OMB No: 0920-0341; Approval Expires: December 31, 1994

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CASE NO: ____________________________

National Employer Health Insurance Survey

conducted for

The United States Department of Health and Human Services

Self-Employed Questionnaire

NATIONAL EMPLOYER HEALTH INSURANCE SURVEY

SELF-EMPLOYED QUESTIONNAIRE

INTRODUCTION:

A. Hello, may I speak with (NAME)?

[IF (NAME) IS TEMPORARILY UNAVAILABLE, TRY TO FIND OUT WHEN SHE/HE WILL BE AVAILABLE. IF (NAME) WILL NOT BE AVAILABLE TO CONDUCT INTERVIEW, (NAME'S) SPOUSE MAY ACT AS PROXY]

My name is (INTERVIEWER NAME) and I am calling for the United States Department of Health and Human Services regarding a study we are conducting about health insurance. (IF ASKED ABOUT PURPOSE: This study is being conducted to collect information on the availability and cost of health insurance. Results will be used to develop estimates of health care spending at the state level and to evaluate health care reform efforts.)

Recently, the National Center for Health Statistics mailed a letter to (you/NAME). Did you have a chance to read this letter?

YES, RECEIVED AND READ....................................1 (C)
NO, NOT RECEIVED OR READ...............................2

B. **The letter stated that this survey information is collected under the authority of the Public Health Service Act. Information will be held in strict confidence and will be used for statistical purposes only, as required by Section 308 (d) of the Act. No individual person or organization will ever be identified in any statistical summary which is released or published. Your participation is voluntary and there is no penalty for not participating in the survey. It will take about 5-15 minutes to collect the information.**

C. **[INTERVIEWER: WHAT TYPE OF RESPONDENT WILL YOU BE INTERVIEWING?]**

SUBJECT (NAME) 1
SPOUSE AS PROXY 2
OTHER PROXY 3

SECTION A.

A1. As of December 31, 1993, did (you/NAME) work at a job or business, not counting work around the house? Include unpaid work in the family business or farm.

YES 1 (A3)
NO 2

A2. Even though you did not work at that time, did you have a job or business on December 31, 1993?

YES 1
NO .... 2 (END)

A3. As of December 31, 1993, (were you/was NAME) . . .

Self-employed in (your/his/her) own business, professional practice, or farm, ... 1
An employee of a private company, business, or individual for wages, salary or commission, ... 2 (END)
An employee of a Federal, state, or local government, ... 3 (END)
Working without pay in a family business or farm, or .... 4 (END)
Something else? (SPECIFY)________________ 6 (END)

[PROBE IF PERSON HAS MORE THAN ONE JOB OR BUSINESS: Please answer for your main job or business.]

A4. As of December 31, did (your/NAME's) business have any paid employees besides (yourself/him/her)?

YES 1
NO 2 (A6)
DON'T KNOW .... 8 (END; CODE AS PROBLEM)

A5. Besides (yourself/him/her), how many employees did (your/NAME's) business have on December 31, 1993?

________ (END)
\# EMPLOYEES

END: Thank you very much. Those are all the questions I have for you.

A6. The next questions are about health insurance coverage (you/NAME) may have had through a public program, through a group, or purchased directly from an insurance company.

As of December 31, 1993, (were you/was NAME) covered by Medicare?

(PROBE: Medicare is a Social Security health program for disabled persons and for persons over 65 years of age.)

YES 1
NO 2

A7. (Were you/Was NAME) covered at that time by (Medicaid/MediCal), a program funded by the state and Federal governments?

YES 1
NO 2

A8. At that time, (were you/was NAME) covered by any other government program that pays for health care, such as CHAMPUS or CHAMPVA?

YES 1
NO 2

A9. On December 31, 1993, did (you/NAME) have any other kind of health insurance plan besides those we have already discussed? Please include an HMO or any other plan that pays hospital or doctor bills.

YES 1
NO ....2 (SECTION D)
DON'T KNOW ....8 (SECTION D)

A10a. What is the name of the plan (you/NAME) were covered under as of December 31, 1993?

PLAN 1. ____ ®

® **RECORD NAME HERE AND ON REFERENCE SHEET.**

A10b. As of December 31, 1993, did (you/NAME) have any other kind of health insurance, like a plan that covers only dental care, vision care, or prescription drugs? [PROBE: Any others?]

YES .... 1 (RECORD BELOW)
NO 2 (A11)

PLAN 2. ______________________ ®

PLAN 3. ______________________ ®

PLAN 4. ______________________ ®

PLAN 5. ______________________ ®

® **RECORD NAME(S) HERE AND ON REFERENCE SHEET.**

A11. Is (PLAN 1) a Blue Cross/Blue Shield plan?

YES 1
NO 2

A12. Is (PLAN 1) an HMO, a PPO, a conventional health insurance plan, a combination of these types, or some other type of health insurance plan? [OFFER DEFINITIONS FROM CARD AS NEEDED.]

HMO/EPO/IPA .... 01 ® (A18)
PPO .... 02 ® (A18)
CONVENTIONAL/INDEMNITY .... 03 ®
COMBINATION/POS/OPEN-END HMO .... 04 ® (A17)

SINGLE SERVICE:
DENTAL .... 05 ® (A18)
VISION .... 06 ® (A18)
PRESCRIPTION DRUGS .... 07 ® (A18)

SPECIAL:
LONG-TERM CARE .... 08 ® (A18)
DREAD DISEASE .... 09 ® (A18)
HOSPITAL/INDEMNITY OR EXTRA CASH .... 10 ® (A18)

OTHER:
DISABILITY .... 11 (Box C-12, p. 22)
LIFE .... 12 (Box C-12, p. 22)

OTHER (Specify) ______________________ 13 ® (A14)
DON'T KNOW .... 98 ® (A14)

® **CODE HERE AND ON REFERENCE SHEET.**

A13. (Do you/Does NAME) pay less if (you/he/she) use(s) particular doctors, or preferred providers, under this plan?

YES ....1 ®
NO 2

® **IF "YES," CHANGE A12 TO "2" ON REFERENCE SHEET.**

SKIP TO A18

A14. Is (PLAN 1) a health insurance plan?

YES 1
NO ....2 (BOX C-12, p. 22)
DON'T KNOW ....8 (BOX C-12, p. 22)

A15. Under this plan, (are you/is NAME) covered only if (you/he/she) see(s) providers participating in the plan?

YES ....1 ® (A18)
NO 2

® **IF "YES," CHANGE A12 TO "1" ON REFERENCE SHEET.**

A16. (Do you/Does NAME) pay less if (you/he/she) use(s) particular doctors, or preferred providers, under this plan?

YES ....1 ®
NO 2

® **IF "YES," CHANGE A12 TO "2" ON REFERENCE SHEET.**

SKIP TO A18

A17. Does (PLAN 1) have an HMO component?

YES 1
NO 2

A18. (Are you/Is NAME) the primary insured person for this plan, or is it someone else? [PROBE: Whose name is on the policy?]

SUBJECT (NAME) IS PRIMARY INSURED........................1 (A21)
OTHER PERSON IS PRIMARY INSURED..........................2
DON'T KNOW..8 (A21)

A19. What is that person's relationship to (you/NAME)?

SPOUSE..1
PARENT..2
OTHER (SPECIFY)...3

A20. Did this person obtain the plan directly from the (HMO/PPO/insurance company), or did (he/she) get it through an employer, a union, or some other group?

[IF THROUGH EMPLOYER, PROBE: Was that an employer (he/she) was working for on December 31, 1993, or a former employer?]

<u>DIRECTLY FROM INSURANCE COMPANY</u>/HMO/PPO....................................1
THROUGH EMPLOYER ON 12/31/93...2 ®
THROUGH FORMER EMPLOYER (COBRA)..3 ®
THROUGH UNION...4
THROUGH PROFESSIONAL OR TRADE ASSOCIATION..................................5
THROUGH ANOTHER GROUP(SPECIFY)________________ 6

® **CODE HERE AND ON REFERENCE SHEET.**

SKIP TO SECTION C, PAGE 8

A21. Did (you/NAME) purchase this plan directly from the (HMO/PPO/insurance company), or did (you/he/she) get it through (your/his/her) business, through an employer, a union, or some other group?

[IF THROUGH EMPLOYER, PROBE: Was that an employer you were working for on December 31 or a former employer?]

<u>DIRECTLY FROM INSURANCE COMPANY</u>/HMO/PPO....................................01 (Sect. C)
THROUGH EMPLOYER ON 12/31/93...02 (BOX C-12)
THROUGH FORMER EMPLOYER (COBRA)..03
THROUGH OWN BUSINESS..04 (Sect. C)
THROUGH UNION...05 (Sect. C)
THROUGH PROFESSIONAL OR TRADE ASSOCIATION..................................06 (Sect. C)
THROUGH ANOTHER GROUP (SPECIFY) ________________ 07 (Sect. C)

A22. Was this plan a retirement benefit?

YES 1
NO 2

SKIP TO BOX C-12, PAGE 22.

SECTION C

C1. Did (PLAN 1) cover only (you/NAME) on December 31, or did it cover other members of (your/NAME's) family as well?

Covered (NAME) only 1 (C4)
Covered other family members as well .... 2 ®
DON'T KNOW 8 (C4)

® **CODE HERE AND ON REFERENCE SHEET.**

C2. Did this plan cover...

		YES	NO
a.	(NAME's) spouse?	1	2
b.	dependent children?	1	2
c.	anyone else in the family?	1	2

C3. Including (you/Name), how many family members did this plan cover altogether? [IF OBVIOUS, CODE WITHOUT ASKING]

____
\# FAMILY MEMBERS

C4. What was the total premium (you/NAME) paid for (PLAN 1) in 1993?

DOLLAR AMOUNT (Specify) $ ________________ 1
PAID NOTHING .... 2 (BOX C-1)
DON'T KNOW .... 8 (BOX C-1)

C5. Was this per month, for the year, or for some other period?

PER MONTH 1
ANNUAL 2
QUARTERLY 3
SOME OTHER PERIOD (SPECIFY) ________________ 4

BOX C-1	® CHECK A20. IF A20=2 OR 3 (INSURANCE PURCHASED THROUGH AN EMPLOYER), CHECK HERE ___ AND ASK QUESTION C6; OTHERWISE GO TO BOX C-2.

C6. Did an employer contribute to the cost of this plan?

YES 1
NO ....2 (BOX C-2)

C7. What was the total premium the employer paid for (PLAN 1) in 1993?

DOLLAR AMOUNT (Specify) $ ________________________ 1
PAID NOTHING ....2 (BOX C-2)
DON'T KNOW...8 (BOX C-2)

C8. Was this per month, for the year, or for some other period?

PER MONTH..1
ANNUAL 2
QUARTERLY...3
SOME OTHER PERIOD (SPECIFY)____________________ 4

BOX C-2	® CHECK A12. IF A12=5, 6, 7, 8, 9 or 10, (SINGLE SERVICE OR SPECIAL PLAN), CHECK HERE ___ AND GO TO BOX C-12, PAGE 22; OTHERWISE CONTINUE WITH C9.

C9. The next questions are about the plan's benefits, including deductibles, copayments, and covered services.

Did this plan cover both <u>inpatient</u> hospital care and <u>outpatient</u> medical services?

[PROBE: "Did this plan pay any of the cost of a hospital stay <u>or</u> a visit to a doctor?"]

YES, BOTH INPATIENT AND OUTPATIENT....................1
NO, COVERS INPATIENT ONLY ....2 ®
NO, COVERS OUTPATIENT ONLY ....3 ®
NO, COVERS NEITHER...4 (BOX C-12, P. 22)

® **CODE HERE AND ON REFERENCE SHEET.**

BOX C-3	® IF A12=1, (HMO PLANS) CHECK HERE ___ AND ASK C10. OTHERWISE, SKIP TO BOX C-4.

C10. Did this HMO or EPO plan cover services received from providers outside the HMO or EPO, other than referrals from HMO doctors and emergency services outside the HMO area?

YES, COVERS OUTSIDE SERVICES .... 1 ®
NO, DOES NOT COVER 2

® **IF "YES," CHANGE A12 TO "4" ON REFERENCE SHEET.**

BOX C-4	® IF C9 = 2, (INPATIENT ONLY) CHECK HERE ___ AND SKIP TO C14. ® IF C9 = 3, (OUTPATIENT ONLY) CHECK HERE ___ AND SKIP TO C17. OTHERWISE, CONTINUE WITH C11.

C11. **IN C11-C17, READ "FROM PREFERRED PROVIDERS OR PROVIDERS IN THE PLAN" IF ® A12= 2 OR 4 (PPO OR COMBINATION PLAN).**

Did this plan have an annual deductible for basic medical services (from preferred providers or providers in the plan)?

[IF ASKED: "Basic medical services include hospital stays and doctor visits".]

[DONT COUNT ANY DEDUCTIBLE THAT APPLIES ONLY TO PRESCRIPTION DRUGS, DENTAL OR MENTAL HEALTH SERVICES.]

YES 1
NO .... 2 (BOX C-5A)
DONT KNOW .... 8 (BOX C-5A)

C12. Did the same deductible apply to both inpatient and outpatient services (from preferred providers or providers in the plan)?

YES 1
NO 2 (C14)
DONT KNOW 8 (C14)

C13. What was the deductible for this plan?

$______________
DOLLAR AMT

BOX C-4A	® IF A12 = 1, 3, 13, OR 98, CHECK HERE _____ AND SKIP TO BOX C-7; OTHERWISE, SKIP TO C19.

C14. Was there a deductible for inpatient services (from preferred providers or providers in the plan)?

YES 1
NO ....2 (BOX C-5)
DON'T KNOW ....8 (BOX C-5)

C15. Was that (inpatient) deductible per hospital admission or for the year?

PER ADMISSION 1
FOR THE YEAR 2

C16. What was that inpatient deductible (using preferred providers or providers in the plan)?

$______________
DOLLAR AMOUNT

BOX C-5	® CHECK C9. IF C9 = 2 (COVERS INPATIENT ONLY), CHECK HERE ___ AND SKIP TO BOX C-5A. OTHERWISE, CONTINUE WITH C17.

C17. Was there an annual deductible for outpatient services (from preferred providers or providers in the plan?)

YES 1
NO ....2 (BOX C-5A)
DON'T KNOW ....8 (BOX C-5A)

C18. What was that outpatient deductible for this plan?

$______________
DOLLAR AMOUNT

BOX C-5A	® IF A12 = 1, 3, 13, OR 18, CHECK HERE _____ AND SKIP TO BOX C-7; OTHERWISE, CONTINUE TO C19.

C19. Did this plan have an annual deductible for basic medical services from non-preferred providers or providers outside the plan?

[IF ASKED: Basic medical services include hospital stays and doctor visits.]

[DON'T COUNT ANY DEDUCTIBLE THAT APPLIES ONLY TO PRESCRIPTION DRUGS, DENTAL OR MENTAL HEALTH SERVICES.]

YES 1
NO .... 2 (BOX C-7)
DON'T KNOW .... 8 (BOX C-7)

C20. Did the same deductible apply to both inpatient and outpatient services from non-preferred providers or providers outside the plan?

YES 1
NO 2 (C22)
DON'T KNOW 8 (C22)

C21. What was the deductible for this plan?

$______________
DOLLAR AMOUNT

SKIP TO BOX C-7

C22. Was there a deductible for <u>inpatient</u> services (from non-preferred providers or providers outside the plan)?

YES 1
NO .... 2 (BOX C-6)
DON'T KNOW .... 8 (BOX C-6)

C23. Was that (inpatient) deductible per hospital admission or for the year?

PER ADMISSION 1
FOR THE YEAR 2

C24. What was that inpatient deductible (using non-preferred providers or providers outside the plan)?

$______________
DOLLAR AMOUNT

BOX C-6	® CHECK C9. IF C9 = 2 (COVERS INPATIENT ONLY), CHECK HERE ___ AND SKIP TO BOX C-7. OTHERWISE, CONTINUE WITH C25.

C25. Was there an annual deductible for <u>outpatient</u> services (from non-preferred providers or providers outside the plan?)

YES 1
NO .... 2 (BOX C-7)
DON'T KNOW .... 8 (BOX C-7)

C26. What was that outpatient deductible for this plan?

$______________
DOLLAR AMOUNT

BOX C-7	® CHECK C1. IF C1=2 (FAMILY INSURANCE PLAN), CHECK HERE ___ AND CONTINUE WITH C27. OTHERWISE SKIP TO BOX C-8.

C27. What was the maximum deductible to be paid by the family in 1993. (RECORD EITHER A DOLLAR AMOUNT, A NUMBER OF PERSONS, OR BOTH.)

$ ______________________
MAXIMUM DEDUCTIBLE

OR

____
NUMBER OF PERSONS MEETING INDIVIDUAL DEDUCTIBLE

OR

NO DEDUCTIBLE 00

BOX C-8	® IF C9=3 OR 4 (INPATIENT SERVICES NOT COVERED), CHECK HERE AND GO TO BOX C-9; OTHERWISE CONTINUE AT C28.

C28. (READ "AFTER THE DEDUCTIBLE HAS BEEN MET" IF ANY DEDUCTIBLE REPORTED FOR PLAN.) (After the deductible had been met), what was the co-insurance rate for basic inpatient services?

[PROBE: After the deductible had been met, what was the inpatient reimbursement rate for basic inpatient service?]

NOT COVERED 01
0% OR NONE 02
10% or "90-10" 03
15% or "85-15" 04
20% or "80-20" 05
25% or "75-25" 06
30% or "70-30" 07
50% or "50-50" 08
VARIES (SPECIFY)________________ 09
OTHER (SPECIFY) ________________ 10

BOX C-9	® IF C9=2 OR 4 (OUTPATIENT SERVICES NOT COVERED), CHECK HERE ___ AND GO TO C32; OTHERWISE CONTINUE AT C29.

C29. (After the deductible had been met), did (you/NAME) have to pay anything when (you/he/she) saw a (doctor/preferred provider or provider in the plan)?

[PROBE: After the deductible had been met, but before the maximum out-of-pocket amount.]

YES 1
NO .... 2 (BOX C-10)
DON'T KNOW .... 8 (BOX C-10)

C30. (After the deductible had been met), how much did (you/NAME) pay when (you/he/she) saw a (doctor/preferred provider or provider in the plan)?

[PROBE: After the deductible had been met, but before the maximum out-of-pocket amount.]

DOLLAR AMOUNT [CO-PAYMENT] (Specify)$ ________________ 1 (BOX C-10)
PERCENT [CO-INSURANCE] 2
OTHER (SPECIFY) ________________ 3 (BOX C-10)

C31. What was the reimbursement rate?

10% or "90-10" 01
15% or "85-15" 02
20% or "80-20" 03
25% or "75-25" 04
30% or "70-30" 05
50% or "50-50" 06
VARIES (SPECIFY)__________ 07
OTHER (SPECIFY) __________ 08

BOX C-10	® IF A12 = 1,3, 13, OR 18, CHECK HERE ___ AND GO TO C34; OTHERWISE CONTINUE AT C32.

C32. (After the deductible had been met), how much did (you/NAME) pay when (you/he/she) used a non-preferred provider or provider outside the plan?

[PROBE: After the deductible had been met, but before the maximum out-of-pocket amount.]

DOLLAR AMOUNT [CO-PAYMENT] (SPECIFY) $__________ 1 (C34)
PERCENT [CO-INSURANCE] 2
NOT COVERED AT ALL 3 (C34)
OTHER (SPECIFY) __________ 4 (C34)
DON'T KNOW 8 (C34)

C33. What was the reimbursement rate?

10% or "90-10" 01
15% or "85-15" 02
20% or "80-20" 03
25% or "75-25" 04
30% or "70-30" 05
50% or "50-50" 06
VARIES (SPECIFY)__________ 07
OTHER (SPECIFY) __________ 08

C34. Was there a maximum amount that this plan would pay over a <u>lifetime</u>? Do not include limits that apply only to mental health, or to certain diseases such as cancer or AIDS.

$1,000,000 (ONE MILLION DOLLARS) 1
OTHER DOLLAR AMT (SPECIFY) $__________ 2
NO LIFETIME LIMIT 3
OTHER (SPECIFY) __________ 4

C35. Did this plan have a waiting period for pre-existing conditions (for you or your dependents)?

YES [INCLUDE FOR SOME CONDITIONS]	1	
NO	2	C-37
DON'T KNOW	8	C-37

C36. How long did (you/NAME) have to wait to be covered for such problems?

[INTERVIEWER: IF WAITING PERIOD DIFFERED BETWEEN "IN TREATMENT" AND NOT, CHECK HERE ____ AND CODE PERIOD FOR IN TREATMENT.]

DAYS (SPECIFY) ____________	1
MONTHS (SPECIFY) ____________	2
YEARS (SPECIFY) ____________	3
NEVER COVERED	4
VARIES (SPECIFY) ____________	5

C37. In 1993, did this plan refuse to cover any family member at all because of a particular health problem or condition?

YES	1
NO	2
NO FAMILY MEMBERS	3

C38. The next questions are about services that may have been covered under this plan in 1993.

Did this plan cover ...

	YES	NO
a. routine mammography screening?	1	2
b. adult routine physical examinations?	1	2
c. routine pap smears?	1	2

C39. Did this plan cover well child care such as ...

	YES	NO
d. childhood immunizations?	1	2
e. other well baby care (routine child care for children under 1 year of age)?	1	2
f. other well child care for children 1-4 years of age?	1	2
g. other well child care for children 5-13 years of age?	1	2

C40. In 1993, did this plan cover <u>outpatient</u> prescription drugs?

YES 1
NO 2 (C44)
DON'T KNOW 8 (C44)

C41. Was there a limit on how much the plan would pay in a year for outpatient prescription drugs?

YES 1
NO 2 (C43)
DON'T KNOW 8 (C43)

C42. What was the dollar limit for <u>outpatient</u> prescription drug coverage?

$__________
DOLLAR LIMIT

C43. Did this plan require that generic drugs be purchased if available?

[PROBE: " 'Generic' drugs use the same formula as brand name drugs and usually cost less than the brand name versions."]

YES 1
NO 2
NO REQUIREMENT, BUT PAID LESS FOR GENERIC 3

C44. In 1993, did this plan cover routine dental care?

YES [INCLUDE "LIMITED"] 1
NO 2

C45. In 1993, did this plan cover orthodontic care other than that required by accident or injury?

YES [INCLUDE "LIMITED"] 1
NO 2

C46. In 1993, did this plan cover routine eye exams?

YES [INCLUDE "LIMITED"] 1
NO 2 (C48)
DON'T KNOW 8 (C48)

C47. Were eyeglasses and contact lenses covered?

YES [INCLUDE "LIMITED"] 1
NO 2

C48. In 1993, was care in a nursing home covered under this plan?

YES 1
NO 2 (C51)
DON'T KNOW 8 (C51)

C49. Was there a limit on the number of days or total dollar amount that would be covered for care received in a nursing home?

YES 1
NO 2 (C51)
DON'T KNOW 8 (C51)

C50. What was the limit for care received in a nursing home? [ENTER ALL THAT APPLY]

______	$________	$________
DAYS	DOLLARS	DOLLARS PER DAY

C51. In 1993, were personal care services in the home covered under this plan?

YES 1
NO 2

C52. In 1993, was home health care covered under this plan?

YES 1
NO 2 (C55)
DON'T KNOW 8 (C55)

C53. Was there a limit on the number of visits or total dollar amount that would be covered for home health care?

YES 1
NO 2 (C55)
DON'T KNOW 8 (C55)

C54. What was the limit for home health care? [ENTER ALL THAT APPLY]

______ VISITS $________ DOLLARS

C55. In 1993, did this plan cover inpatient mental health services?

YES [INCLUDE "LIMITED"] 1
NO 2 (C59)
DON'T KNOW 8 (C59)

C56. Was there a limit on the number of days or the total dollar amount that would be covered for inpatient mental health services?

YES 1
NO 2 (C59)
DON'T KNOW 8 (C59)

C57. Was the limit....

C58. What were the limits? [ENTER ALL THAT APPLY]

	YES	NO		
Per stay?	1	2	______ DAYS	$______ DOLLARS
Per year?	1	2	______ DAYS	$______ DOLLARS
For an individual's lifetime?	1	2	______ DAYS	$______ DOLLARS

C59. In 1993, did this plan cover <u>outpatient</u> mental health services?

YES [INCLUDE "LIMITED"] 1
NO 2 (C62)
DON'T KNOW 8 (C62)

C60. Was there a limit on the number of visits or the total dollar amount that would be covered for <u>outpatient</u> mental health services in a year?

[PROBE: Is that a visit limit, dollar limit, or both?]

YES 1
INCLUDED WITH INPATIENT LIMIT 2 (C62)
NO 3 (C62)
DON'T KNOW 8 (C62)

C61. What was the (visit limit/dollar limit/visit and dollar limits)? [ENTER ALL THAT APPLY]

______ VISITS

$______ DOLLARS

C62. In 1993, did this plan cover <u>substance abuse treatment</u> (including either alcohol or drug abuse treatment or both)?

[ENTER YES IF ANY SUBSTANCE ABUSE TREATMENT IS COVERED]

YES 1
NO 2 (C69)
DON'T KNOW 8 (C69)

C63. Was inpatient treatment for substance abuse covered?

YES 1
NO 2 (C66)
DON'T KNOW 8 (C66)

C64. Was there a limit on the number of days or the total dollar amount that would be covered for inpatient substance abuse treatment?

[PROBE: Is that a day limit, a dollar limit, or both?]

YES 1
INCLUDED WITH MENTAL HEALTH LIMITS 2 (C66)
NO 3 (C66)
DON'T KNOW 8 (C66)

C65. What was the (day limit/dollar limit/day and dollar limits)? [ENTER ALL THAT APPLY]

______ DAYS $______ DOLLARS

C66. Was outpatient substance abuse treatment covered?

YES 1
NO 2 (C69)
DON'T KNOW 8 (C69)

C67. Was there a limit on the number of visits or the total dollar amount that would be covered for outpatient substance abuse treatment?

[PROBE: Is that a visit limit, a dollar limit, or both?]

YES 1
INCLUDED WITH PREVIOUSLY REPORTED LIMITS 2 (C69)
NO 3 (C69)
DON'T KNOW 8 (C69)

C68. What was the (visit limit/dollar limit/visit and dollar limits)? [ENTER ALL THAT APPLY]

_____ VISITS

$_____ DOLLARS

C69. DID RESPONDENT USE A BROCHURE OR PAMPHLET TO ANSWER QUESTIONS ABOUT COVERED SERVICES IN THIS SECTION?

YES 1
NO 2
DON'T KNOW 8

BOX C-12	® IF ANY PLANS LISTED IN A10b, CHECK HERE ___ AND USE SUPPLEMENT TO ASK SECTIONS A AND C FOR EACH PLAN OTHERWISE CONTINUE WITH SECTION D

SECTION D

Finally, I have a few more questions about (your/NAME's) business.

D1. How long (have you/has NAME) been primarily self-employed?

____
\# OF YEARS

FOR D2 - D7, IF THE PERSON HAS MORE THAN ONE SELF-EMPLOYED BUSINESS, ASK ABOUT THE MAIN BUSINESS.

D2. Is (your/NAME's) business incorporated?

YES 1
NO 2

D3. Is (your/NAME's) business for profit or non-profit?

FOR PROFIT 1
NON-PROFIT 2

D4. In filing Federal income tax for 1993, did (you/NAME) file...

		YES	NO
a.	a Schedule C?	1	2
b.	a Schedule F?	1	2

D5. What is the name and address of (your/NAME's) business?

NAME ____

ADDRESS: ____

CITY/STATE: ______________________________________

D6. What kind of business or industry is this? What do (you/NAME) make or do?

____

____

____

____

D7. What were (your/NAME's) most important activities or duties in this business?

____

____

____

____

D8. During 1993, how much money did (your/NAME's) business earn after expenses?

IF MORE THAN ONE SELF-EMPLOYED BUSINESS, PROBE FOR AMOUNT EARNED OR LOST FOR ALL BUSINESSES COMBINED.

$ EARNED: $________________

OR,

$ LOST: $________________

CLOSING: On behalf of the U.S. Department of Health and Human Services, thank you very much for your time and cooperation.