MAIN STUDY - ROUND 1

COMMUNITY COMPONENT

HI. HEALTH INSURANCE

HI1.   People covered by Medicare usually have a card that looks like this. (Do you/Does SP) have such a card?
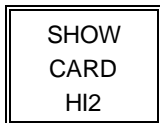
| SHOW CARD HI1 | **MCCARD** | YES .... | 1 | (H14) |
| | | NO .... | 2 | (H12) |

(SP/PROXY) REPORTS THAT (HE/SHE/SP)
IS NOT ELIGIBLE FOR MEDICARE 3 (HI2)
REFUSED... -7 (HI5INTRO)
DON'T KNOW .... -8 (HI2)

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

RRBELIG	YES	1	(H13)
	NO..	2	(HI5INTRO)
	REFUSED	-7	(HI5INTRO)
	DON'T KNOW	-8	(HI5INTRO)

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

SHOW CARD HI2	RRBCARD	YES	1	(H14)
		NO	2	(HI5INTRO)
		REFUSED	-7	(HI5INTRO)
		DON'T KNOW	-8	(HI5INTRO)

HI4.   Ask to see SP's Medicare card OR RRB card to determine the type and date of coverage and verify the number.

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

| **CARDAVAL** | YES .... | 1 | (b) |
| | NO.. | 2 | (INTRO ABOVE HI5) |

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

| **CARDMATC** | YES .... | 1 | (HI5INTRO) |
| | NO.. | 2 | (c) |

1

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

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

d1.   INTERVIEWER: DOES THE NUMBER HAVE HYPHENS? [IS THE SETUP SIMILAR TO THE SOCIAL
            SECURITY NUMBER?] I.E. (000-00-0000)

                             HYPHENS 1   (H14d2:
                             NO HYPHENS 2   DISPLAY
   CARDSET   APPROPRIATE RRB
                                                                      ENTRY FIELD)

d2.   INTERVIEWER:WHAT IS THE NUMBER ON THE CARD?
            PROGRAMMER: DISPLAY APPROPRIATE ENTRY FIELD BASED ON WHETHER HI4c = 1 OR HI4c = 2.

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

                OR

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

e.   INTERVIEWER: WHAT TYPE OF COVERAGE DOES (SP) HAVE?
            PROGRAM: DISALLOW DK OR REFUSED.

            CARDTYPE   HOSPITAL ONLY…………….....…… 1
                                              MEDICAL AND HOSPITAL ..………… 2
                                              MEDICAL ONLY ……………….…… 3

f.   INERVIEWER: WHAT IS THE DATE OF COVERAGE?
            PROMGRAMMER: DISALLOW DK OR REFUSED.

CARDMM   _____/_____/_____
CARDDD   MONTH   DAY   YEAR
CARDYY

   [PLEASE READ THIS INTRODUCTION SLOWLY AND CLEARLY:]

   Medicaid [,also known as (STATE NAME FOR MEDICAID),] 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.

                             [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

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┌─────────────┐
│    SHOW     │
│    CARD     │
│    HI3      │
└─────────────┘
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                                                      YES …………………………..1   (HI6)
                                                      NO …………………………2   (HI11)

HI6.   (Were you/Was SP) covered by Medicaid the whole time between (REF. DATE) and (today/DATE OF DEATH/DATE
          OF INSTITUTIONALIZATION), or only part of the time?

COVTIME   THE WHOLE TIME …………………1   (HI10)
              PART OF THE TIME ………………..2 (HI7)

HI7.   (Are you/Is SP) now covered by Medicaid?

COVNOW   YES …………………………1   BOX HI4
              NO …………………………..2   (HI9)

HI8.   On what date did (your/SP's) (STATE NAME FOR MEDICAID) start during the period of (REF. DATE) to today?

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

HI9.   On what date [since (REF. DATE), did (your/SP's) Medicaid coverage most recently stop?

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

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

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

HI11.   At any time [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], [(have you/has SP) been/was (SP)] covered by any <u>other</u> public program that pays for medical care [for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM), a public program that pays for prescribed medicine]?
     PROGRAM: DISPLAY NAME OF STATE PHARMACEUTICAL ASSISTANCE PROGRAM FOR THOSE STATES THAT HAVE PHARMACEUTICAL ASSISTANCE PROGRAMS.

PUBCOVER   YES ………………………………1   (HI12)
                                 NO ……………………………….2   BOX HI8

HI12.   What is the name of the program that covered (you/SP)?
         PROBE: Any other plans?
         RECORD EACH PLAN ON PLAN ROSTER.
         PLNAME

HI13.   (Were you/Was SP) covered the whole time during that period, or only part of the time?

COVTIME   THE WHOLE TIME ………………………………1   BOX HI9
                 PART OF THE TIME …………………………..2   (HI14)

HI14.   [(Are you/Is SP) now covered by (PROGRAM)?

         COVNOW   YES .... 1 *(HI15)*
                                           NO 2 (HI16)

HI15.   On what date did (your/SP's) (PROGRAM) coverage start during the period of (REF. DATE) and today?

         COVBEGMM   _____/_____/_____
         COVBEGDD   MONTH   DAY   YEAR
         COVBEGYY

HI16.   On what date since (REF. DATE) did (your/SP's) (PROGRAM) coverage most recently stop?

         COVENDMM   _____/_____/_____
         COVENDDD   MONTH   DAY   YEAR
         COVENDYY

I would like to ask about other types of health insurance.

HI17.   At any time [since (REF. DATE), (have you/has SP) been covered by private health insurance (that is, a plan that pays hospital or doctor bills or covers the cost of prescribed medicines)?

         PRVCOVER   YES 1 (HI20)
                                           NO 2 *HI18*

HI18.   [Since (REF. DATE), [(have you/has SP) belonged to a Health Maintenance Organization -- that is, an HMO –or any kind of private prepaid medical plan?

         HMOCOVER   YES 1 (HI20)
                                        NO .... 2 *(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)

HI20.   What is the name of each of the other private plans that provide(d) (your/SP's) medical insurance coverage? Any other plans?
         RECORD EACH PLAN ON PLAN ROSTER.
         PROGRAM: ONLY ALLOW PLANS TO BE ADDED AT THIS SCREEN. IF INTERVIEWER SELECTS A PLAN ALREADY LISTED, DISPLAY: INVALID RESPONNSE. PLANS CAN ONLY BE ADDED AT THIS SCREEN.
         ASK HI21-HI33 FOR EACH PLAN COLLECTED.
         PLNAME

HI21.   (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

HI22.   [(Are you/Is SP) now covered by (PLAN NAME)?]
         COVNOW

HI23.   On what date did (your/SP's) coverage under (PLAN NAME) start during the period of (REF. DATE) to today?
         COVBEGMM   COVBEGDD   COVBEGYY

HI24.   On what date did(your/SP's) coverage under (PLAN NAME) stop?
         COVENDMM   COVENDDD   COVENDYY

HI25.   [CODE WITHOUT ASKING IF VOLUNTEERED.]
         (Is/Was) this an HMO (Health Maintenance Organization)?   **PRVHMO**
         [HMO stands for Health Maintenance Organization, an organization that, for a prepaid fee, provides a full range of health care services.]

HI26.   Who (is/was) listed as the main insured person on the (PLAN NAME) policy or contract?
         DISPLAY PERSON ROSTER. RECORD OR SELECTPERENTER ONLY ONE PERSON.]

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

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

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

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

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**

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

BOX HI1	CYCLE THROUGH QUESTIONS HI21-HI33 FOR EACH PRIVATE PLAN REPORTED IN HI20. GO TO HI34 IF NOT ASKED PREVIOUSLY. OTHERWISE, GO TO HI35.

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)
                                   DON'T KNOW .... -8   (HI35)

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

         PRVOCOV   YES 1   (HI20)
                                   NO 2   ***BOX HI20***