M. HEALTH INSURANCE PAGE

Read to respondent(s): **Medicare is a Social Security health insurance program for disabled persons and for persons 65 years old and over. People covered by Medicare have a card that looks like this.** *Show card.*	

1a. Is anyone in this family, that is *(read names),* **now covered by Medicare?** ☐ Yes ☐ No *(4)* ☐ DK	
b. Is — — now covered?	**1b.** 1 ☐ Covered 9 ☐ DK 2 ☐ Not covered

Ask for each person with "Covered" in 1b: **2a. Is — — now covered by the part of Social Security Medicare which pays for hospital bills?** *Mark box in person's column.*	**2a.** 1 ☐ Yes 9 ☐ DK 2 ☐ No
b. Is — — now covered by that part of Medicare which pays for doctor's bills? This is the Medicare plan for which — — or some agency must pay a certain amount each month. *Mark box in person's column.*	**b.** 1 ☐ Yes 9 ☐ DK 2 ☐ No

Ask for each person with "DK" in 2a and/or b: **3. May I please see the Social Security Medicare card(s) for — — (and — —) to determine the type of coverage?** *Transcribe the information from the card or mark the "Card N.A." box.*	**3.** 1 ☐ Hospital 2 ☐ Medical 3 ☐ Card N.A.

We are interested in all kinds of health insurance plans except those which pay only for accidents. **4a. (Not counting Medicare) Is anyone in the family now covered by a health insurance plan which pays any part of a hospital, doctor's or surgeon's bill?** ☐ Yes ☐ No *(M1)* ☐ DK *(M1)*	
b. What is the name of the plan? *Record in Table H.I.*	
c. Is anyone in the family now covered by any other health insurance plan which pays any part of a hospital, doctor's or surgeon's bill? ☐ Yes *(Reask 4b and c)* ☐ No *(5)*	

TABLE H.I.

▶ PLAN 1	6a. Does this plan pay any part of hospital expenses?	7. Is — — covered under this *(name)* plan?	7.
5a. Was this *(name)* **plan obtained through an employer or union?** 1 ☐ Yes 2 ☐ No *(6)* 9 ☐ DK *(6)* **b. Is it now carried through an employer or union?** 1 ☐ Yes 2 ☐ No 9 ☐ DK	1 ☐ Yes 2 ☐ No 9 ☐ DK **b. Does this plan pay any part of doctor's or surgeon's bills for operations?** 1 ☐ Yes 2 ☐ No 9 ☐ DK		1 ☐ Covered *(NP)* 2 ☐ Not covered *(NP)*
▶ PLAN 2	6a. Does this plan pay any part of hospital expenses?	7. Is — — covered under this *(name)* plan?	7.
5a. Was this *(name)* **plan obtained through an employer or union?** 1 ☐ Yes 2 ☐ No *(6)* 9 ☐ DK *(6)* **b. Is it now carried through an employer or union?** 1 ☐ Yes 2 ☐ No 9 ☐ DK	1 ☐ Yes 2 ☐ No 9 ☐ DK **b. Does this plan pay any part of doctor's or surgeon's bills for operations?** 1 ☐ Yes 2 ☐ No 9 ☐ DK		1 ☐ Covered *(NP)* 2 ☐ Not covered *(NP)*
▶ PLAN 3	6a. Does this plan pay any part of hospital expenses?	7. Is — — covered under this *(name)* plan?	7.
5a. Was this *(name)* **plan obtained through an employer or union?** 1 ☐ Yes 2 ☐ No *(6)* 9 ☐ DK *(6)* **b. Is it now carried through an employer or union?** 1 ☐ Yes 2 ☐ No 9 ☐ DK	1 ☐ Yes 2 ☐ No 9 ☐ DK **b. Does this plan pay any part of doctor's or surgeon's bills for operations?** 1 ☐ Yes 2 ☐ No 9 ☐ DK		1 ☐ Covered *(NP)* 2 ☐ Not covered *(NP)*

M1 *Review 1 and 7 for each person and determine if "Covered" by either Medicare and/or insurance, or "Not covered."*	**M1** 1 ☐ Covered *(NP)* 2 ☐ Not covered under 65 *(NP)* 3 ☐ Not covered 65 and over *(NP)*

Ask for each person "Not covered" in M1. If "Not covered 65 and over," include "or Medicare." **8a.** {**Many people do not carry health insurance for various reasons.**} *Hand Card M.* **Which of those statements describes why — — is not covered by any health insurance (or Medicare)?** **Any other reason?** *Circle all reasons given.*	**8a.** 1 2 3 4 5 6 7 8 ⤸ ___Specify___
Mark box if only one reason. If "Not covered 65 and over," in M1, include "or Medicare." **b. What is the MAIN reason — — is not covered by any health insurance (or Medicare)?**	00 ☐ Only one reason **b.** 1 2 3 4 5 6 7 8 ⤸ ___Specify___

FORM HIS-1 (1984) (6-9-83)

M. HEALTH INSURANCE PAGE, Continued

Ask only if persons under 20 in family: **9a.** Does anyone in this family now receive assistance through the "Aid to Families with Dependent Children" Program, sometimes called "AFDC" or "ADC"? ☐ Yes ☐ No *(10)* ☐ DK	
b. Does — — now receive AFDC or ADC?	**9b.** 1 ☐ Yes 2 ☐ No 9 ☐ DK
10a. Does anyone in this family now receive the "Supplemental Security Income" or "SSI" gold-colored check? ☐ Yes ☐ No *(11)* ☐ DK	
b. Does — — now receive this check?	**10b.** 1 ☐ Yes 2 ☐ No 9 ☐ DK
11a. There is a national program called Medicaid which pays for health care for persons in need. (In this State it is also called *(name)*). During the past 12 months, has anyone in this family received health care which has been or will be paid for by Medicaid (or *(name)*)? ☐ Yes ☐ No *(12)* ☐ DK	
b. Has — — received this care in the past 12 months?	**11b.** 1 ☐ Yes 2 ☐ No 9 ☐ DK
12a. Does anyone in the family now have a Medicaid (or *(name)*) card which looks like this? *Show Medicaid card(s).* ☐ Yes ☐ No *(13)* ☐ DK	
b. Does — — now have this card?	**12b.** 1 ☐ Yes 2 ☐ No 9 ☐ DK

Ask for each person with "Yes" in 12b:
c. May I please see — — (and — —) card(s)?
Mark appropriate box(es) in person's column.
	c. ☐ Medicaid card seen
	    1 ☐ Current
	    2 ☐ Expired
	3 ☐ No card seen
	8 ☐ Other card seen
	
	_____
	Specify

13a. Is anyone in the family now covered by any other public assistance program that pays for health care? ☐ Yes ☐ No *(Next page)* ☐ DK	
b. Is — — now covered?	**13b.** 1 ☐ Yes 2 ☐ No 9 ☐ DK

14a. Does anyone in the family now receive military retirement payments from any branch of the Armed Forces or a pension from the Veterans Administration? Do not include VA disability compensation. ☐ Yes ☐ No *(15)* ☐ DK	
b. Does — — now receive military retirement or a VA pension?	**14b.** 1 ☐ Yes 2 ☐ No 9 ☐ DK
Ask for each person with "Yes" in 14b: **c.** Which does — — receive — the Armed Forces retirement, the VA pension or both? *Mark box in person's column.*	**c.** 1 ☐ Armed Forces 2 ☐ VA 3 ☐ Both
15a. Is anyone in the family now covered by CHAMP—VA, which is medical insurance for dependents or survivors of disabled veterans? ☐ Yes ☐ No *(16)* ☐ DK	
b. Is — — now covered by CHAMP—VA?	**15b.** 1 ☐ Yes 2 ☐ No 9 ☐ DK
16a. Is anyone in the family now covered by any other program that provides health care for military dependents or survivors of military persons? ☐ Yes ☐ No *(M2)* ☐ DK	
b. Is — — now covered?	**16b.** 1 ☐ Yes 2 ☐ No 9 ☐ DK
M2 *Refer to "AF" box above person's column.*	**M2** 1 ☐ AF box marked *(17)* 2 ☐ Other *(NP)*
17a. Does — — have a disability related to — — service in the Armed Forces of the United States?	**17a.** 1 ☐ Yes 2 ☐ No *(NP)*
b. Does — — now receive compensation for this disability from the Veterans Administration?	**b.** 1 ☐ Yes 2 ☐ No

FOOTNOTES

169

18a. During the past 12 months, that is since _(12-month date)_ a year ago, have _(read names of related HH members 18 or over)_ been laid off from a job or lost a job? ☐ Yes ☐ No _(M4)_ ☐ DK _(M4)_	
b. Who was this? _Mark "Laid off/lost job" box in person's column._	**18b.** ₁ ☐ Laid off/lost job
c. Anyone else? ☐ Yes _(Reask 18b and c)_ ☐ No	
Ask 18d, e, and f for each person with "Laid off/lost job" in 18b. **d. How many times has —— been laid off or lost a job during the past 12 months?**	**d.** _____ Times
e. In what month was —— laid off or did —— lose a job ([the last time/the time before that])?	**e.** ☐ Time 1 ☐ Time 2 ☐ Time 3
f. For ANYTIME during [that/those] job layoff(s) or job loss(es), did —— receive unemployment insurance benefits?	₁ ☐ Yes ₂ ☐ No

19a. Because of _(names of persons in 18b)_ job layoff(s) or job loss(es), did anyone in the family lose any health insurance coverage that had been carried through [that/those] job(s)? ☐ Yes ☐ No _(M4)_ ☐ DK _(M4)_	
b. Who was this? _Mark "Lost coverage" box in person's column._	**19b.** ₁ ☐ Lost coverage
c. Anyone else? ☐ Yes _(Reask 19b and c)_ ☐ No	

M3	_Refer to 19b and mark appropriate box._	**M3** ₁ ☐ Lost coverage _(20)_ ₂ ☐ Did not lose coverage _(NP)_

20a. For ANYTIME during [that/those] job layoff(s) or job loss(es), was —— without any type of health insurance coverage? {Do not include health care programs, such as Medicaid, AFDC, or military benefit programs, as health insurance coverage.}	**20a.** ₁ ☐ Yes ₂ ☐ No _(NP)_
b. For how long was —— without some type of health insurance coverage? (How many months is that?)	**b.** ₀₀ ☐ Less than 1 month _____ Months
21a. For ANYTIME during [that/those] job layoff(s) or job loss(es), was —— covered by any health care program, such as Medicaid, AFDC, or a military benefit program?	**21a.** ₁ ☐ Yes ₂ ☐ No _(NP)_
b. For how long was —— covered by some health care program? (How many months is that?)	**b.** ₀₀ ☐ Less than 1 month _____ Months

M4	_Refer to age(s) and mark appropriate box._	**M4** ₁ ☐ No person 55+ in family _(HH pg.)_ ₈ ☐ Other _(Supplement on Aging)_

FORM HIS-1 (1984) (8-9-83)