MCBS MAIN STUDY - ROUND 46, FALL 2006

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)?]

PLANDFLG

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 _____

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

BOX HIS1b	GO TO HIS1.

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 ADVANTAGE MANAGED CARE PLAN	4	***BOX HIS2***
TRICARE	5	***BOX HIS2***
MEDICARE PART D PLAN	6	***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 – HISMC13a, THEN RETURN TO HIS1. IF HIS3 = 5, ASK HIST1 – HIST7, THEN RETURN TO HIS1. IF HIS3 = 6, ASK HIS34 – HIS37, THEN RETURN TO HIS1.

HISMC1. What is the name of the Medicare Advantage 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 WAS CURRENT IN THE PREVIOUS ROUND, GO TO HISMC4. OTHERWISE, GO TO HISMC3.

HISMC3. I recorded previously that (CURRENT MEDICARE MANAGED CARE PLAN NAME) was (your/SP's) current Medicare Advantage 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 GO TO HISMC3a. OTHERWISE, GO TO HISMC4.

HISMC3a. [STOPHMO] What is the most important reason (you/SP) stopped the (MEDICARE MANAGED CARE PLAN NAME) coverage?

YDISNROL
YDISNROS

TOO EXPENSIVE OR COULDN'T AFFORD	1	(HIS1)
SP DISSATISFIED WITH QUALITY OF CARE	2	(HIS1)
TO GET Rx COVERAGE IN ANOTHER PLAN	3	(HIS1)
TO GET BENEFIT COVERAGE OTHER THAN Rx	4	(HIS1)
PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE	5	(HIS1)
PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN	6	(HIS1)
DOCTOR LEFT PLAN/DIED/RETIRED	7	(HIS1)
DIFFICULTIES GETTING APPTS OR SEEING PARTICULAR PROVIDERS	8	(HIS1)
SP MOVED OUT OF PLAN AREA	9	(HIS1)
SP DIDN'T LIKE CHOICE OF DOCTORS	10	(HIS1)
SP WANTED CHOICE OF DOCTORS	11	(HIS1)
OTHER (SPECIFY) _____	91	(HIS1)
REFUSED	-7	(HIS1)
DON'T KNOW	-8	(HIS1)

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
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HISMC3 OMITTED IN ROUND 45.

HISMC4a – HISMC4l OMITTED IN ROUND 45.

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 2006 was $119 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 Medicare-covered 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	(HISMC13a)
REFUSED	-7	(HISMC13a)
DON'T KNOW	-8	(HISMC13a)

HISMC10. Not including the cost of (your/SP's) Medicare Part B premium, what was the additional amount that [you/(SP)] paid for (your/his/her) (HISMC1 PLAN NAME) coverage? [Please do not include any copayments or any amount that may be paid for 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	(HISMC13a)
	REFUSED	-7	(HISMC13a)
	DON'T KNOW	-8	(HISMC13a)

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 OMITTED IN ROUND 46.

HISMC13a. What is the most important reason (you/SP) decided to become a member of (HISMC1 PLAN NAME)?

SHOW CARD HIMC2A

MHMOREAS
MHMOREOS

LOWER COST	1
TO GET Rx COVERAGE	2
TO GET BENEFIT COVERAGE OTHER THAN Rx	3
DOCTOR IS MEMBER OF THIS PLAN	4
SP'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	5
SPOUSE'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	6
PREVIOUS PLAN NAME CHANGED OR WAS BOUGHT BY/MERGED WITH CURRENT PLAN	7
BETTER SELECTION OF PROVIDERS OR QUALITY OF CARE	8
RECOMMENDATION OR REPUTATION	9
SP WANTED CHOICE OF DOCTORS	10
OTHER (SPECIFY) _____	91
REFUSED	-7
DON'T KNOW	-8

HISMC14 OMITTED IN ROUND 44.

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
COVBEGDD
COVBEGYY

_____/_____/_____ (HIS10a)
MM DD YY

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

COVENDMM
COVENDDD
COVENDYY

_____/_____/_____ (HIS10a)
MM DD YY

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	***BOX HIS2C***
REFUSED	-7	***BOX HIS2C***
DON'T KNOW	-8	***BOX HIS2C***

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

BOX HIS2C	IF A MEDICARE PART D (MPDP) PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HIS1. OTHERWISE, GO TO HIS10b1.

HIS10b1. Starting in 2006, some people who receive Medicaid benefits are also enrolled in a Medicare Prescription Drug plan, or Medicare Part D plan, that pays for some or all of their prescribed medicines. The Medicare program automatically enrolls such beneficiaries into a Prescription Drug plan, although the beneficiary may choose to switch to a different plan.

Between January 1, 2006 and (PREVIOUS ROUND INTERVIEW DATE), (were you/was SP/had SP been) enrolled in a Medicare Prescription Drug plan that covered medicines prescribed by a doctor?

MPDCOVER

YES	1	(HIS34)
NO	2	(HIS10c)
REFUSED	-7	(HIS10c)
DON'T KNOW	-8	(HIS10c)

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

BOX HIS2A OMITTED IN ROUND 45.

HIS10c1 – HIS10c11 OMITTED IN ROUND 44.

HIS10c12 OMITTED IN ROUND 45.

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 <u>you</u>/<u>SP</u>) personally had, not what the plan offers everyone.]

TRIRXCOV

YES	1	(HIST3aa)
NO	2	(HIST4)
REFUSED	-7	(HIST4)
DON'T KNOW	-8	(HIST4)

HIST3aa. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), where did (you/SP) usually obtain (your/his/her) medicines? Did (you/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 HIST1 OMITTED IN ROUND 45.

HIST3a – HIST3k OMITTED IN ROUND 44.

HIST3l OMITTED IN ROUND 45.

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 2006 was $119 per day.]

TRINHCOV

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

HIST8 OMITTED IN ROUND 44.

HIST9 OMITTED IN ROUND 44.

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

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

COVENDMM _____/_____/_____
COVENDDD MM DD YY
COVENDYY

HIS16a. 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
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HIS2B OMITTED IN ROUND 45.

HIS16a1 – HIS16a12 OMITTED IN ROUND 45.

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

BOX HIS3A	GO TO HIS21 FOR FIRST/ONLY PLAN ENTERED AT HIS20.

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) or PPO (Preferred Provider Organization)?
[EXPLAIN IF NECESSARY: Managed care plans generally provide a full range of health care services for a prepaid fee. Health care is generally provided by primary care doctors, specialists, or hospitals on the plan's list (network) except in an emergency.]

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

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

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 2006, Medicare beneficiaries are responsible for a $952 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
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HIS3AB OMITTED IN ROUND 45.

HIS30a1 – HIS30a12 OMITTED IN ROUND 45.

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 / **MIPPUNIT**		
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	
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.

HIS34. What is the name of the Medicare Prescription Drug plan that covered (you/SP)?
[ENTER ONLY ONE PLAN.]
PLNAME

HIS35. (Were you/Was SP) covered by or enrolled in (HIS34 PLAN NAME) on (PREVIOUS ROUND INTERVIEW DATE)?

TEMP	YES	1	***BOX HIS5***
	NO	2	***BOX HIS6***
	REFUSED	-7	***BOX HIS6***
	DON'T KNOW	-8	***BOX HIS6***

BOX HIS5	IF NO OTHER MEDICARE PRESCRIPTION DRUG PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HIS1. OTHERWISE, GO TO HIS36.

HIS36. I recorded previously that (CURRENT MEDICARE PRESCRIPTION DRUG PLAN NAME) was (your/SP's) current Medicare Prescription Drug Plan on (PREVIOUS ROUND INTERVIEW DATE). Has this information changed?

TEMP

YES	1	***BOX HIS6***
NO	2	***BOX HIS6***
REFUSED	-7	***BOX HIS6***
DON'T KNOW	-8	***BOX HIS6***

BOX HIS6	IF HIS35 OR HIS36 = 2, THEN MARK PLAN ADDED/SELECTED AT HIS34 AS "STOPPED" AND GO TO HIS37. IF HIS35 OR HIS36 = -7 OR -8, THEN MARK PLAN ADDED/SELECTED AT HIS34 AS "STOPPED" AND GO TO HIS1.

HIS37. What is the most important reason (you/SP) stopped the (MEDICARE PRESCRIPTION DRUG PLAN NAME) coverage?

PDPYSTOP
PDPYSTOS

TOO EXPENSIVE OR COULDN'T AFFORD	1	(HIS1)
SP DISSATISFIED WITH PLAN'S COVERAGE	2	(HIS1)
TO GET Rx COVERAGE IN ANOTHER PLAN	3	(HIS1)
TO GET DIFFERENT HEALTH CARE COVERAGE	4	(HIS1)
PLAN NO LONGER CONTRACTS FOR MEDICARE Rx COVERAGE	5	(HIS1)
PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN	6	(HIS1)
SP MOVED OUT OF PLAN AREA	7	(HIS1)
OTHER (SPECIFY) _____	91	(HIS1)
REFUSED	-7	(HIS1)
DON'T KNOW	-8	(HIS1)

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 ADVANTAGE 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	(HIMC6)
NO	2	(HIMC1b1)
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	(HIMC1c)

HIMC1b OMITTED IN ROUND 44.

HIMC1b1. [STOPHMO] What is the most important reason (you/SP) stopped the (MEDICARE MANAGED CARE PLAN NAME) coverage?

YDISNROL
YDISNROS

TOO EXPENSIVE OR COULDN'T AFFORD	1	(HIMC1c)
SP DISSATISFIED WITH QUALITY OF CARE	2	(HIMC1c)
TO GET Rx COVERAGE IN ANOTHER PLAN	3	(HIMC1c)
TO GET BENEFIT COVERAGE OTHER THAN Rx	4	(HIMC1c)
PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE	5	(HIMC1c)
PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN	6	(HIMC3)
DOCTOR LEFT PLAN/DIED/RETIRED	7	(HIMC1c)
DIFFICULTIES GETTING APPTS OR SEEING PARTICULAR PROVIDERS	8	(HIMC1c)
SP MOVED OUT OF PLAN AREA	9	(HIMC1c)
SP DIDN'T LIKE CHOICE OF DOCTORS	10	(HIMC1c)
SP WANTED CHOICE OF DOCTORS	11	(HIMC1c)
OTHER (SPECIFY) _____	91	(HIMC1c)
REFUSED	-7	(HIMC1c)
DON'T KNOW	-8	(HIMC1c)

BOX HIS4C OMITTED IN ROUND 44.

HIMC1c. [Since (REF. DATE)/Between (REF. DATE) and (DATE OF DEATH/INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Advantage 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 Medicare Advantage plans, such as HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations), to receive their Medicare-covered health care. According to Medicare records, (you are/SP is) currently enrolled in a Medicare Advantage 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 ADVANTAGE PLAN	1	(MC2b)
SP HAS PLAN CALLED (CMS MEDICARE MANAGED CARE PLAN NAME), R DOESN'T THINK IT'S A MEDICARE ADVANTAGE PLAN	2	(MC3)
SP NOW DISENROLLED FROM (CMS MEDICARE MANAGED CARE PLAN NAME), NO LONGER IN ANY MEDICARE ADVANTAGE PLAN	3	(MC2b)
SP ENROLLED IN MEDICARE ADVANTAGE 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 OMITTED IN ROUND 44.

MC2b. [STOPHMO] What is the most important reason (you/SP) stopped the (CMS MEDICARE MANAGED CARE PLAN NAME) coverage?

YDISNROL
YDISNROS

TOO EXPENSIVE OR COULDN'T AFFORD	1
SP DISSATISFIED WITH QUALITY OF CARE	2
TO GET Rx COVERAGE IN ANOTHER PLAN	3
TO GET BENEFIT COVERAGE OTHER THAN Rx	4
PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE	5
PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN	6
DOCTOR LEFT PLAN/DIED/RETIRED	7
DIFFICULTIES GETTING APPTS OR SEEING PARTICULAR PROVIDERS	8
SP MOVED OUT OF PLAN AREA	9
SP DIDN'T LIKE CHOICE OF DOCTORS	10
SP WANTED CHOICE OF DOCTORS	11
OTHER (SPECIFY) _____	91
REFUSED	-7
DON'T KNOW	-8

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

MC3. In many Medicare Advantage plans, such as HMOs or PPOs, 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 Advantage 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 Medicare Advantage plans, such as HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations), to receive their Medicare-covered health care.
(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/had SP) been enrolled in or covered by (one of these/any) Medicare Advantage 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 Advantage 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 Advantage 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 Advantage plan that (currently covers/covered) (you/SP) (on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]
[ENTER ONLY ONE PLAN.]
PLNAME

BOX HIMC1 OMITTED IN ROUND 44.

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/had), not what the plan offers everyone.]

MHMORX

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

BOX HIMC1CC1 OMITTED IN ROUND 44.

BOX HIMC1CC2	IF CURRENT MEDICARE MANAGED CARE PLAN IS SAME PLAN AS PREVIOUS ROUND MEDICARE MANAGED CARE PLAN (HIMC1a = 1), GO TO ***BOX HIMC2***. OTHERWISE, GO TO HIMC7.

HIMC6a OMITTED IN ROUND 39.

HIMC6b – HIMC6m OMITTED IN ROUND 44.

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 2006, the first 20 days are paid in full and the next 80 days require a copayment of $119.00 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/was) 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)/(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 Medicare-covered 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/was) the additional amount that [you pay/(SP) pays/SP paid] for (your/his/her) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage? [Please do not include any copayments or any amount that may (be/have been) paid for anyone other than (you/SP).]

AMOUNT $ _____._____ PER ( )

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

MHMOAMT	PER YEAR	1
MHMOUNIT	QUARTERLY/EVERY 3 MONTHS	2
MHMOUNOS	BIMONTHLY/EVERY 2 MONTHS	3
	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/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) (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/paid) 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 HIMC14a 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 HIMC14a. OTHERWISE, GO TO ***BOX HIMC2***.

HIMC14 OMITTED IN ROUND 44.

HIMC14a. What is the most important reason (you/SP) decided to become a member of (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

SHOW CARD HIMC2A

MHMOREAS
MHMOREOS

LOWER COST	1
TO GET Rx COVERAGE	2
TO GET BENEFIT COVERAGE OTHER THAN Rx	3
DOCTOR IS MEMBER OF THIS PLAN	4
SP'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	5
SPOUSE'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	6
PREVIOUS PLAN NAME CHANGED OR WAS BOUGHT BY/MERGED WITH CURRENT PLAN	7
BETTER SELECTION OF PROVIDERS OR QUALITY OF CARE	8
RECOMMENDATION OR REPUTATION	9
SP WANTED CHOICE OF DOCTORS	10
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 Advantage 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 Advantage 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 HIMC18a.

HIMC18 OMITTED IN ROUND 44.

HIMC18a. What is the most important reason (you/SP) stopped the (MEDICARE MANAGED CARE PLAN NAME) [STOPHMO] coverage?

YDISNROL
YDISNROS

TOO EXPENSIVE OR COULDN'T AFFORD	1
SP DISSATISFIED WITH QUALITY OF CARE	2
TO GET Rx COVERAGE IN ANOTHER PLAN	3
TO GET BENEFIT COVERAGE OTHER THAN Rx	4
PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE	5
PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN	6
DOCTOR LEFT PLAN/DIED/RETIRED	7
DIFFICULTIES GETTING APPTS OR SEEING PARTICULAR PROVIDERS	8
SP MOVED OUT OF PLAN AREA	9
SP DIDN'T LIKE CHOICE OF DOCTORS	10
SP WANTED CHOICE OF DOCTORS	11
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 SP IS DECEASED OR INSTITUTIONALIZED (INS1 = 2 OR 3), GO TO BOX HIMC5. IF FALL "SUPPLEMENTAL" SAMPLE ROUND AND NO CURRENT MEDICARE MANAGED CARE PLAN AND SP IS ALIVE AND NOT INSTITUTIONALIZED (INS1 = 1 OR -1), 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 HI1AAA OMITTED IN ROUND 44 UPGRADE.

HI5a OMITTED IN ROUND 44 UPGRADE.

HI5b OMITTED IN ROUND 44 UPGRADE.

HI5c OMITTED IN ROUND 44 UPGRADE.

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 MM DD YY
COVBEGYY

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 _____/_____/_____ (HI10a)
COVENDDD MM DD YY
COVENDYY

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 HI5C2***
	DON'T KNOW	-8	***BOX HI5C2***

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 HI5C2***.

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 HI5C2***.

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 HI5C2***
HAD TO ENROLL	2	***BOX HI5C2***
DOESN'T REMEMBER	3	***BOX HI5C2***
REFUSED	-7	***BOX HI5C2***

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 HI5C1 OMITTED IN ROUND 45.

BOX HI5C2	IF COMING FROM ST/NS/CPS/CT, AND THERE IS A CURRENT MEDICARE PRESCRIPTION DRUG PLAN, RETURN TO ST/NS/CPS/CT. IF NOT COMING FROM ST/NS/CPS/CT AND A MEDICARE PART D (MPDP) PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO ***BOX HIT1***. OTHERWISE, GO TO HI10c1.

HI10c1. (Starting in 2006, some people who receive Medicaid benefits are also enrolled in a Medicare Prescription Drug plan, or Medicare Part D plan, that pays for some or all of their prescribed medicines. The Medicare program automatically enrolls such beneficiaries into a Medicare Prescription Drug plan, although the beneficiary may choose to switch to a different prescription plan.)

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)] enrolled in a Medicare Prescription Drug plan that (covers/covered) medicines prescribed by a doctor?

MPDCOVER

YES	1	(HI10c2)
NO	2	(HI10d)
REFUSED	-7	(HI10d)
DON'T KNOW	-8	(HI10d)

HI10c2. (Are you/Is SP/Was SP) (currently) covered by or enrolled in a Medicare Prescription Drug plan [on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]?

PDPCURR

YES	1	(HI10c3)
NO	2	(HI10c5)
REFUSED	-7	(HI10c5)
DON'T KNOW	-8	(HI10c5)

HI10c3. [What is the name of the Medicare Prescription Drug plan that (currently covers/covered) (you/SP) (on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]
[ENTER ONLY ONE PLAN.]

PLNAME

HI10c4. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/ INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Prescription Drug plans besides (CURRENT MEDICARE PRESCRIPTION DRUG PLAN)?

[PROBE IF NECESSARY: Please include Medicare Prescription Drug plans (you were/SP was) automatically enrolled in through Medicaid as well as any (you/he/she) enrolled in on (your/his/her) own.]

PDPMORE

YES	1	(HI10c5)
NO	2	***BOX HIT1***
REFUSED	-7	***BOX HIT1***
DON'T KNOW	-8	***BOX HIT1***

HI10c5. Please tell me the names of (the other/all) Medicare Prescription Drug plans that (you have/he has/she has) been enrolled in since (REF. DATE) [besides (CURRENT MEDICARE PRESCRIPTION DRUG PLAN)].

[PROBE IF NECESSARY: Please include Medicare Prescription Drug plans (you were/SP was) automatically enrolled in through Medicaid as well as any (you/he/she) enrolled in on (your/his/her) own.]

[ENTER ALL PLAN NAMES.]

PLNAME

GO TO ***BOX HIT1***

BOX HI5D OMITTED IN ROUND 44.

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

MCDRXCOV

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

BOX HI5E OMITTED IN ROUND 44.

HI10d1 OMITTED IN ROUND 39.

HI10d2 – HI10d12 OMITTED IN ROUND 43.

HI10d13 OMITTED IN ROUND 44.

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	(HIT4)
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
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HIT2 OMITTED IN ROUND 44.

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	***BOX HIT2C***
REFUSED	-7	***BOX HIT2C***
DON'T KNOW	-8	***BOX HIT2C***

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 OMITTED IN ROUND 44.

HIT4a OMITTED IN ROUND 39.

HIT4b – HIT4l OMITTED IN ROUND 43.

HIT4m OMITTED IN ROUND 44.

BOX HIT2B OMITTED IN ROUND 39.

BOX HIT2C

IF SP NOT COVERED BY TRICARE IN THE PREVIOUS ROUND, GO TO HIT5.
IF TRICARE WAS NOT CURRENT (HIT3 = 2, -7, OR -8) IN THE PREVIOUS ROUND, GO TO HIT5.
OTHERWISE, GO TO ***BOX HIT3***.

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 2006, the first 20 days are paid in full and the next 80 days require a copayment of $119.00 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), OR ■ PREVIOUS ROUND WAS FACILITY INTERVIEW (INTERVIEW TYPE = 5, 6), OR ■ HI36 = 2, -7, -8, OR -9 IN PREVIOUS ROUND, GO TO HI36. 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 HI12A***
REFUSED	-7	***BOX HI12A***
DON'T KNOW	-8	***BOX HI12A***

BOX HI8 OMITTED IN ROUND 44.

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	(HI16a)
PART OF THE TIME	2	(HI14)
REFUSED	-7	(HI14)
DON'T KNOW	-8	(HI14)

BOX HI9 OMITTED IN ROUND 44.

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 HI10A***
NO	2	(HI16)
REFUSED	-7	***BOX HI10A***
DON'T KNOW	-8	***BOX HI10A***

BOX HI10 OMITTED IN ROUND 44.

BOX HI10A	IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND AND HI14 = 1, GO TO HI15. OTHERWISE, GO TO HI16a.

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 OMITTED IN ROUND 44.

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

PUBRXCOV

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

BOX HI11B OMITTED IN ROUND 44.

HI16a1 OMITTED IN ROUND 39.

HI16a2 – HI16a13 OMITTED IN ROUND 44.

BOX HI12 OMITTED IN ROUND 44.

BOX HI12A	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 MEDICARE PART D (MPDP) PLAN CURRENT IN THE PREVIOUS ROUND, GO TO HI16ab. AND IF SP REPORTED HAVING A MEDICARE PART D (MPDP) PLAN IN THE CURRENT ROUND MEDICAID SERIES OR REFUSED OR DON'T KNOW (HI10c1 = 1, -7, -8) AND IF PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI21. AND IF SP REPORTED HAVING A MEDICARE PART D (MPDP) PLAN IN THE CURRENT ROUND MEDICAID SERIES OR REFUSED OR DON'T KNOW (HI10c1 = 1, -7, -8) AND IF NO CURRENT PRIVATE PLAN IN THE PREVIOUS ROUND, GO TO HI17. AND IF SP HAS CURRENT MEDICARE HMO RX COVERAGE (HIMC6 = 1 FOR CURRENT MEDICARE MANAGED CARE PLAN) 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. AND MEDICAID IS CURRENT THIS ROUND AND THE SP REPORTED NOT HAVING A MEDICARE PART D (MPDP) PLAN IN THE CURRENT ROUND MEDICAID SERIES (HI10c1 = 2), GO TO HI16b1. AND IF SP DOES NOT HAVE CURRENT MEDICARE HMO RX COVERAGE (HIMC6 ≠ 1 FOR CURRENT MEDICARE MANAGED CARE PLAN), GO TO HI16b.

MEDICARE PRESCRIPTION DRUG PLAN = XXXXXXX

HI16ab. At the time of the last interview (you were/SP was) covered by (MEDICARE PRESCRIPTION DRUG PLAN NAME).
[(Are you/Is SP) now covered by (MEDICARE PRESCRIPTION DRUG PLAN NAME)?] [Was (SP) covered by (MEDICARE PRESCRIPTION DRUG PLAN NAME) on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]

PDPSAME

YES	1	***BOX HI12D***
NO	2	(HI16ac)
REFUSED	-7	***BOX HI12D***
DON'T KNOW	-8	(HI16ad)

HI16ac. What is the most important reason (you/SP) stopped the (MEDICARE PRESCRIPTION DRUG PLAN NAME) coverage?

PDPYSTOP	TOO EXPENSIVE OR COULDN'T AFFORD	1	(HI16ad)
PDPYSTOS	SP DISSATISFIED WITH PLAN'S COVERAGE	2	(HI16ad)
	TO GET RX COVERAGE IN ANOTHER PLAN	3	(HI16ad)
	TO GET DIFFERENT HEALTH CARE COVERAGE	4	(HI16ad)
	PLAN NO LONGER CONTRACTS FOR MEDICARE RX COVERAGE	5	(HI16ad)
	PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN	6	(HI16c)
	SP MOVED OUT OF PLAN AREA	7	(HI16ad)
	OTHER (SPECIFY) _____	91	(HI16ad)
	REFUSED	-7	(HI16ad)
	DON'T KNOW	-8	(HI16ad)

HI16ad. [Since (REF. DATE)/Between (REF. DATE) and (DATE OF DEATH/INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Prescription Drug plans besides (MEDICARE PRESCRIPTION DRUG PLAN CURRENT LAST ROUND)?

PDPOTHER	YES	1	(HI16c)
	NO	2	***BOX HI12D***
	REFUSED	-7	***BOX HI12D***
	DON'T KNOW	-8	***BOX HI12D***

BOX HI12B OMITTED IN ROUND 45.

HI16b. (Starting in 2006, Medicare beneficiaries can receive insurance coverage for prescription drugs through Medicare Prescription Drug plans. These plans are also called "Medicare Part D" plans.)

At any time since (REF. DATE), (have you/has SP/had SP) been enrolled in a Medicare Prescription Drug plan that (covers/covered) medicines prescribed by a doctor?

PDPCOVER	YES	1	(HI16c)
	NO	2	***BOX HI12D***
	REFUSED	-7	***BOX HI12D***
	DON'T KNOW	-8	***BOX HI12D***

HI16b1. You mentioned that (you have/SP has/SP had) not been enrolled in a Medicare Prescription Drug plan associated with (your/his/her) Medicaid coverage.

At any time since (REF. DATE), (have you/has SP/had SP) been enrolled in a Medicare Prescription Drug plan in any way other than through Medicaid?

PDPCOVER	YES	1	(HI16c)
	NO	2	***BOX HI12D***
	REFUSED	-7	***BOX HI12D***
	DON'T KNOW	-8	***BOX HI12D***

HI16c. (Are you/Is SP/Was SP) (currently) covered by or enrolled in a Medicare Prescription Drug plan [on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]?

PDPCURR

YES	1	(HI16e)
NO	2	(HI16g)
REFUSED	-7	(HI16g)
DON'T KNOW	-8	(HI16g)

HI16d. I recorded previously that (CURRENT MEDICARE PRESCRIPTION DRUG PLAN) was (your/SP's) current Medicare Prescription Drug plan. Has this information changed?

PDPCHNG

YES	1	(HI16e)
NO	2	(ST/NS/CT/CPS)
REFUSED	-7	(ST/NS/CT/CPS)
DON'T KNOW	-8	(ST/NS/CT/CPS)

HI16e. [What is the name of the Medicare Prescription Drug plan that (currently covers/covered) (you/SP) (on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]
[ENTER ONLY ONE PLAN.]

PLNAME

BOX HI12C	IF COMING FROM ST/NS/CPS/CT, RETURN TO ST/NS/CPS/CT. OTHERWISE, GO TO HI16f.

HI16f. [Since (REF. DATE)/Between (REF. DATE) and (DATE OF DEATH/ INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Prescription Drug plans besides (CURRENT MEDICARE PRESCRIPTION DRUG PLAN)?

PDPMORE

YES	1	(HI16g)
NO	2	***BOX HI12D***
REFUSED	-7	***BOX HI12D***
DON'T KNOW	-8	***BOX HI12D***

HI16g. [Besides (MEDICARE PRESCRIPTION DRUG PLAN), what)] (What) (other) Medicare Prescription Drug plans covered (your/SP's) medicines since (REF. DATE)?

[ENTER ALL PLAN NAMES.]

PLNAME

BOX HI12D	IF COMING FROM ST/NS/CPS/CT, RETURN TO ST/NS/CPS/CT. 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)?

By "private," I mean a supplemental or Medigap plan, or a plan that is provided by a former or current employer. 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 HI15A***
PART OF THE TIME	2	(HI22)
REFUSED	-7	(HI22)
DON'T KNOW	-8	(HI22)

BOX HI14A OMITTED IN ROUND 5.

BOX HI15 OMITTED IN ROUND 44.

BOX HI15A	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. IF THIS PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI31a. 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 HI16AAA***
NO	2	(HI24)
REFUSED	-7	***BOX HI16AAA***
DON'T KNOW	-8	***BOX HI16AAA***

BOX HI16 OMITTED IN ROUND 44.

BOX HI16AAA	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. IF THIS PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO HI31a. 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	(HI22d)
	(MIP'S) FORMER EMPLOYER	3	(HI22d)
	(MIP'S) UNION	4	(HI22d)
	(MIP'S) FAMILY BUSINESS	5	(HI22b1)
	AARP	6	(HI22b1)
	DECEASED SPOUSE'S EMPLOYER	7	(HI22d)
	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	(HI22d)
	REFUSED	-7	(HI22d)
	DON'T KNOW	-8	(HI22d)

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

PLANLETR PLAN LETTER _____

BOX HI16AA OMITTED IN ROUND 46.

HI22C OMITTED IN ROUND 46.

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

PRVNMCOV NUMBER COVERED _____

HI22d1 OMITTED IN ROUND 44.

HI22d2 OMITTED IN ROUND 44.

HI22e OMITTED IN ROUND 44.

BOX HI16AA1 OMITTED IN ROUND 44.

HI22e1a OMITTED IN ROUND 39.

HI22e1b – HI22e1m OMITTED IN ROUND 44.

BOX HI16A1 OMITTED IN ROUND 44.

HI22e1 – HI22e3 OMITTED IN ROUND 44.

HI22f OMITTED IN ROUND 44.

HI22f1. Supplemental insurance plans may cover a variety of services or may be specific to only certain services, such as prescribed medicines or dental coverage. I'd like to know what (your/SP's) (PLAN NAME) coverage (includes/ included).

	(Does/Did) (your/MIP's) (PLAN NAME) cover…	YES	NO
PRVRXCOV	a. prescribed medicines?	1	2
PRVMSCOV	b. doctor visits or lab work?	1	2
PRVIPCOV	c. inpatient hospital care?	1	2
PRVNHCOV	d. nursing home or long term care?	1	2
MHMODENT	e. dental care?	1	2
MHMOEYE	f. optical services?	1	2
MHMOPCAR	g. preventive care such as routine annual physicals?	1	2

BOX HI16A1A	IF HI22f1a=2 AND THIS PRIVATE PLAN WAS CURRENT IN PREVIOUS ROUND AND THIS PRIVATE PLAN HAD RX COVERAGE (HI22f1a=1 or HI31a=1), GO TO HI22f2. OTHERWISE, GO TO HI22g.

HI22f2. What is the most important reason (you/SP) (do/did) not have prescribed medicine coverage through (PLAN NAME)?

YNORXCOV	THIS IS A SPECIALIZED PLAN (DENTAL ONLY, VISION ONLY, ETC.)	1
	Rx COVERAGE NOT OFFERED BY PLAN	2
	TOO EXPENSIVE/CAN'T AFFORD Rx COVERAGE	3
	HAVE Rx COVERAGE WITH ANOTHER PLAN	4
YNORXCOS	OTHER (SPECIFY) _____	91
	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. OTHERWISE, 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**

_____/_____/_____
MM DD YY

HI23a. What is the most important reason (you/SP) decided to get coverage through (PLAN NAME)?

SHOW CARD HIMC2A

YSTRTCOV **YSTRTCOS**

LOWER COST	1	(HI25)
TO GET Rx COVERAGE	2	(HI25)
TO GET BENEFIT COVERAGE OTHER THAN Rx	3	(HI25)
DOCTOR IS MEMBER OF THIS PLAN	4	(HI25)
SP'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	5	(HI25)
SPOUSE'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	6	(HI25)
PREVIOUS PLAN NAME CHANGED OR WAS BOUGHT BY/MERGED WITH CURRENT PLAN	7	(HI25)
BETTER SELECTION OF PROVIDERS OR QUALITY OF CARE	8	(HI25)
RECOMMENDATION OR REPUTATION	9	(HI25)
SP WANTED CHOICE OF DOCTORS	10	(HI25)
OTHER (SPECIFY) _____	91	(HI25)
REFUSED	-7	(HI25)
DON'T KNOW	-8	(HI25)

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

HI24a. What is the most important reason (you/SP) stopped the coverage through (PLAN NAME)?

YSTOPCOV
YSTOPCOS

TOO EXPENSIVE OR COULDN'T AFFORD	1
SP DISSATISFIED WITH QUALITY OF CARE	2
TO GET Rx COVERAGE IN ANOTHER PLAN	3
TO GET BENEFIT COVERAGE OTHER THAN Rx	4
PLAN WENT OUT OF BUSINESS/DISCONTINUED COVERAGE	5
PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN	6
DOCTOR LEFT PLAN/DIED/RETIRED	7
DIFFICULTIES GETTING APPTS OR SEEING PARTICULAR PROVIDERS	8
SP MOVED OUT OF PLAN AREA	9
SP DIDN'T LIKE CHOICE OF DOCTORS	10
SP WANTED CHOICE OF DOCTORS	11
OTHER (SPECIFY) _____	91
REFUSED	-7
DON'T KNOW	-8

BOX HI17	IF HI24a 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 HI24a 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) or PPO (Preferred Provider Organization)?
[EXPLAIN IF NECESSARY: Managed care plans generally provide a full range of health care services for a prepaid fee. Health care is generally provided by primary care doctors, specialists, or hospitals on the plan's list (network) except in an emergency.]

PRVHMO
PLHMOERR
PPRVHMO

YES	1
NO	2
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	(HI29)
	(MIP'S) FORMER EMPLOYER	3	(HI29)
	(MIP'S) UNION	4	(HI29)
	(MIP'S) FAMILY BUSINESS	5	(HI27a)
	AARP	6	(HI27a)
	DECEASED SPOUSE'S EMPLOYER	7	(HI29)
	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	(HI29)
	REFUSED	-7	(HI29)
	DON'T KNOW	-8	(HI29)

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

PLANLETR PLAN LETTER _____

BOX HI17AA OMITTED IN ROUND 46.

HI28 OMITTED IN ROUND 46.

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

PRVNMCOV NUMBER COVERED _____

HI29a OMITTED IN ROUND 44.

HI29b OMITTED IN ROUND 44.

HI30 OMITTED IN ROUND 44.

BOX HI17AA1 OMITTED IN ROUND 44.

HI30a2 – HI30a13 OMITTED IN ROUND 44.

BOX HI17A OMITTED IN ROUND 44.

HI30a – HI30c OMITTED IN ROUND 44.

HI31 OMITTED IN ROUND 44.

HI31a. Supplemental insurance plans may cover a variety of services or may be specific to only certain services, such as prescribed medicines or dental coverage. I'd like to know what (your/SP's) (PLAN NAME) coverage (includes/included).

	(Does/Did) (your/MIP's) (PLAN NAME) cover…	YES	NO
PRVRXCOV	a. prescribed medicines?	1	2

BOX HI17AB	IF THIS PRIVATE PLAN WAS CURRENT IN PREVIOUS ROUND, GO TO ***BOX HI17AC***. OTHERWISE, GO TO HI31a(b).

PRVMSCOV	b. doctor visits or lab work?	1	2
PRVIPCOV	c. inpatient hospital care?	1	2
PRVNHCOV	d. nursing home or long term care?	1	2
MHMODENT	e. dental care?	1	2
MHMOEYE	f. optical services?	1	2
MHMOPCAR	g. preventive care such as routine annual physicals?	1	2

BOX HI17AC	IF HI31a(a) = 2 AND THIS PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND AND THIS PRIVATE PLAN HAD RX COVERAGE (HI22f1a=1 or HI31a=1), GO TO HI31b. IF HI31a(a) ≠ 2 AND THIS PRIVATE PLAN WAS CURRENT IN THE PREVIOUS ROUND, GO TO ***BOX HI16A***. OTHERWISE, GO TO HI32.

HI31b. What is the most important reason (you/SP) (do/did) not have prescribed medicine coverage through (PLAN NAME)?

YNORXCOV	THIS IS A SPECIALIZED PLAN (DENTAL ONLY, VISION ONLY, ETC.)	1	***BOX HI16A***
	Rx COVERAGE NOT OFFERED BY PLAN	2	***BOX HI16A***
	TOO EXPENSIVE/CAN'T AFFORD RX COVERAGE	3	***BOX HI16A***
	HAVE Rx COVERAGE WITH ANOTHER PLAN	4	***BOX HI16A***
YNORXCOS	OTHER (SPECIFY) _____	91	***BOX HI16A***
	REFUSED	-7	***BOX HI16A***
	DON'T KNOW	-8	***BOX HI16A***

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)	Arizona Health Care Cost Containment System (AHCCCS)
California (CA)	Medi-Cal
Colorado (CO)	Medicaid
Connecticut (CT)	Connecticut Medical Assistance Program
District of Columbia (DC)	DC Healthy Families Program
Delaware (DE)	Delaware Medical Assistance Program (DMAP)
Florida (FL)	Medicaid
Georgia (GA)	Medicaid
Hawaii (HI)	Hawaii Quest, Medicaid Fee-for-Service
Iowa (IA)	Medicaid
Idaho (ID)	Medicaid
Illinois (IL)	Medical Assistance/Medicaid (AABD)
Indiana (IN)	Medicaid
Kansas (KS)	Medicaid
Kentucky (KY)	KY Health Choices
Louisiana (LA)	Medicaid
Maine (ME)	MaineCare
Massachusetts (MA)	MassHealth
Maryland (MD)	Medical Assistance, HealthChoice
Michigan (MI)	Medicaid
Minnesota (MN)	Minnesota 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)	Nebraska Health Connection
New Hampshire (NH)	Medicaid
New Jersey (NJ)	New Jersey FamilyCare
New Mexico (NM)	Medicaid
Nevada (NV)	Nevada Medicaid
New York (NY)	Partnership Plan; Family Health Plus
Ohio (OH)	Ohio Health Plan
Oklahoma (OK)	SoonerCare
Oregon (OR)	Oregon Health Plan
Pennsylvania (PA)	Medical Assistance (MA) Program
Puerto Rico (PR)	Medicaid
Rhode Island (RI)	Medicaid
South Carolina (SC)	Partners for Health
South Dakota (SD)	South Dakota Medical Assistance
Tennessee (TN)	TennCare
Texas (TX)	Medicaid
Utah (UT)	Medicaid
Vermont (VT)	Medicaid
Virginia (VA)	Virginia Medical Assistance Services
Washington (WA)	Medicaid
Wisconsin (WI)	Medicaid
West Virginia (WV)	Medicaid
Wyoming (WY)	EqualityCare

ATTACHMENT HI2

STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
Alaska "SeniorCare Rx" Pharmaceutical Assistance Program	The SeniorCare Senior Information Office 3601 C Street Suite 310	Anchorage, AK 99503-5984	(907) 269-3680 (statewide) (907) 269-3680 (Anchorage)
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 Drug Assistance Program (DPAP)	EDS DPAP P.O. Box 950	New Castle, DE 19720-9914	(302) 577-4900 (800) 996-9969 ext. 17
Delaware Nemours Health Clinic Pharmaceutical Assistance Program	1801 Rockland Rd.	Wilmington, DE 19803	(302) 651-4405 (800) 292-9538
Illinois Pharmaceutical Assistance Program "CircuitBreaker"	Illinois Department on Aging P.O. Box 19021	Springfield, IL 62794-9021	(In IL): (800) 624-2459 (217) 524-0084
Illinois Rx SeniorCare	Illinois Dept. on Aging P.O. Box 19021	Springfield, IL 62794-9021	(800) 252-8966
"HoosierRx" Indiana Prescription Drug Fund	HoosierRx P.O. Box 6224	Indianapolis, IN 46206-6224	(317) 234-1381 (in Indiana) (866) 267-4679
Maine Low Cost Drugs for the Elderly Program (LCD)	Office of Elder Services 442 Civic Center Drive	Augusta, ME 04333-0011	(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) 492-1974
Massachusetts Prescription Advantage Plan	Prescription Advantage P.O. Box 15153	Worcester, MA 01615-0153	(800) 243-4636 (617) 727-7750
Michigan Elder Prescription Insurance Coverage (EPIC) Program	Dept. of Community Health, Sixth Floor, Lewis Cass Building 320 South Walnut Street	Lansing, MI 48913	(517) 373-2559 Toll Free: (866) 747-5844

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ATTACHMENT HI2 (continued)

STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
Minnesota Prescription Drug Program	Minnesota Department of Human Services 444 Lafayette Rd. North	Saint Paul, MN 55155	(651) 297-5404 Senior Linkage Line: (800) 333-2433
Missouri Senior Rx Program	Missouri Rx Plan 205 Jefferson St. P.O. Box 6500 Rm. 1310	Jefferson City, MO 65101	(866) 556-9316
Nevada Senior Rx Insurance Subsidy for Prescription Drugs	Dept. of Health & Human Services 1761 E. College Parkway Bldg. B, Ste. 113	Carson City, NV 89706-7954	In state: (800) 262-7726
New Jersey PAAD - Pharmaceutical Assistance for the Aged and Disabled	PAAD 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	In state: (800) 332-3742 (518) 452-6828
North Carolina Prescription Drug Assistance Plan	Not Available	Not Available	(800) 662-7030 (919) 715-3338
Pennsylvania PACE – Pharmaceutical Assistance Contract for the Elderly	Commonwealth of PA Dept. of Aging 555 Walnut Street 5th Floor	Harrisburg, PA 17101-1919	(717) 652-9028 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
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

ATTACHMENT HI2 (continued)

STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
(GAPS) Gap Assistance Pharmacy Program for Seniors	Division of Central Eligibility Processing 1801 Main Street P.O. Box 100101	Columbia, SC 29202-3101	(888) 549-0820
VHAP Pharmacy – Vermont Health Access Program	Office of Vermont Health Access 103 South Main Street	Waterbury, VT 05676-1201	In state: (800) 529-4060 Out of state: (800) 250-8427
Vermont VSCRIPT and VSCRIPT Expanded	Vermont Agency of Human Services 103 South Main Street	Waterbury, VT 05676-1201	In state: (800) 529-4060 Out of state: (800) 250-8427
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 401 Hathaway Bldg.	Cheyenne, WY 82002	(307) 777-7531 (800) 442-2766

ATTACHMENT HI3

STATES THAT DO NOT HAVE MEDICARE ADVANTAGE PLANS

IN ROUND 46, ALL STATES HAVE AT LEAST
ONE MEDICARE ADVANTAGE PLAN.

ATTACHMENT HI4

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

AK
AL
AR
CT
DE
GA
HI
IL
KS
LA
MD
ME
MI
MS
ND
NH
NM
NV
OH
OK
PA
RI
SD
VA
VT
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 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: "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

HI12, 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 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
HI10c3:	■ set PLRO.COVANYTM = 1 and PLRO.COVCURNT = 1

HI10c5: ■ set PLRO.COVANYTM = 1 and PLRO.COVCURNT = 2
HI16d: ■ if HI16d = 1, set PLRO.COVCURNT = 3
HI16e: ■ set PLRO.COVANYTM = 1 and PLRO.COVCURNT = 1
HI16g: ■ set PLRO.COVANYTM = 1 and PLRO.COVCURNT = 2