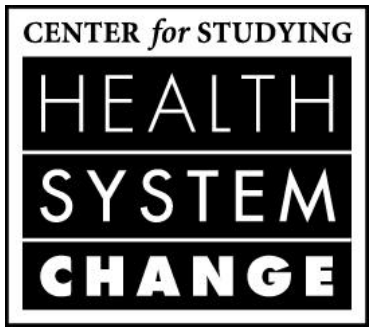

Community Tracking Study
Followback Survey Instrument

(Round Two)

Technical Publication No.

33

January 2002

This is one in a series of technical documents that have been done as part of the Community Tracking Study being conducted by the Center for Studying Health System Change (HSC). HSC welcomes your comments on this document. Write to us at 600 Maryland Avenue, SW, Suite 550, Washington, DC 20024-2512 or visit our web site at www.hschange.org.

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INTRODUCTION

COMMUNITY TRACKING STUDY
ROUND TWO FOLLOWBACK SURVEY

The Community Tracking Study (CTS) is designed to track changes in the health system and their effects on people. The CTS Round Two Followback Survey is a component of the CTS in which the privately financed health insurance policies covering CTS Round Two (1998-99) Household Survey respondents are "followed back" to the organizations that administer the policies. The purpose of the Followback Survey is to obtain more detailed and accurate information about those policies than could be provided by the Household Survey respondents. The information obtained from Followback Survey respondents includes product type, in-network and out-of-network coverage, provider payment methods, and consumer cost sharing. Data collected by the Followback Survey are linked to respondents in the Round Two Household Survey who had private comprehensive health insurance policies.

Additional information on the survey methodology for the Round Two Followback Survey will be available in a forthcoming HSC technical publication. Information on the Round One Followback Survey is available in HSC Technical Publication No. 19 (the Round One survey instrument) and HSC Technical Publication No. 30 (the Round One methodology report). The Round One Followback Survey data have been added to Release 2 of the Round One Household Survey restricted use data file, which is described in HSC Technical Publication No. 17 (the user's guide for the restricted use file).

Under the direction of the Center for Studying Health System Change, Mathematica Policy Research, Inc., was the primary contractor involved with the Round Two Followback Survey design, instrument development, and interviewing. Additional information about the design of the Community Tracking Study is available in two technical documents: Site Definition and Sample Design for the Community Tracking Study. C. Metcalf, P. Kemper, L. Kohn, J. Pickreign. Center for Studying Health System Change, Technical Publication No. 1, Washington, DC, October 1996; and "The Design of the Community Tracking Study." P. Kemper et al. *Inquiry* 33:195-206 (Summer 1996).

HSC technical publications are available on the HSC web site at www.hschange.org.

OVERVIEW OF TOPICS COVERED
IN THE ROUND TWO FOLLOWBACK SURVEY

SECTION A: Entity Information

SECTION B: Product Attributes

- product type and network model type
- availability for individual purchase
- out-of-network coverage
- in-network coverage
- requirement to sign up with a primary care physician, group of doctors, or clinic
- types of providers who can serve as primary care physicians
- consumer cost sharing (copayment, coinsurance, deductible)

SECTION C: Network Size and Physician Payment Arrangements

- physician and hospital network size
- payment methods for primary care providers, specialists, and hospital services
- separate provision or management of mental health and/or substance abuse services

SECTION D: Organizational Information

- for-profit/non-profit
- national/multi-state

CTS Followback Survey
Differences Between Round One and Round Two Survey Questions

The questions in the CTS Followback Survey differed slightly between Round One and Round Two. This is a list of the differences:

- Round Two has two questions (a3a and a3) to determine entity type, whereas Round One has only one question (a3).
- For Round Two, a question was added on whether the product is available for purchase by individuals (b3).
- The order of some of the questions in Section B changed for Round Two (b6, b8, b10, b12).
- Question b8 in Round Two asks whether a referral is ever required for maximum coverage of visits to in-network specialists, whereas the Round One question asked whether there was any coverage for such visits.
- A series of questions was added to Section B in Round Two to obtain more detail on referrals and coverage levels (b91 series, b92 series, b93 series).
- For Round Two, questions on out-of-network consumer cost sharing were added (see b13 series and b14 series).
- The questions on provider network size were changed. In Round Two, the question on physician network size (c1r) offers categories for the respondent to choose, whereas the Round One question was open-ended. The Round Two question on hospital network size asks simply whether enrollees are limited to a single hospital system, whereas the Round One question asked about the number of hospitals.
- There were minor wording changes in these questions: b2, b2a, b5, b6, b10, b13 series, and b14 series.

COMMUNITY TRACKING STUDY
SUMMARY OF FOLLOWBACK SURVEY QUESTIONS
ROUND 2

See the appendix for information on interviewer training and details on the CATI program that was used.

SECTION A: ENTITY INFORMATION

a3a Blue Cross/Blue Shield
ASK IF NOT ALREADY KNOWN, OR CODE: Are you a Blue Cross/Blue Shield Plan?
1 yes
2 no

a3 Entity type
IF a3a^=yes: Please tell me which of the following categories best describes your organization:
2 a licensed insurer or HMO
3 a managed care provider organization, such as a PPO or IPA (not licensed to sell insurance)
4 a third party administrator (TPA)
6 an employer, union or trust plan administrator (including a government employee plan)
8 or something else (SPECIFY)
INTERVIEWER: USE STATUS OF CORPORATE PARENT IF APPLICABLE.

SECTION B: PRODUCT ATTRIBUTES

b2 Product type
Do you think of [PRODUCT] as a(n)...
1 HMO (Health Maintenance Organization)
2 POS (Point of Service Plan)
3 PPO (Preferred Provider Organization)
4 indemnity plan (traditional FFS)
5 or something else? (SPECIFY)

b2a Model type
IF b2 = HMO OR POS: Which of the following describes the medical providers available in [SITE]?
PROBE: Exclude dental, mental and vision providers.
INTERVIEWERS: Ask for individual components of “mixed model".
SELECT ALL THAT APPLY
1 staff model
2 group model (plan contracts with a single group)
3 network and/or IPA (contracts with multiple individual and/or group providers)
4 something else (SPECIFY)
d don’t know
r refused

b3 Individual purchase

Is [PRODUCT] ever sold to individuals in [SITE]?

1 yes
2 no
d don't know
r refused

b5 Network

IF b2=indemnity or other: Is there a directory or list of doctors associated with [PRODUCT] in [SITE]?

1 yes
2 no

b6 Out-of-network coverage

IF (b2=HMO, POS, or PPO) or (b5=yes): Under [PRODUCT] in [SITE], if enrollees do not have a referral and go to *out-of-network* doctors, does the plan cover *any* of the costs for these visits?

PROBE: Exclude emergency care and non-major medical services such as dental and vision care.

PROBE: By "out-of-network" we mean providers of major medical services NOT associated with [PRODUCT].

1 yes
2 no
7 there is no network in this sense
d don't know
r refused

Construct NET:

If [(b2 = HMO, POS, or PPO) or (b5 = yes)] and b6^=7, then set NET=1 and go to b10.
Otherwise set NET=0 and go to b13.

b10 PCP sign-up

IF NET=1: Does [PRODUCT] in [SITE] require members to have a primary care doctor, group of doctors, or clinic to receive maximum coverage for all routine care?

1 yes
2 no
d don't know
r refused

b12 PCP types

IF b10=yes: Which types of providers can serve as primary care physicians for enrollees in this product?

INTERVIEWERS: CODE ALL THAT APPLY

1 generalists, such as an internist, pediatrician, or family practice
2 OB/GYNs
3 other specialists
d don't know
r refused

b8 Maximum in-network coverage

IF NET=1: We are interested in whether referrals are required for specialty care, and how they affect coverage, under [PRODUCT] in [SITE]. For these questions, please consider only major medical services, but not emergency care and other services such as dental, vision, and mental health care.

Under [PRODUCT] in [SITE], is a referral or authorization *ever* required to obtain maximum coverage for an initial visit to an in-network specialist?

PROBE: If specialists can arrange authorization on-the-spot or after the visit, consider this a requirement to get a referral.

1 yes
2 no
d don't know
r refused

b91a Any in-network coverage

IF b8=yes: For the next few questions, "self referral" refers to visits where a patient sees an in-network specialist without obtaining a referral or authorization, even though this is required to obtain maximum coverage. Does [PRODUCT] provide at least some coverage for self-referrals to *any* types of in-network specialists?

1 yes
2 no
d don't know
r refused

b91b In-network coverage for most specialists

IF b91a=yes: Does this coverage for self-referral apply to most types of in-network specialists?

1 yes
2 no
d don't know
r refused

b91c In-network coverage for OB/GYNs

IF b91b=no: Does this coverage for self-referral apply to *most* visits to in-network OB/GYNs?

INTERVIEWER: Coverage of one annual visit does not count.

1 yes
2 no
d don't know
r refused

b91d In-network coverage for nonOB/GYNs

IF b91b=no: Does this coverage for self-referral apply to *any other* types of in-network specialists?

1 yes
2 no
d don't know
r refused

b92 In-network coverage compared to referral

IF b91a=yes: When [PRODUCT] covers in-network self-referrals, is the level of coverage the same as with a physician referral, or is it less than the coverage with a physician referral?

PROBE: Lesser coverage means that the copayment or coinsurance that the enrollee pays is *higher*.

1 same
2 less
3 volunteer: varies
d don't know
r refused

b92b In-network coverage compared to referral for OB/GYNs

IF b92=VARIES and (b91b=yes or b91c=yes): What about in-network self-referrals to OB/GYNs – is the level of coverage the same as with a physician referral, or less than with a physician referral?

PROBE: Lesser coverage means that the copayment or coinsurance that the enrollee pays is *higher*.

1 same
2 reduced
d don't know
r refused

b93 In-network coverage compared to out-of-network coverage

IF b6=yes and b92=(LESS or VARIES) Under [PRODUCT], when the level of coverage for in-network self-referrals is reduced, is that level of coverage better than for out-of-network self-referrals, or the same?

1 better
2 same
3 volunteer: varies
d don't know
r refused

b93b In-network coverage compared to out-of-network coverage for OB/GYNs

IF b93=VARIES and (b91b=yes or b91c=yes): What about in-network self-referrals to OB/GYNs – Is that level of coverage better than for out-of-network self-referrals, or the same?

1 better
2 same
d don't know
r refused

b13 Copayment or coinsurance requirement

Does [PRODUCT] in [SITE] have a fixed copayment per visit, or percentage coinsurance payment for [IF NET=1 fill: in-network] office visits?

PROBE: Whichever is most common for enrollees in this product.

1 copayment
2 coinsurance rate
0 none
d don't know
r refused

b13amtCopayment amount

IF b13=COPAYMENT: What is the typical copayment amount per office visit for [PRODUCT] in [SITE]?

PROBE: The lowest copayment that typically applies for [IF NET=1 fill: in-network] office visits with referrals. Exclude "well" visits if these are different.

<1-2000> dollars
d don't know
r refused

b13perCoinsurance rate

IF b13=COINSURANCE: What is the typical coinsurance percentage for office visits under [PRODUCT] in [SITE]?

PROBE: The coinsurance rate is the percentage for which the enrollee is responsible.

PROBE: The lowest coinsurance rate that typically applies for [IF NET=1 fill: in-network] office visits with referrals. Exclude "well" visits if they are different.

<1-100> percent
d don't know
r refused

b13out Out-of-network copayment or coinsurance requirement

IF b6=yes: For out-of-network office visits without a referral, does [PRODUCT] in [SITE], have a fixed copayment per visit, or percentage coinsurance payment?

PROBE: Whichever is most common for enrollees in this product.

1 copayment
2 coinsurance rate
0 none
d don't know
r refused

b13od Out-of-network copayment amount

IF b13out=COPAYMENT: What is the typical copayment amount for out-of-network office visits under [PRODUCT] in [SITE]?

PROBE: The copayment that typically applies for office visits, without referrals, outside of any network.

<1-2000> dollars
d don't know
r refused

b13op Out-of-network coinsurance rate

IF b13out=COINSURANCE: What is the typical coinsurance percentage for out-of-network office visits under [PRODUCT] in [SITE]?

PROBE: The coinsurance rate is the percentage for which the enrollee is responsible.

PROBE: The coinsurance rate that typically applies for office visits, without referrals, outside of any network.

<1-100> percent
d don't know
r refused

b14 Deductible amount

Under [PRODUCT] in [SITE], what is the dollar amount of the individual deductible that applies to [IF NET=1 fill: in-network] office visits?

PROBE: Your best estimate is fine. Please tell me what is *typical* for this product in [SITE].

<0-10000> dollars

d don't know

r refused

b14out Out-of-network deductible requirement

IF b6=yes: Is there a *separate* deductible for [PRODUCT] in [SITE] that applies to out-of-network office visits?

1 yes

2 no

d don't know

r refused

b14od Out-of-network deductible amount

IF b14out=yes: What is the dollar amount of the *individual deductible* for out-of-network office visits?

PROBE: Your best estimate is fine. Please tell me what is typical for this product in [SITE].

PROBE: The deductible that typically applies for office visits, without referrals, outside of any network.

<0 – 50 – 5000> dollars

d don't know

r refused

SECTION C: NETWORK SIZE AND PHYSICIAN PAYMENT ARRANGEMENTS

c1r Physician network size

If NET=1: Approximately what percentage of all primary care and specialist physicians in [SITE] are associated with [PRODUCT]?

Would you say ...

1 fewer than 25 percent

2 at least 25 percent but less than 50 percent

3 at least 50 percent but less than 75 percent

4 75 percent or more

d don't know

r refused

INTERVIEWER: Do **not** probe "don't know".

c2r Hospital network size

If NET=1: Under [PRODUCT], are enrollees limited to a single hospital system for general acute care services in [SITE]?

PROBE: A single hospital system would be one or more hospitals under the same ownership or management.

1 yes

2 no

d don't know

r refused

c4 PCP payment

Next, I have some questions about payment arrangements for primary care physicians, specialists and hospitals for each product in [SITE]. Since this may vary somewhat depending on the provider, I just want to know what is *typical* for the providers who serve a majority of enrollees in each product.

In [PRODUCT] in [SITE], what is the typical method of payment that your organization uses for primary care services? Is it . . .

PROBE: By that I mean how your organization pays individual providers, medical groups, or other entities for primary care services in [SITE].

PROBE: Capitation is a fixed payment per member per month for a class of services.

INTERVIEWER: Probe carefully between <1> and <2>.

1 fee-for-service, for example, usual and customary rates
2 fixed fee schedule, including discounted FFS or relative value units
3 salaried by your organization
4 capitation (includes combined, "professional" or "global" capitation)
5 other (SPECIFY)
d don't know
r refused

c4a PCP capitation

IF c4=CAPITATION: What *other* services are included in this capitated payment?

INTERVIEWER: CODE ALL THAT APPLY

1 referrals to specialists
2 hospitalizations
3 other services, or
4 none of these
d don't know
r refused

c5 Specialist payment

IF c4a^=1: In [PRODUCT] in [SITE], what is the typical method of payment that your organization uses for *specialty* services? Is it . . .

PROBE: By that I mean how *your* organization pays individual providers, medical groups, or other entities for specialty services in [SITE].

PROBE: Capitation is a fixed payment per member per month for a class of services.

1 fee-for-service, for example, usual and customary rates
2 fixed fee schedule, including discounted FFS or relative value units
3 salaried by your organization, or
4 capitation
5 other (SPECIFY)
d don't know
r refused

c6 Hospital payment

IF c4a^=2: In [PRODUCT] in [SITE], what is the typical method of payment for hospital services? Is it . . .

PROBE: By that I mean how *your* organization pays for hospital services in [SITE]. Exclude physician services delivered during the hospital stay.

PROBE: Capitation is a fixed payment per member per month for a class of services.

1 per diem
2 according to DRG or per stay
3 capitation
4 billed charges or discounted billed charges, or
5 something else (SPECIFY)
7 not applicable; hospitals owned by organization
d don't know
r refused

c7 Mental health benefit

Does [PRODUCT] in [SITE] ever include any mental health and/or substance abuse services?

PROBE: Includes "chemical dependency."

PROBE: Include mental health or substance abuse services you provide by subcontract only if your organization administers that benefit.

1 yes
2 no
d don't know
r refused

c7a Specialty mental health organization

IF c7=yes: Are mental health and/or substance abuse services ever provided or managed separately by a specialty managed behavioral health organization?

1 yes
2 no
d don't know
r refused

c7b Name of mental health organization

IF c7a=yes: Please tell me the name of the specialty managed behavioral health organization you use in [SITE].

1 – 8 codes for specific organizations
9 something else
d don't know
r refused

c7c Location of mental health organization

If c7b=9: In what city and state is this specialty behavioral managed health company located?

SECTION D: ORGANIZATIONAL INFORMATION

d1 Tax status

IF a3a=1 or (a3=2 or 3): What is your organization's tax status? Is it . . .

INTERVIEWER: code organizations with a 501(c)3 or 501(c)4 tax status as non-profit

1 for-profit, privately held
2 for-profit, publicly held, or
3 nonprofit
4 other (SPECIFY)
d don't know
r refused

d2 Subsidiary

Is your organization a division or subsidiary of another health plan organization?

1 yes
2 no
d don't know
r refused

d2a Parent company service area

IF d2 = yes: Is this parent company a national or multi-state organization?

1 yes
2 no
d don't know
r refused

d2b Parent company name

If d2=yes: What is the name of that parent company?

s code from list
o other
d don't know
r refused

d2c Parent company location

If d2b=other: In what city and state is this parent company located?

d3 Entity service area

IF d2 = no: Is your organization a national or multi-state organization?

1 yes
2 no
d don't know
r refused

APPENDIX

Report Describing Interviewer Training and Survey Instrument

MPR Reference No.: 8553-500

COMMUNITY TRACKING STUDY C FOLLOWBACKENTITY SURVEY

Round 2

Interviewer Training and Instrument

September 2001

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CONTENTS

I. INTERVIEWER TRAINING

A. PROJECT OVERVIEW

The Follow-Back Survey is an integral part of the Community Tracking Study (CTS), which is conducted by Mathematica Policy Research, Inc. (MPR) for the Center for Studying Health System Change. The Follow-Back Study follows the CTS Household Survey in which information is collected from household family members on the kind of private insurance coverage they have. This information is "followed back" to the organization that administers the health insurance plan named by the household respondent. In the Follow-Back Survey health plans and health insurance entities are interviewed to collect information on the characteristics of specific health insurance products that are linked to household respondents.

B. BACKGROUND

The purpose of the Community Tracking Study is to develop an information base designed to track and analyze change in the nation's health care market and to inform public and private decision-makers about these changes. The study has three overall objectives.

- ***Tracking Changes in Health Systems.*** The study's first objective is to document changes in the health system through intensive study of selected communities. The major changes that have been reported in the health system include consolidation of the market at all levels (medical groups, hospitals, insurers, and health plans); vertical integration of providers (for example, hospitals and physicians) and of insurers and providers; increased risk sharing by providers; growth of large, national, for-profit health care enterprises; and the adoption of new techniques for managing clinical care (clinical information system quality improvement techniques, utilization management, and so forth). This research is conducted directly by HSC and through other contractors.

- ***Tracking Changes in Access, Service Delivery, Cost and Perceived Quality.*** The second objective of the study is to monitor the effects of health system change on people by tracking indicators of these effects, including favorable or unfavorable changes in access to care, service use and delivery, and quality and cost of care.[1]

- ***Understanding the Effects of Health System Change on People.*** The third objective of the study is to understand how differences in health systems are related to differences in access, service delivery, cost and perceived quality. This objective will be achieved by analyzing – qualitatively and quantitatively – the relationship between health systems and access, delivery, cost, and perceived quality.[2]

C. THE ENTITY SURVEY

1. The Entity Survey Instrument – Basics

The instrument uses a CATI program consists of essentially six modules or sets of questions. These modules are arranged to allow repetition of questions across multiple sites and multiple products. The six modules are:

Module 1: ENTITY AND SITE INFORMATION

Module 2: PRODUCT OFFERINGS

Module 3: CORE ATTRIBUTES OF PRODUCTS

Module 4: CO-PAYMENTS AND DEDUCTABLES

Module 5: NETWORK AND PROVIDER RELATIONS

Module 6: CLOSING

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[1] These issues are covered in the CTS Household Survey.

[2] The Followback Survey contributes mainly to this objective, by obtaining information from the health plan organizations about the specific policies that cover individual people.

The ***first module*** consists of ***questions a1– a3***, and asks basic screening questions about the ***entity***; determines that the respondent is the correct person to answer for all of the sites included in the sample for that entity; and identifies which type of organization the entity is.

ENTITY TYPES:

Licensed Insurer or Health Maintenance Organization (HMO) – Traditional insurance companies sell policies that cover specified services for a fixed premium, usually with a policy-holder contribution for each service. An HMO is an organization that combines the delivery and financing of health care in a single organization that provides comprehensive health services to a defined population of patients or "enrollees" for a set fee.

Managed Care Organization, not licensed to sell insurance – Includes Preferred Provider Organization (PPO) or Independent Practice Association (IPA) that provide health care services but are not licensed to sell insurance to the patients it serves.

Third Party Administrator (TPA) – An organization which administers health care plans (e.g., claims processing), but does not bear any risk for health care costs as an insurer, and does not employ any physicians.

Other Provider Organization – An organization that has selective provider arrangements through a network of providers who are typically paid according to a negotiated fee schedule.

Employer, union or trust plan administrator - An organization that provides health care for its employees or members.

The ***second module*** consists of ***questions b1a – b3***, and asks questions about each of the ***health care products*** **that may be offered** or administered by the entity. If the product is an HMO or a POS, the respondent is also asked what *model* best describes the organization.

HEALTH CARE PRODUCTS:

HMO – A Health Maintenance Organization, in which enrollees may see only the providers within the HMO network. Services provided outside the network are generally not covered

POS – A Point of Service plan, in which enrollees may use the HMO's network of providers for a set co-payment, or may self-refer to providers outside of the network for a larger co-payment or other additional cost. May be referred to as "open-ended or open-access HMO", or as "triple option" or "dual option" plan

PPO – A Preferred Provider Organization, in which enrollees do not need a referral, but have financial incentives to use a "preferred" set of providers, usually through difference in coinsurance or deductibles

INDEMNITY – Traditional fee-for-service arrangement in which enrollees pay for the cost of the service, and do not have financial incentive to use a select set of providers

MODEL TYPES:

STAFF MODEL – An HMO or POS that employ salaried physicians who only serve the HMO's enrollees in the HMO's facilities

GROUP MODEL – An HMO or POS that contracts with a single physician group to provide care to the HMO's enrollees

NETWORK MODEL – An HMO or POS that contracts with two or more group practices or with individual physicians to provide care to the HMO's enrollees

The questions in the second module are repeated for each product in that site before moving on to module three for the same site.

The ***third module*** consists of ***questions b5 – b12*** and asks about ***core attributes*** for each product including:

- whether or not there is a ***list of doctors***,
- whether enrollees have ***any coverage*** for visits ***to out-of-network*** doctors,
- whether ***primary care physicians*** are ***required***;
- whether enrollees may ***"self-refer"*** to ***in-network*** specialty doctors.

COVERAGE TERMINOLOGY:

OUT-OF-NETWORK – visits to providers of major medical services NOT included in the list of doctors specified as belonging to the health plan's network

IN-NETWORK – visits to providers who are included in the list of doctors specified as belonging to the health plan's network of doctors

PRIMARY CARE PHYSICIANS – Physicians who act as the first point of contact for patients seeking care. May include generalists, internists, pediatricians, or family practitioners; and sometimes OB/GYNs and selected specialists

SPECIALIST – Physicians whose services are not considered primary care. May include surgeons, dermatologists, etc. A referral may be required before the patients can see a specialist physician

SELF-REFERRAL – Visits to an in-network specialist without obtaining a referral. Different products offer differing levels of coverage, or none at all

The questions in Module 3 are repeated for each product within the site. Module 2 and Module 3 are completed as a block for each site. In other words,. once Module 3 is completed for all products within a site, the program returns to Module 2 for any additional sites.

The ***fourth module*** consists of ***questions b13-b14*** which ask about any ***co-payments, co-insurance*** **or** ***deductibles*** associated with in-network and out-of-network office visits. It is important to note that the co-payment or co-insurance is the amount that the enrollee pays.

PAYMENT TERMS

CO-PAYMENT – a fixed dollar amount that the enrollee is responsible for paying at each visit

CO-INSURANCE – a fixed percentage of the cost of each visit that the enrollee is responsible for

DEDUCTIBLE - A fixed sum of money that the enrollee is responsible for paying in a given year before coverage begins

The questions in Module 4 are repeated for each product and for each site before moving on to the fifth module.

The ***fifth or Network and Payment module*** consists of ***questions c1r – c7b*** and asks about the primary care physicians and specialist physicians associated with the health plan, as well as the payment mechanism used by the entity for various provider services.

PROVIDER REIMBURSEMENT TERMINOLOGY:

FEE-FOR-SERVICE – A system of payment in which a separate fee is charged for each specific medical service performed

FIXED FEE SCHEDULE – Also called discounted fee for service, or relative value units. A variant fee-for-service in which a pre-negotiated discounted fee is charged for each specific medical service performed

SALARIED – Reimbursement in which the health plan pays the provider a set salary for all covered services the enrollees may require

CAPITATION – Reimbursement to a provider or provider group through the payment of a fixed, periodic payment (usually monthly) for a defined set of services delivered to a set population of patients (literally per head). Under this type of payment system, financial risk for the patients' utilization is borne by the providers

Module 5 is repeated for each product and each site before moving on to questions in the sixth module.

The ***sixth module*** or ***closing section*** consists of ***questions d1 – d3*** which ask for the entities ***tax*** and ***organizational*** status and affiliations.

2. The Entity Survey Instrument – Navigational Specifics

The Follow-Back instrument was programmed for computer-assisted-telephone-interviewing (CATI) because of variation in sites covered and products offered. Some entities may have been reported by a number of different household respondents across a number of different sites. During the entity interview, you will ask about characteristics of the health insurance products that are offered in each of the sites that has been sampled. Each case will be pre-loaded with a number of sites (for example, Little Rock Arkansas, Western Washington state) and a number of products within those sites (for example an HMO, a PPO, etc.), based on reports from the Household and Employer Surveys.

a. Moving Through Modules by Product and Site

Most entities have more than one site. Therefore, the CATI program is designed to move through the product and site combinations on a site bases and then within the site on a product basis. For example, if a company has two products (A and B) both of which are offered in two sites (1 and 2), we begin with site 1, product A, then move to site 1, product B. Then we move on to site 2, product A and finally onto site 2, product B. While this site-by-product flow is the same throughout the CATI program, the process starts and finishes separately in some modules. See Figure 2.1 for details. For example in Module 2 questions about all of the products (A and B) for the first site (site 1) are asked. Then the program moves onto Module 3 and asks all of the questions for all of the products (A and B) for the first site (site 1) before moving back to Module 2 for the next site (site 2). Once all the questions in Module 3 have been asked for all of the sites, the program will move onto Module 4. Module 4 is completed on all the products and sites before moving onto Module 5 and likewise, Module 5 is complete on all products and sites before moving onto Module 6 (however in c7b, in Module 5 is only conducted on a site basis).

FIGURE 2.1

NAVIGATION THROUGH SIX MODULES BY PRODUCT AND SITE

<table>
<tr><td rowspan="2">Module 1
Entity and Site Information

a1 – a3</td><td colspan="2">For each site:
Module 2 then Module 3 for each site before moving onto Module 4</td><td>For each site:</td><td colspan="2">For each site:</td><td rowspan="2">Module 6
Closing

d1 – d3</td></tr>
<tr><td>For each product:</td><td>For each product:</td><td>For each product:</td><td>For each product:</td><td></td></tr>
<tr><td></td><td>Module 2
Product Offerings

b1a – b3</td><td>Module 3
Core Attributes

b5 – b12</td><td>Module 4
Co-Payments & Deductibles

b13 – b14</td><td>Module 5
Network and Provider Payment
c1r – c7a</td><td>Module 5
Network and Provider Payment
c7b</td><td></td></tr>
</table>

b. Deleting, Combining, and Adding Products in Module 2

Product differentiation begins in Module 2. The CATI program allows you to record whether a listed product is offered or not offered for a specific site. It also allows you to record a product that has been renamed, and whether a product should actually be combined with another product, or if it should be deleted from the list. If the product is not offered in one site, but is offered in other sites, you should select the "not offered" category for the first site. The product name will come up again when you ask about additional sites. If the product is not offered in ***any site*** for that entity, you should select the "delete" category. Please note that selecting the "delete" or "combine" categories will remove products entirely for all sites, so use these options only when you are certain that the product is not offered by ***any site***. This should be done at the end of the Module 2 after all sites have been interviewed. Figure 2.2 lists code responses to item B1a.

FIGURE 2.2

KEY TO HANDLING PRODUCTS AT ITEM B1A---

"DID YOU OFFER [PRODUCT] IN [SITE]?"

Code	**Label**	**Use to indicate….**
<1>	Offered	[Product] was offered in [site] during the Summer 1998, either through employers or individual purchasers
<2>	Offered, rename	Same as <1>, but change the name according to the Respondent
<3>	Not Offered	[Product] was **not** offered in [site] during Summer 1998
<4>	Combine	[Product] is the same as another on our list, except for name and minor variations, such as benefit limits, eye or dental coverage; do not combine with another if it differs in ways covered in **core attributes, co-payments and deductibles,** or **provider payment modules**
<5>	Delete	Respondent does not recognize [product] as associated with entity

c. Product Splits Within the Core Attribute Section in Module 3

The questions in Module 3 ask about core attributes for each product, including issues such as out-of-network coverage. According to this study's definition, a "product" must have uniform answers for items b5, b6, b8, and b10 for all contacts and enrollees within that product for a specified site. After each question, you will be asked if the response is true for all enrollees in the site. If it is not true for all enrollees, it cannot be considered one product. This event should be rare, but it if happens you have two alternatives:

- The CATI program will instruct you to split out a separate product. The original product will retain the value you already recorded for the item. An additional product will be added. You will be prompted to name the new product. The program will then copy all product data recorded to that point, and then return you to the original "parent" product that launched the split. On-screen instructions will allow you to skip all previously answered questions. Later you will return to finish other items for the newly created "child" product. The instrument will let you know when you are switching from one product to another.

- "Un-combine" this and another product that were previously combined at **b1a**. You may wish to wait to un-combine until after you have finished the current item block for the current product. Immediately, however, change your answer to the current item verifying that all contracts are the same to "yes".

d. Copying Product Data Across Sites

Once you have completed entering product information for the first site, the CATI program will ask you in Module 2 if certain answers are the same for this product later. If the information is the same, answers from Modules 2 and 3 will be copied for the current site, and you will go on to the next product. If not the same, you will repeat the questions for the products in the new site.

- Item **b1d** will prompt immediately after item **b1a** – [product] offered in [site]. The program will first check whether the product has been offered in another site; if not, this sequence will be skipped.

- You will then be asked which site to copy from. You may only copy from a site where the product is offered, and the program checks which sites are eligible.

- Some items in the inventory block will be copied, but b2a and b3a will be asked anyway, as they are site specific. Most data from the core attributes block will also be copied, without further confirmation.

- You cannot copy data from one product to another ***within*** a site, or from a ***different*** product in another site.

- Once you have entered or copied data for a product, you will not be able to copy again. Do not attempt any irregular movement within this copy sequence.

- Products that are copied can later be edited using myedit function

.

e. The MyEdit Function

In addition to splitting and combining products within questions, the program has an editing feature that allows you to change the status of any product or site. You access the ***MyEdit function*** by pressing the F6 key. This will take you to a series of editing screens. The first screen is a menu with items for: (1) editing, deleting or combining products; (2) adding a product; (3) editing specific site or product data; or (4) leaving the editing program and returning to the question you last encountered. Select the number for the function you want to use. This will move you to the next edit screen. For example, if you select (1), *editing, deleting or combining products* you will move to a screen which lists all of the products in the first column. The delete status for each of those products is shown in the second column, and the combine status for each product is shown in the third column. Use the arrow keys to move the cursor to the product you want to edit, and the item you want to change. All products that have not been deleted will show a default "n" in column two. Change the "n" to an "x" to delete this product. All products not combined will have a default "o" in column three. Change the "o" to the number of the product you want to combine this product with. When you are done editing from this screen, type "d", as directed by the screen instructions. This will take you back to the main *MyEdit function* menu. If you select (2) *adding a product* you will move to an edit screen that

asked for the name of the product, and then appends that product to all sites that the entity operates so that product attribute questions can be asked. If you select (3) *edit specific site/product data,* one of three screens can be selected allowing you to input the site, product and items you wish to edit. If you select (4) *editing complete,* you will leave the editing function and return to the last substantive question you encountered. **NOTE:** It is important to press the Control F key after leaving the *MyEdit function*. This will move the program through all answered questions, changing the data to reflect your editing action and take you to the last unanswered question.

SCREENER--INTRODUCTION

>ia0< Hello, is this [entity]? Could I speak to the Director of Marketing?

PROBE: ...to someone in charge of group health insurance products and contracts?

<1> CONTINUE [goto ia1a]
<2> WRONG NUMBER [goto ia3a]
<3> DOES NOT MARKET OR ADMINISTER HEALTH PLANS [goto ia3a]
<4> CALL BACK [goto cb][1]
<5> REFUSES [goto ia2a]
<6> NEED TO CODE FINAL STATUS (** FOR FINAL STATUS CODES ONLY) [goto fdis][2]

>ia1a< *Use for entities that are being interviewed for the first time in Round 2*

Hello. My name is _____, calling on behalf of the Robert Wood Johnson Foundation. We are conducting a nationwide study of health plans and organizations, and we'd like your organization to participate in a brief survey. The purpose of the study is to track the local-level rapid changes that are going on in the health care industry. In our household survey we recently spoke to people in your area who said they have health care coverage through your organization. We know how busy you are, and we would like to send you our final report in appreciation for your help with the study.

or

Use for entities that were interviewed in Round 1

Hello. My name is_____, calling on behalf of the Robert Wood Johnson foundation. I want to thank (you and) your organization for participating in our survey of health plans for the Community Tracking Study. A few months ago, we sent (you/your organization) reports on the results of the first round of our survey and background on the project. We hope you found the reports and other information available on our research web site (www.hschange.com) helpful.

Since one of the most important objectives of our study is tracking change, we would like to update information (you/your organization) gave us two years ago. We have made many changes to our survey and it shouldn't take much time to complete the telephone interview. Once again, we will provide you with customized reports for your (region/community), as well as updates on other reports we are producing on changes in the health care system.

<1> CONTINUE WITH INTERVIEW [goto a1]
<2> MORE INFO [goto ia2a]
<3> DOES NOT MARKET OR ADMINISTER HEALTH PLANS [goto ia3a]
<4> CALL-BACK [goto cb]
<5> REFUSES [goto ia2a]

[1] See page 49 for data element >cb<.
[2] See page 50 for data element >fdis<.

>ia2a< MORE INFO: DO NOT READ

* Refer to posted materials for more information about the study.

* If permission from a higher corporate office is required, record corporate information on contact sheet.

* Use contact sheet to record new information about respondents.

<1> CONTINUE WITH INTERVIEW [goto a1]
<2> NEW RESPONDENT TO PHONE [goto ia1a]
<3> DOES NOT MARKET OR ADMINISTER HEALTH PLANS [goto ia3a]
<4> CALL-BACK [goto cb]
<5> REFUSES [goto cb]

>ia3a< DOES NOT MARKET OR ADMINISTER HEALTH PLANS, OTHER WRONG NUMBERS: READ AS NEEDED.

Confirm phone number; is there any other organization in the area with similar name? Get contact info.

If they are eligible (according to a1) and can answer our questions about health plan features then they are qualified.

FOR PROVIDER ORGANIZATIONS, STATE AGENCIES, OTHER PLAN SPONSORS: Is your organization affiliated with another organization that does provide or administer basic medical health care plans? Get contact info.

<1> CONTINUE WITH INTERVIEW [goto a1]
<2> NEW RESPONDENT TO PHONE [goto ia1a]
<3> DOES NOT MARKET OR ADMINISTER HEALTH PLANS [goto cb]
<4> CALL-BACK [goto cb]
<5> REFUSES [goto cb]
<7> WRONG NUMBER, OR NEW CONTACT SUPPLIED [goto cb]

MODULE 1: ENTITY AND SITE INFORMATION

>a1< NAME: [Fill Entity Name]
ID: [Fill Entity Identification Number]

YOU SHOULD NOW BE TALKING TO A "REAL" RESPONDENT

Before we begin, I want to confirm that your organization did offer or administer basic medical health care plans at any time since the summer of 1998?

PROBE: Exclude specialty-only health plans (such as cancer only), workers' compensation, supplemental and pharmacy only plans, military facilities, free clinics, and individual providers' offices.

<1> YES
<2> NO [goto ia3a]

>a2_pre< [If the number of sites equals 1, then goto a2a]

>a2< In our household survey, we interviewed people from the following geographic areas who said they were enrolled in one of your health plans since the summer of 1998:
[SITE(S)]

Are you able to answer questions about your health plan products in all of these areas, or are there some areas you do not cover or cannot answer about?

<1-n[3]> SITE NUMBER TO EXCLUDE [goto PROBE]
<g> ALL/REST OKAY [goto a3a]
<d> DISCONTINUE, NEW CONTACT [goto cb]

>PROBE< WHAT'S THE PROBLEM WITH SITE: [SITE]

Is there a different person or office that handles accounts in [SITE], or is it that your organization doesn't offer products in that area?

<1> DIFFERENT PERSON [goto a2t]
<3> NO PRODUCTS OFFERED [if there are no other sites to exclude from a2, goto a3a]
<4> RECIPROCATING ENTITY (RECORD ON PROBLEM SHEET) [goto a3a].

[3] Last site for the entity.

>a2t< Could you give me the name/address/telephone number of a contact person for . . . [SITE]

RECORD CONTACT INFO ON REFERRAL FORM
<g> CONTINUE [goto a3a]

>a2a< In our household survey, we interviewed people from [SITE(S)]

who said they were enrolled in one of your health plans.

Are you able to answer questions about your health plan products in that area?

<1> YES, CONTINUE [goto a3a]
<0> NO, GET NEW CONTACT INFO [goto cb]

>a3a< ASK IF NOT ALREADY KNOWN, OR CODE
Are you a Blue Cross/Blue Shield Plan?

<1> YES [goto b_intro]
<2> NO

>a3< Please tell me which of the following categories best describes your organization:

<2> A licensed insurer or HMO
<3> A managed care provider organization, such as a PPO or IPA (not licensed to sell insurance)
<4> A Third Party Administrator (TPA)
<6> An employer, union or trust plan administrator (including a government employee plan)
<8> Or something else [SPECIFY][4]

INTERVIEWER: USE STATUS OF CORPORATE PARENT IF APPLICABLE

[4] See page 48 for data element >SPECIFY<

MODULE 2: PRODUCT OFFERINGS

b-intro In this part of the interview we'd like to establish what types of health insurance products you offer ([if the number of sites greater than 1] in each geographic area you serve).

By "product," I mean groups of plans or contracts that are similar in how they handle network coverage and referrals. If specific plans or contracts are similar in these ways but differ on copays, deductibles, co-insurance rates, or supplemental benefits such as prescription drugs or dental care, we can consider them the same product. Examples are open-ended HMOs, PPOs without a primary care physician, and traditional indemnity plans.

<g> CONTINUE

begin with the first/next SITE for the entity

>b1a_pre< From our survey of households, we have compiled the following list of products people said they were enrolled in:

[PRODUCT(S)]

Now, I'm going to ask if you offer each of these product(s) in [SITE]. Also tell me if any name is incorrect, or if any of these are different names for the same basic product.

<g> CONTINUE

>editb1< *If a product has been deleted, combined with another product or is not offered the program will skip questions*[5]
[if p_delete equals <X> or p_combine is greater than or equals <1> goto b1_end]

>b1a< The (first/next) product is [PRODUCT]
Did you offer that in [SITE]?

<1> OFFERED [goto b2]
<2> OFFERED, BUT RENAME PRODUCT [goto newname]
<3> NOT OFFERED [goto b1_end]
<4> COMBINE WITH ANOTHER PRODUCT [goto combine]
<5> DELETE FOR ALL SITES [goto b1_end]

>newname< What do you want to call this product instead of [PRODUCT]?
[goto b1d]

[5] See page 44 for data elements >p_delete<, and >p_combine<.

>combine< What product is this the same as?
[goto b1_end]

>b1d< Is that product essentially the same as you previously described?
<1> YES
<2> NO [goto b2]

>b1d_site< READ IF NOT OBVIOUS:
Which site has the same data for [PRODUCT]?

DATA COPIED INTO TEMP SPACE. PRESS {ENTER} TO CONTINUE.

>b2< Do you think of [PRODUCT] as a(n) . . .
<1> HMO (Health Maintenance Organization)
<2> POS (Point of Service Plan)
<3> PPO (Preferred Provider Organization) [goto b3]
<4> Indemnity Plan (Traditional FFS) [goto b3]
<5> or something else? [SPECIFY] [goto b3][6]

>b2a< Which of the following describes the medical providers available in [SITE]?
PROBE: Exclude dental, mental and vision providers.

INTERVIEWERS: ASK FOR INDIVIDUAL COMPONENTS OF "MIXED MODEL." SELECT ALL THAT APPLY
<1> Staff model
<2> Group model (plan contracts with a single group)
<3> Network and/or IPA (contracts with multiple individual and/or group providers) or
<4> something else [SPECIFY][6]
<d> DON'T KNOW
<r> REFUSED
<n> NO MORE CODES
<x> DELETE A CODE [goto xb2a] (*used to correct errors for multiple response questions*)
[go to b3]

>xb2a< THIS SCREEN IS TO DELETE A RESPONSE.
<1> Staff model
<2> Group model (plan contracts with a single group)
<3> Network and/or IPA (contracts with multiple individual and/or group providers) or
<n> NO CODES TO DELETE
[goto b2a]

[6] See page 48 for data element >SPECIFY<.

>b3< Is [PRODUCT] ever sold to individuals in [SITE]?
<1> YES
<2> NO
<d> DON'T KNOW
<r> REFUSED

>b1_end< *go back to b1a to the next product, if there are no more products, then goto b1c.*

>b1c< Do you offer any other products in [SITE]?
<1> YES [pname]
<2> NO [goto b5s_pre]

>pname< What is the name of the product?
Product name is stored.

>pre_sure< YOU HAVE TO DO B1a FOR THESE PRODUCTS / SITES NOW
<g> to continue

>sure< *This item should prompt the interviewer to jump forward. A jump forward occurs when the interviewer has added a new product or in some way changed the path. After the'jf' the path will correct and the data will be correct as well.*

ENTER g TO JUMP FORWARD. YOU MAY ENCOUNTER NEW QUESTIONS BEFORE RETURNING TO ORIGINAL ITEM!
[If b_intro is null goto b_intro else go to the next blank question]

MODULE 3 - CORE ATTRIBUTES OF PRODUCTS

>b5s_pre< *begin with the first/next PRODUCT for the SITE*

>editb5< *If a product has been deleted, combined with another product or is not offered the program will skip questions*[7]
[if p_delete equals <X> or p_combine is greater than or equals <1> or offer_flag equals <0> goto b9_end_real]
[if SPLIT equals <0> goto b5s_end]
[if SPLIT less than <0> goto b5s]
[if SPLIT greater than <0> goto child_beg]
[goto b5s_end]

>b5s< We just finished adding a new product. We'll discuss that product again later.
Now, let's return to the product you called [PRODUCT]
That was a(n) [PRODUCT TYPE].
<g> CONTINUE
[if NET eq <0> goto b9_end]
[if SPLIT eq <-8> goto b8b_end]
[if SPLIT eq <-10> goto b10b_end]
[if SPLIT eq <-6> goto b6b_end]
[if SPLIT eq <-5> goto b5nt]
[goto b9_end]

>child_beg< Now let's continue with the product you called [PRODUCT].
We know some information about this product from a previous product, but we'll review those items.
<g> CONTINUE

>b5s_end< [if b1d equals <1>][goto b9_end]

>b5_pre< [if b2 is less than or equals <3> goto b5nt]
[if SPLIT is greater than or equals <5> goto b5_split]
[goto b5]

>b5_split< When we added it, we agreed that [PRODUCT] did [if b5 equals <2>]NOT[endif] have a network.

<1> ACCEPT [goto b5nt]
<2> CHANGE IT ANYWAY [goto b5]

>b5s_end< [if b1d equals <1> goto b9_end][goto b5_pre]

[7] See page 44 for data elements >p_delete<, >p_combine<, and >offer_flag<, and page 46 for data element >SPLIT<.

>b5_pre< [if b2 is less than or equals <3> goto b5nt][if SPLIT is greater than or eguals <5> goto b5_split][goto b5]

>b5_split< When we added it, we agreed that [PRODUCT] did ([if b5 equals <2> NOT] have a network

<1> ACCEPT [goto b5nt]
<2> CHANGE IT ANYWAY

>b5< Is there a directory or list of doctors associated with [PRODUCT] in [SITE]?

<1> YES
<2> NO

>b5a< Does that apply to all contracts and enrollees under [PRODUCT] in [SITE]?

<1> YES [got to b5nt]
<2> NO

>b5b< We need to treat contracts where there is ([if b5 equals <1>] not) a network of participating providers as a separate product.

<1> CONTINUE
<2> IGNORE, GO ON
<d> DON'T KNOW
<r> REFUSED

>b5b_end< [if b5b eq <1> [goto append][8]

>b5nt< [if b2 is less than or equals <3> or b5 equals <1>, store <1> in NET, otherwise store <0> in NET][9]
[if NET equals <0> goto b9_end]
[if SPLIT is greater than or equals <6> goto b6_split][10]
[goto b6]

>b6_split< When we added it, we agreed that [PRODUCT] did ([if b6 equals <2>] not) cover out-of-network office visits without referrals.

<1> ACCEPT [goto b6b_end]
<2> CHANGE IT ANYWAY

[8] See page 46 for data element >append<.
[9] See page 48 for data element >NET<.
[10] See page 46 for data element >SPLIT<.

>b6< Under [PRODUCT] in [SITE], if enrollees do not have a referral and goto **out-of-network** doctors, does the plan cover **any** of the costs for these visits?

PROBE: Exclude emergency care and non-major medical services such as dental and vision care.

PROBE: By "out-of-network" we mean providers of major medical services **NOT** associated with [PRODUCT].

<1> YES
<2> NO
<7> THERE IS NO NETWORK IN THIS SENSE
<d> DON'T KNOW[11]
<r> REFUSED[11]

>b6_end< [if b6 equals <7>][store <0> in NET] [goto b9_end][else goto b6a].
The program skips over network questions if b6 response is "there is no network".

>b6a< Does that apply to all contracts and enrollees under [PRODUCT] in [SITE]?

<1> YES [goto b6b_end]
<2> NO
<d> DON'T KNOW[12]
<r> REFUSED[12]

>b6b< We need to treat contracts where out-of-network visits without referrals are ([if b6 equals <1>] **not**) covered as a separate product.

<1> CONTINUE
<2> IGNORE, GO ON
<d> DON'T KNOW
<r> REFUSED

>b6b_end< [if b6b equals <1> goto append]
[if SPLIT is greater than or equals <8> goto b10_split]
[goto b10]

>b10_split< When we added it, we agreed that [PRODUCT] did ([if b10 equals <2>]**NOT**) require a PCP.

<1> ACCEPT
<2> CHANGE IT ANYWAY [goto b10]

[11] In final CATI program, <d> and <r> are set to goto the next question, b6a. If this program is to be used again a more appropriate skip for <d> and <r> responses would be goto b10.
[12] In final CATI program, <d> and <r> are set to goto the next question. If this program is to be used again a more appropriate skip at b6a for <d> and <r> responses should be b6b_end.

>b10_sp_end< [if b10_split equals <1>]
[if b10 equals <1> goto b12a_pre]
[goto b8_split_beg]

>b10< Does [PRODUCT] in [SITE] require members to have a primary care doctor, group of doctors, or clinic to receive maximum coverage for all routine care?

<1> YES
<2> NO
<d> DON'T KNOW[13]
<r> REFUSED[13]

>b10a< Does that apply to all contracts and enrollees under [PRODUCT] in [SITE]?

<1> YES [got to b10b_end]
<2> NO
<d> DON'T KNOW[13]
<r> REFUSED[13]

>b10b< We need to treat contracts where primary care providers are ([if b10 equals <1>] **not**) required as a separate product.

<1> CONTINUE
<2> IGNORE, GO ON
<d> DON'T KNOW
<r> REFUSED

>b10b_end< [if b10b equals <1> goto append]

>b12a_pre< [if b10 does not equal<1> goto b8_split_beg]

>b12< ([if SPLIT is greater than or equals <5> and b12 is not null]
I need to confirm….) *This question stem is asked anytime a product has split*

Which types of providers can serve as primary care physicians for enrollees in this product?

INTERVIEWERS: CODE ALL THAT APPLY
<1> Generalists, such as internist, pediatrician, or family practice
<2> OB/GYNs
<3> Other specialists
<n> NO MORE CODES
<x> DELETE A CODE [goto xb12]
<d> DON'T KNOW
<r> REFUSED
[goto b8_split_beg]

[13] In final CATI program, <d> and <r> are set to goto the next question. If this program is to be used again a more appropriate skip at b10a and b10b for <d> and <r> responses would be b10b_end.

>xb12< THIS SCREEN IS TO DELETE A RESPONSE.

<1> Generalists, such as internist, pediatrician, or family practice
<2> OB/GYNs
<3> Other specialists
<n> NO CODES TO DELETE
[goto b12]

>b8_split_beg< [if SPLIT equals <8> goto b8_split][goto b8]

>b8_split< When we added it, we agreed that [PRODUCT] did ([if b8 equals <2>] NOT ever[else] sometimes[endif]) require referals for in-network office visits.

<1> ACCEPT [goto b8b_end]
<2> CHANGE IT ANYWAY

>b8< We are interested in whether referrals are required for specialty care, and how they affect coverage, under [PRODUCT] in [SITE]. For these questions, please consider only major medical services, but not emergency care and other services such as dental, vision, and mental health care.

Under [PRODUCT] in [SITE], is a referral or authorization **ever** required to obtain maximum coverage for an initial visit to an in-network specialist?

PROBE: If specialists can arrange authorization on-the-spot or after the visit, consider this a requirement to get a referral.

<1> YES
<2> NO
<d> DON'T KNOW[14]
<r> REFUSED[14]

>b8a< Does that coverage rule apply to all contracts and enrollees under [PRODUCT] in [SITE]?

<1> YES [goto b8b_end]
<2> NO
<d> DON'T KNOW[14]
<r> REFUSED[14]

>b8b< We need to treat contracts where referral is/is not required as a separate product.

<1> CONTINUE
<2> IGNORE, GO ON
<d> DON'T KNOW
<r> REFUSED

[14] In final CATI program, <d> and <r> are set to goto the next question. If this program is to be used again a more appropriate skip at b8 and b8b for <d> and <r> responses would be b8b_end.

>b8b_end< [if b8b equals <1> goto append]
[if b8 does not equal<1> goto b9_end]

>b91a< For the next few questions "self referral" refers to visits where a patient sees an in-network specialist without obtaining a referral or authorization, even through this is required to obtain maximum coverage.

([if SPLIT is greater than or equals <5> and b91a is not null]
I need to confirm…..) *This question stem is asked anytime a product has split.*

Does [PRODUCT] provide at least some coverage for self-referrals to **any** types of in-network specialists?

<1> YES
<2> NO
<d> DON'T KNOW
<r> REFUSED

>b91a_end< [if b91a does not equal<1> go to b9_end]

>b91b< ([if SPLIT is greater than or equals <5> and b91b is not null]
I need to confirm…..) *This question stem is asked anytime a product has split.*

Does this coverage for self-referral apply to most types of in-network specialists?

<1> YES [goto b92]
<2> NO
<d> DON'T KNOW
<r> REFUSED

>b91c< ([if SPLIT is greater than or equals <5> and b91c is not null]
I need to confirm…..) *This question stem is asked anytime a product has split.*

Does this coverage for self-referral apply to **most** visits to in-network OB/GYNs?

INTERVIEWER: COVERAGE OF ONE ANNUAL VISIT DOES NOT COUNT.

<1> YES
<2> NO
<d> DON'T KNOW
<r> REFUSED

>b91d< ([if SPLIT is greater than or equals <5> and b91d is not null]
I need to confirm…..) *This question stem is asked anytime a product has split*.

Does this coverage for self-referral apply to **any other** types of in-network specialists?

<1> YES
<2> NO
<d> DON'T KNOW
<r> REFUSED

>b92< ([if SPLIT is greater than or equals <5> and b92 is not null]
I need to confirm…..) *This question stem is asked anytime a product has split.*

When [PRODUCT] covers in-network self referrals, is the level of coverage the same as with a physician referral, or is it less than the coverage with a physician referral?

PROBE: Lesser coverage means that the copayment or coinsurance rate that the enrollee pays is **higher**.

<1> SAME
<2> LESS
<3> VOLUNTEER: Varies
<d> DON'T KNOW
<r> REFUSED

>b92t< [if (b92 equals <3> and (b91b equals <1> or b91c <1>)) go to b92b]
[goto b93_pre]

>b92b< ([if SPLIT is greater than or equals <5> and b92b is not null]
I need to confirm…..) *This question stem is asked anytime a product has split.*

What about in-network self-referrals to OB/GYNs - is the level of coverage the same as with a physician referral, or less than with a physician referral?

PROBE: Lesser coverage means that the co-payment or coinsurance rate that the enrollee pays is **higher**.

<1> SAME
<2> REDUCED
<d> DON'T KNOW
<r> REFUSED

>b93_pre< [if b6 equals <1> and (b92 equals <2> or b92 equals <3>) goto b93]
[goto b9_end]

>b93< ([if SPLIT is greater than or equals <5> and b93 is not null]
I need to confirm…..) *This question stem is asked anytime a product has split.*

Under [PRODUCT] when the level of coverage for in-network self-referrals is reduced, is that level of coverage better than for out-of-network self-referrals, or the same?

<1> SAME
<2> LESS
<3> VOLUNTEER: varies
<d> DON'T KNOW
<r> REFUSED

>b93t< [if b93 equals <3> and (b91b equals <1> or b91c equals <1>) goto b93b
[goto b9_end]

>b93b< ([if SPLIT is greater than or equals <5> and b93b is not null]
I need to confirm…..). *This question stem is asked anytime a product has split.*

What about in-network self-referrals to OB/GYNs--Is that level of coverage better than for out-of-network self-referrals, or the same?

<1> BETTER
<2> SAME
<d> DON'T KNOW
<r> REFUSED

>b9_end<

WE ARE DONE WITH INVENTORY/SPLIT SECTION FOR THIS PRODUCT.
PRESS ENTER TO CONTINUE

>b9_end_real< *goto b5s_pre and ask Module 3 questions for the next PRODUCT on the list, if there are no more PRODUCTS for that SITE got to b9s_end. At this point a negative value in SPLIT is changed to a positive value.*

>b9s_end< *goto b1a and ask Module 2 questions for the next SITE on the list if there are no more SITES goto b13_intro.*

MODULE 4: CO-PAYMENTS AND DEDUCTIBLES

b13_intro Now I would like to ask some questions about co-payments and deductibles for each product you offer in each of the sites we have discussed.

<g> CONTINUE

>b13ros< *begin with the first/next SITE for the entity*
begin with the first/next PRODUCT for the SITE

>editb13< *if a product has been deleted, combined with another product or is not offered the program will skip questions on copayment and deductibles.*
[if p_delete equals <X> or p_combine is greater than or equals <1> or offer_flag equals <0> goto bp_end][15]

>b13< Does [PRODUCT] in [SITE] have a fixed co-payment per visit, or percentage co-insurance payment for [if NET equals <1>]in-network [endif] office visits?[16]

PROBE: Whichever is most common for enrollees in this product?

<1> CO-PAYMENT [goto b13amt]
<2> CO-INSURANCE RATE [goto b13per]
<0> NONE
<d> DON'T KNOW[17]
<r> REFUSED[17]
[goto b13out_pre]

>b13amt< What is the typical co-payment amount per office visit for [PRODUCT] in [SITE]?

PROBE: The lowest co-payment that typically applies for [if NET equals <1>] in-network [endif] office visits with referrals. Exclude "well" visits if these are different.

<1-2000> dollars
<d> DON'T KNOW [18]
<r> REFUSED[18]

>b13amt_end<
[if b13amt is less than or equals <50> goto b13out_pre, else goto b13ch1]

[15] See page 44 for data elements >p_delete<, >p_combine<, and >offer_flag<.
[16] See page 48 for data elemert >NET<.
[17] In final CATI program, <d> and <r> are treated as negative numbers, therefore at >b13ch2_end<, <d> and <r> meet the criteria to goto b13out_pre.
[18] In final CATI program, <d> and <r> are treated as negative numbers, therefore at >b13amt_end< , <d> and <r> meet the criteria to goto b13out_pre.

>b13ch1<

I just heard you say that the co-payment for [in-network] office visits is **[b13AMOUNT]**, is that correct?

PROBE: Is that typical for all contracts under this product?

PROBE: The co-payment is the amount the enrollee pays for the visit.

PROBE**:** The lowest co-payment that typically applies for [if NET equals <1>] in-network [endif] office visits with referrals. Exclude "well" visits if these are different.

<1> CORRECT [goto b13out_pre]
<2> NO, GO BACK AND CHANGE [goto b13amt]
<d> DON'T KNOW[19]
<r> REFUSED[19]

>b13per< What is the typical coinsurance percentage for office visits under [PRODUCT] in [SITE]?

PROBE: The coinsurance rate is the percentage for which the enrollee is responsible.

PROBE: The lowest coinsurance that typically applies for [if NET equals <1>] in-network [endif] office visits, with referrals. Exclude "well" visits if these are different.

<1-100> percent
<d> DON'T KNOW[20]
<r> REFUSED[20]

>b13ch2_end<

[if b13per is less than or equals <50> goto b13out_pre, else, goto b13ch2]

[19] In final CATI program, <d> and <r> are set to goto the next question, b13per instead of b14. If this program is to be used again the skip for <d> and <r> response should be changed to goto b14.
[20] In final CATI program, <d> and <r> are treated as negative numbers, therefore at >b13ch2_end<, <d> and <r> meet the criteria to goto b13out_pre.

>b13ch2< I just heard you say that the coinsurance rate for in-network office visits is **[b13PERCENT]**, is that correct?

PROBE: Is that typical for all contracts under this product?

PROBE: The coinsurance rate is the percentage for which the enrollee is responsible.

PROBE: The lowest coinsurance rate that typically applies for ([if NET equals<1>] in-network) office visits with referrals. Exclude "well" visits if these are different.

<1> CORRECT
<2> NO, GO BACK AND CHANGE [goto b13per]
<d> DON'T KNOW[21]
<r> REFUSED[21]

>b13out_pre< [if b6 equals <2> or NET equals <0> goto b14]

>b13out< For out-of-network office visits without a referral does [PRODUCT] in [SITE] have a fixed co-payment per visit, or percentage coinsurance payment?

PROBE: Whichever is most common for enrollees in this product?

<1> CO-PAYMENT [goto b13od]
<2> COINSURANCE [goto b13op]
<0> NONE
<d> DON'T KNOW
<r> REFUSED
[goto b14]

>b13od< What is the typical co-payment amount for out-of-network office visits under [PRODUCT] in [SITE]?

PROBE: The co-payment that typically applies for office visits without referrals, outside of any network.

<1-2000> dollars
<d> DON'T KNOW[22]
<r> REFUSED[22]

>b13od_end<
[if b13od is less than or equals <50> goto b14]

[21] In final CATI program, <d> and <r> are set to goto the next question, b13out_per and onto b13_out instead of b14. If this program is to be used again the skip for <d> and <r> response should be changed to b14.
[22] In final CATI program, <d> and <r> are treated as negative numbers, therefore at >b13od_end<, <d> and <r> meet the criteria to goto b14.

>b13ch3< I just heard you say that the co-payment for out-of-network office visits is **[b13odAMOUNT]**, is that correct?

PROBE: Is that typical for all contracts under this product.

PROBE: The co-payment is the amount the enrollee pays for the visit.

PROBE: The co-payment that typically applies for office visits, without referrals, outside of any network.

<1> CORRECT [goto b14]
<2> NO, GO BACK AND CHANGE [goto b13od]
<d> DON'T KNOW[23]
<r> REFUSED[23]

>b13op< What is the typical coinsurance percentage for out-of-network office visits under [PRODUCT] in [SITE]?

PROBE: The coinsurance rate is the percentage for which the enrollee is responsible.

PROBE: The coinsurance that typically applies for office visits, without referrals, outside of any network?

<1-100> percent
<d> DON'T KNOW[24]
<r> REFUSED[24]

>b13op_end<

[if b13op is less than or equals to <50> goto b14]

>b13ch4< I just heard you say that the coinsurance for out-of-network office visits is **[b13opAMOUNT]**, is that correct?

PROBE: Is that typical for all contracts under this product.

PROBE: The coinsurance is the amount the enrollee pays for the visit.

PROBE: The coinsurance that typically applies for office visits, without referrals, outside of any network.

<1> CORRECT
<2> NO, GO BACK AND CHANGE [goto b13op]
<d> DON'T KNOW
<r> REFUSED

[23] In final CATI program, <d> and <r> are set to goto the next question, b13op instead of b14. If this program is to be used again the skip for <d> and <r> response should be changed to b14.
[24] In final CATI program, <d> and <r> are treated as negative numbers, therefore at >b13op_end< <d> and <r> meet the criteria to goto b14.

>b14< Under [PRODUCT] in [SITE], what is the dollar amount of the individual deductible that applies to [if NET equals <1>] in-network [endif]office visits?

PROBE: Your best estimate is fine. Please tell me what is **typical** for this product in [SITE]?

INTERVIEWER: Enter "0" if none.

<0-100000> dollars[25]
<d> DON'T KNOW[26]
<r> REFUSED[26]

>b14_end< [if (b14 is greater than <0> and b14 is less than <50>) or b14 is greater than <5000> goto b14ch1][goto b14out_pre]

>b14ch1< I just heard you say that the deductible for [if NET equals <1>] in-network [endif] office visits is **[b14AMOUNT]**, is that correct?

PROBE: Is that typical for all contracts under this product?

PROBE: The deductible is the annual amount the enrollee pays.

<1> CORRECT [goto b14out_pre]
<2> NO, GO BACK AND CHANGE [goto b14]
<d> DON'T KNOW
<r> REFUSED

>b14out_pre<
[if NET equals <0> or b6 does not equal <1> goto bp_end]

>b14out< Is there a **separate** deductible for [PRODUCT] in [SITE] that applies to out-of-network office visits?

<1> YES
<2> NO [goto bp_end]
<d> DON'T KNOW[27]
<r> REFUSED[27]

[25] The dollar range at b14 is <0-10000>. If this program is to be used again the dollar range should be revised.
[26] In final CATI program, <d> and <r> are treated as negative numbers, therefore at >b14_end<, <d> and <r> meet the criteria to goto b14out_pre.
[27] In final CATI program, <d> and <r> are set to goto the next question, b14od instead of bp_end. If this program is to be used again the skip for <d> and <r> response should be changed to bp_end.

>b14od< What is the dollar amount of the **individual deductible** for out-of-network office visits?

PROBE: Your best estimate is fine. Please tell me what is typical for this product in [SITE]?

<0-50-5000> dollars[28]
<d> DON'T KNOW[29]
<r> REFUSED[29]

>b14od_end<

[if (b14od is greater than <0> and b14od is less than <50>) or b14od is greater than <5000> goto b14ch2][gotobp_end]

>b14ch2< I just heard you say that the deductible for out-of-network office visits is **[b14od AMOUNT],** is that correct?

PROBE: Is that typical for all contracts under this product?

PROBE: The deductible is the annual amount the enrollee pays.

<1> CORRECT [goto bp_end]
<2> NO, GO BACK AND CHANGE [goto b14od]
<d> DON'T KNOW
<r> REFUSED

>bp_end< *goto b13 and ask Module 4 questions for the next PRODUCT on the list, if there are no more PRODUCTS for that SITE got to bs_end*

>bs_end< *goto b13 and ask Module 4 questions for the next SITE on the list if there are no more SITES goto c_beg.*

[28] The dollar range at b14od the dollar range is <0-50-5000>. If this program is to be used again the dollar range should be revised.

[29] In final CATI program, <d> and <r> are treated as negative numbers, therefore at >b14od_end< <d> and <r> meet the criteria to goto b14ch2. But the criteria should be set for <d> and <r> to goto bp_end.

MODULE 5: NETWORK AND PROVIDER RELATIONS

>c_beg< I now have a few questions about the providers associated with each product.

<g> CONTINUE

begin with the first/next SITE for the entity
begin with the first/next PRODUCT for the SITE

>editc1r< *if a product has been deleted, combined with another product or is not offered the program will skip questions on network and provider relations.*
[if p_delete equals <X> or p_combine is greater than or equals <1> or offer_flag equals <0> goto cp_end][if NET equals <0> goto c4_1]

>c1r< Approximately what percentage of all primary care and specialist physicians in [SITE] are associated with [PRODUCT]? Would you say? . . .

INTERVIEWER: DO **NOT** PROBE DK.

<1> fewer than 25 percent
<2> at least 25 percent but less than 50 percent
<3> at least 50 percent but less than 75 percent
<4> 75 percent or more
<d> DON'T KNOW
<r> REFUSED

>c2r< Under [PRODUCT] are enrollees limited to a single hospital system for general acute care services in [SITE]?

PROBE: A single hospital system would be one or more hospitals under the same ownership or management.

<1> YES
<2> NO
<d> DON'T KNOW
<r> REFUSED

>c4_1< Next, I have some questions about payment arrangements for primary care physicians, specialists, and hospitals for each product in [SITE]. Since this may vary somewhat depending on the provider, I just want to know what is **typical** for the providers who serve a majority of enrollees in each product.

<g> CONTINUE

>c4_2< In [PRODUCT] in [SITE], what is the typical method of payment that your organization uses for primary care services? Is it? . . .

PROBE: By that I mean how your organization pays individual providers, medical groups, or other entities for primary care services in [SITE].

PROBE: Capitation is a fixed payment per member per month for a class of services.

INTERVIEWER**:** Probe carefully between <1> and <2>.

<1> Fee-for-service, for example, usual and customary rates
<2> Fixed fee schedule, including discounted FFS or relative value units
<3> Salaried by your organization, or . . .
<4> Capitation (includes combined "professional" or "global" capitation)
<5> OTHER (SPECIFY) [SPECIFY] END WITH // [30]
<d> DON'T KNOW
<r> REFUSED

>c4a_pre< [if c4_2 does not equal <4> goto c5]

>c4a< What **other** services are included in this capitated payment?

INTERVIEWER**:** CODE ALL THAT APPLY

<1> Referrals to specialists
<2> Hospitalizations
<3> Other services
<n> NO MORE CODES/NONE OF THESE
<x> DELETE A CODE [goto xc4a]
<d> DON'T KNOW
<r> REFUSED
[goto c5_pre]

>xc4a< THIS SCREEN IS TO DELETE A RESPONSE.

<1> Referrals to specialists
<2> Hospitalizations
<3> Other services
<n> NO CODES TO DELETE
[goto c4a]

>c5_pre< [if c4a equal <1> goto c6_pre]

[30] See page 48 for data element >SPECIFY<.

>c5< In [PRODUCT] in [SITE] what is the typical method of payment that **your** organization uses for specialty services. Is it? . . .

PROBE: By that I mean how **your** organization pays individual providers, medical groups, or other entities for specialty services in [SITE].

PROBE: Capitation is a fixed payment per member per month for a class of services.

<1> Fee-for-service, for example, usual and customary rates
<2> Fixed fee schedule, including discounted FFS or relative value units
<3> Salaried by your organization, or . . .
<4> Capitation
<5> OTHER (SPECIFY) [SPECIFY] END WITH // [31]
<d> DON'T KNOW
<r> REFUSED

>c6_pre< [if c4a equals <2> goto c7t][32]

>c6< In [PRODUCT] in [SITE] what is the typical method of payment for hospital services? Is it? . . .

PROBE: By that I mean how **your** organization pays for hospital services in [SITE]. Exclude physician services delivered during the hospital stay.

PROBE: Capitation is a fixed payment per member per month for a class of services.

<1> Per diem
<2> According to DRG or per stay
<3> Capitation
<4> Billed charges, or discounted billed charges, or
<5> Something else (SPECIFY) [specify] END WITH //
<7> NOT APPLICABLE; HOSPITALS OWNED BY ORGANIZATION
<d> DON'T KNOW
<r> REFUSED

[31] See page 48 for data element >SPECIFY<.
[32] The final CATI program reads, if c4a equals <2> goto c7t. The program should have read, if c4a equals <2> goto c7.

>c7< Does [PRODUCT] in [SITE] ever include any mental health and/or substance abuse services?

PROBE: Includes "chemical dependency."

PROBE: Includes mental health or substance abuse services you provide by subcontract only if your organization administers that benefit.

<1> YES
<2> NO
<d> DON'T KNOW
<r> REFUSED

>c7t< [if c7 does not equal <1> goto cp_end]

>c7a< Are mental health and/or substance abuse services ever provided or managed separately by a specialty managed behavioral health organization?

<1> YES
<2> NO
<d> DON'T KNOW
<r> REFUSED

>cp_end< *goto c_beg and ask Module 5 questions for the next PRODUCT on the list, if there are no more PRODUCTS for that SITE got to c7b.*

>c7a_any< [if p_delete does not equal <X> or p_combine equals <0> or offer_flag equals <1>][if c7a equals <1>][store <1> in c7a_any][endif]
[if c7a_any equals <0> goto cs_end]

>c7b< Please tell me the name of the specialty managed behavioral health organization you use in [SITE]?

SELECT ALL THAT APPLY

<1> American Psych System
<2> Healthcare Value Mgt.
<3> MAGELLAN Behavioral Health
<4> Managed Health Network
<5> MAPSI Mid Atlantic Psych Services
<6> Private Health Care Systems (PHCS)
<7> Pro Behavioral Health Plan
<8> Sagamore
<9> Something else [goto c7c]
<d> DON'T KNOW
<r> REFUSED
<n> NO MORE CODES
<x> DELETE A CODE [goto xc7b]
[goto cs_end]

>xc7b< THIS SCREEN IS TO DELETE A RESPONSE.
<1> American Psych System
<2> Healthcare Value Mgt.
<3> MAGELLAN Behavioral Health
<4> Managed Health Network
<5> MAPSI Mid Atlantic Psych Services
<6> Private Health Care Systems (PHCS)
<7> Pro Behavioral Health Plan
<8> Sagamore
<9> Something else: SPECIFY WHICH ORGANIZATION TO DELETE [specify] [33]
<n> NO CODES TO DELETE
[goto c7b]

>c7c< [if c7cName is not null goto c7c2]

RECORD NAME IF NOT LISTED
NAME: >c7cName<

In what city and state is this specialty behavior health company located?
CITY:
STATE:

[33] See page 48 for data element >SPECIFY<.

>c7c2< [if c7c2Name is not null goto c7c3] [34]
RECORD NAME IF NOT LISTED

NAME: >c7c2Name<

In what city and state is this specialty behavior health company located?

CITY:
STATE:
[goto tc7b]

>c7c3< RECORD ADDITIONAL OTHERS ON PROBLEM SHEET. PRESS ENTER TO CONTINUE

>cs_end< *Goto c_beg and ask Module 5 questions for the next SITE on the list, if there are no more SITEs got to d1_pre.*

[34] c7c2 may be an unnecessary data element

MODULE 6: CLOSING

>d1_pre< [if a3a does not equal <1> and a3 does not equal <2> and <3> and <5> goto d2]

>d1< I just have a few final questions about your organization . . .

What is your organization's tax status? Is it? . . .

INTERVIEWER: CODE ORGANIZATIONS WITH A 501(c)3 or 501(c)4 TAX STATUS AS NON-PROFIT

<1> for-profit, privately held
<2> for-profit, publicly held, or . . .
<3> nonprofit
<4> OTHER (SPECIFY) [SPECIFY] END WITH // [35]
<d> DON'T KNOW
<r> REFUSED

>d2< Is your organization a division or subsidiary of another health plan organization?

<1> YES [goto d2a]
<2> NO
<d> DON'T KNOW
<r> REFUSED
[goto d3]

>d2a< Is this parent company a national or multi-state organization?
<1> YES [goto d2b]
<2> NO
<d> DON'T KNOW
<r> REFUSED
[goto c7a_ent]

>d2b< What is the name of that parent company?
NAME:
<s> scroll [nat_codes][36]
<o> other [goto d2c]
<d> DON'T KNOW [goto c7a_ent]
<r> REFUSED [goto c7a_ent]
or ENTER CODE a between <01 – 66>[37]

[if code is greater than or equal to <01> and less than or equal to <66>, goto c7a_ent]
[goto d2b]

[35] See page 48 for data element >SPECIFY<.
[36] See page 43 for data element >nat_codes< -- a list of National Parent Company Names.
[37] See page 43, the codes (>nat_codes<) and their associated National Parent Company Names are listed

>d2c< In what city and state is this parent company located?

NAME:
CITY:
STATE:
[goto c7a_ent]

>d3< Is your organization a national or multi-state organization?

<1> YES
<2> NO
<d> DON'T KNOW
<r> REFUSED

>c7a_ent< [If no sites were deleted and c7a equals <1>, store <1> in c7a_ent].
[if c7a_ent equals <0> goto d5]

>d4< **IF ANY PRODUCT COVERS MENATL HEALTH SERVICES:**
Finally, may I have the name and phone number of the person within your organization who could answer questions about mental health and/or substance about benefits?

PROBE: I'd like the name of someone within your organization, not at the managed behavioral health organization.
NAME:
PHONE NUMBER:
ORGANIZATION:

>d5< Finally, in order to send you our report on this study, may I have your name, title and mailing address.
NAME:
TITLE:
ORGANIZATION:
STREET ADDRESS OR PO BOX:
CITY:
STATE:
ZIP CODE:
[goto done_pre][38]

[38] See page 49 for data element >done_pre<

>nat_codes< *List of National Parent Company Names*

01	Admar Corp. Med Network
02	Aetna Life Insurance Co.
03	Aetna Services Inc. (Aetna Health Plans -- managed care)
04	Allstate Life Insurnace
05	AMERICAID, Inc.
06	American HMO
07	American Medical Security, Inc.
08	AmeriChoice Corp.
09	AmeriHealth, Inc.
10	Anthem Health Plans
11	Apex Health Care, Inc.
12	Beech Street Corp.
13	Blue Cross and Blue Shield System
14	CAPP Care
15	CIGNA Health Plans, Inc.
16	Community Health Plan, Inc.
17	Connecticut General Life Insurance Co.
18	Coventry Corp.
19	FHP, Inc.
20	Fortis Benefits
21	Foundation Health Corp.
22	Great Western Life and Accident
23	Group Health Cooperative of Puget Sound
24	Guardian Life Insurance Co.
25	Harvard/Pilgrim Health Care
26	Health Insurance Plan of Greater New York
27	Health Management Associates
28	Health Systems International, Inc.
29	HealthCare COMPARE Corp./The AFFORDABLE Medical Networks
30	HealthSource, Inc.
31	Henry Ford Health Care Corp.
32	Home Life Financial
33	Humana, Inc.
34	John Alden Life
35	John Deere Health Care, Inc.
36	John Hancock Life
37	Kaiser Foundation Health Plans, Inc.
38	Managed Health Network, Inc.
39	Maxicare Health Plans, Inc.
40	Medica
41	MedView Services Inc.
42	Mid-Atlantic Medical Services, Inc.
43	MultiPlan Inc.
44	Mutual of Omaha (managed care division)
45	Mutual of Omaha Insurance Co.
46	National Preferred Provider Network, Inc.
47	New York Life
48	NYLCare Health Plans, Inc.
49	Oxford Health Plans, Inc.
50	PacifiCare Health Systems, Inc.
51	PHS, Inc.
52	Physician Corp. of America
53	Preferred Health Network
54	Principal Financial
55	Principal Health Care, Inc.
56	Principal Mutual
57	Private Healthcare Systems
58	Provident Life and Accident Insurance Co.
59	Prudential Health Care Plans, Inc. (managed care division)
60	Prudential Insurance Co. of America
61	Sisters of Providence
62	United American HealthCare Corp.
63	United HealthCare Corp.
64	US Healthcare, Inc.
65	USA Health Network
66	WellCare Management Group, Inc.

DATA ELEMENTS : ADD, COMBINE, EDIT, OR SPLIT PRODUCTS

MyEdit Function[39]

>myedit<

<1> Edit Delete and Combine Flags [goto flags]
<2> Add a product [goto add]
<3> Edit specific Site/Product data [goto edit]
<4> Editing complete [goto sure]

IF YOU HAVE CHANGED DELETE AND COMBINE STATUS FOR PRODUCTS (OPTION 1)

YOU MAY WANT TO CHANGE OFFER STATUS BY SITE NOW (OPTION 3)

>flags<

ENTER 'd" ON ANY FIELD (except combine) WHEN DONE EDITING

Column1	*Column2*	*Column3*
Product Roster	*Delete Status*	*Combine Status*
	Store in >p_delete<	*Store in>p_combine<*
	(enter x here)	*(enter another product number here)*

[goto myedit]

>p_delete< *A variable per product, x = product was deleted*

>p_combine< *A variable per product. If greater than 0 the product has been combined with another product*.

>offer_flag< *Indicator set to 1 if product offered, or 0 if product not offered*

>add< What is the name of the product you want added to ALL sites
new product name is stored
[goto myedit]

>edit< ENTER THE SITE YOU WANT TO EDIT
list site roster

Enter SITE number [goto p_edit]

[39] See page 12 for a detailed description of the MyEdit Function.

>p_edit< What product did you want to edit in [SITE]?

Enter PRODUCT number

>item< What item do you want to edit in SITE for PRODUCT?

<1> Offer/combine/delete products (item b1a)
<2> Core/split attributes (item b5)
<3> Copays (item b13)
<4> Network and payment (item c1r)

>warn< This ends the editing function.
You will be entering the questionnaire for [SITE]'s [PRODUCT] product at item
[if item equals <1> b1a]
[if item equals <2> b5]
[if item equals <3> b13]
[if item equals <4> c1r]

If you made a mistake then back up now to change it.
[goto gotoprod]

>gotoprod<

[store <> in myedit]
begin list of Sites and Products
[if PRODUCT does not equal p_edit goto prod_no]
[if item equals <1> goto editb1]
[if item equals <2> goto editb5]
[if item equals <3> goto editb13]
[if item equals <4> goto editc1r]
[goto myedit]

>prod_no<
end list of PRODUCTS

>site_no<
end list of Sites

SPLITTING

The following data elements are used to split a product from either b5b_end, b6b_end, b10b_end or b8b_end.

>append< YOU ARE ABOUT TO SPLIT AN ADDITIONAL PRODUCT FROM THIS PRODUCT
<g> CONTINUE [goto newname2]

>newname2<
SITE: [SITE]
PARENT PRODUCT: [PRODUCT]

What do you want to call this product?

Name of new product is stored.
Program stores a negative value in >SPLIT< equal to the number corresponding to the item where the split occurred. For example, if a split occurred at b5, SPLIT becomes <–5>.
[goto app]

>app< *If the number of products is less than 18, add the product to the product list and go to the next unanswered question, otherwise goto >maxprod<.*

For example, the program after identifying the added product returns to the item where the split occurred and proceeds to collect the rest of the attributes on the original product. When the original product data is complete, the program begins a questioning cycle on the added product. For the items up until the split occurred, the questioning cycle for the added product is designed to verify the information collected on the original product also applies to the added one. When the interviewer reaches the split item, the questioning for the added product begins anew.

>maxprod<
You have exceeded the maximum number of products allowed in this interview.
You can NOT add this product.
Please back up and change your answers so you don't add this product.
If you have any questions please contact your supervisor.
Go back to b5b or b6b or b10b or b8b

>SPLIT< *Since splitting a product into multiple products can occur at four different points in the interview b5b or b6b or b10b or b8b, the value of the >SPLIT< indicates where the split occurred. For example, if >SPLIT< equals <–5>, the split occurred at b5b. The value of >SPLIT< will determine what series of questions will be asked next. SPLIT will remain a positive number (i.e., at b5 SPLIT equals 5) until it is reset to a negative number at either b5b, b6b, b10b or b8b. SPLIT is reset to a positive value at b9_end_real if a split occurred.*

Example of Program Flow for Splits.

As discussed in section I.C.2.c, (page 11) the CATI program was designed to allow the interviewer to split a product into two if the attribute responses at items b5, b6, b8 or b10 were not the same within the site. This process helped to ensure that product definitions were attribute based to account for within-site contract level variation. Overall, this situation occurred infrequently with a maximum of 54 (1.8%) of the 2,946 product site combinations resulting from splits.

As an example, suppose that an insurer offered an "POS Gold" plan in a specified site. Then, during the interview the insurer responded that for most contracts, if enrollees went to an out-of-network doctor without a referral, the plan would not cover any of the costs (b6=No). For other contracts, this plan does cover some costs in this situation (b6=Yes) and gets the name "POS Gold Freedom." As a result, what we originally thought was one product became two, POS Gold and POS Gold Freedom. In this case, the CATI program was designed to allow the interviewer to identify a new name for the second product and then to collect information separately about both. The program after identifying the added product returns to the item where the split occurred and proceeds to collect the rest of the attributes on the original product and the attributes on the new product (see data element app on page 46).

Given the questionnaire flow in a split situation is different depending on where the split occurred, in an effort to avoid confusion, we designed this document to describe the general questionnaire path in the absence of such situations. To provide the reader with a general understanding of the skip patterns in a split situation, we provide the following example.

Using our example above, suppose that for the original product, POS Gold, the respondent provides a somewhat iffy response of "No" to b6, and then answers "No" to b6a, indicating this is not true for all contracts in that site. The interviewer then confirms this fact in b6b (b6b=1), which as indicated in b6b_end takes the interviewer to the append screen. At the append screen, the interviewer obtains a new product name for the added product (newname2), in this case entering "POS Gold Freedom." Since the split occurred at question b6, the program stores a <–6> in SPLIT. Next, the program returns to b5s, evaluates SPLIT as <–6>, and follows the skip pattern to b6b_end. The skip pattern at b6b_end takes the interviewer to b10 to finish the rest of the questions on the original product. Once the original product attributes are obtained at b9_end, the program, via b9_end_real, (the value of SPLIT is changed from <-6> to <6> at this point as well) returns to b5s_pre to begin the collection of the product attributes for the added product.

For the added product, at editb5, with SPLIT now equal to <6>, the program takes the interviewer to child_beg, and then to b5s_end and b5_pre. At b5_pre, with SPLIT=<6>, the program goes to b5_split, then presumably to b5nt, and finally onto b6_split to verify the original product responses apply to the added product. At b6b_end, since SPLIT=<6> the program returns to b10, the normal question path. At modules 4 and 5, the appended product is treated as a separate product and follows the standard questioning sequence.

>NET< *The value of >NET< is determined by the response to questions b2, b5 and b6 and the value will determine what series of questions will be asked next.*

Storing verbatim responses

>SPECIFY< *A opened ended response will be stored for the particular question. Open ends responses are allowable at a3, b2, b2a, c4_2, c, c6, xc7b and d1.*

DATA ELEMENTS : INTERIM OR FINAL STATUS CASE

Screen that comes up at the end if the respondent could not answer for one or more products.

>done_pre<

Hold for one minute while I check all my questions.....

[goto sure][40]
[If probe equals <1> goto new_resp,otherwise goto comp][41]

>new_resp<
Earlier you said you could not tell me about products in:
[SITE]

Do you think you could answer for any of those sites now?

<1> YES, WILL DO MORE SITES [goto a2]
<2> NO
[goto comp]

>cb< CODING CURRENT DISPOSITION

<20> CALLBACK--FIRM APPOINTMENT [goto cb20]
<21> CALLBACK--NO APPOINTMENT [goto xit1]
<22> NO ANSWER/BUSY [goto xit1]
<23> ANSWERING MACHINE--NO HUMAN CONTACT [goto xit1]
<24> SEARCHING--WRONG#--# CHANGED [goto xit1]
<25> INITIAL REFUSAL [goto xit1]
<26> INCOMPLETE--BREAKOFF [goto xit1]
<27> WAITING FOR LETTER [goto xit1]
<28> RESPONDENT WILL CALL MPR [goto xit1]
<40> OUT OF BUSINESS [goto fdis]
<42> NOT A HEALTH PLAN--NO NEW CONTACT [goto cls1]
<38> SUPERVISOR REVIEW [goto fdis]

>cb20< ENTER DATE & TIME FOR A FIRM APPOINTMENT [goto note]

[40] See page 20 for data element >sure<.
[41] See page 16 for data element >PROBE<.

>fdis< CODING FINAL DISPOSITION
<11> RETIRED—MERGER—ALL LINKS GO ELSEWHERE [goto xit2]
<12> MAX CALLS—END OF EFFORT [goto xit2]
<13> UN-LOCATABLE [goto xit2]
<15> FINAL REFUSAL [goto xit2]
<16> INCOMPLETE/BREAKOFF [goto xit2]
<17> CHRONIC NO ANSWER/BUSY [goto xit2]
<19> OTHER [goto sp2]
<40> OUT OF BUSINESS [goto xit2]
<41> INELIGIBLE—NOT A HEALTH PLAN [goto xit2]

>sp2< INTERVIEWER: SPECIFY OTHER FINAL DISPOSITION REASON [goto xit2]

>xit1< YOU ARE ABOUT TO EXIT THIS CASE.
ENTER DISPOSITON ON CONTACT SHEET AND TYPE <g> TO EXIT [goto note].

>c1s1< That's all the questions I have.
Your establishment is not selected to participate in the study.

INTERVIEWER: GIVE REASON FOR INELIGIBILITY IF ASKED.

>xit2< THIS CASE WILL BE SENT TO CLEAN.
ENTER DISPOSITON ON CONTACT SHEET AND TYPE <g> TO EXIT.

>note< INTERVIEWER: ARE THERE ANY NOTES ABOUT THIS CASES ?
<1> YES [specify]
<2> NO

>zend< *CATI sets time, date and exits*

>comp< CASE IS ABOUT TO COMPLETE.
TYPE <g> TO CONTINUE.

>cmp1<

Thank you very much. We appreciate your participation. Those are all the questions I have, though we may contact you again.

Thank you and goodbye.