 PLAN NAME) would begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT	YES	1	(HISMC4b)
	NO	2	(HISMC4c)
	REFUSED	-7	(HISMC4c)
	DON'T KNOW	-8	(HISMC4c)

What is the amount of the deductible that (you/SP) had to pay before (HISMC1 PLAN NAME) began to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

RXDEAMT	AMOUNT: $_____.____	
	PER YEAR	1
RXDEUNIT	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
RXDEUNOS	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HISMC4c. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Did the amount (you/SP) paid for medicines prescribed by a doctor depend on whether the medicine was a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT	YES	1	(HISMC4f)
	NO	2	(HISMC4d)
	PLAN DID NOT COVER BRAND NAME RX.	3	(HISMC4h)
	REFUSED	-7	(HISMC4d)
	DON'T KNOW	-8	(HISMC4d)

What is the amount that (you/SP) usually paid for a prescribed medicine obtained through (your/SP's) (HISMC1 PLAN NAME) plan?

RXPLUNIT	PERCENTAGE 1	_____%__	(HISMC4j)
RXPLAMT	DOLLARS 2	$_____._____	(HISMC4j)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HISMC4j)
	REFUSED	-7	(HISMC4e)
	DON'T KNOW	-8	(HISMC4e)

HISMC4e. Was it more or less than $15?

RXPLMORL	MORE	1	(HISMC4j)
	LESS	2	(HISMC4j)
	REFUSED	-7	(HISMC4j)
	DON'T KNOW	-8	(HISMC4j)

What is the amount that (you/SP) usually paid for a brand name prescribed medicine obtained through (your/SP's) (HISMC1 PLAN NAME) plan?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DID NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HISMC4c AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE 1	_____%__	(HISMC4h)
RXBRAMT	DOLLARS 2	$_____._____	(HISMC4h)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HISMC4h)
	REFUSED	-7	(HISMC4g)
	DON'T KNOW	-8	(HISMC4g)

HISMC4g. Was it more or less than $15?

RXBRMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HISMC4h

HISMC4h. What is the amount that (you/SP) usually paid for a generic prescribed medicine obtained through (your/SP's) (HISMC1 PLAN NAME) plan?

RXGNUNIT	PERCENTAGE 1	_____%__	(HISMC4j)
RXGNAMT	DOLLARS 2	$_____._____	(HISMC4j)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HISMC4j)
	REFUSED	-7	(HISMC4i)
	DON'T KNOW	-8	(HISMC4i)

HISMC4i. Was it more or less than $15?

RXGNMORL	MORE	1	
	LESS	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HISMC4j

HISMC4j. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Did (your/SP's) (HISMC1 PLAN NAME) plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HISMC4k)
	NO	2	(HISMC4l)
	REFUSED	-7	(HISMC4l)
	DON'T KNOW	-8	(HISMC4l)

HISMC4k. HISMC4l

HISMC4k. What was the coverage limit that (HISMC1 PLAN NAME) would pay for costs of prescribed medicines? [PROBE IF NECESSARY: Was that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1	
RXLIMUNT	PER MONTH.....	2	
RXLIMUOS	PER QUARTER	3	
	OTHER (SPECIFY) _____	91	
	REFUSED	-7	
	DON'T KNOW	-8	

HISMC4l. How would you rate (your/SP's) prescription drug coverage through (HISMC1 PLAN NAME)? Would you say that (your/his/her) prescription drug coverage was . . .

RXRATE

excellent,	1
very good,	2
good,	3
fair, or	4
poor?	5
REFUSED	-7
DON'T KNOW	-8

HISMC5. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), 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. The first 20 days are paid in full and the next 80 days require a copayment, which in 2005 was $114 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 <u>additional</u> 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 anyone other than (you/SP).]

[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)?

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 MANAGED CARE PLAN NAME CHANGED OR WAS BOUGHT BY/ MERGED WITH CURRENT PLAN	9
	BETTER SELECTION OF PROVIDERS	10
	BETTER QUALITY OF CARE	11
	COULDN'T GET MEDICARE SUPPLEMENTAL INSURANCE (MEDIGAP)	12
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

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

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

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

HIS3a OMITTED IN ROUND 23.

HIS4 - HIS5 OMITTED IN ROUND 2.

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	(HIS7)
	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	

HIS10c. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did [your/(SP's)] Medicaid plan cover medicines prescribed by a doctor?

MCDRXCOV	YES	1	***BOX HIS2A***
	NO	2	(HIS1)
	REFUSED	-7	(HIS1)
	DON'T KNOW	-8	(HIS1)

BOX HIS2A	IF INS1 = 1 AND HIS6 = 1 OR HIS7 = 1, GO TO HIS10c1. OTHERWISE, GO TO HIS1.

HIS10c1. Did (your/SP's) Medicaid plan require (you/him/her) to pay a deductible before (your/his/her) Medicaid plan would begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT	YES	1	(HIS10c2)
	NO	2	(HIS10c3)
	REFUSED	-7	(HIS10c3)
	DON'T KNOW	-8	(HIS10c3)

HIS10c2. What is the amount of the deductible that (you/SP) had to pay before (your/his/her) Medicaid plan began to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

AMOUNT: $_____._____

RXDEAMT	PER YEAR	1
RXDEUNIT	QUARTERLY/EVERY 3 MONTHS	2
RXDEUNOS	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

HIS10c3. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Did the amount (you/SP) paid for medicines prescribed by a doctor depend on whether the medicine was a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT	YES	1	(HIS10c6)
	NO	2	(HIS10c4)
	MEDICAID DID NOT COVER BRAND NAME RX	3	(HIS10c8)
	REFUSED	-7	(HIS10c4)
	DON'T KNOW	-8	(HIS10c4)

HIS10c4. What is the amount that (you/SP) usually paid for a prescribed medicine obtained through (your/his/her) Medicaid plan?

RXPLUNIT	PERCENTAGE 1	_____%__	(HIS10c10)
RXPLAMT	DOLLARS 2	$_____._____	(HIS10c10)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS10c10)
	REFUSED	-7	(HIS10c5)
	DON'T KNOW	-8	(HIS10c5)

HIS10c5. Was it more or less than $15?

RXPLMORL	MORE	1	(HIS10c10)
	LESS	2	(HIS10c10)
	REFUSED	-7	(HIS10c10)
	DON'T KNOW	-8	(HIS10c10)

HIS10c6. What is the amount that (you/SP) usually paid for a brand name prescribed medicine obtained through (your/his/her) Medicaid plan?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DID NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HIS10c3 AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE 1	_____%__	(HIS10c8)
RXBRAMT	DOLLARS 2	$_____._____	(HIS10c8)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS10c8)
	REFUSED	-7	(HIS10c7)
	DON'T KNOW	-8	(HIS10c7)

HIS10c7. Was it more or less than $15?

RXBRMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HIS10c8. What is the amount that (you/SP) usually paid for a generic prescribed medicine obtained through (your/his/her) Medicaid plan?

RXGNUNIT	PERCENTAGE ..... 1 _____%__		(HIS10c10)
RXGNAMT	DOLLARS ..... 2 $_____._____		(HIS10c10)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS10c10)
	REFUSED	-7	(HIS10c9)
	DON'T KNOW	-8	(HIS10c9)

HIS10c9. Was it more or less than $15?

RXGNMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HIS10c10. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Did (your/SP's) Medicaid plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HIS10c11)
	NO	2	(HIS10c12)
	REFUSED	-7	(HIS10c12)
	DON'T KNOW	-8	(HIS10c12)

HIS10c11. What was the coverage limit that (your/SP's) Medicaid plan would pay for costs of prescribed medicines? [PROBE IF NECESSARY: Was that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1
RXLIMUNT	PER MONTH	2
RXLIMUOS	PER QUARTER	3
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HIS10c12. How would you rate (your/SP's) prescription drug coverage through (your/his/her) Medicaid plan? Would you say that (your/his/her) prescription drug coverage was . . .

RXRATE	excellent, ...	1
	very good, ...	2
	good, ...	3
	fair, or	4
	poor?	5
	REFUSED	-7
	DON'T KNOW	-8

HIS11 OMITTED IN ROUND 2.

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

COVTIME

THE WHOLE TIME	1	(HIST3)
PART OF THE TIME	2	(HIST2)
REFUSED	-7	(HIST2)
DON'T KNOW	-8	(HIST2)

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

COVNOW

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

HIST3. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did [your/(SP's)] TRICARE plan cover medicines prescribed by a doctor?

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

TRIRXCOV

YES	1	***BOX HIST1***
NO	2	(HIST4)
REFUSED	-7	(HIST4)
DON'T KNOW	-8	(HIST4)

BOX HIST1	IF INS1 = 1 AND HIST1 = 1 OR HIST2 = 1, GO TO HIST3a. OTHERWISE, GO TO HIST4.

HIST3a. Did (your/SP's) TRICARE plan require (you/him/her) to pay a deductible before TRICARE would begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT

YES	1	(HIST3b)
NO	2	(HIST3c)
REFUSED	-7	(HIST3c)
DON'T KNOW	-8	(HIST3c)

HIST3b. What is the amount of the deductible that (you/SP) had to pay before TRICARE began to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

AMOUNT: $_____.____

RXDEAMT	PER YEAR	1
RXDEUNIT	QUARTERLY/EVERY 3 MONTHS	2
RXDEUNOS	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

HIST3c. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Did the amount (you/SP) paid for medicines prescribed by a doctor depend on whether the medicine was a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT	YES	1	(HIST3f)
	NO	2	(HIST3d)
	TRICARE DID NOT COVER BRAND NAME RX	3	(HIST3h)
	REFUSED	-7	(HIST3d)
	DON'T KNOW	-8	(HIST3d)

HIST3d. What is the amount that (you/SP) usually paid for a prescribed medicine obtained through TRICARE?

RXPLUNIT	PERCENTAGE	1 _____%__	(HIST3j)
RXPLAMT	DOLLARS	2 $_____.____	(HIST3j)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIST3j)
	REFUSED	-7	(HIST3e)
	DON'T KNOW	-8	(HIST3e)

HIST3e. Was it more or less than $15?

RXPLMORL	MORE	1	(HIST3j)
	LESS	2	(HIST3j)
	REFUSED	-7	(HIST3j)
	DON'T KNOW	-8	(HIST3j)

HIST3f. What is the amount that (you/SP) usually paid for a brand name prescribed medicine obtained through TRICARE?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DID NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HIST3c AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE ..... 1 _____%__		(HIST3h)
RXBRAMT	DOLLARS ..... 2 $_____._____		(HIST3h)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIST3h)
	REFUSED	-7	(HIST3g)
	DON'T KNOW	-8	(HIST3g)

HIST3g. Was it more or less than $15?

RXBRMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HIST3h. What is the amount that (you/SP) usually paid for a generic prescribed medicine obtained through TRICARE?

RXGNUNIT	PERCENTAGE ..... 1 _____%__		(HIST3j)
RXGNAMT	DOLLARS ..... 2 $_____._____		(HIST3j)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIST3j)
	REFUSED	-7	(HIST3i)
	DON'T KNOW	-8	(HIST3i)

HIST3i. Was it more or less than $15?

RXGNMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HIST3j. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Did (your/SP's) TRICARE plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HIST3k)
	NO	2	(HIST3l)
	REFUSED	-7	(HIST3l)
	DON'T KNOW	-8	(HIST3l)

HIST3k. What was the coverage limit that TRICARE would pay for costs of prescribed medicines? [PROBE IF NECESSARY: Was that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1
RXLIMUNT	PER MONTH	2
RXLIMUOS	PER QUARTER	3
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HIST3l. How would you rate (your/SP's) prescription drug coverage through TRICARE? Would you say that (your/his/her) prescription drug coverage was . . .

RXRATE	excellent,	1
	very good,	2
	good,	3
	fair, or	4
	poor?	5
	REFUSED	-7
	DON'T KNOW	-8

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

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

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

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

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

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

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

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. The first 20 days are paid in full and the next 80 days require a copayment, which in 2005 was $114 per day.]

TRINHCOV

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

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

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

TRIINS

YES	1	(HIST9)
NO	2	(HIS1)
REFUSED	-7	(HIS1)
DON'T KNOW	-8	(HIS1)

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

AMOUNT $ _____._____ PER ( )

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

TRIAMT
TRIUNIT
TRIUNOS

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

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	(HIS14)
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
COVBEGDD
COVBEGYY

_____/_____/_____ (HIS16a)
MM DD YY

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

COVENDMM
COVENDDD
COVENDYY

_____/_____/_____
MM DD YY

HIS16a. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did [your/(SP's)] (HIS12 PUBLIC PLAN NAME) plan cover medicines prescribed by a doctor?

PUBRXCOV

YES	1	***BOX HIS2B***
NO	2	***BOX HIS3***
REFUSED	-7	***BOX HIS3***
DON'T KNOW	-8	***BOX HIS3***

BOX HIS2B	IF INS1 = 1 AND HIS13 = 1 OR HIS14 = 1, GO TO HIS16a1. OTHERWISE, GO TO ***BOX HIS3***.

HIS16a1. Did (your/SP's) (HIS12 PUBLIC PLAN NAME) plan require (you/him/her) to pay a deductible before (HIS12 PUBLIC PLAN NAME) would begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT	YES	1	(HIS16a2)
	NO	2	(HIS16a3)
	REFUSED	-7	(HIS16a3)
	DON'T KNOW	-8	(HIS16a3)

HIS16a2. What is the amount of the deductible that (you/SP) had to pay before (HIS12 PUBLIC PLAN NAME) began to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

AMOUNT: $_____._____

RXDEAMT	PER YEAR	1
RXDEUNIT	QUARTERLY/EVERY 3 MONTHS	2
RXDEUNOS	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

HIS16a3. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Did the amount (you/SP) paid for medicines prescribed by a doctor depend on whether the medicine was a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT	YES	1	(HIS16a6)
	NO	2	(HIS16a4)
	PLAN DID NOT COVER BRAND NAME RX	3	(HIS16a8)
	REFUSED	-7	(HIS16a4)
	DON'T KNOW	-8	(HIS16a4)

HIS16a4. What is the amount that (you/SP) usually paid for a prescribed medicine obtained through (HIS12 PUBLIC PLAN NAME)?

RXPLUNIT	PERCENTAGE 1	_____%__	(HIS16a10)
RXPLAMT	DOLLARS 2	$_____._____	(HIS16a10)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS16a10)
	REFUSED	-7	(HIS16a5)
	DON'T KNOW	-8	(HIS16a5)

HIS16a5. Was it more or less than $15?

RXPLMORL	MORE	1	(HIS16a10)
	LESS	2	(HIS16a10)
	REFUSED	-7	(HIS16a10)
	DON'T KNOW	-8	(HIS16a10)

HIS16a6. What is the amount that (you/SP) usually paid for a brand name prescribed medicine obtained through (HIS12 PUBLIC PLAN NAME)?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DID NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HIS16a3 AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE 1	_____%__	(HIS16a8)
RXBRAMT	DOLLARS 2	$_____._____	(HIS16a8)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS16a8)
	REFUSED	-7	(HIS16a7)
	DON'T KNOW	-8	(HIS16a7)

HIS16a7. Was it more or less than $15?

RXBRMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HIS16a8. What is the amount that (you/SP) usually paid for a generic prescribed medicine obtained through (HIS12 PUBLIC PLAN NAME)?

RXGNUNIT	PERCENTAGE 1	_____%__	(HIS16a10)
RXGNAMT	DOLLARS 2	$_____._____	(HIS16a10)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS16a10)
	REFUSED	-7	(HIS16a9)
	DON'T KNOW	-8	(HIS16a9)

HIS16a9. Was it more or less than $15?

RXGNMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HIS16a10. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Did (your/SP's) (HIS12 PUBLIC PLAN NAME) plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HIS16a11)
	NO	2	(HIS16a12)
	REFUSED	-7	(HIS16a12)
	DON'T KNOW	-8	(HIS16a12)

HIS16a11. What was the coverage limit that (your/SP's) (HIS12 PUBLIC PLAN NAME) plan would pay for costs of prescribed medicines?
[PROBE IF NECESSARY: Was that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1
RXLIMUNT	PER MONTH	2
RXLIMUOS	PER QUARTER	3
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HIS16a12. How would you rate (your/SP's) prescription drug coverage through (HIS12 PUBLIC PLAN NAME)? Would you say that (your/his/her) prescription drug coverage was . . .

RXRATE	excellent,	1
	very good,	2
	good,	3
	fair, or	4
	poor?	5
	REFUSED	-7
	DON'T KNOW	-8

HIS17 - HIS18 OMITTED IN ROUND 2.

BOX HIS3	GO TO HIS13 FOR NEXT PUBLIC PLAN ADDED AT HIS12. IF NO OTHER PUBLIC PLAN, THEN GO TO HIS1.

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

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

COVTIME

THE WHOLE TIME	1	(HIS25)
PART OF THE TIME	2	(HIS22)
REFUSED	-7	(HIS22)
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
PLHMOERR

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

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

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

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

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

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

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

PLANLETR PLAN LETTER _____

BOX HIS3AA	IF HIS27 = 5, GO TO HIS28. OTHERWISE, GO TO HIS29.

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: _____

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

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

PRVMSCOV

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

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

[EXPLAIN IF NECESSARY: For example, in 2005, Medicare beneficiaries are responsible for a $912 deductible when admitted to a hospital and Medicare pays for most of the rest of the costs. Did (your/MIP's) (PLAN NAME) plan pay any portion of the hospital deductible or other cost?]

PRVIPCOV

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

HIS30. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did (your/MIP's) (HIS20 PLAN NAME) plan cover medicines prescribed by a doctor?

PRVRXCOV

YES	1	***BOX HIS3AB***
NO	2	***BOX HIS3A***
REFUSED	-7	***BOX HIS3A***
DON'T KNOW	-8	***BOX HIS3A***

BOX HIS3AB	IF INS1 = 1 AND HIS21 = 1 OR HIS22 = 1, GO TO HIS30a1. OTHERWISE, GO TO ***BOX HIS3A***.

HIS30a1. Did (your/SP's) (HIS20 PLAN NAME) plan require (you/him/her) to pay a deductible before (HIS20 PLAN NAME) would begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT

YES	1	(HIS30a2)
NO	2	(HIS30a3)
REFUSED	-7	(HIS30a3)
DON'T KNOW	-8	(HIS30a3)

HIS30a2. What is the amount of the deductible that (you/SP) had to pay before (HIS20 PLAN NAME) began to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

AMOUNT: $_____.____

RXDEAMT	PER YEAR	1
RXDEUNIT	QUARTERLY/EVERY 3 MONTHS	2
RXDEUNOS	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

HIS30a3. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Did the amount (you/SP) paid for medicines prescribed by a doctor depend on whether the medicine was a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT	YES	1	(HIS30a6)
	NO	2	(HIS30a4)
	PLAN DID NOT COVER BRAND NAME RX	3	(HIS30a8)
	REFUSED	-7	(HIS30a4)
	DON'T KNOW	-8	(HIS30a4)

HIS30a4. What is the amount that (you/SP) usually paid for a prescribed medicine obtained through (HIS20 PLAN NAME)?

RXPLUNIT	PERCENTAGE ..... 1 _____%__		(HIS30a10)
RXPLAMT	DOLLARS ..... 2 $_____.____		(HIS30a10)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS30a10)
	REFUSED	-7	(HIS30a5)
	DON'T KNOW	-8	(HIS30a5)

HIS30a5. Was it more or less than $15?

RXPLMORL	MORE	1	(HIS30a10)
	LESS	2	(HIS30a10)
	REFUSED	-7	(HIS30a10)
	DON'T KNOW	-8	(HIS30a10)

HIS30a6. What is the amount that (you/SP) usually paid for a brand name prescribed medicine obtained through (HIS20 PLAN NAME)?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DID NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HIS30a3 AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE 1	_____%__	(HIS30a8)
RXBRAMT	DOLLARS 2	$_____._____	(HIS30a8)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS30a8)
	REFUSED	-7	(HIS30a7)
	DON'T KNOW	-8	(HIS30a7)

HIS30a7. Was it more or less than $15?

RXBRMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HIS30a8. What is the amount that (you/SP) usually paid for a generic prescribed medicine obtained through (HIS20 PLAN NAME)?

RXGNUNIT	PERCENTAGE 1	_____%__	(HIS30a10)
RXGNAMT	DOLLARS 2	$_____._____	(HIS30a10)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIS30a10)
	REFUSED	-7	(HIS30a9)
	DON'T KNOW	-8	(HIS30a9)

HIS30a9. Was it more or less than $15?

RXGNMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HIS30a10. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Did (your/SP's) (HIS20 PLAN NAME) plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HIS30a11)
	NO	2	(HIS30a12)
	REFUSED	-7	(HIS30a12)
	DON'T KNOW	-8	(HIS30a12)

HIS30a11. What was the coverage limit that (HIS20 PLAN NAME) would pay for costs of prescribed medicines? [PROBE IF NECESSARY: Was that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1
RXLIMUNT	PER MONTH	2
RXLIMUOS	PER QUARTER	3
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HIS30a12. How would you rate (your/SP's) prescription drug coverage through (HIS20 PLAN NAME)? Would you say that (your/his/her) prescription drug coverage was . . .

RXRATE	excellent,	1
	very good,	2
	good,	3
	fair, or	4
	poor?	5
	REFUSED	-7
	DON'T KNOW	-8

BOX HIS3A	IF PLAN IS A MANAGED CARE PLAN (HIS25 = 1), GO TO HIS30a. OTHERWISE, GO TO HIS31.

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	
	NO	2	
	REFUSED	-7	
	DON'T KNOW	-8	

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

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?
[Please do not include any amount that may be paid for anyone other than (you/SP).]
[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
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 (HIS25 = 1), GO TO HIS33c. OTHERWISE, GO TO ***BOX HIS4***.

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.

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

[PRESS ENTER TO CONTINUE.]

BOX HIS4A	IF SUPPLEMENTAL SAMPLE (INTERVIEW TYPE = 3) OR ORD OR DUAL ELIGIBLE SAMPLES: IF ANY CMS MEDICARE MANAGED CARE PLANS WERE LOADED AT HOME OFFICE, GO TO MC1. IF NO CMS MEDICARE MANAGED CARE PLANS WERE LOADED AT HOME OFFICE, GO TO HIMC1. NON-SUPPLEMENTAL

	SAMPLE CASES, GO TO ***BOX HIS4B***.

BOX HIS4B	IF MEDICARE MANAGED CARE PLAN CURRENT AS OF PREVIOUS ROUND, GO TO HIMC1a. OTHERWISE, GO TO HIMC1.

MEDICARE MANAGED CARE PLAN = XXXXXXX

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

YES	1	***BOX HIS4C***
NO	2	(HIMC1b)
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	(HIMC1c)

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

DISENROL
DISENROS

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

BOX HIS4C	IF THIS PLAN "CURRENT" AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HIMC6. OTHERWISE, GO TO ***BOX HIMC2***.

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)
NO	2	***BOX HIMC4***
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	***BOX HIMC4***

BOX MC1 OMITTED IN ROUND 24.

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

LOADCORR

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

MC2. (CMS MEDICARE MANAGED CARE PLAN NAME)

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

WHATWRNG

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

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

DISENROL	TOO EXPENSIVE	1	***BOX MC1A***
DISENROS	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***
	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 (CMS 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 IN ROUND 16.

BOX MC3 OMITTED IN ROUND 16.

MC8-MC9 OMITTED IN ROUND 16.

BOX MC4 OMITTED IN ROUND 16.

MC10 OMITTED IN ROUND 16.

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

MC13 OMITTED IN ROUND 16.

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 HIMC4***
	REFUSED	-7	***BOX HIMC4***
	DON'T KNOW	-8	***BOX HIMC4***

BOX HIMC1A OMITTED IN ROUND 43.

HIMC1INT OMITTED IN ROUND 43.

HIMC1aa OMITTED IN ROUND 43.

HIMC1bb OMITTED IN ROUND 43.

HIMC1cc OMITTED IN ROUND 20.

HIMC1cc1 OMITTED IN ROUND 43.

BOX HIMC1AA OMITTED IN ROUND 43.

HIMC1cc2 OMITTED IN ROUND 43.

HIMC1dd OMITTED IN ROUND 43.

HIMC1ee OMITTED IN ROUND 43.

BOX HIMC1B OMITTED IN ROUND 43.

HIMC1ff OMITTED IN ROUND 43.

HIMC1gg OMITTED IN ROUND 43.

HIMC1hh OMITTED IN ROUND 43.

HIMC1ii OMITTED IN ROUND 43.

HIMC2 OMITTED IN ROUND 20.

BOX HIMC1BB OMITTED IN ROUND 20.

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

MHMOCURR

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

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

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

MHMOCHNG

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

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

BOX HIMC1	IF THIS IS THE FALL "SUPPLEMENTAL" ROUND OR HIMC6 NEVER ASKED FOR THIS MEDICARE MANAGED CARE PLAN OR IF THIS MEDICARE MANAGED CARE PLAN WAS SELECTED (I.E., THE SP HAS RE-STARTED THIS PLAN), GO TO HIMC6. OTHERWISE, GO TO ***BOX HI1***/ST/NS/CT/CPS.

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

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

MHMORX

YES	1	***BOX HIMC1CC1***
NO	2	(HIMC7)
REFUSED	-7	(HIMC7)
DON'T KNOW	-8	(HIMC7)

BOX HIMC1CC1	IF INS1 = 1 OR -1, GO TO HIMC6b. OTHERWISE, GO TO HIMC7.

HIMC6a OMITTED IN ROUND 39.

HIMC6b. Does (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) plan require (you/him/her) to pay a deductible before (CURRENT MEDICARE MANAGED CARE PLAN NAME) will begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT	YES	1	(HIMC6c)
	NO	2	(HIMC6d)
	REFUSED	-7	(HIMC6d)
	DON'T KNOW	-8	(HIMC6d)

HIMC6c. What is the amount of the deductible that (you/SP) must pay before (CURRENT MEDICARE MANAGED CARE PLAN NAME) begins to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

RXDEAMT	AMOUNT: $_____.____		
	PER YEAR	1	
RXDEUNIT	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	
RXDEUNOS	OTHER (SPECIFY) _____	91	
	REFUSED	-7	
	DON'T KNOW	-8	

HIMC6d. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Does the amount (you pay/SP pays) for medicines prescribed by a doctor depend on whether the medicine is a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT	YES	1	(HIMC6g)
	NO	2	(HIMC6e)
	PLAN DOES NOT COVER BRAND NAME RX	3	(HIMC6i)
	REFUSED	-7	(HIMC6e)
	DON'T KNOW	-8	(HIMC6e)

HIMC6e. What is the amount that (you/SP) usually (pay/pays) for a prescribed medicine obtained through (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) plan?

RXPLUNIT	PERCENTAGE 1	_____%__	(HIMC6k)
RXPLAMT	DOLLARS 2	$_____.____	(HIMC6k)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIMC6k)
	REFUSED	-7	(HIMC6f)
	DON'T KNOW	-8	(HIMC6f)

HIMC6f. Is it more or less than $15?

RXPLMORL	MORE	1	(HIMC6k)
	LESS	2	(HIMC6k)
	REFUSED	-7	(HIMC6k)
	DON'T KNOW	-8	(HIMC6k)

HIMC6g. What is the amount that (you/SP) usually (pay/pays) for a brand name prescribed medicine obtained through (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) plan?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DOES NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HIMC6d AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE 1	_____ %__	(HIMC6i)
RXBRAMT	DOLLARS 2	$_____._____	(HIMC6i)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIMC6i)
	REFUSED	-7	(HIMC6h)
	DON'T KNOW	-8	(HIMC6h)

HIMC6h. Is it more or less than $15?

RXBRMORL	MORE	1	
	LESS	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HIMC6i. What is the amount that (you/SP) usually (pay/pays) for a generic prescribed medicine obtained through (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) plan?

RXGNUNIT	PERCENTAGE 1	_____ %__	(HIMC6k)
RXGNAMT	DOLLARS 2	$_____._____	(HIMC6k)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HIMC6k)
	REFUSED	-7	(HIMC6j)
	DON'T KNOW	-8	(HIMC6j)

HIMC6j. Is it more or less than $15?

RXGNMORL	MORE	1	
	LESS	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HIMC6k. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Does (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HIMC6l)
	NO	2	(HIMC6m)
	REFUSED	-7	(HIMC6m)
	DON'T KNOW	-8	(HIMC6m)

HIMC6l. What is the coverage limit that (CURRENT MEDICARE MANAGED CARE PLAN NAME) will pay for costs of prescribed medicines?
[PROBE IF NECESSARY: Is that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1
RXLIMUNT	PER MONTH	2
RXLIMUOS	PER QUARTER	3
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HIMC6m. How would you rate (your/SP's) prescription drug coverage through (CURRENT MEDICARE MANAGED CARE PLAN NAME)? Would you say that (your/his/her) prescription drug coverage is . . .

RXRATE	excellent,	1
	very good,	2
	good,	3
	fair, or	4
	poor?	5
	REFUSED	-7
	DON'T KNOW	-8

BOX HIMC1CC OMITTED IN ROUND 39.

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 2005, the first 20 days are paid in full and the next 80 days require a copayment of $114.00 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 <u>additional</u> 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 anyone other than (you/SP).]

AMOUNT $ _____._____ PER ( )

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

MHMOAMT
MHMOUNIT
MHMOUNOS

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

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?

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 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 ***BOX HIMC2***.

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 OMITTED IN ROUND 43.

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

DISENROL
DISENROS

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

BOX HIMC4	IF NOT A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO ***BOX HI1***. IF FALL "SUPPLEMENTAL" SAMPLE ROUND AND NO CURRENT MEDICARE MANAGED CARE PLAN AND SP IS ALIVE (INS1 ≠ 3), GO TO HIMC21. OTHERWISE, GO TO HIMC19.

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 OMITTED IN ROUND 43.

HIMC20b OMITTED IN ROUND 43.

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 OMITTED IN ROUND 43.

BOX HIMC5	IF SP NEVER HAD A MEDICARE MANAGED CARE PLAN (NO PLANTYPE = 5 ON PLAN ROSTER) OR IF NO CURRENT MEDICARE MANAGED CARE PLAN OR IF HIMC24 HAS BEEN ASKED AT ANY TIME, GO TO ***BOX HI1***. 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. IF INTERVIEW TYPE = 2, 3, 5, OR 6, GO TO HI5INTRO. IF MEDICAID WAS NOT CURRENT IN THE PREVIOUS ROUND, GO TO HI5INTRO. OTHERWISE, IF MEDICAID WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI6.

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 SP LIVES DOES NOT OFFER A MEDICAID MANAGED CARE PLAN (SHOWN IN ATTACHMENT HI4), 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 HIT1***
REFUSED	-7	***BOX HIT1***
DON'T KNOW	-8	***BOX HIT1***

BOX HI2 OMITTED IN ROUND 35.

HI6. [MEDICAID PROGRAM NAME]
(At the time of the last interview (you were/SP was) covered by Medicaid(, also known as [READ FROM ABOVE].) (Were you/Was SP) covered by Medicaid the whole time between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION), or only part of the time?

COVTIME

THE WHOLE TIME	1	***BOX HI5A***
PART OF THE TIME	2	(HI7)
REFUSED	-7	(HI7)
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***
	NO	2	(HI9)
	REFUSED	-7	(HI10a)
	DON'T KNOW	-8	***BOX HI5A***

BOX HI4	IF MEDICAID WAS CURRENT IN THE PREVIOUS ROUND, GO TO ***BOX HI5A***. IF MEDICAID WAS NOT CURRENT IN THE 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** **COVBEGYY** _____/_____/_____
MM DD YY

BOX HI5A	IF INS1 = 1 or -1, GO TO HI10. OTHERWISE, GO TO HI10a.

BOX HI5 OMITTED IN ROUND 20.

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)
MM DD YY

BOX HI6 OMITTED IN ROUND 20.

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	(HI10a1)
	CARD AVAILABLE, EXPIRED	2	(HI10a1)
	CARD NOT AVAILABLE OR NOT SEEN	3	(HI10a)
AIDTYPOS	OTHER CARD SEEN (SPECIFY) _____	91	(HI10a1)

HI10a1. INTERVIEWER: 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***.

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***

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	(A) IF MEDICAID WAS NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI10d. (B) IF MEDICAID WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HI10d. (C) OTHERWISE, GO TO ***BOX HIT1***.

HI10d. (Does/Did) [your/(SP's)] Medicaid plan cover medicines prescribed by a doctor?

MCDRXCOV	YES	1	***BOX HI5E***
	NO	2	***BOX HIT1***
	REFUSED	-7	***BOX HIT1***
	DON'T KNOW	-8	***BOX HIT1***

BOX HI5E	IF INS1 = 1 OR -1 AND HI6 = 1 OR HI7 = 1, GO TO HI10d13. OTHERWISE, GO TO ***BOX HIT1***.

HI10d1 OMITTED IN ROUND 39.

HI10d2 – HI10d12 OMITTED IN ROUND 43.

HI10d13. How would you rate (your/SP's) prescription drug coverage through (your/his/her) Medicaid plan? Would you say that (your/his/her) prescription drug coverage is . . .

RXRATE

excellent,	1
very good,	2
good,	3
fair, or	4
poor?	5
REFUSED	-7
DON'T KNOW	-8

BOX HIT1	IF INTERVIEW TYPE = 2, 3, 5 OR 6 OR IF SP NOT COVERED BY TRICARE IN THE PREVIOUS ROUND, GO TO HIT1. IF TRICARE WAS CURRENT (HIT2 = 1 OR HIT3 = 1) IN THE PREVIOUS ROUND, GO TO HIT2 FOR THIS ROUND. IF TRICARE WAS NOT CURRENT (HIT3 = 2, -7, OR -8) IN THE PREVIOUS ROUND, GO TO HIT1.

HIT1. As you (may) know, the Department of Defense sponsors a regionally managed health care program called TRICARE for active duty and retired members of the uniformed Armed Forces, their families, and survivors.

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

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

SHOW CARD HIT1

TRICOVER

YES	1	(HIT2)
NO	2	***BOX HIT3***
REFUSED	-7	***BOX HIT3***
DON'T KNOW	-8	***BOX HIT3***

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

COVTIME

THE WHOLE TIME	1	***BOX HIT2***
PART OF THE TIME	2	(HIT3)
REFUSED	-7	(HIT3)
DON'T KNOW	-8	(HIT3)

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

COVNOW

YES	1	***BOX HIT2***
NO	2	***BOX HIT2***
REFUSED	-7	***BOX HIT2***
DON'T KNOW	-8	***BOX HIT2***

BOX HIT2	(A) IF SP NOT COVERED BY TRICARE IN THE PREVIOUS ROUND, GO TO HIT4. (B) IF TRICARE WAS NOT CURRENT (HIT3 = 2, -7, OR -8) IN THE PREVIOUS ROUND, GO TO HIT4. (C) IF TRICARE WAS CURRENT (HIT2 = 1 OR HIT3 = 1) IN THE PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HIT4. (D) IF TRICARE WAS CURRENT (HIT2 = 1 OR HIT3 = 1) IN THE PREVIOUS ROUND AND IT IS NOT A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO ***BOX HIT3***.

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

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

TRIRXCOV

YES	1	(HIT4a1)
NO	2	(HIT5)
REFUSED	-7	(HIT5)
DON'T KNOW	-8	(HIT5)

HIT4a1. Where (do you/does SP/did you/did SP) usually obtain (your/his/her) medicines? (Do you/Does SP/Did you/Did SP) usually obtain them at …

SHOW CARD HIT2

TRIMEDS
TRIMEDOS

a TRICARE mail order pharmacy (TMOP), ...	1
a TRICARE retail pharmacy network pharmacy (TRRx), ...	2
a military treatment facility pharmacy (MTF), .	3
a non-network retail pharmacy, or ...	4
somewhere else? (SPECIFY) _____	91
REFUSED ...	-7
DON'T KNOW ...	-8

BOX HIT2A	IF INS1 = 1 OR -1 AND HIT2 = 1 OR HIT3 = 1, GO TO HIT4m. OTHERWISE, GO TO HIT5.

HIT4a OMITTED IN ROUND 39.

HIT4b – HIT4L OMITTED IN ROUND 43.

HIT4m. How would you rate (your/SP's) prescription drug coverage through TRICARE? Would you say that (your/his/her) prescription drug coverage is . . .

RXRATE

excellent,	1
very good,	2
good,	3
fair, or	4
poor?	5
REFUSED	-7
DON'T KNOW	-8

BOX HIT2B OMITTED IN ROUND 39.

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

TRIDENT

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

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

TRIEYE

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

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

TRIPCAR

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

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

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. In 2005, the first 20 days are paid in full and the next 80 days require a copayment of $114.00 per day.]

TRINHCOV

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

HIT9 OMITTED IN ROUND 43.

HIT10 OMITTED IN ROUND 43.

BOX HIT3	IF SUPPLEMENTAL SAMPLE (INTERVIEW TYPE = 3), GO TO ***BOX HI7***. IF PREVIOUS ROUND WAS FACILITY INTERVIEW (INTERVIEW TYPE = 2, 5, 6) AND ■ SP COVERED BY TRICARE IN THE CURRENT ROUND, OR ■ SP SERVED IN THE ARMED FORCES (EN9 OR EN11 = 1), GO TO HIT11. IF MTFCOVER ≠ 1 IN ANY PREVIOUS ROUND AND ■ SP COVERED BY TRICARE IN THE CURRENT OR THE PREVIOUS ROUND, OR ■ SP SERVED IN THE ARMED FORCES (EN9 OR EN11 = 1). GO TO HIT11. OTHERWISE, GO TO ***BOX HI20***.

HIT11. [We recorded that (you/SP) served in the Armed Forces of the United States.] Since (REF. DATE), [(have you/has SP) received/did (SP) receive] health care or health services or prescribed medicines at a Military Treatment Facility or MTF?

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

MTFCOVER

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

BOX HI20	IF SP SERVED IN THE ARMED FORCES (EN9 OR EN11 = 1) AND ■ THIS IS FIRST UTILIZATION INTERVIEW FOR SP (INTERVIEW TYPE = 2, 7, 10), GO TO HI36, OR ■ PREVIOUS ROUND WAS FACILITY INTERVIEW (INTERVIEW TYPE = 5, 6), OR ■ HI36 = 2, -7, -8, OR -9 IN PREVIOUS ROUND. IF SP DID NOT SERVE IN THE ARMED FORCES (EN9 AND EN11 = 2, -7, -8, OR -9), OR SP SERVED IN THE ARMED FORCES (EN9 OR EN11 = 1), AND HI36 = 1 IN PREVIOUS ROUND, GO TO ***BOX HI7***.

HI36. We recorded that (you/SP) served in the Armed Forces of the United States. Since (REF. DATE), [(have you/has SP) received/did (SP) receive] health care or health services or prescribed medicines through the Department of Veterans Affairs or V.A.?

VACOVER

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

BOX HI7	IF PUBLIC PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF NO CURRENT PUBLIC PLAN IN THE 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 public program other than Medicaid that pays for medical care [for example, a public program that pays for prescribed medicines/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM), a public program that pays for prescribed medicines/
for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM1) or (STATE PHARMACEUTICAL ASSISTANCE PROGRAM2)/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM1), (STATE PHARMACEUTICAL ASSISTANCE PROGRAM2), or (STATE PHARMACEUTICAL ASSISTANCE PROGRAM3), public programs that pay for prescribed medicines]?

PUBCOVER

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

BOX HI8	IF HI11 = 2, -7, OR -8 AND PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF HI11 = 2, -7 OR -8 AND NO CURRENT PRIVATE PLAN IN THE PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.

HI12. What is the name of each of the public programs other than Medicaid 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	(HI14)
DON'T KNOW	-8	(HI14)

BOX HI9	(A) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI16a. (B) IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HI16a. (C) OTHERWISE, IF ANOTHER PUBLIC PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI13 OR GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND. (D) ASK HI13 FOR EACH NEW PUBLIC PLAN COLLECTED IN HI12. (E) IF PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF NO CURRENT PRIVATE PLAN IN THE PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.

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	(A) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND AND HI14 = 1, GO TO HI15. (B) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND AND HI14 = -7 OR -8, GO TO HI16a. (C) IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HI16a. (D) OTHERWISE, IF ANOTHER PUBLIC PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI13 OR GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND. (E) ASK HI13 FOR EACH NEW PUBLIC PLAN COLLECTED IN HI12. (F) IF PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF NO CURRENT PRIVATE PLAN IN THE PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.

HI15. On what date did (your/SP's) (PUBLIC PLAN NAME) coverage start between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

COVBEGMM
COVBEGDD
COVBEGYY

_____/_____/_____(HI16a)
MM DD YY

BOX HI11 OMITTED IN ROUND 25.

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

COVENDMM
COVENDDD
COVENDYY

_____/_____/_____
MM DD YY

BOX HI11A	(A) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI16a. IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HI16a. OTHERWISE, (IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS NOT A FALL "SUPPLEMENTAL" ROUND), GO TO (B). (B) IF ANOTHER PUBLIC PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN FROM THE PREVIOUS ROUND. IF NO OTHER PUBLIC PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND.

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

PUBRXCOV

YES	1	***BOX HI11B***
NO	2	***BOX HI12***
REFUSED	-7	***BOX HI12***
DON'T KNOW	-8	***BOX HI12***

BOX HI11B	IF INS1 = 1 OR -1 AND HI13 = 1 OR HI14 = 1, GO TO HI16a2. OTHERWISE, GO TO ***BOX HI12***.

HI16a1 OMITTED IN ROUND 39.

HI16a2. Does (your/SP's) (PUBLIC PLAN NAME) plan require (you/him/her) to pay a deductible before (PUBLIC PLAN NAME) will begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT

YES	1	(HI16a3)
NO	2	(HI16a4)
REFUSED	-7	(HI16a4)
DON'T KNOW	-8	(HI16a4)

HI16a3. What is the amount of the deductible that (you/SP) must pay before (PUBLIC PLAN NAME) begins to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

AMOUNT: $_____.____

RXDEAMT
RXDEUNIT
RXDEUNOS

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

HI16a4. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Does the amount (you pay/SP pays) for medicines prescribed by a doctor depend on whether the medicine is a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT

YES	1	(HI16a7)
NO	2	(HI16a5)
PLAN DOES NOT COVER BRAND NAME RX	3	(HI16a9)
REFUSED	-7	(HI16a5)
DON'T KNOW	-8	(HI16a5)

HI16a5. What is the amount that (you/SP) usually (pay/pays) for a prescribed medicine obtained through (PUBLIC PLAN NAME)?

RXPLUNIT	PERCENTAGE ..... 1 _____%__		(HI16a11)
RXPLAMT	DOLLARS ..... 2 $_____._____		(HI16a11)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI16a11)
	REFUSED	-7	(HI16a6)
	DON'T KNOW	-8	(HI16a6)

HI16a6. Is it more or less than $15?

RXPLMORL	MORE	1	(HI16a11)
	LESS	2	(HI16a11)
	REFUSED	-7	(HI16a11)
	DON'T KNOW	-8	(HI16a11)

HI16a7. What is the amount that (you/SP) usually (pay/pays) for a brand name prescribed medicine obtained through (PUBLIC PLAN NAME)?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DOES NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HI16a4 AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE ..... 1 _____%__		(HI16a9)
RXBRAMT	DOLLARS ..... 2 $_____._____		(HI16a9)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI16a9)
	REFUSED	-7	(HI16a8)
	DON'T KNOW	-8	(HI16a8)

HI16a8. Is it more or less than $15?

RXBRMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HI16a9. What is the amount that (you/SP) usually (pay/pays) for a generic prescribed medicine obtained through (PUBLIC PLAN NAME)?

RXGNUNIT	PERCENTAGE ..... 1 _____%__		(HI16a11)
RXGNAMT	DOLLARS ..... 2 $_____._____		(HI16a11)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI16a11)
	REFUSED	-7	(HI16a10)
	DON'T KNOW	-8	(HI16a10)

HI16a10. Is it more or less than $15?

RXGNMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HI16a11. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Does (your/SP's) (PUBLIC PLAN NAME) plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HI16a12)
	NO	2	(HI16a13)
	REFUSED	-7	(HI16a13)
	DON'T KNOW	-8	(HI16a13)

HI16a12. What is the coverage limit that (your/SP's) (PUBLIC PLAN NAME) plan will pay for costs of prescribed medicines?
[PROBE IF NECESSARY: Is that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1
RXLIMUNT	PER MONTH	2
RXLIMUOS	PER QUARTER	3
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HI16a13. How would you rate (your/SP's) prescription drug coverage through (PUBLIC PLAN NAME)? Would you say that (your/his/her) prescription drug coverage is . . .

RXRATE	excellent,	1
	very good,	2
	good,	3
	fair, or	4
	poor?	5
	REFUSED	-7
	DON'T KNOW	-8

BOX HI12	IF HI16a BEING ASKED FOR PUBLIC PLAN FROM PREVIOUS ROUND, GO TO HI13 IF ANOTHER PUBLIC PLAN WAS CURRENT IN THE PREVIOUS ROUND. IF NO OTHER PUBLIC PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI11 TO COLLECT ANY NEW PUBLIC PLANS FOR THIS ROUND. IF HI16a BEING ASKED FOR PUBLIC PLAN COVERAGE FOR THIS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN ADDED THIS ROUND. IF SP NOT COVERED BY ANOTHER PUBLIC PLAN FOR THIS ROUND AND IF PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI21. OTHERWISE, IF NO CURRENT PRIVATE PLAN IN THE PREVIOUS ROUND, GO TO HI17.

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)?

Such plans cover the cost of hospital or doctor visits, prescribed medicines, or dental care.

PRVCOVER

YES	1	(HI20)
NO	2	***BOX HI13A***
REFUSED	-7	***BOX HI13A***
DON'T KNOW	-8	***BOX HI13A***

BOX HI13 OMITTED IN ROUND 39.

HI18 OMITTED IN ROUND 15.

BOX HI13A	IF CASE IS NEW COMMUNITY CASE (INTERVIEW TYPE = 2 OR 3), GO TO HI19. OTHERWISE, GO TO ***BOX HI19***.

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	(HI22)
DON'T KNOW	-8	(HI22)

BOX HI14A OMITTED IN ROUND 5.

BOX HI15	IF THIS PLAN WAS NOT CURRENT IN THE PREVIOUS ROUND, GO TO HI25. IF THIS PLAN IS 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 WAS NOT CURRENT IN THE PREVIOUS ROUND AND HI22 = 1, GO TO HI23. IF THIS PLAN WAS NOT CURRENT IN THE PREVIOUS ROUND AND HI22 = -7 OR -8, GO TO HI25. IF THIS PLAN IS 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, 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)
	(MIP'S) FORMER EMPLOYER	3	(HI22c)
	(MIP'S) UNION	4	(HI22d)
	(MIP'S) FAMILY BUSINESS	5	(HI22b1)
	AARP	6	(HI22b1)
	DECEASED SPOUSE'S EMPLOYER	7	(HI22c)
	DECEASED SPOUSE'S UNION	8	(HI22d)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9	(HI22d)
	SOME OTHER WAY (SPECIFY) _____	91	(HI22d)
PRVGETOS	REFUSED	-7	(HI22d)
PPRVGTOS	DON'T KNOW	-8	(HI22d)

HI22b1. Many Medicare Supplemental or Medigap plans are referred to by a plan letter. There are standardized policies labeled **Plan "A" through Plan "L"**. (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)?

PLANLETR PLAN LETTER _____

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 _____

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

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

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

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

[EXPLAIN IF NECESSARY: For example, in 2005, Medicare beneficiaries are responsible for a $912 deductible when admitted to a hospital and Medicare pays for most of the rest of the costs. (Does/Did) (your/MIP's) (PLAN NAME) plan pay any portion of the hospital deductible or other cost?]

PRVIPCOV

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

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

PRVRXCOV

YES	1	***BOX HI16AA1***
NO	2	***BOX HI16A1***
REFUSED	-7	***BOX HI16A1***
DON'T KNOW	-8	***BOX HI16A1***

BOX HI16AA1	IF INS1 = 1 OR -1, GO TO HI22e1b. OTHERWISE, GO TO ***BOX HI16A1***.

HI22e1a OMITTED IN ROUND 39.

HI22e1b. Does (your/SP's) (PLAN NAME) plan require (you/him/her) to pay a deductible before (PLAN NAME) will begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT

YES	1	(HI22e1c)
NO	2	(HI22e1d)
REFUSED	-7	(HI22e1d)
DON'T KNOW	-8	(HI22e1d)

HI22e1c. What is the amount of the deductible that (you/SP) must pay before (PLAN NAME) begins to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

AMOUNT: $_____.____

RXDEAMT	PER YEAR	1
RXDEUNIT	QUARTERLY/EVERY 3 MONTHS	2
RXDEUNOS	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

HI22e1d. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Does the amount (you pay/SP pays) for medicines prescribed by a doctor depend on whether the medicine is a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT	YES	1	(HI22e1g)
	NO	2	(HI22e1e)
	PLAN DOES NOT COVER BRAND NAME RX	3	(HI22e1i)
	REFUSED	-7	(HI22e1e)
	DON'T KNOW	-8	(HI22e1e)

HI22e1e. What is the amount that (you/SP) usually (pay/pays) for a prescribed medicine obtained through (PLAN NAME)?

RXPLUNIT	PERCENTAGE 1	_____%__	(HI22e1k)
RXPLAMT	DOLLARS 2	$_____.____	(HI22e1k)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI22e1k)
	REFUSED	-7	(HI22e1f)
	DON'T KNOW	-8	(HI22e1f)

HI22e1f. Is it more or less than $15?

RXPLMORL	MORE	1	(HI22e1k)
	LESS	2	(HI22e1k)
	REFUSED	-7	(HI22e1k)
	DON'T KNOW	-8	(HI22e1k)

HI22e1g. What is the amount that (you/SP) usually (pay/pays) for a brand name prescribed medicine obtained through (PLAN NAME)?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DOES NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HI22e1d AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE ..... 1 _____%__		(HI22e1i)
RXBRAMT	DOLLARS ..... 2 $_____._____		(HI22e1i)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI22e1i)
	REFUSED	-7	(HI22e1h)
	DON'T KNOW	-8	(HI22e1h)

HI22e1h. Is it more or less than $15?

RXBRMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HI22e1i. What is the amount that (you/SP) usually (pay/pays) for a generic prescribed medicine obtained through (PLAN NAME)?

RXGNUNIT	PERCENTAGE ..... 1 _____%__		(HI22e1k)
RXGNAMT	DOLLARS ..... 2 $_____._____		(HI22e1k)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI22e1k)
	REFUSED	-7	(HI22e1j)
	DON'T KNOW	-8	(HI22e1j)

HI22e1j. Is it more or less than $15?

RXGNMORL	MORE	1
	LESS	2
	REFUSED	-7
	DON'T KNOW	-8

HI22e1k. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Does (your/SP's) (PLAN NAME) plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HI22e1l)
	NO	2	(HI22e1m)
	REFUSED	-7	(HI22e1m)
	DON'T KNOW	-8	(HI22e1m)

HI22e1l. What is the coverage limit that (PLAN NAME) will pay for costs of prescribed medicines? [PROBE IF NECESSARY: Is that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1
RXLIMUNT	PER MONTH	2
RXLIMUOS	PER QUARTER	3
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HI22e1m. How would you rate (your/SP's) prescription drug coverage through (PLAN NAME)? Would you say that (your/his/her) prescription drug coverage is . . .

RXRATE	excellent,	1
	very good,	2
	good,	3
	fair, or	4
	poor?	5
	REFUSED	-7
	DON'T KNOW	-8

BOX HI16A1	IF THIS PLAN IS A MANAGED CARE PLAN (HI25 = 1), GO TO HI22e1. OTHERWISE, GO TO HI22f.

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

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

HI22e2. (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

HI22e3. (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

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? [Please do not include any amount that may be paid for anyone other than (you/SP).] [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 A MANAGED CARE PLAN (HI25 = 1), 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 managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

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

BOX HI16A	IF ANOTHER PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI21 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)
MM DD YY

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** _____/_____/_____
MM DD YY

BOX HI17	IF HI24 BEING ASKED FOR PRIVATE PLAN FROM PREVIOUS ROUND, GO TO HI21 IF ANOTHER PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND. IF NO OTHER PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI17 TO COLLECT ANY NEW PRIVATE PLANS FOR THIS ROUND. IF HI24 BEING ASKED FOR PRIVATE PLAN COVERAGE FOR THIS ROUND, GO TO HI25.

HI25. [CODE WITHOUT ASKING IF VOLUNTEERED.]
(Is/Was) this a managed care plan, such as an HMO (Health Maintenance Organization)?
[EXPLAIN IF NECESSARY: Managed care plans generally provide a full range of health care services for a prepaid fee. The major types of managed care plans are health maintenance organizations (HMOs), HMOs with a point-of-service option, Provider-Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs).]

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, 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)
	(MIP'S) FORMER EMPLOYER	3	(HI28)
	(MIP'S) UNION	4	(HI29)
	(MIP'S) FAMILY BUSINESS	5	(HI27a)
	AARP	6	(HI27a)
	DECEASED SPOUSE'S EMPLOYER	7	(HI28)
	DECEASED SPOUSE'S UNION	8	(HI29)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9	(HI29)
	SOME OTHER WAY (SPECIFY) _____	91	(HI29)
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 standardized policies labeled **Plan "A" through Plan "L"**. (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 _____

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

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

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 _____

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

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

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

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

[EXPLAIN IF NECESSARY: For example, in 2005, Medicare beneficiaries are responsible for a $912 deductible when admitted to a hospital and Medicare pays for most of the rest of the costs. (Does/Did) (your/MIP's) (PLAN NAME) plan pay any portion of the hospital deductible or other cost?]

PRVIPCOV

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

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

PRVRXCOV

YES	1	***BOX HI17AA1***
NO	2	***BOX HI17A***
REFUSED	-7	***BOX HI17A***
DON'T KNOW	-8	***BOX HI17A***

BOX HI17AA1	IF INS1 = 1 OR -1 AND HI21 = 1 OR HI22 = 1, GO TO HI30a2. OTHERWISE, GO TO ***BOX HI17A***.

HI30a2. Does (your/SP's) (PLAN NAME) plan require (you/him/her) to pay a deductible before (PLAN NAME) will begin to pay for the costs of medicines prescribed by a doctor?

[EXPLAIN IF NECESSARY: Some health plans require that a beneficiary pay an amount called a deductible before the health plan begins paying for health care costs. For example, some plans have an annual deductible of $100 that must be paid by the beneficiary; after this deductible is satisfied, the plan will begin paying its share of the medical costs.]

RXDEDUCT

YES	1	(HI30a3)
NO	2	(HI30a4)
REFUSED	-7	(HI30a4)
DON'T KNOW	-8	(HI30a4)

HI30a3. What is the amount of the deductible that (you/SP) must pay before (PLAN NAME) begins to pay for costs of prescribed medicines?
[Please tell me the amount of (your/SP's) individual deductible.]
[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

AMOUNT: $_____.____

RXDEAMT	PER YEAR	1
RXDEUNIT	QUARTERLY/EVERY 3 MONTHS	2
RXDEUNOS	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

HI30a4. Beneficiaries of a health insurance plan may pay different amounts for generic or brand name prescribed medicines. Does the amount (you pay/SP pays) for medicines prescribed by a doctor depend on whether the medicine is a generic or brand name medicine?

[EXPLAIN IF NECESSARY: A brand name medicine is a prescription medicine that has been produced or sold by a specific company and may be protected by a trademark. A generic medicine is a prescription medicine that contains the same active ingredient as a specific brand name medicine.]

RXDIFAMT	YES	1	(HI30a7)
	NO	2	(HI30a5)
	PLAN DOES NOT COVER BRAND NAME RX	3	(HI30a9)
	REFUSED	-7	(HI30a5)
	DON'T KNOW	-8	(HI30a5)

HI30a5. What is the amount that (you/SP) usually (pay/pays) for a prescribed medicine obtained through (PLAN NAME)?

RXPLUNIT	PERCENTAGE ..... 1 _____%__		(HI30a11)
RXPLAMT	DOLLARS ..... 2 $_____.____		(HI30a11)
RXPLPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI30a11)
	REFUSED	-7	(HI30a6)
	DON'T KNOW	-8	(HI30a6)

HI30a6. Is it more or less than $15?

RXPLMORL	MORE	1	(HI30a11)
	LESS	2	(HI30a11)
	REFUSED	-7	(HI30a11)
	DON'T KNOW	-8	(HI30a11)

HI30a7. What is the amount that (you/SP) usually (pay/pays) for a brand name prescribed medicine obtained through (PLAN NAME)?

INTERVIEWER: IF RESPONSE INDICATES THAT SP'S PLAN DOES NOT COVER BRAND NAME PRESCRIBED MEDICINES, USE CTRL/B TO RETURN TO SCREEN HI30a4 AND ENTER CODE 3.

RXBRUNIT	PERCENTAGE 1	_____%__	(HI30a9)
RXBRAMT	DOLLARS 2	$_____._____	(HI30a9)
RXBRPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI30a9)
	REFUSED	-7	(HI30a8)
	DON'T KNOW	-8	(HI30a8)

HI30a8. Is it more or less than $15?

RXBRMORL	MORE	1	
	LESS	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HI30a9. What is the amount that (you/SP) usually (pay/pays) for a generic prescribed medicine obtained through (PLAN NAME)?

RXGNUNIT	PERCENTAGE 1	_____%__	(HI30a11)
RXGNAMT	DOLLARS 2	$_____._____	(HI30a11)
RXGNPCT	NO COST FOR PRESCRIBED MEDICINES	3	(HI30a11)
	REFUSED	-7	(HI30a10)
	DON'T KNOW	-8	(HI30a10)

HI30a10. Is it more or less than $15?

RXGNMORL	MORE	1	
	LESS	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HI30a11. [Some health insurance plans place a limit on the total amount that they will pay for prescription drug coverage. This is sometimes called a "coverage limit."] Does (your/SP's) (PLAN NAME) plan have a coverage limit for prescribed medicines?

RXLIMIT	YES	1	(HI30a12)
	NO	2	(HI30a13)
	REFUSED	-7	(HI30a13)
	DON'T KNOW	-8	(HI30a13)

HI30a12. What is the coverage limit that (PLAN NAME) will pay for costs of prescribed medicines? [PROBE IF NECESSARY: Is that per year, per month, per quarter, or what?]

AMOUNT: $_____._____

RXLIMAMT	PER YEAR	1
RXLIMUNT	PER MONTH	2
RXLIMUOS	PER QUARTER	3
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HI30a13. How would you rate (your/SP's) prescription drug coverage through (PLAN NAME)? Would you say that (your/his/her) prescription drug coverage is . . .

RXRATE	excellent,	1
	very good,	2
	good,	3
	fair, or	4
	poor?	5
	REFUSED	-7
	DON'T KNOW	-8

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

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

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

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

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

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

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

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

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

HI32. [Do you/Does (MIP)/Did (you/MIP)/Did (MIP)] pay any or all of the premium or cost for the (PLAN NAME) coverage?
[Do not include the cost of any deductibles (you/SP) or (your/SP's) family may (have/have had) to pay.]

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

BOX HI18 OMITTED IN ROUND 20.

HI33. How much [do you/does (MIP)/did (you/MIP)/did (MIP)] pay for the (PLAN NAME) coverage?
[Please do not include any amount that may be paid for anyone other than (you/SP).]
[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	
	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 (HI25 = 1), GO TO HI33c. OTHERWISE, GO TO ***BOX HI19***.

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

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

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

BOX HI19	CYCLE THROUGH QUESTIONS HI21-HI33c FOR EACH PRIVATE PLAN REPORTED IN HI20. IF HI34 ≠ 1 IN ANY PREVIOUS ROUND AND IF HI34 = -1 FOR THIS ROUND, GO TO HI34. IF HI34 = 1 IN ANY PREVIOUS ROUND OR HI34 ≠ -1 FOR THIS ROUND, THEN: ■ IF HI13 ≠ 1 IN ANY PREVIOUS ROUND AND HI35 = -1 FOR THIS ROUND, GO TO HI35. ■ OTHERWISE, GO TO ***BOX HI21A***.

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

OTHNHCOV

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

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

PRVOCOV

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

BOX HI20 MOVED TO FOLLOW HIT11 IN ROUND 36.

HI36 MOVED TO FOLLOW HIT11 IN ROUND 36.

BOX HI21 OMITTED IN ROUND 33.

BOX HI21A	GO TO ***BOX DM1***.

ATTACHMENT HI1

STATE MEDICAID PROGRAMS

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

ATTACHMENT HI1 (continued)

STATE MEDICAID PROGRAMS

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

ATTACHMENT HI2

STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
Alaska "SeniorCare Rx" Pharmaceutical Assistance Program	The Senior Care Senior Information Office 3601 C Street Suite 310	Anchorage, AK 99503-5984	(907) 269-3680 (statewide) (800) 478-6065
CT Pharmaceutical Assistance Contract to the Elderly and the Disabled (ConnPACE)	Connecticut Dept. of Social Services 25 Sigourney Street	Hartford, CT 06106	EDS: (860) 832-9265 In CT: (800) 423-5026
Delaware Prescription Assistance Program (DPAP)	Division of Social Services 1901 N. Dupont Highway P.O. Box 906	New Castle, DE 19720	(302) 255-9500 (800) 372-2022
Delaware Nemours Health Clinic Pharmaceutical Assistance Program	1801 Rockland Rd.	Wilmington, DE 19803	(302) 651-4403 (800) 842-1900
Florida Silver SaveRx Prescription Drug Program	Dept. of Children & Families Silver Saver Program 1317 Winewood Blvd. Bldg. 3, 1st Floor, Ste. 101	Tallahassee, FL 32399-0700	(888) 419-3456 (850) 414-8306
Illinois Pharmaceutical Assistance Program "CircuitBreaker"	Illinois Department on Aging P.O. Box 19021	Springfield, IL 62794-9021	(800) 624-2459
Illinois Rx SeniorCare	Senior Care Illinois Dept. on Aging P.O. Box 19021	Springfield, IL 62794-9021	(800) 624-2459 (800) 252-8966
"HoosierRx" Indiana Prescription Drug Fund	HoosierRx P.O. Box 6224	Indianapolis, IN 46206-6224	(317) 234-1381 (866) 267-4679
Kansas Senior Pharmacy Assistance Program	Kansas Dept. on Aging New England Building 503 S. Kansas Avenue	Topeka, Kansas 66603-3404	(785) 296-4986 (800) 432-3535
Maine Low Cost Drugs for the Elderly Program (LCD)	Bureau of Elder and Adult Services 11 State House Station 442 Civic Center Drive	Augusta, ME 04333	(888) 600-2466 (207) 287-2674
Maryland Pharmacy Assistance Program	Maryland Pharmacy Program P.O. Box 386	Baltimore, MD 21203-0386	(800) 226-2142
Maryland Senior Prescription Drug Program		Baltimore, MD 21203	(410) 767-5394 (800) 226-2142

OMB # 0938-0568
Exp. 3/31/07

ATTACHMENT HI2 (continued)

STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
Massachusetts Prescription Advantage Plan	Executive Office of Elder Affairs One Ashburton Pl., 5th Fl.	Boston, MA 02108	(617) 727-7750 Toll Free: (800) 243-4636
Michigan Elder Prescription Insurance Coverage (EPIC) Program	Dept. of Community Health, Sixth Floor, Lewis Cass Building 320 South Walnut Street	Lansing, MI 48913	(517) 241-3424 Toll Free: (866) 747-5844
Minnesota Prescription Drug Program	Minnesota Department of Human Services 444 Lafayette Rd. North	Saint Paul, MN 55155	(Twin Cities) (651) 296-7675 Outside Twin Cities (800) 657-3739 Senior Linkage Line: (800) 333-2433
Missouri Senior Rx Program	Missouri Senior Rx 205 Jefferson St. Rm. 1310	Jefferson City, MO 65101	(800) 375-1406
Nevada Senior Rx Insurance Subsidy for Prescription Drugs	Dept. of Human Resources 1761 E. College Parkway Bldg. B, Ste. 113	Carson City, NV 89706-7954	(800) 262-7726 In state: (866) 303-6323
New Jersey PAAD - Pharmaceutical Assistance for the Aged and Disabled	PAAD-HAAAD P.O. Box 715	Trenton, NJ 08625-0715	(609) 588-7048 In NJ: (800) 792-9745
New Jersey Senior Gold Prescription Discount Program	Senior Gold Prescription Discount Program P.O. Box 724	Trenton, NJ 08625-0724	(609) 588-7048 In NJ: (800) 792-9745
New York EPIC – Elderly Pharmaceutical Insurance Coverage	EPIC P.O. Box 15018	Albany, NY 12212-5018	(800) 332-3742 In state: (518) 452-6828
North Carolina Senior Care Health Plan	Office of the Governor NC Senior Care Program P.O. Box 10068	Raleigh, NC 27605-5068	(In-state) (866) 226-1388 (919) 733-2040
Pennsylvania PACE – Pharmaceutical Assistance for the Elderly	Commonwealth of PA Dept. of Aging 555 Walnut Street 5th Floor	Harrisburg, PA 17101-1919	(717) 783-1550 In PA: (800) 225-7223
Pennsylvania PACENET – PACE Needs Enhancement Tier	Commonwealth of PA Dept. of Aging 555 Walnut Street 5th Floor	Harrisburg, PA 17101-1919	(717) 652-9028 In PA: (800) 225-7223

ATTACHMENT HI2 (continued)

STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
RIPAE – Rhode Island Pharmaceutical Assistance for the Elderly	R.I. Dept. of Elderly Affairs John O. Pastore Center Benjamin Rush-Bldg. #55 35 Howard Avenue	Cranston, RI 02920	(401) 222-2880
South Carolina Silverx Card – Seniors' Prescription Drug Program	Division of Central Eligibility Processing 1801 Main Street P.O. Box 100101	Columbia, SC 29202-3101	(877) 239-5277 (803) 734-1061
VHAP Pharmacy – Vermont Health Access Program	Office of Vermont Health Access 103 South Main Street	Waterbury, VT 05671-1201	(800) 529-4060 (in state) (800) 250-8427 (out of state)
Vermont VSCRIPT and VSCRIPT Expanded	Vermont Agency of Human Services 103 South Main Street	Waterbury, VT 05671-0201	(800) 529-4060 (in state) (800) 250-8427 (out of state)
Wisconsin SeniorCare Prescription Drug Assistance Program	SeniorCare P.O. Box 6710	Madison, WI 53716-0710	(800) 657-2038
Wyoming Prescription Drug Assistance Program (PDAP)	Dept. of Health 2300 Capitol Avenue Hathaway Bldg, Rm. 147	Cheyenne, WY 82002	(307) 777-7531 (800) 442-2766

ATTACHMENT HI3

STATES THAT DO NOT HAVE MEDICARE HMOs

AK
DE
ME
MS
VT
WY

ATTACHMENT HI4

STATES THAT DO NOT HAVE MEDICAID HMOs
IN WHICH MEDICARE BENEFICIARIES CAN ENROLL

AK
AL
CT
DE
GA
IA
IL
LA
MD
ME
MI
MS
MT
ND
NE
NH
NJ
NV
OK
SC
SD
TN
TX
VT
WA
WV
WY

HI Addendum

Segments: ACCS
HRND
PLAN
PLRO

HIS1: "current as of previous round interview date" includes the following

- MHMODFLG ≠ 1 and PLANDFLG ≠ 1 and PLANHIDE ≠ 1 and LOSEPLFG = -1
- If PLANTYPE = 5:
  (COVANYTM = 1 and COVCURNT = 1) or (COVANYTM = 2)
- If PLANTYPE ≠ 5:
  (COVTIME = 1 or COVNOW = 1)

HIS2, HISCM1, HIS12, HIS20: "current as of previous round interview date" includes the following

- PLANHIDE ≠ 1 and LOSEPLFG = -1
- If PLANTYPE = 5:
  MHMODFLG ≠ 1 and COVANYTM = 1 and COVCURNT = 1
- If PLANTYPE ≠ 5:
  COVTIME = 1 or COVNOW = 1

HISMC3: "stopped" includes the following

- COVANYTM = 1 and COVCURNT = 2

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

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

BOX HISMC1: "current" includes the following

- COVCURNT = 1

BOX HIS4B: "previous" includes the following

- If INTTYPE = 1, 7 : Current round minus 1
- If INTTYPE = 4, 9, 10 : Current round minus 2

BOX MC2: "flag as current" includes the following

- COVANYTM = 1 and COVCURNT = 1

BOX HIMC1, BOX HIMC1D: "Re-started" includes the following

- (No previous round PLRO) or (previous round PLRO and COVCURNT ≠ 1 and PLANHIDE ≠ 1 and LOSEPFLG = -1)

BOX HIMC4, BOX HIMC5: "current" includes the following

- CURRENT ROUND PLRO with COVCURNT = 1 and (PLANDFLG ≠ 1 and PLANHIDE ≠ 1 and LOSEPFLG = -1)

BOX HI1, HI6, BOX HI4, BOX HI7, BOX HI8, BOX HI16A, BOX 17: "current" includes the following

- PLANDFLG ≠ 1 and PLANHIDE ≠ 1 and LOSEPFLG = -1 and (COVTIME = 1 or COVNOW = 1)

HI10a, BOX HI5B, BOX HI5C:

- "was not current at the time of the last interview" includes the following
  - COVTIME ≠ 1 and COVNOW ≠ 1
- "was current at the time of the last interview" includes the following
  - COVTIME = 1 or COVNOW = 1

BOX HIT1, BOX HIT2: "not covered by TRICARE in previous round" includes the following

- No previous round TRICARE PLRO

BOX HIT3:

- EN9 = SPAFEVER
- EN11 = SPNGEVER
- "covered" includes the following
  - TRICARE PLRO exists
  - HIT2 ≠ -1 (COVTIME) and PLANDFLG ≠ 1
- "not covered by TRICARE in previous round" includes the following
  - no previous round TRICARE PLRO

BOX HI5D, HI12, BOX HI9, BOX HI10, BOX HI11A, BOX HI12, BOX HI13A, HI20:

- "current" includes the following
  - PLANDFLG ≠ 1 and PLANHIDE ≠ 1 and LOSEPFLG = -1 and (COVTIME = 1 or COVNOW = 1)
- "not current" includes the following
  - no PLRO or (previous round PLRO and COVTIME ≠ 1 and COVNOW ≠ 1)

BOX HI15, BOX HI16:

- "current in the previous round" includes the following
  - PLANDFLG ≠ 1 and PLANHIDE ≠ 1 and LOSEPFLG = -1 and (COVTIME = 1 or COVNOW = 1)
- "current" in the present round includes the following
  - COVTIME = 1 or COVNOW = 1

HI17, HI34, HI35:

- MHMODFLG ≠ 1 and PLANDFLG ≠ 1 and PLANHIDE ≠ 1 and LOSEPLFG = -1
- If PLANTYPE = 5:
  - (COVANYTM = 1 and COVCURNT = 1) or (COVANYTM = 2)
- If PLANTYPE ≠ 5:
  - COVTIME = 1 or COVNOW = 1

Setting COVANYTM and COVCURNT:

HISMC1:	■ set PLRO.COVANYTM = 1
HISMC2:	■ if HISMC2 = 2, -7, -8, set PLRO.COVCURNT = 2
BOX HISMC1:	■ if no other MHMO is current, set PLRO.COVCURNT = 1
HISMC3:	■ if HISMC3 = 1, set PLRO.COVCURNT = 1 and change previous round current MHMO PLRO.COVCURNT = 2 ■ if HIMC3 = 2, -7, -8, set PLRO.COVCURNT = 2
HIMC1a:	■ set PLRO.COVANYTM = 1 ■ if HIMC1a = 1, set PLRO.COVCURNT = 1 ■ if HIMC1a = 2, -7, -8, set PLRO.COVCURNT = 2
MC1:	■ set PLRO.COVANYTM = 1 [done in home office before fielding] ■ if MC1 = 1, set PLRO.COVCURNT = 1 ■ if MC1 = -7, -8, set PLRO.COVCURNT = 2
MC2:	■ if MC2 = 1, 3, 5, -7, -8, set PLRO.COVCURNT = 2 ■ if MC2 = 2, set PLRO.COVCURNT = 1
MC4:	■ if MC4 = 1, set PLRO.COVCURNT = 1 ■ if MC4 = 2, -7, -8, set PLRO.COVCURNT = 2
MC5:	■ set PLRO.COVANYTM = 1 and PLRO.COVCURNT = 1
MC11:	■ set PLRO.COVANYTM = 1 and PLRO.COVCURNT = 1
HIMC4:	■ if HIMC4 = 1, set PLRO.COVCURNT = 3
HIMC5:	■ set PLRO.COVANYTM = 1 and PLRO.COVCURNT = 1
HIMC17:	■ set PLRO.COVANYTM = 1 and PLRO.COVCURNT = 2