SECTION P

BENEFITS

07/28/95

This section is administered at the plan level for PLANTYPE = 1, 2 & 3 (comprehensive plans) for all interview types. Section L must be complete before Section P can be done and Section P must be complete before Section S can be done.

SEGMENT = BENE

THE PLANTYPE VARIABLE COLLECTS PLAN TYPE IN SECTION E. PLANTYPE IS USED TO CONTROL SKIPS IN SECTION P.

COR_ORAG: GLOBAL DISPLAY: IF SOURCE = DMI(1), "company or organization", ELSE, "organization or agency"

PYEND: GLOBAL DISPLAY - DEFINED IN SECTION D TO INDICATE HEALTH INSURANCE PLAN YEAR. IF D9=2, “the year that ended D10MONB, D10YEARB”, else “1993”.

PLMONYR: GLOBAL DISPLAY - DEFINED IN SECTION D TO INDICATE HEALTH INSURANCE PLAN YEAR IF D9=2, “D10MONA, D10YEARA to D10MONB**,** D10YEARB”, else, “January, 1993 to December, 1993”.

DISPLAY BOX IS SHOWN ON SCREENS P1 - P21

[ASK TO SPEAK WITH R. WHEN R ON PHONE, READ INTRODUCTION.]

[My name is {INTERVIEWER NAME} and I am calling for the United States Department of Health and Human Services regarding a study about health benefits. This study collects information on the cost of providing health benefits to employees. Results will be used to develop estimates of health care spending and to evaluate health care reform.]

PGATE:

The (next/first) questions are about the plan's benefits, including deductibles and co-payments.

PLAN: {PLANNAME}
PLAN YEAR: {PLMONYR}

(1)

1. CONTINUE SECTION P WITH {RESPNAME}
3. GO TO QUESTIONNAIRE MANAGEMENT SCREEN QMS)
GT. GO TO RESULT
8. (NOT DISPLAYED - FOR DATAPREP PURPOSES ONLY. INDICATES SECTION WAS NOT ASKED AND -9 WAS ASSIGNED TO APPROPRIATE QUESTIONS IN THIS QUESTIONNAIRE SECTION OF PARTIALLY COMPLETE PLAN.)
*88. (NOT DISPLAYED - FOR DATAPREP PURPOSES ONLY. INDICATES SECTION WAS NOT ASKED, THIS QUESTIONNAIRE SECTION OF UNSTARTED PLAN LEFT EMPTY (ALL -1*S).)*

SKIP: SET P1 = 1 (PLAN COVERS BOTH INPATIENT AND OUTPATIENT CARE) GO TO P1A IF PLANTYPE = 1 (HMO), ELSE GO TO BOX P1

1 = PGATE, SIZE = C2

ASK IF PLANTYPE INSET(1,2,3) (COMPREHENSIVE PLANS) WHEN PGATE = 8 SET P1 =1

P1. **Did this plan cover both <u>inpatient</u> hospital care and <u>outpatient</u> medical services?**

(1)

1. YES, BOTH INPATIENT AND OUTPATIENT (SKIP)
2. NO, COVERS INPATIENT ONLY (SKIP)
3. NO, COVERS OUTPATIENT ONLY (SKIP)
4. NO, COVERS NEITHER (SPECIFY) (P1AA)

DK/REF GO TO P1AA. SKIP: GO TO P1A IF PLANTYPE = 1 (HMO), ELSE GO TO BOX P1

1 = P1, SIZE = N2

ASK IF P1 = 4, DK/REF (NOT DETERMINED THAT INPATIENT OR OUTPATIENT CARE COVERED)

P1AA. Did this plan cover hospital stays?

(1)

1. YES
2. NO

ALL RESPONSES INCLUDING DK/REF GO TO P1B

1 = P1AA, SIZE = N2

ASK IF P1 = 4, DK/REF (NOT DETERMINED THAT INPATIENT OR OUTPATIENT CARE COVERED)

P1B. Did this plan cover visits to the doctor?

[PROBE: Excluding visits from the doctor during a stay in the hospital.]

(1) (SKIP)

1. YES
2. NO

SKIP: IF P1AA=1 & P1B=1, RESET P1=1 AND GO TO P1A, IF PLANTYPE = 1 (HMO),ELSE GO TO BOX P1,(IF HOSPITAL STAYS & VISITS TO THE DOCTOR COVERED, SET P1 = BOTH INPATIENT AND OUTPATIENT SERVICES COVERED);

ELSE, IF P1AA=1 & P1B=2/DK/REF, RESET P1=2 AND GO TO P1A, IF PLANTYPE = 1 (HMO), ELSE GO TO BOX P1, (IF HOSPITAL STAYS ONLY COVERED, SET P1 = INPATIENT SERVICES COVERED ONLY);

ELSE, IF P1AA=2,DK/REF AND P1B=1, RESET P1=3 AND GO TO PIA,IF PLANTYPE = 1 (HMO), EKSE GI TI BIX P1,(IF VISITS TO THE DOCTOR ONLY COVERED, SET P1 = OUTPATIENT SERVICES COVERED ONLY)

ELSE, IF P1AA & P1B = 2/DK/REF, GO TO OVERLAY: (IF NEITHER HOSPITAL STAYS OR VISITS TO THE DOCTOR COVERED, SET P1 = NEITHER INPATIENT NOR OUTPATIENT SERVICES COVERED)

1 = P1B, SIZE = N2

OVERLAY:

P1OTH. What does this plan cover?

(2) SET PLANTYPE = 99* & GO TO NEXT PLAN SKIP P & S

2 = P1OTH, SIZE = C60 (show as text line)

*** NOTE: PLANTYPE "99" was a temporary value later reviewed by data preparation specialists. Upon review, it was updated to either a valid health insurance plan type or a "98" (enumerated in-scope, but not a health insurance plan).**

ASK IF PLANTYPE=1 (HMO), ELSE GO TO BOX P1

P1A. **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?**

(1)

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

ALL RESPONSES, INCLUDING DK/REF GO TO BOX P1

1 = P1A, SIZE = N2

BOX P1	**IF P1 = 1 (BOTH INPATIENT AND OUTPATIENT COVERED), GO TO P2** **IF P1 = 2 (INPATIENT ONLY COVERED), GO TO P3** **ELSE, IF P1 = 3 (OUTPATIENT ONLY COVERED), GO TO P4**

ASK FOR ALL PLAN TYPES IF P1=1 (BOTH INPATIENT & OUTPATIENT COVERED).

DISPLAY1 = "when the employee used {DISPLAY2}?" IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A=1) (HMO W/ OUTSIDE SERVICES COVERED), ELSE " ".

DISPLAY2: "preferred providers?" if PLAN TYPE = 2; "providers in the plan?" if PLAN TYPE = 1

P2. **Did this plan have an annual deductible for basic medical services {DISPLAY1}?**

[PROBE: Basic medical service include hospital stays and doctor visits.]

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

(1)

1. YES (P2A)
2. NO (BOX P1A)

DK/REF GO TO BOX P1A

1 = P2, SIZE = N2

BOX P1A	**IF PLANTYPE = 3 (CONVENTIONAL) OR (PLANTYPE =1 & P1A ^= 1) (HMO/OUTSIDE SERVICES <u>NOT</u> COVERED) GO TO P7; ELSE GO TO P5**

ASKED FOR ALL PLAN TYPES IF P2=1 (HAS DEDUCTIBLE AND PLAN COVERS BOTH INPATIENT AND OUTPATIENT)

DISPLAY1 = "when the employee used {DISPLAY2}?" IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A=1) (HMO W/ OUTSIDE COV.), ELSE " ".

DISPLAY2: "preferred providers?" if PLAN TYPE = 2; "providers in the plan?" if PLAN TYPE = 1

P2A. Did the same deductible apply to both inpatient and outpatient services {DISPLAY1}?

(1)

1. YES, SAME DEDUCTIBLE (P2B)
2. NO, DIFFERENT DEDUCTIBLES (P3)

DK/REF GO TO (P3)

1 = P2A, SIZE = N2

ASKED FOR ALL PLAN TYPES IF P2A=1 (SAME DEDUC. FOR INPATIENT & OUTPATIENT)

DISPLAY1 = "when the employee used {DISPLAY2}?" IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A=1) (HMO W/ OUTSIDE COV.), ELSE " ".

DISPLAY2: "preferred providers?" if PLAN TYPE = 2; "providers in the plan?" if PLAN TYPE = 1

P2B. **What was the deductible for an individual with single coverage {DISPLAY1}?**

(1)

1. SINGLE DOLLAR AMOUNT $(2)
2. RANGE $(3) TO $(4)

ALL RESPONSES, INCLUDING DK/REF GO TO BOX P3

1 = P2BFMT, SIZE = N2
2 = P2BAMT, SIZE = N5, HR: 1 TO 99,999, SR: 100 TO 2,000 ***(NOTE: ONE P2BAMT WAS LATER UPDATED TO 0)***
3 = P2BAMTL, SIZE = N5, HR: 0 TO 99,999, SR: 0 TO 5,000
4 = P2BAMTH, SIZE = N5, HR: 1 TO 99,999, SR: 200 TO 5,000

SOFT EDIT: P2BAMTH MUST BE > P2BAMTL. IF NOT, SHOW REVERSE VIDEO MESSAGE BELOW. REASK P2B. IF DISCREPANCY RESOLVED SET CCRNP2B = 1, ELSE SET CCRNP2B = 2. THE HIGH END OF THE RANGE MUST BE GREATER THAN THE LOW END OF THE RANGE.

ASKED FOR ALL PLAN TYPES IF (P1=1 & P2A = 2/DK/REF) (BOTH COVERED, NOT THE SAME DEDUCTIBLE) OR P1=2 (INPATIENT ONLY)

DISPLAY1 = "when the employee used {DISPLAY2}?" IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A=1) (HMO W/ OUTSIDE COV.), ELSE " ".

DISPLAY2: "preferred providers?" if PLAN TYPE = 2; "providers in the plan?" if PLAN TYPE = 1

P3. Was there a deductible for <u>inpatient</u> services {DISPLAY1}?

(1)

1. YES (P3A)
2. NO (BOX P2)

DK/REF GO TO BOX P2

1 = P3, SIZE = N2

ASKED FOR ALL PLAN TYPES IF P3=1. (WAS AN INPATIENT DEDUCTIBLE)

P3A. **Was that (inpatient) deductible per hospital admission or for the year**?

(1)

1. PER ADMISSION
2. FOR THE YEAR
3. *PER DAY (Not displayed. For DP use only.)*

ALL RESPONSES, INCLUDING DK/REF GO TO P3B

1 = P3A, SIZE = N2

ASKED FOR ALL PLAN TYPES IF P3=1 (WAS AN INPATIENT DEDUCTIBLE)

DISPLAY1 = "when the employee used {DISPLAY2}?" IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A=1) (HMO W/ OUTSIDE COV.), ELSE " ".

DISPLAY2: "preferred providers?" if PLAN TYPE = 2; "providers in the plan?" if PLAN TYPE = 1

P3B. What was that (inpatient) deductible for an individual with single coverage {DISPLAY1}?

(1)

1. SINGLE DOLLAR AMOUNT $(2)
2. RANGE $(3) TO $(4)

ALL RESPONSES, INCLUDING DK/REF GO TO BOX P2

1 = P3BFMT, SIZE = N2
2 = P3BAMT, SIZE = N5, HR: 1 TO 99,999, SR: 100 TO 2,000
3 = P3BAMTL, SIZE = N5, HR: 0 TO 99,999, SR: 0 TO 5,000
4 = P3BAMTH, SIZE = N5, HR: 1 TO 99,999, SR: 200 TO 5,000

SOFT EDIT: P3BAMTH MUST BE > P3BAMTL. IF NOT, SHOW REVERSE VIDEO MESSAGE BELOW. REASK P3B. IF DISCREPANCY RESOLVED SET CCRNP3B = 1, ELSE SET CCRNP3B = 2. THE HIGH END OF THE RANGE MUST BE GREATER THAN THE LOW END OF THE RANGE.

BOX P2	**IF (PLANTYPE = 3 OR (PLANTYPE = 1 & P1A ^= 1)) & P1 = 2 (INPATIENT ONLY BY CONVENTIONAL OR HMO WITH OUTSIDE SERVICES NOT COVERED) GO TO BOX P6** **ELSE IF P1 = 2 (INPATIENT ONLY BY PPO OR HMO WITH OUTSIDE SERVICES COVERED)** **ELSE (BOTH INPATIENT & OUTPATIENT COVERED) GO TO P4**

ASKED IF P1=3 (OUTPATIENT ONLY) OR (P1=1 & P2A = 2/DK/REF) (BOTH COVERED, NOT THE SAME DEDUCTIBLE

DISPLAY1 = "when the employee used {DISPLAY2}?" IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A=1) (HMO W/ OUTSIDE COV.), ELSE " ".

DISPLAY2: "preferred providers?" if PLAN TYPE = 2; "providers in the plan?" if PLAN TYPE = 1

P4. **Was there an annual deductible for <u>outpatient</u> services {DISPLAY1}?**

(1)

1. YES (P4A)
2. NO (BOX P3)

DK/REF GO TO BOX P3

1 = P4, SIZE = N2

ASKED FOR ALL PLAN TYPES IF P4=1. (WAS OUTPATIENT DEDUCTIBLE)

DISPLAY1 = "when the employee used {DISPLAY2}?" IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A=1) (HMO W/ OUTSIDE COV.), ELSE " ".

DISPLAY2: "preferred providers?" if PLAN TYPE = 2; "providers in the plan?" if PLAN TYPE = 1

P4A. **What was that (outpatient) deductible for an individual with single coverage {DISPLAY1}?**

(1)

1. SINGLE DOLLAR AMOUNT $(2)
2. RANGE $(3) TO $(4)

ALL RESPONSES, INCLUDING DK/REF GO TO BOX P3

1 = P4AFMT, SIZE = N2
2 = P4AAMT, SIZE = N5, HR: 1 TO 99,999, SR: 100 TO 2,000
3 = P4AAMTL, SIZE = N5, HR: 0 TO 99,999, SR: 0 TO 5,000
4 = P4AAMTH, SIZE = N5, HR: 1 TO 99,999, SR: 200 TO 5,000

SOFT EDIT: P4AAMTH MUST BE > P4AAMTL. IF NOT, SHOW REVERSE VIDEO MESSAGE BELOW. REASK P4A. IF DISCREPANCY RESOLVED SET CCRNP4A = 1, ELSE SET CCRNP4A = 2. THE HIGH END OF THE RANGE MUST BE GREATER THAN THE LOW END OF THE RANGE.

BOX P3	**IF PLANTYPE = 3 OR (PLANTYPE = 1 & P1A ^= 1) (CONVENTIONAL OR HMO WITH OUTSIDE SERVICES NOT COVERED) GO TO BOX P6** **ELSE IF P1 = 3 (OUTPATIENT ONLY) GO TO P5F** **ELSE GO TO P5**

QUESTIONS P5 - P5G REFER SOLELY TO "NON-PREFERRED PROVIDERS" OR "PROVIDERS OUTSIDE THE PLAN" FOR PPO AND HMO WITH OUTSIDE SERVICES COVERED. ASK P5 IF (PLANTYPE = 2 & P1 = 1) OR ((PLANTYPE=1 & P1A = 1) & P1=1), (BOTH INP. & OUTPATIENT COVERAGE BY PPO OR HMO WITH OUTSIDE SERVICES COVERED)

DISPLAY1: "non-preferred providers?" if PLAN TYPE = 2; "providers outside the plan?" if PLAN TYPE = 1

P5. **Did this plan have an annual deductible for basic medical services when the employee used {DISPLAY1}?**

[PROBE: Basic medical service include hospital stays and doctor visits.]

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

(1)

1. YES (P5A)
2. NO (BOX P6)

DK/REF GO TO BOX P6

1 = P5, SIZE = N2

ASKED IF P5=1 (HAS DEDUCTIBLE FOR NON-PREFERRED PROVIDERS AND PLAN COVERS BOTH INPATIENT AND OUTPATIENT)

DISPLAY1: "non-preferred providers?" if PLAN TYPE = 2; "providers outside the plan?" if PLAN TYPE = 1

P5A. **Did the same deductible apply to both inpatient and outpatient services when the employee used {DISPLAY1}?**

(1)

1. YES, SAME DEDUCTIBLE (P5B)
2. NO, DIFFERENT DEDUCTIBLES (P5C)

DK/REF GO TO P5C

1 = P5A, SIZE = N2

ASKED IF P5A=1 (FOR NON-PREFERRED PROVIDERS, SAME DEDUCTIBLE FOR BOTH INPATIENT AND OUTPATIENT)

DISPLAY1: "<u>non-preferred</u> providers?" if PLAN TYPE = 2; "providers outside the plan?" if PLAN TYPE = 1

P5B. What was the deductible for an individual with single coverage when the employee used {DISPLAY1}?

(1)

1. SINGLE DOLLAR AMOUNT $(2)
2. RANGE $(3) TO $(4)

ALL RESPONSES, INCLUDING DK/REF GO TO BOX P6

1 = P5BFMT, SIZE = N2
2 = P5BAMT, SIZE = N5, HR: 1 TO 99,999, SR: 100 TO 2,000 ***(NOTE: ONE P5BAMT WAS LATER UPDATED TO "NOT ASCERTAINED" BY DATA PREP).***
3 = P5BAMTL, SIZE = N5, HR: 0 TO 99,999, SR: 0 TO 5,000
4 = P5BAMTL, SIZE = N5, HR: 1 TO 99,999, SR: 200 TO 5,000

SOFT EDIT: P5BAMTH MUST BE > P5BAMTL. IF NOT, SHOW REVERSE VIDEO MESSAGE BELOW. REASK P5B. IF DISCREPANCY RESOLVED SET CCRNP5B = 1, ELSE SET CCRNP5B = 2 THE HIGH END OF THE RANGE MUST BE GREATER THAN THE LOW END OF THE RANGE.

ASK P5C IF P5A = 2/DK/REF (FOR NON-PREFERRED PROVIDERS, INPATIENT AND OUTPATIENT DEDUCTIBLE NOT THE SAME) OR IF P1 = 2 (INPATIENT ONLY) & (PLANTYPE= 2 OR (1 (WITH P1A=1)) (PPO OR HMO WITH OUTSIDE SERVICES COVERED)

DISPLAY1: "non-preferred providers?" if PLAN TYPE = 2; "providers outside the plan?" if PLAN TYPE = 1

P5C. Was there a deductible for inpatient services when the employee used {DISPLAY1}?

(1)

1. YES (P5D)
2. NO (BOX P4)

DK/REF GO TO BOX P4

1 = P5C, SIZE = N2

ASKED IF P5C=1 (HAD INPATIENT DEDUCTIBLE FOR NON-PREFERRED PROVIDERS)

P5D. Was that (inpatient) deductible per hospital admission or for the year?

(1)

1. PER ADMISSION
2. FOR THE YEAR
3. *PER DAY (Not displayed. For DP use only.)*

ALL RESPONSES, INCLUDING DK/REF GO TO P5E

1 = P5D, SIZE = N2

ASKED IF P5C=1 (HAD INPATIENT DEDUCTIBLE FOR NON-PREFERRED PROVIDERS)

DISPLAY1: "non-preferred providers?" if PLAN TYPE = 2; "providers outside the plan?" if PLAN TYPE = 1

P5E. **What was that (inpatient) deductible for an individual with single coverage when the employee used {DISPLAY1}?**

(1)

1. SINGLE DOLLAR AMOUNT $(2)
2. RANGE $(3) TO $(4)

ALL RESPONSES, INCLUDING DK/REF GO TO BOX P4

1 = P5EFMT, SIZE = N2
2 = P5EAMT, SIZE = N5, HR: 1 TO 99,999, SR: 100 TO 2,000
3 = P5EAMTL, SIZE = N5, HR: 0 TO 99,999, SR: 0 TO 5,000
4 = P5EAMTH, SIZE = N5, HR: 1 TO 99,999, SR: 200 TO 5,000

SOFT EDIT: P5EAMTH MUST BE > P5EAMTL. IF NOT, SHOW REVERSE VIDEO MESSAGE BELOW. REASK P5E. IF DISCREPANCY RESOLVED SET CCRNP5E=1, ELSE SET CCRNP5E = 2. THE HIGH END OF THE RANGE MUST BE GREATER THAN THE LOW END OF THE RANGE.

BOX P4	**IF P1 = 2 (INPATIENT ONLY) GO TO BOX P6** **ELSE GO TO P5F**

ASK IF P5A = 2/DK/REF (INPATIENT AND OUTPATIENT DEDUCTIBLES NOT THE SAME FOR NON-PREFERRED PROVIDERS) OR P1 = 3 & (PLANTYPE = 2 OR (PLANTYPE = 1 & P1A = 1)) (OUTPATIENT ONLY BY PPO OR HMO WITH OUTSIDE SERVICES COVERED)

DISPLAY1: "non-preferred providers?" if PLAN TYPE = 2; "providers outside the plan?" if PLAN TYPE = 1

P5F. **Was there an annual deductible for outpatient services when the employee used {DISPLAY1}?**

(1)

1. YES (P5G)
2. NO (BOX P6)

DK/REF GO TO BOX P6

1 = P5F, SIZE = N2

ASKED IF P5F=1 (HAD OUTPATIENT DEDUCTIBLE FOR NON-PREFERRED PROVIDERS)

DISPLAY1: "<u>non-preferred</u> providers?" if PLAN TYPE = 2; "providers outside the plan?" if PLAN TYPE = 1

P5G. **What was that (outpatient) deductible for an individual with single coverage when the employee used {DISPLAY1}?**

(1)

1. SINGLE DOLLAR AMOUNT $(2)
2. RANGE $(3) to $(4)

ALL RESPONSES, INCLUDING DK/REF GO TO BOX P6

1 = P5GFMT, SIZE = N2
2 = P5GAMT, SIZE = N5, HR: 1 TO 99,999, SR: 100 TO 2,000
3 = P5GAMTL, SIZE = N5, HR: 0 TO 99,999, SR: 0 TO 5,000
4 = P5GAMTH, SIZE = N5, HR: 1 TO 99,999, SR: 200 TO 5,000

SOFT EDIT: P5GAMTH MUST BE > P5GAMTL. IF NOT, SHOW REVERSE VIDEO MESSAGE BELOW. REASK P5G. IF DISCREPANCY RESOLVED SET CCRNP5G = 1, ELSE SET CCRNP5G = 2. THE HIGH END OF THE RANGE MUST BE GREATER THAN THE LOW END OF THE RANGE.

BOX P6	ASK P6 UNLESS: PLAN.FAMILY ^=1 OR IF PLANTYPE=3 OR (PLANTYPE=1 & P1A^=1) AND P1=1 & P2^=1, OR P1=2 & P3^=1, OR P1=3 & P4^=1 OR IF PLANTYPE=2 OR (PLANTYPE=1 & P1A=1) AND P1=1 & P2^=1 & P5^=1, OR P1=2 & P3^=1 & P5C^=1, OR P1=3 & P4^=1 & P5F^=1 ASK P6 UNLESS: FAMILY COVERAGE NOT OFFERED OR THERE WAS NO DEDUCTIBLE ELSE, GO TO P7 IF P1 ^=3 (NOT OUTPATIENT ONLY) ELSE GO TO P8

P6. What was the maximum deductible to be paid by the family in {PYEND}?

(1)

1. NUMBER OF PEOPLE MEETING INDIVIDUAL DEDUCTIBLES (2)
2. DOLLAR AMOUNT $ (3)
3. NUMBER OF PEOPLE (4) OR DOLLAR AMOUNT (5)
4. *NO MAXIMUM (Not displayed. For DP use only.)**
5. *MAXIMUM AS A PERCENTAGE OF ANNUAL SALARY (6) (Not displayed. For DP use only.)**

91. OTHER (7)

ALL RESPONSES INCLUDING DK/REF GO TO P7 IF P1 ^= 3 (NOT OUTPATIENT ONLY), ELSE GO TO P8

1 = P6FMT, SIZE=N2
2 = P6NUMA, SIZE=N2, HR: 1 TO 99, SR: 2 TO 6
3 = P6AMTA, SIZE=N5, HR: 1 TO 99,999, SR: 200 TO 10,000 ***(NOTE: ONE P6AMTA WAS LATER UPDATED TO 0 BY DATA PREP)***
4 = P6NUMB, SIZE=N2, HR: 1 TO 99, SR: 2 TO 6
5 = P6AMTB, SIZE=N5, HR: 1 TO 99,999, SR: 200 TO 10,000
6 = P6PCT, SIZE=N3, HR: 1 TO 100
7 = P6OTH, SIZE=C40

***See appendix at end of Section P**

ASK P7 IF P1^=3 (BOTH OR INPATIENT ONLY)

DISPLAY1: "After the deductible had been met, what" if P2A=1 or P3=1, ELSE "What"

P7. **{DISPLAY1} was the co-insurance rate for basic inpatient services?**

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

(1)

1. NOT COVERED
2. 0% OR NONE
3. 10% or "90-10"
4. 15% or "85-15"
5. 20% or "80-20"
6. 25% or "75-25"
7. 30% or "70-30"
8. 50% or "50-50"
9. VARIES (2)
10. *5% or "95-5" (Not displayed. For DP use only.)**
11. *35% or "65-35" (Not displayed. For DP use only.)**
12. *40% or "60-40" (Not displayed. For DP use only.)**
13. *INPATIENT CO-PAY (4) (Not displayed. For DP use only.)**

91. OTHER (SPECIFY) (3)

ALL RESPONSES INCLUDING DK/REF GO TO P8 IF P1 ^= 2 (NOT INPATIENT ONLY), ELSE GO TO P15.

1 = P7, SIZE=N2
2 = P7VAR, SIZE=C40
3 = P7OTH, SIZE=C40
4 = P7AMT, SIZE=N5, HR: 1 TO 99,999 ***(NOTE: SOME P7AMT WERE LATER UPDATED TO "NOT ASCERTAINED")***

***See appendix at end of Section P**

ASK P8 IF P1^=2 (BOTH OR OUTPATIENT ONLY)

DISPLAY1: "After the deductible had been met, did" if P2A=1 or P4=1, ELSE "Did"

DISPLAY2: "doctor who was a preferred provider?" if PLANTYPE=2; "doctor who was a provider in the plan ?" if PLANTYPE=1 & P1A=1; ELSE "doctor?".

P8. **{DISPLAY1} employees have to pay anything when they saw a {DISPLAY2}**

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

(1)

1. YES (P9)
2. NO (SKIP)

DK/REF GO TO SKIP

1 = P8, SIZE=N2

SKIP: GO TO P11 IF PLANTYPE = 2 OR (PLANTYPE = 1 & P1A = 1) (PPO OR HMO WITH OUTSIDE SERVICES COVERED), ELSE GO TO P15.

ASK P9 IF P8 = 1 (EMPLOYEE HAD TO PAY WHEN HE SAW A DOCTOR)

DISPLAY1: "After the deductible had been met, how" if P2A=1 or P4=1, ELSE "How".

DISPLAY2: "doctor who was a preferred provider?" if PLANTYPE=2; "doctor who was a provider in the plan ?" if PLANTYPE=1 & P1A=1; ELSE "doctor?"

P9. {DISPLAY1} much did the employee pay when they saw a {DISPLAY2}

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

[PROBE: What was the reimbursement rate?]

(1)

1. DOLLAR AMOUNT [CO-PAYMENT] $(2)
2. PERCENT [CO-INSURANCE] (P10)
3. RANGE $(3) TO (4)
4. *DOLLAR AMOUNT OR PERCENT (Not displayed. For DP use only.)**
91. OTHER (5)

ALL RESPONSES INCLUDING DK/REF GO TO P11 (RESPONSE 2 GOES TO P10 FIRST) IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A = 1) (HMO WITH OUTSIDE SERVICES COVERED), ELSE GO TO P15.

1 = P9UNT, SIZE=N2
2 = P9AMT, SIZE=N3, HR: 1 TO 999, SR: 2 TO 50 ***(NOTE: SOME P9AMT WERE LATER UPDATED TO 0 BY DATA PREP)***
3 = P9AMTL, SIZE = N3, HR: 1 TO 999, SR: 2 TO 50 ***(NOTE: SOME P9AMTL WERE LATER UPDATED TO 0 BY DATA PREP)***
4 = P9AMTH, SIZE = N3, HR: 1 TO 999, SR: 2 TO 50
5 = P9OTH, SIZE=C40

SOFT EDIT: P9AMTH MUST BE > P9AMTL. IF NOT, SHOW REVERSE VIDE MESSAGE BELOW. REASK P9. IF DISCREPANCY RESOLVED SET CCRNP9A = 1, ELSE SET CCRNP9A = 2. THE HIGH END OF THE RANGE MUST BE GREATER THAN THE LOW END OF THE RANGE.

See appendix at end of Section P

ASK P10 IF P9UNT=2 **(EMPLOYEE PAID A PERCENTAGE WHEN HE SAW A DOCTOR)**

DISPLAY1: "After the deductible had been met, what" if P2A=1 or P4=1, ELSE "What"

DISPLAY2: "doctor who was a preferred provider?" if PLANTYPE=2; "doctor who was a provider in the plan ?" if PLAN TYPE=1 & P1A=1; ELSE "doctor?"

P10. {DISPLAY1} was the co-insurance rate when an employee saw a {DISPLAY2}

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

[IF OBVIOUS, CODE WITHOUT ASKING]

(1)

1. 10% OR "90-10"
2. 15% OR "85-15"
3. 20% OR "80-20"
4. 25% OR "75-25"
5. 30% OR "70-30"
6. 40% OR "60-40"
7. 50% OR "50-50"
8. CO-INSURANCE RATE VARIES (2)
9. *35% OR "65-35" (Not displayed. For DP use only.)**
10. *5% OR "95-5" (Not displayed. For DP use only.)**

ALL RESPONSES INCLUDING DK/REF GO TO P11. IF PLANTYPE = 2 (PPO) OR (PLANTYPE = 1 & P1A = 1) (HMO WITH OUTSIDE SERVICES COVERED), ELSE GO TO P15.

1 = P10, SIZE=N2
2 = P10VAR, SIZE=C40

See appendix at end of Section P

***ASK P11 IF (PLANTYPE = 2 & P1^=2) OR* IF ((PLANTYPE=1 & P1A=1) & P1^=2)) (NOT OUTPATIENT ONLY AND PLANTYPE = PPO OR HMO WITH OUTSIDE SERVICES COVERED)**

DISPLAY1: "After the deductible had been met, how" if P5A=1 or P5F=1; ELSE "How"

DISPLAY2: "doctor who was a non-preferred provider?" if PLAN TYPE=2; "doctor who was a provider outside the plan ?" if PLANTYPE=1 & P1A=1, ELSE, "doctor".

P11. **{DISPLAY1} much did an employee pay when they saw a {DISPLAY2}?**

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

[PROBE: What was the reimbursement rate?]

(1)

1. DOLLAR AMOUNT [CO-PAYMENT] $(2)
2. PERCENT [CO-INSURANCE] (P12)
3. NOT COVERED AT ALL
4. *DOLLAR AMOUNT/RANGE $ (3) TO (4)*
5. *CO-PAY THEN CO-INSURANCE (NOT DISPLAYED. FOR DP USE ONLY.)**

91. OTHER (SPECIFY) (5)

ALL RESPONSES INCLUDING DK/REF GO TO P15 (RESPONSE 2 GOES TO P12 FIRST)

1 = P11UNT, SIZE=N2
2 = P11AMT, SIZE=N3, HR: 1 TO 999, SR: 2 TO 75 *(NOTE: SOME P11AMT WERE LATER UPDATED TO 0 BY DATA PREP)**
3 = P11AMTL, SIZE = N3, HR: 1 TO 999, SR: 2 TO 75 *(NOTE: SOME P11AMTL WERE LATER UPDATED TO 0 BY DATA PREP)**
4 = P11AMTH, SIZE = N3, HR: 1 TO 999, SR: 2 TO 75
5 = P11OTH, SIZE=C40

SOFT EDIT: P11AMTH MUST BE > P11AMTL. IF NOT, SHOW REVERSE VIDEO MESSAGE BELOW. REASK P11. IF DISCREPANCY RESOLVED SET CCRNP11 = 1, ELSE SET CCRNP11 = 2. THE HIGH END OF THE RANGE MUST BE GREATER THAN THE LOW END OF THE RANGE.

See appendix at end of Section P

ASK P12 IF P11UNT = 2 (EMPLOYEE PAID PERCENTAGE SHEN HE SAW NON-PREFFERED PROVIDER)

DISPLAY1: "After the deductible had been met, what" if P5=1 or 2; ELSE "What"

DISPLAY2: "doctor who was a non-preferred provider?" if PLAN TYPE=2; "doctor who was a provider outside the plan ?" if PLANTYPE=1 & P1A=1, ELSE, "doctor"..

P12. **{DISPLAY1} was the co-insurance rate when an employee used a {DISPLAY1}**

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

[IF OBVIOUS, CODE WITHOUT ASKING]

(1) (P15)

1. 10% OR "90-10"
2. 15% OR "85-15"
3. 20% OR "80-20"
4. 25% OR "75-25"
5. 30% OR "70-30"
6. 40% OR "60-40"
7. 50% OR "50-50"
8. CO-INSURANCE RATE VARIES (2)
9. *35% OR "65-35" (Not displayed. For DP use only.)**
10. *5% OR "95-5" (Not displayed. For DP use only.)**

DK/REF GO TO P15

1 = P12, SIZE=N2
2 = P12VAR, SIZE=C40

**** See appendix at end of Section P***

ASKED OF ALL COMPREHENSIVE PLAN TYPES (PLANTYPE = 1, 2, OR 3)

P15. **Was there a maximum amount that this plan would pay over an employee's <u>lifetime</u>?**

[PROBE: Do not include limits that apply only to mental health, or to certain diseases such as cancer or AIDS.]

(1) (P16)

1. YES, ONE MILLION DOLLARS
2. YES, OTHER DOLLAR AMOUNT $(2)
3. NO LIFETIME LIMIT
91. OTHER (SPECIFY) (3)

DK/REF GO TO P16

1 = P15FMT, SIZE=N2
2 = P15AMT, SIZE=N8, HR: 1 TO 99,999,999, SR: 1,000 TO 1,000,000 ***(NOTE: SOME P15AMT WERE LATER UPDATED TO 0 BY DATA PREP*****)**
3 = P15OTH, SIZE=C40

ASKED OF ALL COMPREHENSIVE PLAN TYPES (PLANTYPE = 1, 2, OR 3)

DISPLAY1: "or their dependents" if PLAN.FAMILY = 1, ELSE, " ".

P16. **Could this plan refuse to cover employees {DISPLAY1} who had particular health problems or conditions?**

(1)

1. YES (P17)
2. NO (P20)

DK/REF GO TO P20

1 = P16, SIZE=N2

ASKED IF P16 = 1 (PLAN COULD REFUSE TO COVER CERTAIN EMPLOYEES)

DISPLAY1: "or their dependents" IF PLAN.FAMILY = 1, ELSE, " ".

DISPLAY2: "Was that active employees, dependents, or both?" IF PLAN.FAMILY = 1, ELSE, " ".

CATEGORIES 2 & 3 ARE SHOWN ONLY IF PLAN.FAMILY = 1, ELSE, " ".

P17. **In {PYEND}, were any of your active employees {DISPLAY1) refused coverage because of a particular health problem or condition?**

{DISPLAY2}

(1)

1. YES, ACTIVE EMPLOYEES (P18)
{2. YES, DEPENDENTS (P19)}
{3. YES, BOTH (P18)}
4. NO (P20)

DK/REF GO TO P20

1 = P17, SIZE=N2

ASKED IF P17 = 1 OR 3 (ACTIVE EMPLOYEES WERE REFUSED COVERAGE)

P18. **How many <u>active</u> employees were refused coverage at the end of {PYEND}?**

[WILL ACCEPT AN ESTIMATE IF NUMBER NOT KNOWN]

(1) EMPLOYEES (BOX P8)

DK/REF GO TO BOX P8

1 = P18, SIZE=N3, HR: 1 TO 999, SR: 1 TO 100

BOX P8	**IF P17 = 3 (BOTH EMPLOYEES & THEIR DEPENDENTS WERE REFUSED COVERAGE) GO TO P19** **ELSE GO TO P20**

ASKED IF P17 = 2 OR 3 (DEPENDENTS WERE REFUSED COVERAGE)

P19. **How many <u>dependents</u> of employees were refused coverage at the end of {PYEND}?**

[WILL ACCEPT AN ESTIMATE IF NUMBER NOT KNOWN]

(1) DEPENDENTS (P20)

DK/REF GO TO P20

1 = P19, SIZE=N3, HR: 0 TO 999, SR: 0 TO 100

ASKED OF ALL COMPREHENSIVE PLAN TYPES (PLANTYPE = 1, 2, OR 3)

DISPLAY1: "or their dependents" if PLAN.FAMILY = 1, ELSE, " ".

P20. **Did this plan have a waiting period for pre-existing conditions for employees {DISPLAY1}?**

(1)

1. YES [INCLUDE FOR SOME EMPLOYEES OR CONDITIONS] (P21)
2. NO

IF P20 = 2 OR DK/REF GO TO RESPONDENT'S NEXT SECTION.

1 = P20, SIZE=N2

ASKED IF P20 = 1 (PLAN HAD WAITING PERIOD FOR PRE-EXISTING CONDITIONS)

DISPLAY BOTH PARTS TO QUESTION ON ONE SCREEN; PART TWO IS NOT AN OVERLAY

P21. **How long did a person have to wait to be covered for such problems?**

[IF WAITING PERIOD DIFFERED BETWEEN "IN TREATMENT" AND "NOT IN TREATMENR", ENTER PERIOD FOR <u>IN TREATMENT</u>.]

(1)

1. DAYS (2)
2. MONTHS (3)
3. YEARS (4)
4. NEVER COVERED
91. OTHER (SPECIFY) (5)

IF P21 ^= 4 COLLECT P21TX, ELSE GO TO RESPONDENT'S NEXT SECTION.

P21TX. **[WERE THE WAITING PERIODS DIFFERENT BETWEEN "IN TREATMENT" AND "NOT IN TREATMENT"?]**

[IF NOT VOLUNTEERED, ENTER 2.]

(6)

1. YES
2. NO

1 = P21UNT, SIZE=N2
2 = P21DAY, SIZE=N3, HR: 1 TO 999, SR: 1 TO 365
3 = P21MON, SIZE=N2, HR: 1 TO 99, SR: 1 TO 24
4 = P21YEAR, SIZE=N2, HR: 1 TO 99, SR: 1 TO 2
5 = P21VAR, SIZE=C40
6 = P21TX, SIZE=N2

GO TO RESPONDENT'S NEXT SECTION.

SECTION P APPENDIX

BENE.P1OTH

Does the plan cover inpatient or outpatient services, other/specify
This is the variable that holds the description of what the plan covers when it does not cover inpatient services, outpatient services or both. These responses were reviewed, and recoded to covering both inpatient and outpatient services. All plans originally coded as PLANTYPE = 99 were refielded to complete sections P and S or coded as partially complete if the interview could not be completed.

BENE.P6FMT

Maximum deductible to be paid by a family
New value:

4 NO MAXIMUM
5 PERCENT OF ANNUAL SALARY

Note: when P6FMT = 5 then a percentage was coded in P6PCT.

BENE.P6PCT

Maximum deductible to be paid by a family as a percentage of annual salary
Variable added.

BENE.P6OTH

Maximum family deductible other/specify
This is the variable holding the description of the maximum family deductible when P6FMT was coded "other". These responses were reviewed and recoded as follows:

- "Number of people meeting $X deductible" -- coded to -9.
- "$X deductible per person (family member, or covered person, etc.)", "doesn't apply", "didn't have any" etc. -- coded to 4 NO FAMILY MAXIMUM.
- "$X to $X" -- coded the highest dollar amount.
- "$X for preferred, $X for non-preferred" -- coded the non-preferred amount.
- "X% up to first $5,000" -- coded 4 NO FAMILY MAXIMUM.
- "X% of annual salary" -- coded to 5 PERCENT OF ANNUAL SALARY.

P6OTH was then reset to -1.

BENE.P7

Inpatient co-insurance
New values:

10 5% or "95 - 5"
11 35% or "65 - 35"
12 40% or "60 - 40"
13 INPATIENT CO-PAY

Note: when P7 = 13, then an amount was coded in P7AMT.

BENE.P7AMT

Inpatient co-pay (dollar amount)
Variable added.

BENE.P7VAR

Inpatient co-insurance varies/specify
This is the variable holding the description of the inpatient co-insurance rate when P7 was coded "varies". These responses were reviewed and coded as follows:

- "$X" -- coded to 13 INPATIENT CO-PAY.
- "X% for preferred, X% for non-preferred" -- coded preferred.
- "X%, X% or X%" -- coded the lowest co-insurance rate (the rate most generous to the employee, for example given "80-20 or 70-30", 20% or "80-20" was coded.)
- "100%" -- coded to 2 0% OR NONE.
- "X% for single, X% for family" -- coded single.
- All other responses were coded to -9.

P7VAR or P7OTH was then reset to -1.

BENE.P7OTH

Inpatient co-insurance other/specify

This is the variable holding the description of the inpatient co-insurance rate when P7 was coded "other". These responses were reviewed and recoded.
See coding specifications under BENE.P7VAR.

BENE.P9UNT

Preferred provider outpatient co-pay
New values:
4 CO-PAY OR CO-INSURANCE
Note: when P9UNT = 4, then an amount was coded in P9AMT and a percent in P1

BENE.P90TH

Preferred provider outpatient co-pay other/specify
This is the variable that holds the description of the outpatient co-pay when P9UNT was coded "other". These responses were reviewed and coded as follows:
- "$0", "0%", "employee pays nothing", etc. -- coded P8 = 2.
- "$X (X%) for preferred, $X (X%) for non-preferred" -- coded the preferred.
- "100%", "100% then file a claim (then reimbursed, etc.)" -- coded P9UNT = -9.
- "$X or X%" -- coded 4 CO-PAY OR CO-INSURANCE.
- "$X to $X", "X% to X%" -- coded the low end of the range or the one most generous to the employee (given "$10 - $15", $10 was coded).
- All other responses -- coded P9UNT = -9.

P9OTH or P10VAR were then reset to -1.

BENE.P10

Preferred provider outpatient co-insurance rate
New values:
9 35% or "65 - 35"
10 5% or "95 - 5"

BENE.P10VAR

Preferred provider outpatient co-insurance rate varies/specify
This is the variable that holds the description of the outpatient co-insurance rate when P10 was coded "varies". These responses were reviewed and coded.
See the coding specifications under BENE.P9OTH.

BENE.P11UNT

Non-preferred provider outpatient co-pay
New value:
5 CO-PAY THEN CO-INSURANCE
Note: when P11UNT = 5, an amount was coded in P11AMT and a percent in P12.

BENE.P11OTH

Non-preferred provider outpatient co-pay other/specify
This is the variable that holds the description of the outpatient co-pay when P11UNT is coded "other". These responses were reviewed and coded as follows:
- "$0", "0%", "employee pays nothing", etc. -- coded P11UNT = 1, and P11AMT = 0
- "$X plus X%" -- coded P11UNT = 5 CO-PAY THEN CO-INSURANCE.
- "$X if referral (preferred), $X if not referral (non-preferred)" -- coded non-preferr
- "$X to $X", "X% to X%" -- coded the high end of the range or the one least genero to the employee (given "80-20 or 70-30", 30% or "70-30" was coded).
- "100%", "100% after deductible", "all", etc. -- coded P11UNT = 3 NOT COVERE
- "100% then file a claim (reimbursed)" -- coded P11UNT = -9.
- All other responses -- coded P11UNT = -9.

P11OTH was then reset to -1.

BENE.P12

Non-preferred provider outpatient co-insurance rate
New values:
9 35% or "65 - 35"
10 5% or "95 - 5 "

BENE.P12VAR

Non-preferred provider outpatient co-insurance rate varies/specify

This is the variable that holds the description of the co-insurance rate when P12 was coded "varies". These responses were reviewed and coded as follows:

- "55%" -- coded P12 = 7 50% or "50 - 50".
- "100%" -- coded P11UNT = 3 NOT COVERED AT ALL.
- "X% or X%" -- coded the higher co-insurance rate or the rate least generous to the employee (given "80-20 or 70-30", 30% or "70-30" was coded).
- "X% for referral, X% w/out referral" -- coded the non-preferred (no referral)
- All other responses -- coded P11UNT = -9.

P12VAR was then reset to -1.

BENE.P15OTH *Maximum lifetime benefit other/specify*

This is the variable that holds the description of the maximum lifetime benefit payable when P15FMT was coded "other". These responses were reviewed and coded as follow

- "$X in PPO, $X out of PPO" -- coded the "in PPO" limit.
- "$X to $X" -- coded the high end of the range or the absolute maximum limit.
- "$1,000" or "$X per year (annually, yearly, etc.)" -- coded P15FMT = -9.
- "Not sure", "Don't know", etc. -- coded P15FMT = -8.
- "$1 million every 5 years", "each occurrence", "$150K for 1ST year, then $10K aft coded P15FMT = -9.

P15OTH was then reset to -1.

BENE.P16 *Could the plan refuse coverage to employees or dependents with particular health*

P16 was coded "No" when comments indicated that the plan could only refuse coverage if an employee did not enroll by the open enrollment deadline.

BENE.P21VAR *Waiting period for pre-existing condition varies/specify*

This is the variable that holds the description of the waiting period when P21UNT was coded "varies". These responses were reviewed and coded as follows:

- "X limit in treatment, X limit not in treatment" -- coded in treatment limit, set P21T
- "varied by condition", "depends", "depends on illness" -- coded P21UNT = -9.
- "difference between employee or dependent" -- coded employee limit if given, else
- "X limit in network, X limit out of network" -- coded the in network limit if given, el
- "X to X months" -- coded the high end of the range.
- "next enrollment time" -- coded one year.
- Any response indicating that there is no waiting period -- coded P20 = 2.
- Any response indicating that the insurer won't ever cover the condition -- coded P21UNT = 4 NEVER COVERED.
- All other responses -- coded P21UNT = -9.

P21VAR was then reset to -1.