Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing

			HEALTH INSURANCE QUESTIONNAIRE SPECIFICATIONS
			
			CRITERIA
			INTTYPE=C001, C002, C003, C004, C005, C006, C007, C010
			SPALIVE=ALL
			SEASON=ALL
			SPPROXY=SP or PROXY
			Other: N/A
			
			PLACEMENT
			If (INTTYPE in(C001, C002, C004, C005, C006) and SEASON=FALL) or (INTTYPE=C003), administer after HAQ.
			If (INTTYPE in(C001, C002, C004, C005, C006) and SEASON=WINTER or SUMMER) or (INTTYPE in (C007, C010)), administer after ENS.		

	BOX HIBEG	routing	IF (SP IS IN THE SUPPLEMENTAL SAMPLE), GO TO HIMCINTR - HIINTR1. ELSE GO TO BOX MC1AA.		
HIINTR1	HIMCINTR	no entry	SHOW CARD HI1 The next questions are about [your/(SP's)] health insurance benefits. This card outlines the types of health insurance that I'll be asking you about. [INTERVIEWER SHOULD POINT TO HEALTH INSURANCE OPTIONS ON FRONT OF SHOWCARD HI1.] Please refer to this card as we talk about [your/(SP's)] health insurance coverage. It would also be helpful if I could look at a health plan card, insurance statement, or something with the plan name on it. These materials will ensure that I record the information accurately. (EXPAIN IF NECESSARY: We ask about health insurance coverage because it is important to understand how beneficiaries cover the costs of their medical care, such as doctor visits, prescribed medicines, and hospital stays.)		BOX MC1AA
	BOX MC1AA	routing	IF (SP IS IN THE SUPPLEMENTAL SAMPLE) AND (SP HAS A LOADED CMS MEDICARE MANAGED CARE PLAN), GO TO MC1 - LOADCORR. ELSE IF (SP IS NOT IN THE SUPPLEMENTAL SAMPLE) AND (SP HAS A MEDICARE MANAGED CARE PLAN THAT WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW), GO TO HIMC1A - MHMOSAME. ELSE GO TO HIMC1 - MHMOCOV.		
LOADCORR	MC1	yes/no	As you (may) know, Medicare beneficiaries can enroll in either Original Medicare or a Medicare Advantage plan, such as an HMO (Health Maintenance Organization) and PPO (Preferred Provider Organization). 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? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) BOX HIMC1 (02) MC2 - WHATWRNG (-8) MC11 - REFERMED (-9) BOX HIMC4
WHATWRNG	MC2	code 1	How is this information incorrect? SELECT ONLY ONE. IF MORE THAN ONE RESPONSE IS APPLICABLE, SELECT THE RESPONSE THAT IS CLOSEST TO THE TOP OF THE LIST.	(01) SP DISENROLLED FROM (CMS MHMO PLAN NAME), ENROLLED IN NEW MEDICARE ADVANTAGE PLAN (02) SP HAS PLAN CALLED (CMS MHMO PLAN NAME), R DOESN'T THINK IT'S A MEDICARE ADVANTAGE PLAN (03) SP NOW DISENROLLED FROM (CMS MHMO PLAN NAME), NO LONGER IN ANY MEDICARE ADVANTAGE PLAN (04) SP ENROLLED IN MEDICARE ADVANTAGE PLAN, BUT NEVER (CMS MHMO PLAN NAME) (05) SP NEVER COVERED BY OR ENROLLED IN (CMS MHMO PLAN NAME)	(01) MC2B - YDISNROL (02) MC3 - PRIMPHYS (03) MC2B - YDISNROL (04) MC4 - SAMEPLAN (05) MC11 - REFERMED

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
YDISNROL	MC2B	code 1	What is the most important reason [you/(SP)] stopped the (CMS MEDICARE MANAGED CARE PLAN NAME) coverage?	(01) TOO EXPENSIVE OR COULDN'T AFFORD (02) SP DISSATISFIED WITH QUALITY OF CARE (03) TO GET RX COVERAGE IN ANOTHER PLAN (04) TO GET BENEFIT COVERAGE OTHER THAN RX (05) PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE (06) PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN (07) DOCTOR LEFT PLAN/DIED/RETIRED (08) DIFFICULTIES GETTING APPTS OR SEEING PARTICULAR PROVIDERS (09) SP MOVED OUT OF PLAN AREA (10) SP DIDN'T LIKE CHOICE OF DOCTORS (11) SP WANTED CHOICE OF DOCTORS (91) OTHER (-8) Don't Know (-9) Refused	(01) BOX MC1A (02) BOX MC1A (03) BOX MC1A (04) BOX MC1A (05) BOX MC1A (06) BOX MC1A (07) BOX MC1A (08) BOX MC1A (09) BOX MC1A (10) BOX MC1A (11) BOX MC1A (91) MC2B - YDISNROS (-8) BOX MC1A (-9) BOX MC1A
YDISNROS	MC2B	verbatim text	OTHER (SPECIFY)		BOX MC1A
	BOX MC1A	routing	IF MC2 - WHATWRNG = 1/EnrolledNewPlan, GO TO MC5 - PLAN_MHMOMCA. ELSE GO TO HIMC16 - MHMOMORE.		
PRIMPHYS	MC3	yes/no	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?	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HIMC1
SAMEPLAN	MC4	code 1	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?	(01) SAME PLANS (02) NOT THE SAME PLANS (-8) Don't Know (-9) Refused	(01) BOX HIMC1 (02) MC5 - PLAN_MHMOMCA (-8) MC5 - PLAN_MHMOMCA (-9) MC5 - PLAN_MHMOMCA
PLAN_MHMOMCA	MC5	roster	What is the name of the Medicare Advantage Plan that provides [your/(SP's)] health care benefits? [MEDICARE ADVANTAGE PLAN LOOKUP CALLED AT THIS SCREEN]		BOX HIMC1
REFERMED	MC11	code 1	Do you refer to [your/(SP's)] Medicare coverage by any name besides Medicare? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) MEDICARE ONLY (02) OTHER NAME (-8) Don't Know (-9) Refused	(01) BOX HIMC4 (02) MC12 - PLAN_MHMOMCB (-8) BOX HIMC4 (-9) BOX HIMC4
PLAN_MHMOMCB	MC12	roster	What do you call [your/(SP's)] coverage? SELECT OR ADD ONLY ONE MEDICARE ADVANTAGE PLAN AT THIS ROSTER.		BOX HIMC1
MHMOSAME	HIMC1A	yes/no	At the time of the last interview [you were/(SP) was] covered by the Medicare Advantage Plan named (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)?] [IF THE RESPONDENT DROPPED THE INDICATED COVERAGE SINCE THE PREVIOUS INTERVIEW DATE, BUT PICKED UP THE COVERAGE AGAIN AND CURRENTLY IS COVERED BY THE NAMED PLAN, SELECT "YES" FOR THIS QUESTION.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) BOX HIMC1 (02) HIMC1B - COVENDMM (-8) BOX HIMC4 (-9) HIMC1C - MHMOOTHR
COVENDMM	HIMC1B	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicare Advantage Plan's coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	COVENDYY
COVENDYY	HIMC1B	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicare Advantage Plan's coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HIMC1B1 - YDISNROL

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
YDISNROL	HIMC1B1	code 1	What is the most important reason [you/(SP)] stopped the (MEDICARE MANAGED CARE PLAN NAME) coverage?	(01) TOO EXPENSIVE OR COULDN'T AFFORD (02) SP DISSATISFIED WITH QUALITY OF CARE (03) TO GET RX COVERAGE IN ANOTHER PLAN (04) TO GET BENEFIT COVERAGE OTHER THAN RX (05) PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE (06) PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN (07) DOCTOR LEFT PLAN/DIED/RETIRED (08) DIFFICULTIES GETTING APPTS OR SEEING PARTICULAR PROVIDERS (09) SP MOVED OUT OF PLAN AREA (10) SP DIDN'T LIKE CHOICE OF DOCTORS (11) SP WANTED CHOICE OF DOCTORS (91) OTHER (-8) Don't Know (-9) Refused	(01) HIMC1C - MHMOOTHR (02) HIMC1C - MHMOOTHR (03) HIMC1C - MHMOOTHR (04) HIMC1C - MHMOOTHR (05) HIMC1C - MHMOOTHR (06) HIMC1C - MHMOOTHR (07) HIMC1C - MHMOOTHR (08) HIMC1C - MHMOOTHR (09) HIMC1C - MHMOOTHR (10) HIMC1C - MHMOOTHR (11) HIMC1C - MHMOOTHR (91) HIMC1B1 - YDISNROS (-8) HIMC1C - MHMOOTHR (-9) HIMC1C - MHMOOTHR
YDISNROS	HIMC1B1	verbatim text	OTHER (SPECIFY)		HIMC1C - MHMOOTHR
MHMOOTHR	HIMC1C	yes/no	SHOW CARD HI2 [Since (REFERENCE DATE)/Between (REFERENCE DATE) and (DATE OF DEATH/INSTITUTIONALIZATION)], [have you/has (SP) been/was (SP)] covered by any other Medicare Advantage Plans besides (MEDICARE MANAGED CARE PLAN)?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HIMC5-PLAN_MHMO (02) BOX HIMC4 (-8) BOX HIMC4 (-9) BOX HIMC4
MHMOCOV	HIMC1	yes/no	SHOW CARD HI2 As you (may) know, Medicare beneficiaries can enroll in either Original Medicare or a Medicare Advantage plan, such as an HMO (Health Maintenance Organization) and PPO (Preferred Provider Organization). (Please look at this card.) At any time [since (REFERENCE DATE)/between (REFERENCE 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? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HIMC5-PLAN_MHMO (02) BOX HIMC4 (-8) BOX HIMC4 (-9) BOX HIMC4
PLAN_MHMO	HIMC5	roster	What is the name of the Medicare Advantage Plan that [currently covers/covered] [you/(SP)] [on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]?] SELECT OR ADD ONLY ONE MEDICARE ADVANTAGE PLAN AT THIS ROSTER. [MEDICARE ADVANTAGE PLAN LOOKUP CALLED AT THIS SCREEN]		COVTIME
COVTIME	HIMC3	code 1	Were you covered by (MEDICARE ADVANTAGE PLAN NAME) the whole time between [(REFERENCE DATE) and (today], or only part of the time?	(01) THE WHOLE TIME (02) PART OF THE TIME (-8) Don't Know (-9) Refused	(01) BOX HIMC1 (02) HI2-CURRCOV (-8) HI2-CURRCOV (-9) HI2-CURRCOV
CURRCOV	HI2	yes/no	[[Are you/Is (SP)] now covered by (MEDICARE ADVANTAGE PLAN NAME)? [Was (SP) covered by (MEDICARE ADVANTAGE PLAN NAME) on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI3-COVBEGMM (02) HI3A - COVENDMM (-8) BOX HIMC1 (-9) BOX HIMC1
COVBEGMM	HI3	date	When did [your/(SP's)] (MEDICARE ADVANTAGE PLAN NAME) start between (REFERENCE DATE) and [today/(DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)]?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI3-COVBEGYY
COVBEGYY	HI3	date	When did [your/(SP's)] (MEDICARE ADVANTAGE PLAN NAME) start between (REFERENCE DATE) and [today/(DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)]?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HIMC1
COVENDMM	HI3A	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicare Advantage Plan's coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	COVENDYY
COVENDYY	HI3A	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicare Advantage Plan's coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HIMC1
	BOX HIMC1	routing	IF (THIS MEDICARE MANAGED CARE PLAN IS NEW) OR THIS IS A FALL ROUND GO TO MHMOCVR. ELSE GO TO BOX HIMC2		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
MHMOCVR	MHMOCVR	mark all	SHOWCARD HI6 I'd like to know what [your/SP's] [CURRENT MEDICARE MANAGED CARE PLAN] coverage [includes/included]. (Please look at this card). Which services [are/were] covered through [CURRENT MEDICARE MANAGED CARE PLAN)]? [PROBE: I am asking about the type of insurance coverage that [you personally have/(SP) personally has/(SP) personally had], not what the plan offers everyone.] [IF NEEDED: Other services may include physical therapy, occupational therapy, speech therapy, health education, or gym membership.] CHECK ALL THAT APPLY	(01) Prescribed medicines (02) Visits to a doctor or other health professional (03) Lab work (04) Inpatient hospital care (05) Nursing home or long term care (06) Dental care (07) Optical or vision care (08) Hearing care (09) Behavioral health care (e.g., counseling, psychotherapy, mental health and substance use disorder services) (91) Other services (-8) Don't Know (-9) Refused	(01)-(09) HIMC11 - MHMOPAY (91) MHMOCVOS (-8) HIMC11 - MHMOPAY (-9) HIMC11 - MHMOPAY
MHMOCVOS	MHMOCVOS	verbatim text	[IF NEEDED: Other services may include physical therapy, occupational therapy, speech therapy, health education, or gym membership.] OTHER (SPECIFY)	(01) [Continuous Answer]	HIMC11 - MHMOPAY
MHMOPAY	HIMC11	yes/no	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/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 Original Medicare such as prescribed medicines, and dental, vision, or hearing care. Plans that have premiums typically charge from $50 to $75 per month.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HIMC12 - MHMOAMT (02) BOX HIMC2 (-8) BOX HIMC2 (-9) BOX HIMC2
MHMOAMT	HIMC12	quantity unit hybrid	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/(SP)'s] (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)].) [PROBE IF NECESSARY: Is that per year, per month, per week, or what?]	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	(01) HIMC12 - MHMOUNIT (-8) HIMC12 - MHMOUNIT (-9) HIMC12 - MHMOUNIT
MHMOUNIT	HIMC12	quantity unit hybrid	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/(SP)'s] (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)].) [PROBE IF NECESSARY: Is that per year, per month, per week, or what?]	(01) PER YEAR (02) QUARTERLY/EVERY 3 MONTHS (03) BIMONTHLY/EVERY 2 MONTHS (04) PER MONTH (05) PER WEEK (06) SEMI-ANNUALLY/2 TIMES PER YEAR (07) SEMI-MONTHLY/2 TIMES PER MONTH (91) OTHER (-8) Don't Know (-9) Refused	(01)-(07) BOX MHMOCAT (91) MHMOUNOS-MHMOUNOS (-8) BOX MHMOCAT (-9) BOX MHMOCAT
MHMOUNOS	MHMOUNOS	verbatim text	OTHER (SPECIFY)		BOX MHMOCAT
	BOX MHMOCAT	routing	IF MHMOAMT=DK AND MHMOUNIT=1/PER YEAR, GO TO MHMOPYR. ELSE IF MHMOAMT=DK AND MHMOUNIT=2/QUARTERLY, GO TO MHMOQR. ELSE IF MHMOAMT=DK AND MHMOUNIT=3/BIMONTHLY, GO TO MHMOBI. ELSE IF MHMOAMT=DK AND MHMOUNIT=4/PER MONTH, GO TO MHMOMO. ELSE IF MHMOAMT=DK AND MHMOUNIT=5/PER WEEK, GO TO MHMOWE. ELSE IF MHMOAMT=DK AND MHMOUNIT=6/SEMI-ANNUALLY/2 TIMES PER YEAR, GO TO MHMOSA. ELSE IF MHMOAMT=DK AND MHMOUNIT=7/SEMI-MONTHLY/2 TIMES PER MONTH, GO TO MHMOSM. ELSE GO TO HI33A-MHMOCOST.		
MHMOPYR	MHMOPYR	code 1	PER YEAR: Please tell me which is the closest…	(01) <250 (02) 250-749 (03) 750-1499 (04) 1500-3999 (05) 4000+	HI33A-MHMOCOST
MHMOQR	MHMOQR	code 1	PER QUARTER: Please tell me which is the closest…	(01) <200 (02) 200-399 (03) 400-599 (04) 600-899 (05) 900+	HI33A-MHMOCOST

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
MHMOBI	MHMOBI	code 1	BIMONTHLY: Please tell me which is the closest…	(01) <150 (02) 150-299 (03) 300-449 (04) 450-599 (05) 600+	HI33A-MHMOCOST
MHMOMO	MHMOMO	code 1	PER MONTH: Please tell me which is the closest…	(01) <50 (02) 50-99 (03) 100-199 (04) 200-399 (05) 400+	HI33A-MHMOCOST
MHMOWE	MHMOWE	code 1	PER WEEK: Please tell me which is the closest…	(01) <10 (02) 10-24 (03) 25-74 (04) 75-149 (05) 150+	HI33A-MHMOCOST
MHMOSA	MHMOSA	code 1	2 TIMES/YEAR: Please tell me which is the closest…	(01) <100 (02) 100-299 (03) 300-999 (04) 1000-1999 (05) 2000+	HI33A-MHMOCOST
MHMOSM	MHMOSM	code 1	2 TIMES/MONTH: Please tell me which is the closest…	(01) <10 (02) 10-34 (03) 35-99 (04) 100-199 (05) 200+	HI33A-MHMOCOST
MHMOCOST	HI33A	yes/no	[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?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HIMC12B - MHMOWHO (02) BOX HIMC2 (-8) BOX HIMC2 (-9) BOX HIMC2
MHMOWHO	HI33B	code 1	Who else [pays/paid] all or some portion of the cost for [your/(MIP's)] (PRIVATE PLAN NAME) coverage?	(01) [(SP's)/(MIP's)] CURRENT EMPLOYER (02) (SP's/MIP's) FORMER EMPLOYER (03) (SP's/MIP's) UNION (04) SPOUSE'S CURRENT EMPLOYER (05) SPOUSE'S FORMER EMPLOYER (06) PROFESSIONAL/FRATERNAL ORGANIZATION (07) MEDICAID/MEDICAL ASSISTANCE (91) OTHER (-8) Don't Know (-9) Refused	(01) BOX HIMC2 (02) BOX HIMC2 (03) BOX HIMC2 (04) BOX HIMC2 (05) BOX HIMC2 (06) BOX HIMC2 (07) BOX HIMC2 (91) HIMC12B - MHMOWHOS (-8) BOX HIMC2 (-9) BOX HIMC2
MHMOWHOS	HIMC12B	verbatim text	OTHER (SPECIFY)		BOX HIMC2
	BOX HIMC2	routing	IF ADMINISTERING ST, GO TO BOX ST69A. ELSE IF ADMINISTERING NS, GO TO BOX NS69A. ELSE IF ADMINISTERING CPS, GO TO BOX CPS29A. ELSE IF HIMC1A - MHMOSAME = 1/Yes, GO TO BOX HIMC4. ELSE IF HI2-CURRCOV = 2/No, DK OR RF, GO TO HIMC17 - PLAN_MHMOOTHER. ELSE GO TO HIMC16 - MHMOMORE.		
MHMOMORE	HIMC16	yes/no	SHOW CARD HI2 [Since (REFERENCE DATE)/Between (REFERENCE DATE) and (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Advantage Plans besides (MEDICARE MANAGED CARE PLAN and MEDICARE MANAGED CARE PLAN)? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HIMC17 - PLAN_MHMOOTHER (02) BOX HIMC4 (-8) BOX HIMC4 (-9) BOX HIMC4
PLAN_MHMOOTHER	HIMC17	roster	Besides (MEDICARE MANAGED CARE PLAN [and MEDICARE MANAGED CARE PLAN]), what other/What] Medicare Advantage Plans provided [your/(SP's)] health care since (REFERENCE DATE)? SELECT OR ADD MEDICARE ADVANTAGE PLAN NAMES AT THIS ROSTER. [MEDICARE ADVANTAGE PLAN LOOKUP CALLED AT THIS SCREEN]		BOX HIMC4
	BOX HIMC4	routing	IF FALL ROUND AND (SP IS ALIVE AND NOT INSTITUTIONALIZED) AND (SP HAS A MEDICARE MANAGED CARE PLAN THAT IS "CURRENT"), GO TO HIMC19 - RECMHMO. ELSE GO TO BOX HI1.		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
RECMHMO	HIMC19	yes/no	Would you recommend (CURRENT MEDICARE MANAGED CARE PLAN NAME) to your family or friends?	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HIMC5
	BOX HIMC5	routing	IF (SP HAS A MEDICARE MANAGED CARE PLAN THAT IS "CURRENT") AND (THE NUMBER OF YEARS THE SP WAS COVERED BY A MANAGED CARE PLAN HAS NEVER BEEN COLLECTED), GO TO HIMC24 - HMONUMYR. ELSE GO TO BOX HI1.		
HMONUMYR	HIMC24	numeric	How many years [have you/has (SP)] been enrolled in a Medicare Advantage plan? [IF THE RESPONDENT HAS BEEN ENROLLED IN MORE THAN ONE MEDICARE ADVANTAGE PLAN, THEN ENTER THE TOTAL NUMBER OF YEARS THAT HE/SHE HAS BEEN ENROLLED IN ALL MEDICARE ADVANTAGE PLANS.]	(01) [Continuous answer.] (-7) Empty (-8) Don't Know (-9) Refused	HIMC24 - HMONUM96
HMONUM96	HIMC24	numeric	How many years [have you/has (SP)] been enrolled in a managed care plan?	(01) LESS THAN ONE YEAR (-7) Empty	BOX HI1
	BOX HI1	routing	IF A MEDICAID PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO HI6 - COVTIME. ELSE GO TO HI5INTRO - MCAIDINT.		
MCAIDINT	HI5INTRO	no entry	SHOW CARD HI3 PLEASE READ THIS INTRODUCTION SLOWLY AND CLEARLY: Medicaid[, also known as (MEDICAID STATE PLAN NAME),] 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.		BOX HI1B
	BOX HI1B	routing	IF STATE IN WHICH SP LIVES DOES NOT OFFER A MEDICAID MANAGED CARE PLAN, GO TO HI5 - AIDCOVER. ELSE GO TO HI5INTRB - MCAIDINTB.		
MCAIDINTB	HI5INTRB	no entry	SHOW CARD HI4 Some people receive their Medicaid benefits from plans that have names like those listed on this card.		HI5 - AIDCOVER
AIDCOVER	HI5	yes/no	At any time [since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], [have you/has (SP) been/was (SP)] covered by Medicaid? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI6 - COVTIME (02) BOX HIT1 (-8) BOX HIT1 (-9) BOX HIT1
COVTIME	HI6	code 1	(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 (REFERENCE DATE) and [(today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], or only part of the time?	(01) THE WHOLE TIME (02) PART OF THE TIME (-8) Don't Know (-9) Refused	(01) BOX HI1C (02) BOX HI1C (-8) BOX HI1C (-9) BOX HI1C
	BOX HI1C	routing	IF THIS PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO BOX HI4. ELSE IF COVTIME = THE WHOLE TIME, GO TO HI10A-MCAIDHMO, ELSE GO TO HI7-CURRCOV.		
CURRCOV	HI7	yes/no	[[Are you/Is (SP)] now covered by Medicaid?] [Was (SP) covered by Medicaid on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI8-COVBEGMM (02) HI9 - COVENDMM (-8) HI10A - MCAIDHMO (-9) HI10A - MCAIDHMO
	BOX HI4	routing	IF COVTIME=PART OF THE TIME, GO TO COVENDMM, ELSE IF COVTIME=THE WHOLE TIME AND [(IT'S A NEW PLAN) OR (IT'S A FALL ROUND)], GO TO HI10A - MCAIDHMO, ELSE GO TO BOX HIT1.		
COVBEGMM	HI8	date	Between (REFERENCE DATE) and [today/(DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)], when did [your (SP's) Medicaid coverage start?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI8-COVBEGYY
COVBEGYY	HI8	date	Between (REFERENCE DATE) and [today/(DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)], when did [your (SP's) Medicaid coverage start?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI10A - MCAIDHMO
COVENDMM	HI9	date	[since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicaid coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI9 - COVENDYY

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
COVENDYY	HI9	date	[since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicaid coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HI4A
	BOX HI4A	routing	IF THIS MEDICAID PLAN IS NEW, GO TO HI10A-MCAIDHMO, ELSE GO TO BOX HIT1.		
MCAIDHMO	HI10A	yes/no	(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]? [ONLY SELECT "YES" IF THE RESPONDENT IS ACTUALLY ENROLLED IN THE PLAN; SOME STATES MAY OFFER MANAGED CARE, BUT NOT REQUIRE ENROLLMENT.] [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HI5D
	BOX HI5D	routing	IF ((ADMINISTERING ST, NS OR CPS) AND SP WAS COVERED BY A MEDICARE PRESCRIPTION DRUG PLAN ANYTIME DURING THE CURRENT ROUND) OR (ADMINSTERING HI AND THERE WAS A MEDICARE PRESCRIPTION DRUG PLAN THAT WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW), GO TO BOX HIT1. ELSE IF (ADMINISTERING ST, NS OR CPS) AND SP WAS NOT COVERED BY A MEDICARE PRESCRIPTION DRUG PLAN ANYTIME DURING THE CURRENT ROUND, GO TO HI10D - MCDRXCOV. ELSE GO TO HI10C1 - MPDCOVER.		
MPDCOVER	HI10C1	yes/no	(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 (REFERENCE DATE)/between (REFERENCE DATE) AND (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], [have you been/has (SP) been/was (SP)] enrolled in a Medicare Prescription Drug plan that [covers/covered] medicines prescribed by a doctor or other health professional? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI10C2 - PDPCURR (02) HI10D - MCDRXCOV (-8) HI10D - MCDRXCOV (-9) HI10D - MCDRXCOV
PDPCURR	HI10C2	yes/no	[Are you/Is (SP)/Was (SP)] [currently] covered by or enrolled in a Medicare Prescription Drug plan [on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI10C3 - PLAN_CAIDMPDP (02) HI10D-MCDRXCOV (-8) HI10D-MCDRXCOV (-9) HI10D-MCDRXCOV
PLAN_CAIDMPDP	HI10C3	roster	[What is the name of the Medicare Prescription Drug plan that (currently covers/covered) [you/(SP)] [on (DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)]?] SELECT OR ADD ONLY ONE MEDICARE PRESCRIPTION DRUG PLAN AT THIS ROSTER. [PRESCRIPTION DRUG PLAN LOOKUP CALLED AT THIS SCREEN]		HI10C4 - PDPMORE
PDPMORE	HI10C4	Yes/No	[Since (REFERENCE DATE)/Between (REFERENCE 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/(SP)] enrolled in on [your/(SP)'s] own.) [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI10C5 - PLAN_CAIDMPDPOTHR (02) BOX HIT1 (-8) BOX HIT1 (-9) BOX HIT1
PLAN_CAIDMPDP OTHR	HI10C5	roster	Please tell me the names of [the other/all] Medicare Prescription Drug plans that [you have/(SP) has] been enrolled in since (REFERENCE 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/(SP)] enrolled in on [your/(SP)'s] own.] SELECT OR ADD MEDICARE PRESCRIPTION DRUG PLAN NAMES AT THIS ROSTER. [PRESCRIPTION DRUG PLAN LOOKUP CALLED AT THIS SCREEN]		BOX HIT1

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
MCDRXCOV	HI10D	yes/no	(Does/Did) [your/(SP's)] Medicaid plan cover medicines prescribed by a doctor or other health professional?	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HIT1
	BOX HIT1	routing	IF ADMINISTERING ST, GO TO BOX ST69A. ELSE IF ADMINISTERING NS, GO TO BOX NS69A. ELSE IF ADMINISTERIGN CPS, GO TO BOX CPS29A. ELSE IF A TRICARE PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO HIT2 - COVTIME. ELSE GO TO HIT1 - TRICOVER.		
TRICOVER	HIT1	yes/no	SHOW CARD 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 (REFERENCE 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).)	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HIT2 - COVTIME (02) BOX HIT3 (-8) BOX HIT3 (-9) BOX HIT3
COVTIME	HIT2	code1	[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 [(REFERENCE DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], or only part of the time?	(01) THE WHOLE TIME (02) PART OF THE TIME (-8) Don't Know (-9) Refused	(01) BOX HIT2A (02) BOX HIT2 (-8) BOX HIT2 (-9) BOX HIT2
	BOX HIT2	routing	IF THIS PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO BOX HIT2A, ELSE GO TO HIT3-CURRCOV.		
CURRCOV	HIT3	yes/no	[[Are you/Is (SP)] now covered by TRICARE?] [Was (SP) covered by TRICARE on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HIT5-COVBEGMM (02) HIT4-COVENDMM (-8) TRICOV (-9) TRICOV
	BOX HIT2A	routing	IF COVTIME=PART OF THE TIME, GO TO HIT4-COVENDMM, ELSE IF COVTIME=THE WHOLE TIME AND [(IT'S A NEW PLAN) OR (IT'S A FALL ROUND)], GO TO TRICOV. ELSE GO TO BOX HIT3.		
COVENDMM	HIT4	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] TRICARE coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HIT4 - COVENDYY
COVENDYY	HIT4	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] TRICARE coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HIT2AA
	BOX HI2AA	routing	IF THIS TRICARE PLAN IS NEW, GO TO HI10A-TRICOV, ELSE GO TO BOX HIT3.		
COVBEGMM	HIT5	date	When did [your/(SP's)] TRICARE plan start between (REFERENCE DATE) and [today/(DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)]?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HIT5-COVBEGYY
COVBEGYY	HIT5	date	When did [your/(SP's)] TRICARE plan start between (REFERENCE DATE) and [today/(DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)]?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	TRICOV
TRICOV	TRICOV	mark all	SHOWCARD HI6 TRICARE 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)] TRICARE coverage [includes/included]. (Please look at this card). Which services are covered through TRICARE? [PROBE: I am asking about the type of insurance coverage that you personally [have/have had], not what the plan offers everyone.] [IF NEEDED: Other services may include physical therapy, occupational therapy, speech therapy, health education, or gym membership.] CHECK ALL THAT APPLY	(01) Prescribed medicines (02) Visits to a doctor or other health professional (03) Lab work (04) Inpatient hospital care (05) Nursing home or long term care (06) Dental care (07) Optical or vision care (08) Hearing care (09) Behavioral health care (e.g., counseling, psychotherapy, mental health and substance use disorder services) (91) Other services (-8) Don't Know (-9) Refused	BOX HIT2B (91) TRICOVOS

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
TRICOVOS	TRICOVOS	verbatim text	[IF NEEDED: Other services may include physical therapy, occupational therapy, speech therapy, health education, or gym membership.] OTHER (SPECIFY)	(01) [Continuous Answer]	BOX HIT2B
	BOX HIT2B	routing	If TRICOV includes 01/Prescribed medicines, GO TO TRIMEDS; ELSE GO TO BOX HIT3		
TRIMEDS	HIT4A1	code 1	SHOW CARD HIT2 Where [do you/does (SP)/did you/did (SP)] usually obtain [your/(SP)'s] medicines? [Do you/Does (SP)/Did you/Did (SP)] usually obtain them at a TRICARE mail order pharmacy (TMOP), a TRICARE retail pharmacy network pharmacy (TRRx), a military treatment facility pharmacy (MTF), a non-network retail pharmacy, or somewhere else?	(01) A TRICARE MAIL ORDER PHARMACY (TMOP) (02) A TRICARE RETAIL PHARMACY NETWORK PHARMACY (TRRX) (03) A MILITARY TREATMENT FACILITY PHARMACY (MTF) (04) A NON-NETWORK RETAIL PHARMACY (91) SOMEWHERE ELSE (-8) Don't Know (-9) Refused	(01) BOX HIT3 (02) BOX HIT3 (03) BOX HIT3 (04) BOX HIT3 (91) TRIMEDOS-TRIMEDOS (-8) BOX HIT3 (-9) BOX HIT3
TRIMEDOS	TRIMEDOS	verbatim text	SOMEWHERE ELSE (SPECIFY)	(01) [Continuous Answer]	BOX HIT3
	BOX HIT3	routing	IF ADMINISTERING ST, GO TO BOX ST69A. ELSE IF ADMINISTERING NS, GO TO BOX NS69A. ELSE IF ADMINISTERING CPS, GO BOX CPS29A. ELSE IF [(SP DID NOT REPORT RECEIVING HEALTH CARE SERVICES FROM M.T.F IN THE PREVIOUS ROUND) AND ((SP WAS COVERED BY TRICARE IN THE CURRENT OR PREVIOUS ROUND)] OR (SP SERVED IN THE ARMED FORCES)}, GO TO HIT11- MILTHOSP. ELSE GO TO BOX HI20.		
MILTHOSP	HIT11	yes/no	[We recorded that [you/(SP)] served in the Armed Forces of the United States.] Since (REFERENCE DATE), [have you/has (SP) received/did (SP) receive] health care or health services or prescribed medicines at a TRICARE Military Treatment Facility or MTF? [EXPLAIN IF NECESSARY: A TRICARE Military Treatment Facility is any military hospital or clinic located on a military base or post around the world. MTFs are different from VA facilities.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HI20
	BOX HI20	routing	IF FALL ROUND AND (SP SERVED IN THE ARMED FORCES, P_SPAFEVER =1), GO TO VACARCOV-VACARCOV. ELSE GO TO BOX HI7.		
VACARCOV	VACARCOV	yes/no	Since (TODAY'S DATE - 12 MONTHS, MONTH AND YEAR), did [you/(SP)] receive any care at a Veteran's Health Administration facility or receive any other health care paid for by the VA? [IF NEEDED: Veteran's Health Administration facilities include VA hospitals, VA medical centers, VA outpatient clinics, and VA nursing homes.]INCLUDE PRESCRIBED MEDICINES THROUCH THE DEPARTMENT OF VETERANS AFFAIRS OR VA.	(01) YES (02) NO (-8) Don't Know (-9) Refused	
VAENROLL	VAENROLL	yes/no	Since (TODAY'S DATE - 12 MONTHS, MONTH AND YEAR), [have you been/has (SP) been/was (SP)] enrolled in VA health care?	(01) YES (02) NO (-8) Don't Know (-9) Refused	
	BOX HI7	routing	IF AT LEAST ONE PUBLIC PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO HI11PREV - PUBINTRO. ELSE GO TO HI11 - PUBCOVER.		
PUBINTRO	HI11PREV	no entry	The next questions are about public plans [you were/(SP) was] covered by as of (REFERENCE DATE).	(01) CONTINUE (-7) Empty	HI13 - COVTIME
PUBCOVER	HI11	yes/no	SHOW CARD HI6 At any time [since (REFERENCE 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?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI12 - PLAN_PUBLIC (02) BOX HI12AA (-8) BOX HI12AA (-9) BOX HI12AA
PLAN_PUBLIC	HI12	roster	What is the name of each of the public programs other than Medicaid that covered [you/(SP)]? SELECT OR ADD ALL PUBLIC PROGRAM NAMES AT THIS ROSTER. [WHEN YOU ENTER A PLAN, VERIFY WITH THE RESPONDENT THAT IT IS A PUBLIC PLAN.]	(01) ADD NEW PLAN	(01) HI13 - COVTIME
COVTIME	HI13	code 1	[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 [(REFERENCE DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], or only part of the time?	(01) THE WHOLE TIME (02) PART OF THE TIME (-8) Don't Know (-9) Refused	(01) BOX HI10 (02) BOX HI8 (-8) BOX HI8 (-9) BOX HI8
	BOX HI8	routing	IF THIS PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO BOX HI10, ELSE GO TO HI14-CURRCOV.		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
CURRCOV	HI14	yes/no	[[Are you/Is (SP)] now covered by (PUBLIC PLAN NAME)?] [Was (SP) covered by (PUBLIC PLAN NAME) on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI15 - COVBEGMM (02) HI16 - COVENDMM (-8) PUBCOV (-9) PUBCOV
	BOX HI10	routing	IF COVTIME=PART OF THE TIME, GO TO HI16-COVENDMM, ELSE-IF COVTIME=THE WHOLE TIME AND [(IT'S A NEW PLAN) OR (IT'S A FALL ROUND)], GO TO PUBCOV. ELSE GO TO BOX HI12.		
COVBEGMM	HI15	date	When did [your/(SP's)] (PUBLIC PLAN NAME) coverage start [between (REFERENCE DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI15 - COVBEGYY
COVBEGYY	HI15	date	When did [your/(SP's)] (PUBLIC PLAN NAME) coverage start [between (REFERENCE DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	PUBCOV
COVENDMM	HI16	date	[Since (REFERENCE DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] (PUBLIC PLAN NAME) coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI16 - COVENDYY
COVENDYY	HI16	date	[Since (REFERENCE DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] (PUBLIC PLAN NAME) coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HI11
	BOX HI11	routing	IF THIS PUBLIC PLAN IS NEW, GO TO PUBCOV. ELSE GO TO BOX HI12.		
PUBCOV	PUBCOV	mark all	SHOWCARD HI6 I'd like to know what your PUBLIC PLAN coverage [includes/included]. (Please look at this card). Which services [are/were] covered through [your/(SP's)] PUBLIC PLAN? [PROBE: I am asking about the type of insurance coverage that you personally [have/had], not what the plan offers everyone.] [IF NEEDED: Other services may include physical therapy, occupational therapy, speech therapy, health education, or gym membership.] CHECK ALL THAT APPLY	(01) Prescribed medicines (02) Visits to a doctor or other health professional (03) Lab work (04) Inpatient hospital care (05) Nursing home or long term care (06) Dental care (07) Optical or vision care (08) Hearing care (09) Behavioral health care (e.g., counseling, psychotherapy, mental health and substance use disorder services) (91) Other services (-8) Don't Know (-9) Refused	(01)-(08), (-8), (-9) BOX HI12 (91) PUBCOVOS
PUBCOVOS	PUBCOVOS	verbatim text	[IF NEEDED: Other services may include physical therapy, occupational therapy, speech therapy, health education, or gym membership.] OTHER (SPECIFY)	(01) [Continuous Answer]	BOX HI12
	BOX HI12	routing	IF ADMINISTERING ST, GO TO BOX ST69A. ELSE IF ADMINISTERING NS, GO TO BOX NS69A. ELSE IF ADMINISTERIGN CPS, GO TO BOX CPS29A. ELSE IF REVIEWING ADDITIONAL PUBLIC PLANS THAT WERE "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO HI13-COVTIME. ELSE GO TO PUBMORE.		
PUBMORE	PUBMORE	code one	[Since (REFERENCE DATE)/Between (REFERENCE DATE) and (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other public program other than Medicaid that pays for medical care [for example, a public program that pays for prescribed medicines? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI12-PLAN_PUBLIC (02) BOX HI12AA (-8) BOX HI12AA (-9) BOX HI12AA
	BOX HI12AA	routing	IF (SP HAS A MEDICARE PRESCRIPTION DRUG PLAN THAT WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW), GO TO HI16AB - PDPSAME. ELSE IF ((SP DOES NOT HAVE A MEDICARE PRESCRIPTION DRUG PLAN THAT WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW) AND (SP DOES NOT HAVE A "CURRENT" MEDICARE MANAGED CARE PLAN WITH RX COVERAGE) AND (HI10C1 - MPDCOVER = empty)), GO TO HI16B - PDPCOVER. ELSE IF ((SP DOES NOT HAVE A MEDICARE PRESCRIPTION DRUG PLAN THAT WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW) AND (SP DOES NOT HAVE A "CURRENT" MEDICARE MANAGED CARE PLAN WITH RX COVERAGE) AND (HI10C1 - MPDCOVER = 2/No)), GO TO HI16B1 - PDPCOVER. ELSE GO TO BOX HI12A.		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PDPSAME	HI16AB	yes/no	At the time of the last interview [you were/(SP) was] covered by a Medicare Prescription Drug Plan named (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)?] [IF THE RESPONDENT DROPPED THE INDICATED COVERAGE SINCE THE PREVIOUS INTERVIEW DATE, BUT PICKED UP THE COVERAGE AGAIN AND CURRENTLY IS COVERED BY THE NAMED PLAN, SELECT "YES" FOR THIS QUESTION.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) BOX HI12A (02) HI16ABB - COVENDMM (-8) BOX HI12A (-9) HI16AD - PDPOTHER
COVENDMM	HI16ABB	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicare Prescription Drug Plan's coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	COVENDYY
COVENDYY	HI16ABB	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicare Prescription Drug Plan's coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI16AC - PDPYSTOP
PDPYSTOP	HI16AC	code 1	What is the most important reason [you/(SP)] stopped the (MEDICARE PRESCRIPTION DRUG PLAN NAME) coverage?	(01) TOO EXPENSIVE OR COULDN'T AFFORD (02) SP DISSATISFIED WITH PLAN'S COVERAGE (03) TO GET RX COVERAGE IN ANOTHER PLAN (04) TO GET DIFFERENT HEALTH CARE COVERAGE (05) PLAN NO LONGER CONTRACTS FOR MEDICARE RX COVERAGE (06) PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER PLAN (07) SP MOVED OUT OF PLAN AREA (91) OTHER (-8) Don't Know (-9) Refused	(01) HI16AD - PDPOTHER (02) HI16AD - PDPOTHER (03) HI16AD - PDPOTHER (04) HI16AD - PDPOTHER (05) HI16AD - PDPOTHER (06) HI16AD - PDPOTHER (07) HI16AD - PDPOTHER (91) HI16AC - PDPYSTOS (-8) HI16AD - PDPOTHER (-9) HI16AD - PDPOTHER
PDPYSTOS	HI16AC	verbatim text	OTHER (SPECIFY)		HI16AD - PDPOTHER
PDPOTHER	HI16AD	yes/no	[Since (REFERENCE DATE)/Between (REFERENCE 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)? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?] ONLY ENTER STAND-ALONE PRESCRIPTION DRUG PLANS AT THIS QUESTION. IF THE R HAS RX COVERAGE THROUGH ANOTHER INSURANCE PLAN, SUCH AS A MEDICARE ADVANTAGE PLAN, DO NOT ENTER A SEPARATE PRESCRIPTION DRUG PLAN.	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI16E-PLAN_MPDP (02) BOX HI12A (-8) BOX HI12A (-9) BOX HI12A
PDPCOVER	HI16B	yes/no	(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 (REFERENCE DATE), [have you/has (SP)/had (SP)] been enrolled in a Medicare Prescription Drug plan that [covers/covered] medicines prescribed by a doctor or other health professional? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?] ONLY ENTER STAND-ALONE PRESCRIPTION DRUG PLANS AT THIS QUESTION. IF THE R HAS RX COVERAGE THROUGH ANOTHER INSURANCE PLAN, SUCH AS A MEDICARE ADVANTAGE PLAN, DO NOT ENTER A SEPARATE PRESCRIPTION DRUG PLAN.	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI16E-PLAN_MPDP (02) BOX HI12A (-8) BOX HI12A (-9) BOX HI12A
PDPCOVER	HI16B1	yes/no	You mentioned that [you are not currently/(SP) is not currently/(SP) had not been] enrolled in a Medicare Prescription Drug plan that is associated with [your/(SP)'s] Medicaid coverage. At any time since (REFERENCE DATE), [have you/has (SP)/had (SP)] been enrolled in a Medicare Prescription Drug plan in any way other than through Medicaid? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI16E-PLAN_MPDP (02) BOX HI12A (-8) BOX HI12A (-9) BOX HI12A

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PLAN_MPDP	HI16E	roster	What is the name of the Medicare Prescription Drug plan that [currently covers/covered] [you/(SP)] [on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]?] SELECT OR ADD ONLY ONE MEDICARE PRESCRIPTION DRUG PLAN AT THIS ROSTER. [PRESCRIPTION DRUG PLAN LOOKUP CALLED AT THIS SCREEN]		COVTIME
COVTIME	HIMPDP	code 1	Were you covered by (Medicare Prescription Drug PLAN NAME) the whole time between [(REFERENCE DATE) and (today], or only part of the time?	(01) THE WHOLE TIME (02) PART OF THE TIME (-8) Don't Know (-9) Refused	(01) BOX HIEA (02) HI16C-CURRCOV (-8) HI16C-CURRCOV (-9) HI16C-CURRCOV
CURRCOV	HI16C	yes/no	[Are you/Is (SP)/Was (SP)] [currently] covered by or enrolled in (Medicare Prescription Drug PLAN NAME) [on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI16D-COVBEGMM (02) HI16H-COVENDMM (-8) BOX HI12A (-9) BOX HI12A
COVBEGMM	HI16D	date	When did [your/(SP's)] Medicare Prescription Drug Plan start between (REFERENCE DATE) and [today/(DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)]?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI8-COVBEGYY
COVBEGYY	HI16D	date	When did [your/(SP's)] Medicare Prescription Drug Plan start between (REFERENCE DATE) and [today/(DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)]?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HIEA
COVENDMM	HI6H	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicare Prescription Drug Plan's coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	COVENDYY
COVENDYY	HI16H	date	[Since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] Medicare Prescription Drug Plan's coverage [most recently/last] stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HIEA
	BOX HIEA	routing	IF ADMINISTERING ST, GO TO BOX ST69A. ELSE IF ADMINISTERING NS, GO TO BOX NS69A. ELSE IF ADMINISTERING CPS, GO TO BOX CPS29A. ELSE GO TO HI16F - PDPMORE.		
PDPMORE	HI16F	yes/no	[Since (REFERENCE DATE)/Between (REFERENCE 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: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI16G - PLAN_MPDPOTHR (02) BOX HI12A (-8) BOX HI12A (-9) BOX HI12A
PLAN_MPDPOTHR	HI16G	roster	[Besides (CURRENT PRESCRIPTION DRUG PLAN), what other/Besides (PREVIOUS ROUND PRESCRIPTION DRUG PLAN), what other/What] Medicare Prescription Drug plans covered [your/(SP's)] medicines since (REFERENCE DATE)? SELECT OR ADD MEDICARE PRESCRIPTION DRUG PLAN NAMES AT THIS ROSTER. [PRESCRIPTION DRUG PLAN LOOKUP CALLED AT THIS SCREEN]		BOX HI12A
	BOX HI12A	routing	IF AT LEAST ONE PRIVATE PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO HI17PREV - PRIVINTRO. ELSE GO TO HI17 - PRIVCOV		
PRIVINTRO	HI17PREV	no entry	The next questions are about private plans [you were/(SP) was] covered by as of (REFERENCE DATE).	(01) CONTINUE (-7) Empty	HI21 - COVTIME
PRIVCOV	HI17	yes/no	You reported that [you are/(SP) is/(SP) was] covered by [READ PLAN NAME(S) AND PLAN TYPE(S) LISTED ABOVE]. (Now, I would like to ask about another type of health insurance.) At any time [since (REFERENCE 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 plans? Private plans include supplemental or Medigap plans, plans that are provided by a former or current employer, and plans that you have directly purchased. Such plans cover the cost of hospital or doctor visits, prescribed medicines, dental care, vision care, or hearing care.	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI18A - EXCHGCOV (02) BOX HI13A (-8) BOX HI13A (-9) BOX HI13A

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
EXCHGCOV	HI18A	yes/no	As you may know, every state now offers a health insurance marketplace, also referred to as an exchange. The marketplace[, known as (STATE MARKETPLACE NAME),] allows residents to compare and purchase available health insurance options that meet their needs. While most Medicare beneficiaries are not eligible for insurance from a health insurance marketplace, there are some special circumstances that allow enrollment. At any time [since (REFERENCE DATE)/between (REFERENCE DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION),] [have you/has (SP)/had (SP)] been enrolled in or covered by one of these exchange plans? [MEDICARE BENEFICIARIES ARE NOT ELIGIBLE TO OBTAIN INSURANCE THROUGH THESE PLANS. THE RESPONSE TO THIS QUESTION SHOULD ALMOST ALWAYS BE "NO". HOWEVER, SOME RESPONDENTS MAY SIGN UP FOR THESE PLANS DUE TO CONFUSION ABOUT THE PROGRAM.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	HI20 - PLAN_PRIVATE
	BOX HI13A	routing	IF (SP IS IN THE SUPPLEMENTAL SAMPLE) OR (SP IS NEW FROM FACILITY), GO TO HI19 - GAPCOVER. ELSE GO TO BOX HI19B.		
GAPCOVER	HI19	yes/no	Some people who are eligible for Medicare have additional coverage through a private insurance carrier referred to as Medigap or Medicare Supplement -insurance. These plans help pay some of the health care costs that Original Medicare doesn't cover, like copayments, coinsurance and deductibles. At any time since (REFERENCE DATE) did [you/(SP)] have this type of health insurance coverage? [PROBE IF NECESSARY: Do you have a health plan card, insurance statement, or something with the plan name on it?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI20 - PLAN_PRIVATE (02) HI35 - PRVOCOV (-8) HI35 - PRVOCOV (-9) HI35 - PRVOCOV
PLAN_PRIVATE	HI20	roster	What is the name of the private plan that [provides/provided] [your/(SP's)] medical insurance coverage? SELECT OR ADD ALL PRIVATE PLAN NAMES AT THIS ROSTER.	(01) continuous answer (996) PLAN ENTERED IN ERROR	HI21-COVTIME
COVTIME	HI21	code 1	[At the time of the last interview [you were/(SP) was] covered by a private plan named (PRIVATE PLAN NAME).] [Were you/Was (SP)] covered by (PRIVATE PLAN NAME) the whole time between (REFERENCE DATE) and [today/ DATE OF DEATH/DATE OF INSTITUTIONALIZATION], or only part of the time?	(01) THE WHOLE TIME (02) PART OF THE TIME (-8) Don't Know (-9) Refused	(01) BOX HI17 (02) BOX HI14 (-8) BOX HI14 (-9) BOX HI14
	BOX HI14	routing	IF THIS PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW AND COVTIME=PART OF THE TIME, GO TO COVENDMM, ELSE GO TO HI22-CURRCOV.		
CURRCOV	HI22	yes/no	[[Are you/Is (SP)] now covered by (PRIVATE PLAN NAME)?] [Was (SP) covered by (PRIVATE PLAN NAME) on (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)?]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI23-COVBEGMM (02) HI24 - COVENDMM (-8) BOX HI17 (-9) BOX HI17
COVBEGMM	HI23	date	When did [your/(SP's)] coverage under (PRIVATE PLAN NAME) start between (REFERENCE DATE) and [today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION]?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI23 - COVBEGYY
COVBEGYY	HI23	date	When did [your/(SP's)] coverage under (PRIVATE PLAN NAME) start between (REFERENCE DATE) and [today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION]?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HI17
COVENDMM	HI24	date	[since (REFERENCE DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] coverage under (PRIVATE PLAN NAME) stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	HI24 - COVENDYY
COVENDYY	HI24	date	[since (REFERENCE DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], when did [your/(SP's)] coverage under (PRIVATE PLAN NAME) stop?	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HI17
	BOX HI17	routing	IF THIS PRIVATE PLAN IS NEW, GO TO HI25 - PPRVHMO ELSE IF THIS PRIVATE PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW AND IS STILL "CURRENT", AND IT IS A FALL ROUND, GO TO HI26 - PERS_MIPNUM. ELSE GO TO BOX HI19.		
PPRVHMO	HI25	yes/no	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.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	HI26 - PERS_MIPNUM

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PERS_MIPNUM	HI26	roster	Who [is/was] listed as the main insured person on the (PRIVATE PLAN NAME) policy or contract? SELECT OR ADD ONLY ONE PERSON.	DISPLAY PERSON ROSTER AS RESPONSE OPTIONS: 1. [PERSON 1] 2. [PERSON 2] … (01-N) LIST ALL PERSONS AS RESPONSE OPTIONS (N+1) ADD ANOTHER DISPLAY: 1 First Name Display ROST.ROSTFNAM. 2 Last Name Display ROST.ROSTLNAM. 3 Relationship to SP Display relationship: If ROST.ROSTREL=91/OtherRelative or 92/OtherNon-Relative, display ROST.ROSTREOS. Else display ROST.ROSTREL relationship.	(01-N) BOX HI15 (N+1) HI26_NEW-ROSTFNAM IF EXISTING PERSON SELECTED, GO TO BOX HI15 ELSE IF "ADD ANOTHER" SELECTED, GO TO HI26_NEW-ROSTFNAM
ROSTFNAM	HI26_NEW	text	[What is the name of the person and relationship to (SP)?]	(01) continuous answer	HI26_NEW - ROSTLNAM
ROSTLNAM	HI26_NEW	text	[What is the name of the person and relationship to (SP)?]	(01) continuous answer	HI26_NEW - ROSTREL
ROSTREL	HI26_NEW	code one	[What is the name of the person and relationship to (SP)?]	(02) SPOUSE (56) PARTNER (58) CHILD (59) GRANDCHILD (60) PARENT (61) SIBLING (91) OTHER (-8) Don't Know (-9) Refused	(01) DO NOT DISPLAY (02) BOX HI15 (56) BOX HI15 (58) BOX HI15 (59) BOX HI15 (60) BOX HI15 (61) BOX HI15 (91) HI26_NEW - ROSTREOS (-8) BOX HI15 (-9) BOX HI15
ROSTREOS	HI26_NEW	verbatim text	[What is the name of the person and relationship to (SP)?]	(01) continuous reponse (-8) Don't Know (-9) Refused	BOX HI15
	BOX HI15	routing	IF PRIVOBTN HAS NEVER BEEN ASKED FOR THIS PLAN (PLAN.PRIVOBTN=.), GO TO PRIVOBTN, ELSE GO TO PRVNMCOV.		
PRIVOBTN	HI27	code 1	For the (PRIVATE 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?	(01) DIRECTLY (02) (MIP'S) CURRENT EMPLOYER (03) (MIP'S) FORMER EMPLOYER (04) (MIP'S) UNION (05) (MIP'S) FAMILY BUSINESS (06) AARP (07) DECEASED SPOUSE'S EMPLOYER (08) DECEASED SPOUSE'S UNION (09) PROFESSIONAL/FRATERNAL ORGANIZATION (91) SOME OTHER WAY (-8) Don't Know (-9) Refused	(01) HI29 - PRVNMCOV (02) HI29 - PRVNMCOV (03) HI29 - PRVNMCOV (04) HI29 - PRVNMCOV (05) HI29 - PRVNMCOV (06) HI29 - PRVNMCOV (07) HI29 - PRVNMCOV (08) HI29 - PRVNMCOV (09) HI29 - PRVNMCOV (91) HI27 - PRIVOBOS (-8) HI29 - PRVNMCOV (-9) HI29 - PRVNMCOV
PRIVOBOS	HI27	verbatim text	OTHER (SPECIFY)		HI29 - PRVNMCOV
PRVNMCOV	HI29	numeric	How many family members, including [yourself/(SP)], [are/were] covered by [your/(MIP's)] (PRIVATE PLAN NAME)? [INCLUDE ALL FAMILY MEMBERS COVERED BY THE PLAN REGARDLESS OF WHETHER OR NOT THEY LIVE WITH THE RESPONDENT. MAKE SURE THE RESPONDENT IS INCLUDED IN THE COUNT.]	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	BOX HI17AB
	BOX HI17AB	routing	IF (THIS PRIVATE PLAN IS NEW) OR (THIS PRIVATE PLAN WAS "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW AND IS STILL "CURRENT", AND IT IS A FALL ROUND), GO TO HI31A - PRIVSERV. ELSE GO TO BOX HI19.		

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
PRIVSERV	HI31A	mark all	SHOWCARD HI6 Private 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]. (Please look at this card). Which services [are/were] covered through [PLAN NAME]? [PROBE: I am asking about the type of insurance coverage that [you/(SP) personally [have/has/had], not what the plan offers everyone.] [IF NEEDED: Other services may include physical therapy, occupational therapy, speech therapy, health education, or gym membership.] CHECK ALL THAT APPLY	(01) Prescribed medicines (02) Visits to a doctor or other health professional (03) Lab work (04) Inpatient hospital care (05) Nursing home or long term care (06) Dental care (07) Optical or vision care (08) Hearing care (09) Behavioral health care (e.g., counseling, psychotherapy, mental health and substance use disorder services) (91) Other services (-8) Don't Know (-9) Refused	HI32 - MIPPINS (91) PRIVSVOS
PRIVSVOS	PRIVSVOS	text	[IF NEEDED: Other services may include physical therapy, occupational therapy, speech therapy, health education, or gym membership.] OTHER (SPECIFY)	(01) [Continuous answer]	HI32 - MIPPINS
MIPPINS	HI32	yes/no	[Do/Does/Did] [you/(MIP)] pay any or all of the premium or cost for the (PRIVATE PLAN NAME) coverage? [Do not include the cost of any deductibles [you/(SP)] or [your/(SP's)] family may [have/have had] to pay.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI33 - MIPPAMT (02) HI33A - MHMOCOST (-8) HI33A - MHMOCOST (-9) HI33A - MHMOCOST
MIPPAMT	HI33	quantity unit hybrid	How much [do/does/did] [you/(MIP)] pay for the (PRIVATE PLAN NAME) coverage? [Please include the full amount paid for the coverage, including 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?] IF MORE THAN ONE PERSON (EX: SPOUSE, FAMILY MEMBER) IS COVERED BY THIS PLAN, THEN ENTER THE TOTAL AMOUNT PAID, INCLUDING THE COST FOR THESE OTHER MEMBERS.	(01) [Continuous answer.] (-8) Don't Know (-9) Refused	(01) HI33 - MIPPUNIT (-8) HI33-MIPPUNIT (-9) HI33-MIPPUNIT
MIPPUNIT	HI33	quantity unit hybrid	How much [do/does/did] [you/(MIP)] pay for the (PRIVATE 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?]	(01) PER YEAR (02) QUARTERLY/EVERY 3 MONTHS (03) BIMONTHLY/EVERY 2 MONTHS (04) PER MONTH (05) PER WEEK (06) SEMI-ANNUALLY/2 TIMES PER YEAR (07) SEMI-MONTHLY/2 TIMES PER MONTH (91) OTHER (-8) Don't Know (-9) Refused	(01)-(07) BOX PRIVCAT (91) HI33 - MIPPUNOS (-8) BOX PRIVCAT (-9) BOX PRIVCAT
MIPPUNOS	HI33	verbatim text	OTHER (SPECIFY)		BOX PRIVCAT
	BOX PRIVCAT	routing	IF MIPPAMT=DK AND MIPPUNIT=1/PER YEAR, GO TO MIPPYR. ELSE IF MIPPAMT=DK AND MIPPUNIT=2/QUARTERLY, GO TO MIPPQR. ELSE IF MIPPAMT=DK AND MIPPUNIT=3/BIMONTHLY, GO TO MIPPBI. ELSE IF MIPPAMT=DK AND MIPPUNIT=4/PER MONTH, GO TO MIPPMO. ELSE IF MIPPAMT=DK AND MIPPUNIT=5/PER WEEK, GO TO MIPPWE. ELSE IF MIPPAMT=DK AND MIPPUNIT=6/SEMI-ANNUALLY/2 TIMES PER YEAR, GO TO MIPPSA. ELSE IF MIPPAMT=DK AND MIPPUNIT=7/SEMI-MONTHLY/2 TIMES PER MONTH, GO TO MIPPSM. ELSE GO TO HI33A-MHMOCOST.		
MIPPYR	MIPPYR	code 1	PER YEAR: Please tell me which is the closest…	(01) <250 (02) 250-749 (03) 750-1499 (04) 1500-3999 (05) 4000+	HI33A-MHMOCOST
MIPPQR	MIPPQR	code 1	PER QUARTER: Please tell me which is the closest…	(01) <200 (02) 200-399 (03) 400-599 (04) 600-899 (05) 900+	HI33A-MHMOCOST
MIPPBI	MIPPBI	code 1	BIMONTHLY: Please tell me which is the closest…	(01) <150 (02) 150-299 (03) 300-449 (04) 450-599 (05) 600+	HI33A-MHMOCOST

Variable Name	MR Screen Name	Question Type	Question Text/Description	Code List	Routing
MIPPMO	MIPPMO	code 1	PER MONTH: Please tell me which is the closest…	(01) <50 (02) 50-99 (03) 100-199 (04) 200-399 (05) 400+	HI33A-MHMOCOST
MIPPWE	MIPPWE	code 1	PER WEEK: Please tell me which is the closest…	(01) <10 (02) 10-24 (03) 25-74 (04) 75-149 (05) 150+	HI33A-MHMOCOST
MIPPSA	MIPPSA	code 1	2 TIMES/YEAR: Please tell me which is the closest…	(01) <100 (02) 100-299 (03) 300-999 (04) 1000-1999 (05) 2000+	HI33A-MHMOCOST
MIPPSM	MIPPSM	code 1	2 TIMES/MONTH: Please tell me which is the closest…	(01) <10 (02) 10-34 (03) 35-99 (04) 100-199 (05) 200+	HI33A-MHMOCOST
MHMOCOST	HI33A	yes/no	[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)] (PRIVATE PLAN NAME) coverage?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI33B - MHMOWHO (02) BOX HI17B (-8) BOX HI17B (-9) BOX HI17B
MHMOWHO	HI33B	code 1	Who else [pays/paid] all or some portion of the cost for [your/(MIP's)] (PRIVATE PLAN NAME) coverage?	(01) [(SP's)/(MIP's)] CURRENT EMPLOYER (02) (SP's/MIP's) FORMER EMPLOYER (03) (SP's/MIP's) UNION (04) SPOUSE'S CURRENT EMPLOYER (05) SPOUSE'S FORMER EMPLOYER (06) PROFESSIONAL/FRATERNAL ORGANIZATION (07) MEDICAID/MEDICAL ASSISTANCE (91) OTHER (-8) Don't Know (-9) Refused	(01) BOX HI17B (02) BOX HI17B (03) BOX HI17B (04) BOX HI17B (05) BOX HI17B (06) BOX HI17B (07) BOX HI17B (91) HI33B - MHMOWHOS (-8) BOX HI17B (-9) BOX HI17B
MHMOWHOS	HI33B	verbatim text	OTHER (SPECIFY)		BOX HI17B
	BOX HI17B	routing	IF THIS PRIVATE PLAN IS A MANAGED CARE PLAN, GO TO HI33C - MHMOPOS. ELSE GO TO BOX HI19.		
MHMOPOS	HI33C	yes/no	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/Were/Is/Was] [you/(SP)] enrolled in a point-of-service option offered by (PRIVATE 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.]	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HI19
	BOX HI19	routing	IF ADMINISTERING ST, GO TO BOX ST69A. ELSE IF ADMINISTERING NS, GO TO BOX NS69A. ELSE IF ADMINISTERING CPS, GO TO BOX CPS29A. ELSE IF REVIEWING ADDITIONAL PRIVATE PLANS THAT WERE "CURRENT" AT THE TIME OF THE PREVIOUS ROUND INTERVIEW, GO TO HI21-COVTIME. ELSE GO TO HI35-PRVOCOV.		
PRVOCOV	HI35	yes/no	We've talked about [READ PLAN(S) LISTED ABOVE]. [Do you/Does (SP)/Did (SP)] have medical coverage under any (other) private insurance plans we haven't talked about?	(01) YES (02) NO (-8) Don't Know (-9) Refused	(01) HI20 - PLAN_PRIVATE (02) BOX HI19B (-8) BOX HI19B (-9) BOX HI19B
	BOX HI19B	routing	IF (SP IS IN THE SUPPLEMENTAL SAMPLE) OR (SP IS NEW FROM FACILITY), GO TO HI34 - OTHNHCOV. ELSE GO TO BOX HI21A.		
OTHNHCOV	HI34	yes/no	[Other than the plans you have already told me about, [do you/does (SP)/did (SP)]/[Do you/Does (SP)/Did (SP)]] have any insurance that [pays/paid] just for nursing home care or other long term care?	(01) YES (02) NO (-8) Don't Know (-9) Refused	BOX HI21A
	BOX HI21A	routing	IF SEASON=FALL, GO TO MBQ. IF SEASON= WINTER OR SUMMER, GO TO PVQ.		