The National Health Interview Survey's Family Health Insurance Section and Proposed Affordable Care Act-Related Questions: 2014 Cognitive Interviewing Results

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This report documents the results of the cognitive interviewing study examining a sub-set of the 2014 Family Health Insurance (FHI) section of the National Health Interview Survey (NHIS), as well as a number of proposed Patient Protection and Affordable Care Act (ACA)-related FHI questions. Overall, this section of the NIHIS and the proposed questions are designed to measure and monitor the healthcare coverage rates and habits of the American civilian, non-institutionalized population.

Due to the passage of the ACA in 2010, and the implementation of its exchange provisions in late 2013, new questions on the NHIS became necessary in order to better capture and characterize the insured and un-insured population. The Questionnaire Design Research Laboratory (QDRL) began preliminary ethnographic work in order to determine 1) what potential NHIS respondents understood about health insurance and the various ACA-related sales vehicles (i.e. healthcare.gov, the state-based insurance marketplaces, the "navigators" program, etc.) and 2) how potential NHIS respondents actually spoke and communicated about health insurance and the ACA. This preliminary ethnographic work will be reported elsewhere, but suffice to say the information gleaned from this preliminary work contributed to a series of questions designed to supplement the current Family Health Insurance section of the NHIS. This cognitive interviewing project evaluated the newly-designed ACA supplemental questions and a sub-set of the 2014 FHI section of the NHIS. The overall research questions for this project were:

1. How do potential NHIS respondents understand and respond to both the current and supplemental FHI survey questions?
2. Are potential NHIS respondents able to accurately report about, and characterize, their health insurance coverage?

The majority of this report will present a question-by-question analysis. Not all questions were probed during the cognitive interview. For those questions that were, the reported findings of each question include descriptions of respondents' interpretations and the types of experiences that respondents considered in their answer. Question numbers with the prefix "FHI" (as in Question FHI.050) were found on the 2014 NHIS, while question numbers with either the prefix "BLS" or "QDRL" were proposed questions and *were not* on the 2014 NHIS.

It is important to note that the full set of Family Health Insurance questions are used by NCHS' Division of Health Interview Statistics when processing the data, including questions such as Question FHI.131 and FHI.160 that ask for the full name of a health insurance plan. In fact, many of the questions across this section function as "validity checks," insuring that a respondent or family member does not get assigned to an incorrect insurance status or insurance type during processing and editing. The new ACA-related questions were designed to fit into this larger schema—giving DHIS greater confidence that the people they report as having obtained their health insurance coverage through the ACA will be reported as such.

The next section presents an overview of cognitive interviewing methodology generally, as well as the specific methodology used to evaluate the FHI section of the NHIS. Next, a summary of conclusions is

presented, centering upon the research goals outlined above. The final section of the report presents findings for each question.

METHODS

This section details the methodology of this study. First, an overview of cognitive interviewing methodology will be presented. Then, the specific methods used for this project will be described.

Cognitive Interviewing

The aim of a cognitive interviewing study is to investigate how survey questions perform when asked of respondents, that is, if respondents understand the questions according to their intended design and if they can provide accurate answers based on that intent (Miller et al, 2014; Willis 2004). As a qualitative method, the primary benefit of cognitive interviewing is that it provides rich, contextual insight into the ways in which respondents 1) interpret a question, 2) consider and weigh out relevant aspects of their lives and, finally, 3) formulate a response based on that consideration. As such, cognitive interviewing provides in-depth understanding of the ways in which a question operates, the kind of phenomena that it captures, and how it ultimately serves the scientific goal. Findings of a cognitive interviewing project typically lead to recommendations for improving a survey question, or results can be used in post-survey analysis to assist in data interpretation.

Traditionally, cognitive testing is performed by conducting in-depth, semi-structured interviews with a small sample of approximately twenty to forty respondents. The typical interview structure consists of respondents first answering the evaluated question and then answering a series of follow-up probe questions that reveal what respondents were thinking and their rationale for that specific response. In this regard, cognitive interviews unfold within a narrative format. Through this semi-structured design, various types of question-response problems, such as interpretive errors or recall accuracy, are uncovered—problems that often go unnoticed in traditional survey interviews. By asking respondents to provide textual verification and the process by which they formulated their answer, elusive errors are revealed.

As a qualitative method, the sample selection for a cognitive interviewing project is purposive. Respondents are not selected through a random process, but rather are selected for specific characteristics such as gender or race or some other attribute that is relevant to the type of questions being examined. When studying questions designed to identify persons with health insurance, for example, the sample would likely consist of respondents who self-report having health coverage, allowing for the discovery of potential causes of false negatives. Additionally, to discover potential causes of false negative reporting, some respondents who self-report that they do not have health insurance coverage will be included as well. Because of the small sample size, not all social and demographic groups are represented. Analysis of cognitive interviews does not produce generalizable findings in a statistical sense, but rather, provides an explicit understanding of response processes including patterns of interpretation.

As is the case for analyses of qualitative data, the general process for analyzing cognitive interview data involves synthesis and reduction—beginning with a large amount of textual data and ending with conclusions that are meaningful and serve the ultimate purpose of the study. For analysis of cognitive

interviews, reduction and synthesis can be conceptualized within five incremental steps—conducting interviews, producing summaries, comparing across respondents, comparing across subgroups of respondents, and reaching conclusions. In practice, these steps are iterative; varying levels of analysis typically occur throughout the qualitative research process.

As each step is completed, data are reduced such that meaningful content is systematically extracted to produce a summary that details a question's performance. In detailing a question's performance, it is possible to understand the ways in which a question is interpreted by various groups of respondents, the processes that respondents utilize to formulate a response as well as any difficulties that respondents might experience when attempting to answer the question. It is the ultimate goal of a cognitive interviewing study to produce this conceptual understanding, and it is through data reduction that this type of understanding is possible. In reducing the cognitive interview data, the analyst produces a more comprehensive understanding of a question's performance; as analysis is performed, understanding of the question response process becomes more complex and complete. In the beginning it is only possible to understand how each individual respondent makes sense of and answers the survey question. By the end, individual interpretations are understood as well as how those interpretations relate across groups and within the overall context of the question's performance.

NHIS Family Health Insurance Cognitive Interviewing Study

40 face-to-face cognitive interviews were conducted for the NHIS Family Health Insurance Cognitive Interviewing Study. The interviews were conducted by a team of QDRL interviewers[1] between January 2014 and April 2014. Interviews were conducted both in the QDRL at NCHS, and outside the lab at respondents' houses, places of business, or other such agreed-upon meeting places (such as coffee shops).

The testing project was divided into three rounds of interviews, with a different questionnaire used in each round. Changes between the questionnaire versions were made in consultation with NHIS staff, and were largely designed to determine the framing effects of various question orderings. The questionnaires used in the three rounds are included at the end of this report in Appendices A, B, and C. Table 1 below shows the distribution of respondents across the three rounds of testing:

Table 1: Distribution of Respondents by Round of Cognitive Testing

Testing Round	Number of Respondents
1	12
2	9
3	19
Total	40

The cognitive interviews in this project followed the typical course for this method: The respondents were asked the survey questions, and were then immediately asked follow-up probes about each question. In some cases and at the discretion of the cognitive interviewer, this concurrent probing was supplemented by retrospective probing after the questionnaire was administered in its entirety. The

[1] The author would like to thank Stephanie Willson, Meredith Massey, Lauren Creamer, and Valerie Chepp for their assistance conducting interviews throughout the course of this project.

types of follow-up questions asked by interviewers depended on respondents' interpretation of the questions; however, typical follow-up questions included, "Why did you say that?" and "What were you thinking when you answered this question?"

Interviews typically lasted an hour. They were video recorded if done in the QDRL, and audio recorded if conducted off-site.

Respondents. Respondents were recruited by the QDRL in order to construct a purposive sample that was diverse on a number of characteristics, including gender, self-reported race, and the type of insurance coverage held at the time of the interview. Tables 2, 3, and 4 show the break down of the sample by these characteristics, respectively:

Table 2: Distribution of Respondents' Genders by Testing Round

Testing Round	Male	Female
1	9	3
2	2	7
3	8	11
Total	19	21

Table 3: Distribution of Respondents' Races by Testing Round

Testing Round	Black	White	Asian
1	8	4	0
2	4	4	1
3	9	10	0
Total	21	18	1

Table 4: Distribution of Respondents' Coverage Sources by Testing Round

Testing Round	ACA Coverage	Private Coverage	Medicaid
1	5	3	4
2	4	3	2
3	9	6	4
Total	18	12	10

Method of analysis. After an interview was conducted, cognitive interviewers recorded summary notes for each question, in English. Summary notes included the way in which a respondent interpreted and processed individual questions, what experiences or perceptions the respondent included as they formulated their answer, and any response difficulties experienced by the respondent. Audio and video-recordings of interviews were used to ensure the accuracy of summaries and to examine verbatim quotes.

After all interviews and summaries were completed, interviews were compared to identify common patterns of interpretation and response difficulties for each question. For this project, the interpretive patterns involving the respondents' experiences with their coverage were particularly salient. Once themes were identified for each question, themes were compared across questions to identify commonalities and to develop a larger conceptual understanding regarding the performance of the set as a whole. This final level of analysis provides a summary understanding of the questions' performances, that is, whether together they capture the intended analytic intent of the survey.

A data entry and analysis software application (Q-Notes) was used to conduct analysis. Q-Notes, developed by the QDRL, helps to ensure systematic and transparent analysis across all cognitive interviews, as well as to provide an audit trail depicting the way in which findings are generated from the raw interview data.

SUMMARY OF CONCLUSIONS

This section provides an overview of the evaluation's significant findings. The question-by-question overview following the methods section provides more detailed discussion of each question's performance.

Health Insurance Terminology Causes Confusion The most important overarching theme that emerged from this evaluation project was to confirm the suspicion that respondents do not have a uniform understanding of health insurance terminology, such as "premiums," "co-pays," and "deductibles." While in some cases respondents are able to relate these terms to more everyday uses—such as equating health insurance deductibles to car insurance deductibles—in most cases they have to either rely on a definition given in the question text or to guess at a term's meaning.

In some ways, this may be difficult for question designers and subject matter experts to understand. Given the focus that the news media has placed on these and other health insurance technicalities recently, designers and subject matter experts might assume that the public's knowledge of the intricacies of health insurance plans and the Affordable Care Act are higher than they, in fact, are. The evidence gleaned through this project, however, indicates that emphasis in the media is not translating to respondents' abilities to interpret and answer survey questions, and instead there is quite a lot of variation in how respondents understand and think about health insurance and healthcare terms.

As an example of the low level of salience that these terms hold, consider Questions QDRL.13, FHI.230, and FHI.241, about deductibles, premiums, and deductibles, respectively:

QDRL.13	*Your deductible is the amount you must pay out of your own pocket each year before your health insurance begins paying for health care services. Does your health insurance have a deductible?*

FHI.230	*How much do you currently spend for health insurance premiums for your plan? Please include payroll deductions for premiums.*

FHI.241	*VERSION_A [If only 1 person is covered by the plan]: Is the annual deductible for medical care for this plan less than $1,250 or $1,250 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.* *1. Less than [$1,250/$2,500]* *2. [$1,250/$2,500] or more* *Refused* *Don't know*

Throughout this evaluation project, these three questions were administered in two different orders. In Round 1 and 2, Question FHI.230 was administered immediately following Question QDRL.13, while in Round 3, Question FHI.241 was administered immediately following Question QDRL.13. This shift was made in an attempt to see whether the framing of the definition of "deductible" in provided in Q QDRL.13 could be used to lower the proportion of respondents who were thinking about premiums, and

not about deductibles, in Q FHI.241. As outlined in Table 5 below, this framing did indeed affect how the respondents interpreted the following questions. Please note that in the first ordering, there are six questions (Questions FHI.230, FHI.231, FHI.235, FHI.237, FHI.238, and FHI.240) between Q QDRL.13 and Q FHI.241, whereas in the second ordering, there are no questions between Q QDRL.13 and Q FHI.241.

Table 5: Order Effects of Selected Deductible and Premium Questions

Question Order	Interpretive Patterns		
QDRL.13>FHI.230>…>FHI.241	Only Deductibles	Mostly Premiums	Split between Premiums and Deductibles
QDRL.13>FHI.241>FHI.230	Only Deductibles	Split between Premiums and Deductibles	Mostly Deductibles

It is clear that the framing provided by the definition of a deductible in Q QDRL.13 was strong enough for most respondents to carry their interpretations forward into the next question (as we see with the second ordering of questions), but not strong enough to affect one six questions down the line (as is the case with the first ordering). Furthermore, while in the first ordering most respondents correctly thought about health insurance premiums when answering Q FHI.230, a much smaller proportion did in the second ordering—with many respondents continuing to think about the deductibles asked about in Qs QDRL.13 and FHI.241. The fact that the respondents' understandings and definitions of these terms are so very malleable indicate that this terminology is not culturally salient for many respondents.

While much more work is necessary, the fact that definitions and framing do appear to be effective—up to a point—in focusing respondents' interpretations of questions about these health insurance terminologies suggests a way forward. It may be wise to individually group and separate all questions about a particular health insurance concept, including deductibles, premiums, co-pays, co-insurance, and out-of-pocket maximums.

Type of Health Insurance is Salient As noted above, many of the questions in the Family Health Insurance section of the NHIS questionnaire are designed to primarily function as "validity checks" of other questions—follow up questions used to determine whether or not the respondent's answer to an initial question was correct. Given the low level of knowledge surrounding some health insurance terminology, as noted above, this questionnaire structure can certainly be a worthwhile use of respondent burden. However, throughout this evaluation project, a few areas emerged that respondents were quite knowledgeable about—calling into question the effectiveness and utility of the follow-up questions.

In particular, the type of private health insurance respondents hold (i.e. PPOs, HMOs, etc) appeared to be highly salient. Question FHI.240 asks respondents to identify the type of private insurance they hold:

FHI.240 *Is [fill 1] an HMO (Health Maintenance Organization), an IPA (Individual Practice Association), a PPO (Preferred Provider Organization), a POS (Point-Of-Service), fee-for-service or is it some other kind of plan?*

As noted below in the question-by-question analysis, nearly all the respondents were able to (correctly, as far as could be ascertained through probing or by checking their insurance card) identify their insurance type. They either did this through a heuristic—simply knowing (or looking at their card) for what type of insurance they had signed up—or by comparing their plan's features to a prototypical HMO or PPO. In this comparative pathway, respondents tended to focus on either the number of doctors available to them, or the number of restrictions they had to follow to obtain care (i.e. referrals). They generally understood PPOs to have more choices and fewer restrictions than HMOs, and based their answer on these interpretations.

While respondents appeared quite able to produce valid answers when responding to Question FHI.240, their interpretations to Q FHI.240's follow-up questions (Questions FHI.243, FHI.244, FHI.246, FHI.248, and FHI.248.5) were much broader. In some cases the respondents' interpretations of the follow-up question matched their answer to the main question consistently. For example, in Question FHI.246, all respondents who indicated that they had an HMO in Q FHI.240 also said that their plan will not pay for any services from a doctor not in the plan. Likewise, all respondents who indicated in the main question that they had a PPO indicated that their plan would pay some reduced benefits if they used the services of a non-plan doctor. However, this consistency in *interpretation* did not extent to all of the validity check questions. For instance, a respondent who answers that she has a PPO in Q FHI.240 should (according to the validity check scheme) answer "any doctor" to Question FHI.243 (asking whether they were constrained to a restricted set of doctors as in an HMO, or whether they could choose any doctor at all as in a PPO). However, this was not always the case—a number of respondents who answered (correctly, according to our probing) that they had PPOs went on to report that they had to "select from a group/list" in Q FHI.243, while others went on to report that they could "choose any doctor." Therefore, a question such as Q FHI.243 where respondents have divergent interpretations of the answer categories, does not function well as a validity check.

On the face, this could indicate that the respondent answered Q FHI.240 incorrectly. However, since probing revealed that the respondents had answered the main question correctly, and actually knew their insurance type, the variation seen in the follow-up questions does not indicate an error in their answer to FHI.240. Rather, it indicates that the follow-up question *do not function well as checks*.

<u>The Many Names of the Affordable Care Act</u> One of the most important principals in questionnaire and question design is to use phrasing and terminology that respondents understand, and if possible, use themselves. The Family Health Insurance section of the NHIS is undergoing revision due, in large part, to the passage of the ACA and the implementation of a number of its provisions including the state and federal health insurance exchanges. With these implementations, and the accompanying media coverage, a set of terms have emerged in the popular discourse about the ACA that parallel the "official" terms used in policy discussions. These range from how potential respondents refer to the tax benefits they might receive as part of the ACA, to how they reference and name the online exchanges and marketplaces, to what they call and refer to the law itself. The risk for survey design and implementation is that by writing questions using the *policy* language, instead of the *popular* language, respondents might become confused or employ a wider range of interpretations—thus increasing the potential for response error. While a more systematic examination of the language potential NHIS respondents use to refer to ACA-related terms is necessary (especially now that major aspects of the law have been in effect for more than a year), the cognitive interviews provided some data indicating how respondents talk about the law and its provisions.

The most basic question of ACA-related terminology has to do with what the respondents call the law itself. This is important as referencing the law can give context to both questions and answer categories, helping respondents judge how to answer ACA-related questions. Chart 1 shows the relative proportion of the respondents who used the terms "Affordable Care Act," "ACA," or "Obamacare" when referring to the law and its various provisions. Both the acronym and the slang were clearly more popular than the actual title of the law, with "Obamacare" being by far the most commonplace way of talking about the act.

Respondents did not just use the terms ACA and Obamacare to refer to the law, but also to the actual insurance they purchased or received because of it. For instance, one respondent explained that he "got Obamacare from the website, about a month ago after trying a few times." Another respondent noted that "I pay my ACA every month—I don't have any option to pay either by pay-period or yearly."

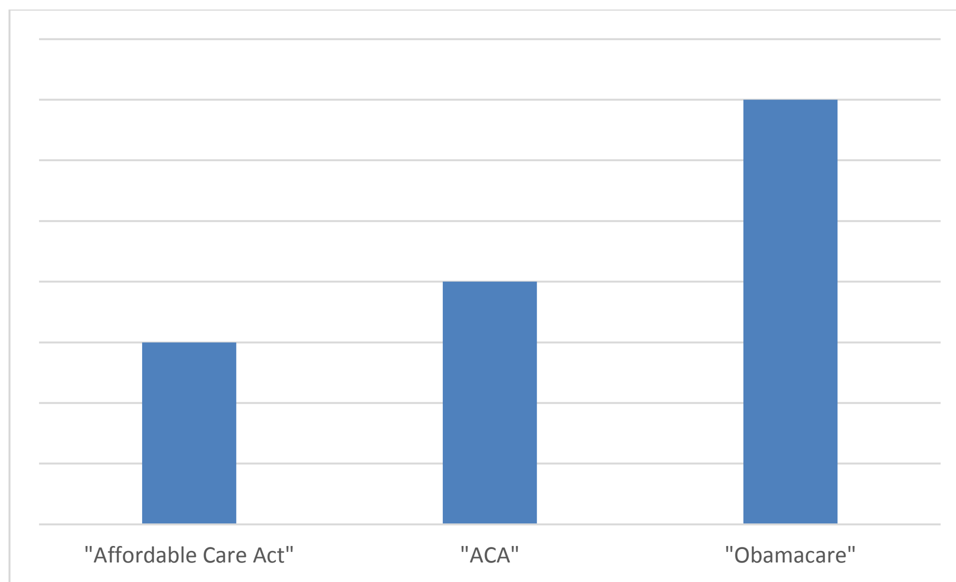

Chart 1: Relative Proportion of Respondents who Use Term

While a number of respondents used more than one of these terms in the course of talking about their health insurance and their experiences with it, not all respondents understood these terms as synonymous. For instance, one respondent who received Medicaid through the District of Columbia's ACA website, explained her "yes" answer to Question FHI.135:

> Affordable Care Act? I've never hear of that I don't think. But it reminds me of Obamacare, so that's why I said 'yes.' They seem like they're related, cause I went to the website.

Besides the name of the act itself, respondents also tended to prefer non-policy language when referring to its various provisions. For example, no respondents called the websites where they searched for and bought health insurance "exchanges," and only a couple referred to them as "marketplaces" (even though this was the term used in the question text of Qs FHI135 and FHI.215). Rather, respondents used terms such as "the Obamacare site," "that healthcare website," and (most commonly) "healthcare.gov." Interestingly, even though respondents who had used or been to state-based exchanges (in this sample, Maryland's and the District of Columbia's) referred to the website as

"healthcare.gov." This appears to be both because healthcare.gov became a common term throughout the implementation of the ACA, and because the respondents did not recognize that they switched from the federal site to a state site during the shopping process.

QUESTION BY QUESTION REVIEW

This section presents detailed findings of individual questions. Findings primarily include the various phenomena captured by each question. However, when relevant, discussion also includes difficulties experienced by respondents as they attempted to answer the question as well as potential response error. Each question is presented below, followed by the analysis of that specific question. If no answer categories are presented alongside the question text, the answer categories are:

1. Yes
2. No
Don't Know
Refused

FHI.050 Are you covered by any kind of health insurance or some other kind of health care plan?

Question FHI.050 was administered to all 40 members of the cognitive interviewing sample. Only one respondent said no—he was screened into the cognitive interview by saying that he had health insurance, but in fact it had not yet gone into effect. This question was not probed extensively during the cognitive interview, and no findings are available.

FHI.051 What kind of health insurance or health care coverage do you have? INCLUDE those that pay for only one type of service (nursing home care, accidents, or dental care). EXCLUDE private plans that only provide extra cash while hospitalized.

1. Private health insurance
2. Medicare
3. Medi-Gap
4. Medicaid
5. SCHIP (CHIP/ Children's Health Insurance Program)
6. Military health care (TRICARE/VA/CHAMP-VA)
7. Indian Health Service
8. State-sponsored health plan
9. Other government program
10. Single service plan (e.g., dental, vision, prescriptions)
11. No coverage of any type
12. Don't Know

Question FHI.051 asks respondents to not only answer (at least in their head) a series of yes/no questions about whether or not they have various types of health insurance, but also to do so while considering a complex list of both inclusions and exclusions. Given the extensive cognitive work that the respondents must do to not only comprehend this question, but also to judge their response, their overall patterns of interpretation and response processes varied greatly.

Figure 1 below shows the response patterns the respondents used to navigate Q.051. There are two basic pathways the respondents used: a heuristic pathway and a comparative pathway:

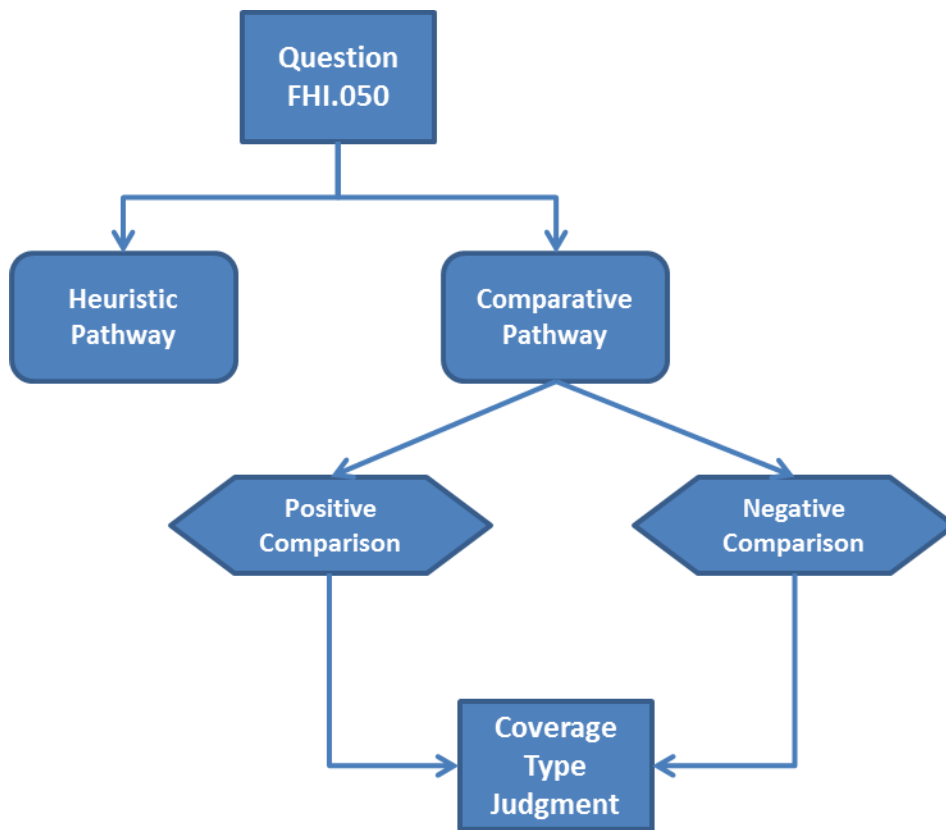

Figure 1: Response Pathways for Question FHI.051

In the "Heuristic Pathway" respondents reported simply "knowing" what type of health insurance they have. This immediate knowledge could be either correct or not. While most respondents who used the heuristic revealed that they were very familiar with their insurance type because of various administrative tasks (i.e. filling out paperwork, using the coverage extensively, or recently purchasing it on an ACA marketplace), a few were unable to provide any solid reason why they "knew" what their insurance type was. One such respondent reported that she had "Medicare" as soon as the question was asked. However, upon probing it turns out that the respondent actually had "Medicaid."

The Comparative Pathway is naturally more complex than the heuristic one, and was much more common across the cognitive interviewing sample. The respondents used a variety of features and identifiers for each of the various types of insurance during this comparative exercise. In a way, this question functioned as an iterative cycle of comprehension and judgment for each of the 11 coverage types read out loud—for each category, the respondent would identify that type's features and compare them to his or her insurance. In this pathway, respondents either make a positive comparison (i.e. "I have feature X as a part of my health insurance, and these other plans do not.") or a negative comparison (i.e. "I do not have feature X as part of my health insurance plan, and these others do.") of their plan to list of 11 coverage types provided in the answer categories. Overall, respondents who used this pathway were initially unsure of their answers, but were able to use some form of deductive logic to arrive at an answer. For example, one respondent who needed the question repeated two times eventually answered "private." When asked to explain how he got to that response, he said "[it] doesn't sound like any of the others." He went on to explain that he considered the "other government programs" option (he worked for the federal government), but thought that option probably referred to Medicare or Medicaid, and he knew that he didn't have those, because he paid for his insurance.

There is potential for misclassification in the Comparative Pathway that stems from the fact that respondents may not either fully understand what features their own plan has, or not comprehend which features correctly correspond to the answer categories. For example, as she went through the list of potential answer categories, one respondent explained that she did not have Medicaid, "because that program is for old people, like once you retire"—confusing Medicare with Medicaid. This *interpretation error* did not result in a *response error* in this case, as respondent went on to choose "private," as she had purchased her insurance through the federal marketplace, and did not believe that she fit into any of the other categories. In another example, one respondent who answered "private" because she had what she considered to be a "name brand" plan (a large HMO in the DC region) actually had Medicaid, which became clear later in the survey when she produced her insurance card to answer Question FHI.160. So in the first of these two examples, the respondent's interpretation error—misclassifying the features of a type of insurance—did not lead to a response error; however in the second example, the respondent's interpretation error did in fact lead to a response error.

FHI.072 *Are you covered by Medicare?*

No respondents in the cognitive interviewing sample received Question FHI.072, and no findings are available.

FHI.073 *There is a program called Medicaid that pays for health care for persons in need. In this State it is also called (DC/MD/VA =Medical Assistance/Medical Assistance Program, Healthchoice, or REM Program/Virginia Medallion or Medallion 2). Are you covered by Medicaid?*

Question FHI.073, designed to be a check for those who did not answer "Medicaid" in Q.051, elicited only two "yes" answers across the members of cognitive interviewing sample who received it. These two respondents indicated that they were not entirely sure whether or not they had Medicaid, but decided to answer the question "yes" anyway. However, both of these respondents referred to their insurance as coming from the state—either "state-sponsored" or "government assistance," and not as "Medicaid" itself. One of these respondents explained that he did not know what the plan was called, but that he knew he was getting help from the government, and he had to "recertify" that assistance every year.

Other than these two respondents, the remaining respondents answered the question "no." Probing confirmed that none of these respondents carried Medicaid. However, as noted above in Q.051, the interpretations of what Medicaid actually was (and who it covered) varied. The respondents who answered "no" to Q.073 considered a wide set of supposed features of Medicaid —ranging from "for the elderly" to "for low income individuals"—when considering whether or not they carried this type of insurance. Of these interpretations, "for the elderly" is the most problematic—for although elderly individuals *can* be on Medicaid (in addition to Medicare), the primary eligibility criterion of Medicaid is income, not age. In the cognitive interviewing sample, this problematic interpretation did not lead to any response errors, though it is certainly possible in a larger or (simply a different) sample, both false positive and false negative answers might be expected.

FHI.074 Do you have any type of insurance that pays for only one type of service such as dental, vision, or prescriptions?

Like Q.073, Question FHI.074 functions as a check on the respondents' answers to Q.051, and is specifically given to respondents who do not say they carry a "single service plan." In general, the respondents interpreted this question in one of two ways: whether they have *separate* dental or vision coverage, or whether they have dental or vision coverage under their main health insurance plan.

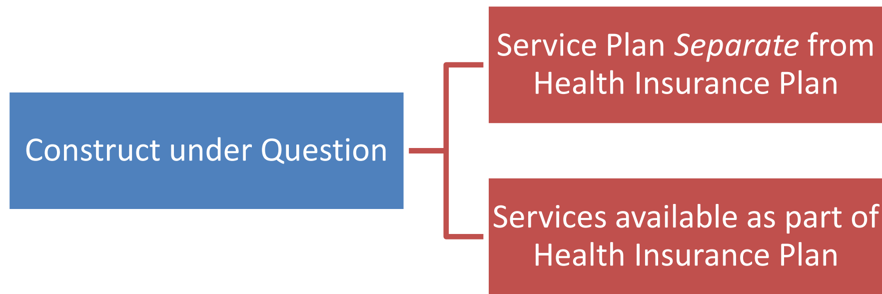

Figure 2: Response Schema for Question FHI.074

The first pattern of interpretation in this schema—the comprehension of Q.074 as asking about stand-alone service plans—was the most common among respondents who answered this question "no." When explaining their answers, most respondents who employed this pattern of interpretation used the word "separate," differentiating a single-service plan from their main health insurance plans. For example, one respondent who is retired and maintained her health benefits as part of her severance package noted that her dental insurance "…has a separate premium from my Blue Cross [Blue Cross/Blue Shield PPO]." A few respondents who answered Q.074 "yes," also used this first pattern of interpretation. For instance, one woman who had just bought a healthcare plan from the federal healthcare marketplace (which she referred to as "the Obamacare site") noted that she decided to pay for an extra, separate dental plan. This respondent went on to explain that vision was included in the main health insurance plan she bought, so she did not have to purchase a separate vision plan as well.

The second pattern of interpretation—whether or not the respondent's health insurance included dental or vision coverage—was the dominant interpretation among the respondents who answered Q.074 "yes," In short, given that the question was specifically asking about *single-service* plans, these "yes" responses were false positives. Take for instance one respondent who explained her "yes" response like this:

> I do have health insurance that pays for dental. But it also pays for other healthcare services…like my checkups and prescriptions.

This respondent is talking about her HMO plan, which includes dental coverage. Follow-up probes revealed that she did not have a separate dental plan, nor did she pay a separate premium for her dental coverage.

While this second, problematic pattern of interpretation was most common among "yes" responses, a few respondents who replied "no" employed it as well. For example, one respondent noted that his health insurance plan (a PPO) did not include either dental or vision coverage, and therefore he felt like "no" was the correct response. Upon further probing, he said that he also did not pay for a separate plan for either dental or vision. However, his immediate interpretation of the question was not about a separate plan, but whether or not he had dental or vision coverage. Thus again, as seen previously in Q.073, there are clear *interpretation errors* present that could lead to response errors (specifically false positives) in different or larger samples.

Medicaid Pathway

FHI.120 *The next questions are about Medicaid coverage. In this State it is also called (DC/MD/VA= Medical Assistance/Medical Assistance Program, Healthchoice, or REM Program/Virginia Medallion or Medallion 2). You are listed as having Medicaid coverage. Can you go to ANY doctor who will accept Medicaid or MUST choose from a book or list of doctors or is a doctor assigned?*

1. Any doctor
2. Select from book/list
3. Doctor is assigned
Refused
Don't know

Question FHI.120 confused a large number of respondents and produced a wide variety of patterns of interpretation. Overall, respondents approached this as a triple-barreled question, and largely interpreted it as asking about *choice* (instead of *restrictions*). The respondents approached this triple series of questions in the following manner:

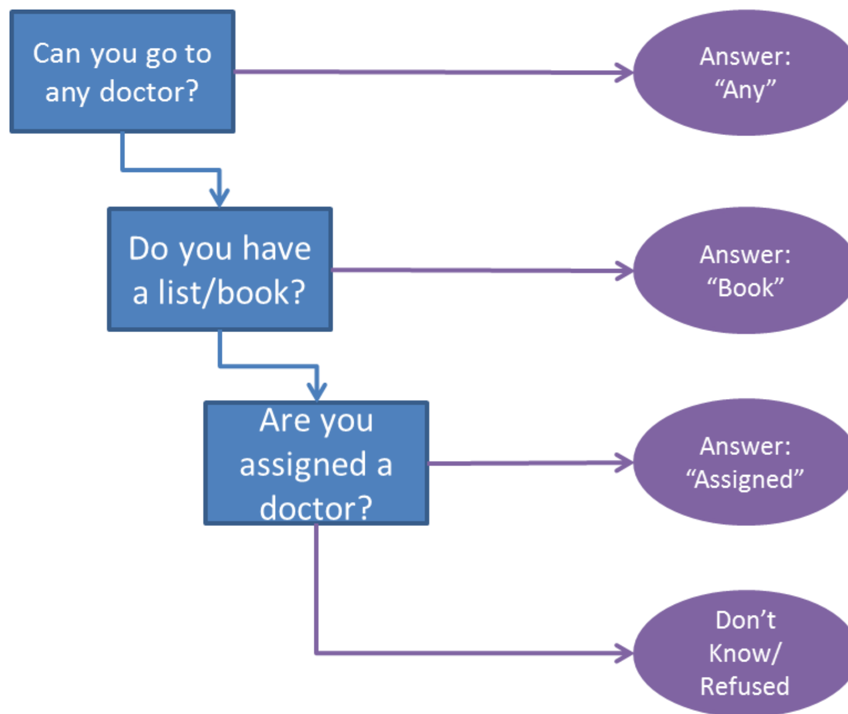

Figure 3: Response Pathways for Question FHI.120

Right off the bat, some respondents clearly thought the question was asking about whether they could go to any doctor, while others thought the question was about whether or not they received a list of doctors from a company or Medicaid (which was most frequently referred to as the state "social services" office, and not as any specific program name or office). Very few respondents either answered using the "doctor is assigned" category, or even appeared to consider whether or not their doctor was assigned or not—indicating that the cognitive load of the first two "questions" in the triple-barreled series was more than enough for the respondents to consider. In addition to respondents answering the questions separately, two respondents' immediate reactions to the question were to answer "all of the above," clearly not comprehending that this was designed as a "pick one of the above" type question. One of these respondents explained his answer by saying:

> It's actually all of the above. If you don't choose your doctor, they'll [the Medicaid plan] will assign one for you. And you can choose any plan…[and] each doctor has certain plans they accept.

This respondent considered his ability to choose any plan to be equivalent to the ability to choose any doctor. Upon further probing, he explained that the state sent a book of doctors that indicated which plan each doctor accepted, so that you could either choose your plan by doctor, or conversely, your doctor by plan.

The complexity of this question is not simply limited to its multiple-barreled nature however. Respondents employed a variety of patterns of interpretation to reach each of the four possible answers (the purple ovals above in Figure 3). For instance, some respondents who answered "Any Doctor" were considering their ability to call up any doctor and ask if he or she would take their plan. Others were considering the fact that under their current plan they could go to the same doctor that they had been going to in the past, while still others were thinking about the fact that they had been able to go to any doctor they wanted to and had never been turned away. Finally, some few others considered whether or

not they had access to any doctor who accepted Medicaid. Table 7 shows the patterns of interpretation the respondents employed when considered the three barrels of Question FHI.120

Table 6: Constructs Captured by the Three "Barrels" of Question FHI.120

Can you go to any doctor?	Do you have a list or book?	Are you assigned a doctor?
• Ability to call up doctor and ask • Whether or not past doctors are still accessible • Access to any doctor • Access to any doctor who accepts Medicaid	• Ability to call up doctor and ask • Physical book or list available online • List available online only • Physical book only	• Assigned by state social services office, Medicaid program, or Medicaid provider • Assigned by a hospital or clinic • Whether or not a referral to a specialist is necessary

It is important to consider these patterns of interpretation alongside the response process presented above in Figure 3. A respondent could respond to whichever pattern they choose for the first question—"Can you go to any doctor"—in either an affirmative way (in which case they would answer "Any Doctor") or in a negative way. In this case they would then move on to the "Do you have a list or book?" question, and then choose to employ one of its patterns of interpretation. Then, again depending on both their interpretation and their answer to this second question, they might move on to the third question about being assigned a doctor and answer it based on any of its patterns of interpretation. In short, without extensively probing each respondent, it will be difficult for a survey analyst to know exactly what a respondent actually meant when he or she answered Q FHI.120.

FHI.130 *What is the name of the health plan that provided the book or list?*

1. [OPEN RESPONSE]

Of the seven respondents who received Question FHI.130, two indicated that they did not know and could not answer this question. The remaining respondents were split between providing a name of an actual health plan or provider on one hand, or providing the name of the state agency or Medicaid program in which they are enrolled on the other hand. So, for example, one respondent might answer "Blue Cross Blue Shield[2]," while another (answering about the same insurance) might say "Maryland Medicaid."

[2] In order to protect confidentiality, this is not a verbatim answer from a respondent.

FHI.131 *What is the name of the health plan that assigned the doctor?*

1. [OPEN RESPONSE]

The same interpretive patterns seen above in Q FHI.130 hold are present here in Question FHI.131. Again, respondents either considered the health plan itself, or the state (or District) agency responsible for Medicaid implementation.

FHI.135 [ROUNDS 1 and 2] *Was your Medicaid obtained through Healthcare.gov or the [DC/MD/VA= Health Insurance Marketplace, such as DC Health Link/ Health Insurance Marketplace, such as Maryland Health Connection/Health Insurance Marketplace]?*

[ROUND 3] *Was your Medicaid obtained through Healthcare.gov or a state Health Insurance Marketplace?*

Two versions of Question FHI.135 were tested. The first version, used in Rounds 1 and 2, included the state-based fill-in "Health Insurance Marketplace such as..." "DC Health Link," or "Maryland Health Connection" for District and Maryland respondents, respectively. Virginia, which uses the federal health insurance marketplace, had no specific fill-in. The references to these specific websites were dropped during Round 3 of testing, as (as detailed below) they appeared to elicit a large number of both false positives and false negatives.

In the first version of this question, the one with the names of the specific websites, respondents tended to consider this question in one of two ways: 1) whether or not they obtained their Medicaid through a website, or 2) whether or not they obtained their Medicaid through a government program. The respondents who employed this first pattern tended to mention "healthcare.gov," but neither of the state exchanges' names. All the respondents who said yes using this pattern of interpretation started their health insurance buying process not at the state-specific websites, but at the federal site (healthcare.gov)—whether or not their state had its own exchange.

On the other hand, those respondents who employed the second pattern of interpretation considered whether or not they got their Medicaid coverage through a government program or office—a clear misinterpretation. These respondents all explained that they thought the question was asking whether or not they got their Medicaid through a state government office, and they all reported that the name of the program they went to was either "DC Health Link" or "Maryland Health Connection." (In fact, the District of Columbia's program is called "DC Medicaid" or the Department of Health Care Finance, while the Maryland program is called "Maryland Medical Assistance.") Upon probing these respondents explained that the specific name in the question text reminded them of the program or office where they went to sign up for Medicaid. For example, one respondent explained that she thought the name of DC's Medicaid was "DC Health Link," and since she had DC Medicaid, she answered yes. Further probing, however, revealed that she did not sign up for this insurance through the DC or federal website, but rather through an appointment at a "social services office." So in other words, these respondents were conflating the name of the state health insurance marketplace with the name of the state Medicaid program though which they (legitimately) obtained their health insurance.

The second version of this question dropped the state-specific website names, and simply asked the respondents if they obtained their Medicaid through "Healthcare.gov or a State Health Insurance

Marketplace?" This version produced far fewer clear response errors than did the first version, with most respondents interpreting "Healthcare.gov or a State Health Insurance Marketplace" as either the federal health insurance website or their state one. One respondent thought about how the website she eventually used to sign up for Medicaid related to the federal website:

> Healthcare.gov is just a switchboard…it is the trunk, DC Healthlink [the DC health insurance website] is the branch, DC Healthy Families [the particular Medicaid program] are the stems, and Trusted Health [a DC Medicaid provider] is the leaves.

Across this second version, there was some variation in how respondents answered (and interpreted) signing up for Medicaid without personally using the federal or state websites. For instance, one respondent, who answered "don't know," explained that he went to his county's social services office, and they used a computer to sign him up. He was unsure whether or not they used the Maryland health insurance website, and was therefore not certain what his answer to Q FHI.135 should be. On the other hand, another respondent who received help from a "navigator" [specially-trained ACA advocates] answered the question "yes," because the navigator used the federal website to show her the various options—even though she didn't use the website herself.

FHI.137_2 *Under your Medicaid plan is there an enrollment fee or premium?*

All the respondents who received Question FHI.137_2, save one, answered "no." The one respondent who did answer this question "yes" explained that she was thinking about the fact that she had to pay for some of her prescription drugs, as she understood the term "premium" to mean "…how much money you have to pay out of pocket." [The term "premium" confused respondents across the cognitive interviewing sample. A more in-depth discussion is found below in Question QDRL.8 on Page 26.]. Upon further probing, this respondent said that she did not have to pay an enrollment fee.

This respondent who confused "premium" with "out of pocket expenses" provided the only response error across the cognitive interviewing sample. All of the other respondents answered "no," and probing confirmed that they did not in fact pay enrollment fees or premiums for their Medicaid coverage. However, the respondents who answered this question "no" did not all interpret it the same way, thus opening this question up to *interpretation errors* (that, again, could lead to response errors in other samples). Figure 4 below shows the interpretive schema that respondents used while responding to Q FHI.1374_2.

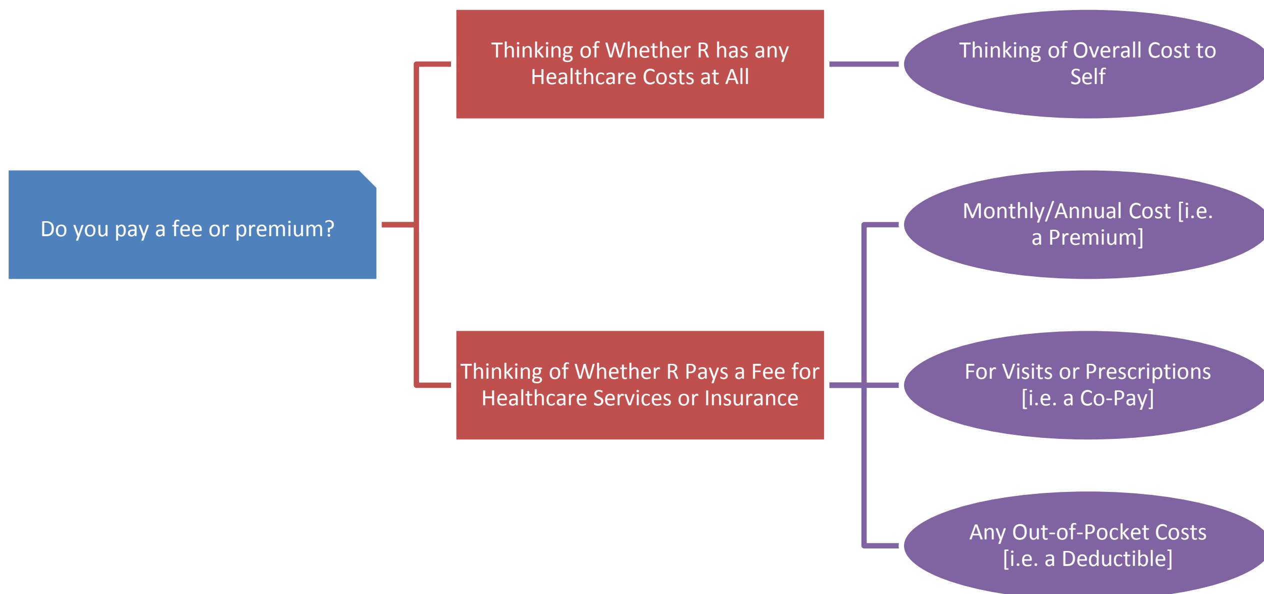

Figure 4: Response Schema for Question FHI.137_2

Four basic patterns of interpretation emerged from the analysis of this question. Of these four patterns, one is clearly in-scope ("monthly/annual cost"), two of them ("co-pay" and "deductible/out-of-pocket costs") are clearly out-of-scope, while another one ("thinking of overall cost to self") could be either in- or out-of-scope, depending on the respondent's situation.

First, some respondents considered whether or not they paid or had a monthly or annual fee in order to have access to their Medicaid coverage. The respondents who employed this pattern were directly thinking about premiums and enrollment fees—clearly in-scope constructs.

Next, some respondents thought about their overall cost of healthcare—not just about individual fees or costs, but whether they paid for anything. For example, one respondent simply said, "It's [her health care] free," while another respondent explained "I pay for nothing." Both of these respondents answered the question "no." This pattern of interpretation captures a very wide range of constructs—basically anything a respondent could have to pay for healthcare—including enrollment fees and deductibles. For those respondents who are actually paying nothing for any healthcare—such as in these two examples—there is no problem with their "no" responses. However, it is possible that since this pattern of interpretation considers *all* healthcare costs, a respondent in another sample who does not pay either an enrollment fee or deductible, but does pay other costs (such as co-pays or for prescriptions), could incorrectly answer "yes."

The other two patterns of interpretation—thinking about co-pays for visits and for prescriptions, and thinking about out-of-packet costs and deductibles—capture out-of-scope constructs. As noted above, save the one respondent who was thinking about co-pays and answered the survey question "yes," all of these respondents answered the question "no." In doing so, they were not saying, "no, I do not pay an enrollment fee or premium," but rather "no, I do not pay any co-pays or have any out-of-pocket costs." Coincidently, none of these respondents paid any enrollment fees or premiums (which is a relatively new concept in Medicaid, and is found only in a few states—none of which were in sampling area for this study). Therefore, while all of their "no" answers to Q FHI.137_2 accurately describe their situation

vis-à-vis the payment of enrollment fees or premiums, this is coincidental, and in another sample these misinterpretations could lead to response errors.

FHI.137_3 *Is the premium paid for this Medicaid plan based on income?*

Only one respondent answered Q FHI.137_2 "yes" and went on to receive Question FHI.137_3. This respondent, who based her response to the previous question on the fact that she had to pay for some of her prescriptions, also answered this question "yes," and explained:

> I could say so, because when you go to the social services, they [people in general] go because they're low income or are going through a struggle and need help.

So here, the respondent is not thinking about the *cost* of her Medicaid plan, but rather her *eligibility* for Medicaid in general. Further probing revealed that she did not believe that the amount of money she pays for prescription medicines (again, what she was considering in terms of "premiums" in the previous question) varies based on her income.

FHI.140 *Are you required to sign up with a certain primary care doctor, group of doctors, or certain clinic which you must go to for all of your routine care? Do not include emergency care or care from a specialist you were referred to.*

Question FHI.140, much like Q FHI.120 above, is a triple-barreled question and a large proportion of the respondents expressed difficulty when answering this question. Specifically, a number of respondents attempted to answer the question using "primary care physician," "group of doctors," or "clinic" as the answer categories instead of "yes" or "no." (The previous triple-barreled question the respondents received, Q FHI.120, used this multiple-answer category format instead of the binary yes/no format.)

In general, respondents used a "tied" response pattern to navigate this question similar to what they did in Q FHI.120 (see Figure 3 above). The respondents first considered whether or not they had to sign up with a primary care physician (PCP). Only after considering their response to this sub-question would they move on to the second (group of doctors) or third (clinic) sub-questions. A majority of respondents considered only whether or not they had to sign up with a primary care physician, and, answering that yes, they did need to sign up with a PCP, never considered whether or not they had to sign up with a group of doctors or a clinic. The only respondents who considered whether or not they had to sign up with a group of doctors or a clinic were those who were not required to sign up with an individual PCP. This response process does not represent a problem, because unlike the previous triple-barreled question (Q FHI.120), the answer categories for Q FHI.140 are yes and no—the only way a respondent would respond "no" to this question is if he or she answered "no" to all three of the barrels. In other words, it does not matter if a respondent who is required to sign up with an individual PCP (thus answering the first sub-question "yes," and therefore the survey question "yes") does not also consider if they have to sign up with a group or a clinic.

FHI.150 *Under your Medicaid plan, if you to go to a different doctor or place for special care do you need approval or a referral? Do not include emergency care.*

FHI.150 *Under your Medicaid plan, if you to go to a different doctor or place for special care do you need approval or a referral? Do not include emergency care.*

Overall, respondents interpreted Question FHI.150 as asking about how they get access to specialists. Most respondents indicated that they had to get a referral (a term that the respondents overwhelming used) from their PCP in order to see a specialist—and correspondingly answered the question "yes."

However, a few respondents had slightly alternative interpretations. First, a couple of respondents noted that they did not think they *had* to get a referral, but instead *should* get one because they would then be assured of the specialist taking their insurance. In other words, they saw referrals not as strictly necessary, but as a time-saving device. One respondent who employed this pattern of interpretation answered the question "yes," while the other answered it "no." Another couple of respondents noted that while they were generally required to get referrals to see specialists, they could actually choose certain specialists that they went to a lot (these two respondents specifically mentioned an OB/GYN and an oncologist) as their primary care physician—eliminating the need to obtain a referral to see these particular doctors. However, both these respondents answered Q FHI.150 "yes," explaining that they would need to get a referral to see any specialists other than the one they chose as their PCP.

Private Insurance Pathway

FHI.160 *The next questions are about private health insurance plans. These plans can be obtained through work, purchased directly, or through a state or local government program or community program.*

It is important that we record the complete and accurate name of each health insurance plan. What is the COMPLETE name of the first plan? Do NOT include plans that only provide extra cash while in the hospital or plans that pay for only one type of service, such as nursing home care, accidents, or dental care.

1. [OPEN RESPONSE]

The respondents all understood this question to be asking about their current insurance plans, and all were able to provide a response. About half of the respondents pulled out and consulted their insurance card when answering this question, and the others did not use their cards and simply relied on their memory (or they guessed) to respond.

FHI.170 *Which family members are covered by **[this plan]**?*

1. [OPEN RESPONSE]

No variation in how the respondents interpreted Question FHI.170 emerged, with all of the respondents understanding this question to be asking about any family members other than themselves.

FHI.171 *Are there any more private health insurance plans?*

The respondents all understood Question FHI.171 to be asking about whether or not they had any full healthcare plans in addition to the one they answered about in Q FHI.170. All respondents answered this question "no."

FHI.172 *What is the name of the next plan?*

1. [OPEN RESPONSE]

No respondents skipped into Question FHI.172 as none of them answered "yes" to the previous question, Q FHI.171; no findings are available.

FHI.200 *I would like to ask you about [your private plan/Plan X (if multiple plans)]. Health insurance plans are usually obtained in one person's name even if other family members are covered. That person is called the policyholder. In whose name is this plan?*

1. *Respondent's Name*
2. *Household member*
3. *Non-Household member*

Refused
Don't Know

The respondents all interpreted Question FHI.200 as asking about who was the person who paid for this plan, or which person's work provided the plan. While there was no variation in the interpretation of this question, a few respondents who said "no" to Q FHI.170 appeared to be slightly off-put by this question—as they had just moments ago explained that they were the only people covered by their plan.

FHI.202 *How are you related to the policyholder?*

1. *Child (including Stepchild)*
2. *Spouse*
3. *Former Spouse*
4. *Some other relationship*

Refused
Don't know

FHI.202 *How are you related to the policyholder?*

1. *Child (including Stepchild)*
2. *Spouse*
3. *Former Spouse*
4. *Some other relationship*

Refused
Don't know

Only three respondents answered “Household Member” to Q FHI.200 and went on to receive Question FHI.202. All three of these respondents answered this question “spouse.” This question was not probed, and no findings are available.

FHI.204 *Does this plan cover anyone else who does not live here?*

The respondents all understood Question FHI.204 to be asking about people who do not live in their house at the moment of the interview. Respondents with college-aged children (who were on their health insurance) all noted that they were counting them towards this question.

Again, a few respondents who answered “no” to Q FHI.170 appeared annoyed that they were being asked another—in their minds—redundant and irrelevant question. In a couple of cases, this series of questions appeared to make the respondent sad or uncomfortable—believing perhaps that the questions implied that normal behavior was to have multiple people on an insurance plan, and since they did not live with anyone else they were outside the norm. The survey designers should consider skipping respondents who answer “no” to Q FHI.170 over both Q FHI.200 and Q FHI.204.

FHI.210 [ROUNDS 1 and 2] *Which one of these categories best describes how this plan was obtained?*

1. Through employer
2. Through union
3. Through workplace, but don't know if employer or union
4. Through workplace, self-employed or professional association
5. Purchased directly
6. Through a state/local government or community program
7. Other (specify)
Refused
Don't know

[ROUND 3] *Which one of these categories best describes how this plan was obtained?*

1. Through employer
2. Through union
3. Through workplace, but don't know if employer or union
4. Through workplace, self-employed or professional association
5. Through Healthcare.gov, or the Affordable Care Act, sometimes known as Obamacare
6. Purchased directly
7. Through a state/local government or community program
8. Other (specify)
Refused
Don't know

Question FHI.210 was changed between Rounds 2 and 3 due to preliminary findings from the first two rounds. The first version of this question included seven answer categories, while the second version added an answer category that explicitly included the ACA marketplace.

Across both versions of the question, respondents who obtained their health insurance through their workplace all answered using the “through employer” answer category except one respondent who selected the third option (“through workplace, but don’t know if employer or union”). This respondent explained that he wasn’t sure to what degree the union at his office had in setting the health insurance plans, but he figured they must have had some impact. When asked whether he went to his union representative or his HR contact for information on the health plans, he said that he went through HR and that the cost of the insurance was deducted from his monthly paycheck.

While the respondents who had employee-sponsored health insurance were overwhelming clear on which answer category fit their response, those respondents who obtained their healthcare coverage through the ACA or healthcare.gov had difficulty. In Version 1—used in Rounds 1 and 2—these respondents were not given a clear answer category to use (“purchased directly” was the preferred category of the survey designers). Correspondingly, the Round 1 and 2 respondents who bought their insurance through the ACA used three different answer categories to answer the question—“purchased directly,” “through a state/local government or community program,” and “other.” One respondent, who answered the question “purchased directly” explained that he, “just went online and bought it.” This

respondent noted that he had the option to buy insurance through his work, but that "Obamacare gave me another option."

Most respondents who obtained their insurance through an ACA channel used the "state/local government or community program" answer category in Version 1. For example, one respondent explained that he picked this category because "it [his health insurance] was purchased by an outlet via the government and government funding." When asked how he differentiated this from purchasing the insurance directly, he said that "purchased directly" implied that he went out and "googled [it]…you do the work to find and get it." This illustrates a common interpretation across the sample and both versions: respondents generally understood this question be asking about who (or what organization) *put the work into* finding the health insurance plan.

Interestingly, "state/local government…" answer category captured respondents not only from states with state-based exchanges (in this sample, Maryland and the District of Columbia), but also from those without state-based marketplaces (Virginia in this case). Often, these respondents realized that their state did not have its own exchange, but were able to reason through their case and fit it into the limitations of the category. For example, one respondent explained her answer by saying:

> Well it was healthcare.gov, so that would be the government program, but that's not state or local. Well yes it is I guess because they show plans for Virginia

Since the respondent had no other obvious answer category to choose, she had to rationalize her answer to fit.

In response to this, Version 2—used in Round 3—of Q FHI.210 added an answer category: "Through Healthcare.gov, or the Affordable Care Act, sometimes known as Obamacare." A more in-depth discussion of the use of the term "Obamacare" is presented above in the Summary of Conclusions section. Suffice to say here that Rounds 1 and 2 of this project, as well as previous ethnographic work, have shown that respondents 1) call and recognize the ACA as "Obamacare," 2) that they correlate the term "Obamacare" with the online health insurance marketplaces, and 3) that they largely did not find "Obamacare" to be a derogatory term. In Round 3, all of the respondents who obtained their insurance through an ACA channel used this new category to answer Question FHI.120.

FHI.210.1 *How was this plan obtained?*

1. [OPEN RESPONSE]

The three respondents who received Question FHI.210.1 because they answered "other" to Q FHI.210 all reported obtaining their insurance through an ACA marketplace. All three of these respondents received Version 1 of Q FHI.210. No respondents who received Version 2 of Q FHI.210 answered "other."

This question was not probed, and no findings are available.

FHI.215 *Was the plan obtained through the Healthcare.gov or the [DC/MD/VA= Health Insurance Marketplace, such as DC Health Link/ Health Insurance Marketplace, such as Maryland Health Connection/Health Insurance Marketplace]?*

Respondents who answered anything other than “through employer,” “through union,” “through workplace…union,” and “through workplace…association” received Question FHI.215 in Versions 1 and 2. In Version 3, respondents who answered using the new ACA answer category in Question FHI.210.1, “Through Healthcare.gov, or the Affordable Care Act, sometimes known as Obamacare” also skipped this question.

Of the respondents who received Q FHI.215, there were no clear response errors: all who had obtained their health insurance through an ACA channel answered the question “yes,” while those that had not correctly reported “no.” (Because of the new answer category in Version 3’s Q FHI.210.1, no respondents who received ACA coverage skipped into this question.) However, the respondents did report some difficulty when answering this question—mostly stemming from the second phrase of the question text (“or the Health Insurance Marketplace…”).

Two respondents thought that the “or” in the question text denoted that “healthcare.gov” and “the health insurance marketplace…” were two different answer categories. One respondent’s immediate reaction was, “Aren’t they the same thing?” She continued, saying, “If I had to pick one or the other, then I wouldn’t be able to.” After repeating the question three times, this respondent decided that it was a yes or no question, and that she didn’t have to choose.

As seen throughout this cognitive interviewing project, as well as the proceeding ethnographic design work, respondents do not appear to use the terms “marketplace” or “exchange” vernacularly in reference to the ACA exchange outlets, but instead tend to call all ACA-related sites “healthcare.gov.” By introducing an uncommon term next to a common one, the risk that respondents perceive (and respond) to this question as a double-barreled one increases.

BLS1 *Is this policy a platinum, gold, silver, bronze, or catastrophic plan?*

1. *Platinum plan*
2. *Gold plan*
3. *Silver plan*
4. *Bronze plan*
5. *Catastrophic plan*

Refused
Don't know

There was some variation in the interpretation of this question—which resulted in clear response errors. However, this variation appears largely to be due to incorrect skips and previous interpretation and response errors: respondents who should not have received Question BLS1 interpreted it in a variety of ways; respondents who should have received Q BLS1 showed no variation in their interpretation of this question and had little difficulty answering it.

During Round 1 of the testing, the cognitive interviewers simply followed the skip patterns that were associated with each respondent's answers—even if they were clear response errors (as ascertained through probing). This led, for instance, to a number of respondents who in actuality had Medicaid coverage answering questions in the Private Insurance section (where Q BLS1 is located), because of their incorrect answers to Q FHI.051. Four respondents received Q BLS1 in Round 1, two of whom did not obtain their coverage through an ACA vehicle (one purchased it directly from an insurance website, and the other had only Medicaid). These two respondents had widely divergent interpretations of the question—the respondent who had Medicaid thought that the metal had to do with the amount of time one has had a certain plan. This gentleman reported that he was bronze since he just signed up for a new plan, but that he expected to obtain "silver status" after a year or so. The respondent who had purchased his own insurance directly choose "platinum" because he perceived that as the most expensive metal, and his plan was quite expensive and covered everything. The other two respondents that received this question in Round 1 actually did buy their insurance through the ACA, and both knew the metals of their plans—remembering it both from the purchasing process and through the various mailings they received from their insurer since their purchase.

In the subsequent two rounds, the skip patterns were clarified and respondents who clearly should not receive the Private Insurance questions did not. In Round 2 only two respondents received Q BLS1, while in Round 3 nine respondents did—all of whom indicated that they held private insurance obtained through an ACA outlet. All of these respondents in the latter two rounds actually bought their insurance on either a federal or state marketplace, or all understood this question to be asking about which metal category they chose during the purchasing process. Respondents generally understood the metal levels to be related to both the overall cost of the plan (i.e. their premium) as well as the amount of coverage (their deductible) and the extent of services offered.

Overall, respondents who actually went through the ACA insurance purchasing process clearly understood and were able to answer this question about the particular metal level of coverage they bought. Some respondents were not completely sure of the *logic* behind the metal levels (i.e. the relationship between premiums and deductibles). However, choosing a metal level appears to be a salient concept for respondents who go through the ACA process.

FHI.220 *Who pays for this health insurance plan? [ALL THAT APPLY]*

1. Self or Family (living in the household)
2. Employer or Union
3. Someone outside the household
4. Medicare
5. Medicaid
6. CHIP (SCHIP/Children's Health Insurance Program)
7. State or local government or community program
Refused
Don't know

Across all three rounds, all respondents who received Question FHI.220 answered either "self or family," and/or "employer or union," with all of those respondents who obtained their health insurance coverage through an ACA vehicle using the former of these two answer categories.

Some of these ACA respondents expressed some unease or frustration with the question—explaining that since (at least in some cases) they were receiving government money (in the form of tax credits applied to their premiums), "self and family" was not an *entirely accurate* answer category. Two respondents, who lived in Maryland, also included the "state or local government or community program" answer category, figuring that since they used a Maryland-specific website to get their insurance, the state of Maryland somehow paid for their tax credits. On the other hand, a respondent from Virginia noted that she used the federal website, and wanted there to be a "federal" option in addition to the "state or local government…" one. In the end, this respondent only chose "self or family," as she did not know where she should allocate the federal money that helped pay for her insurance.

Respondents clearly understood the "employer or union" answer category to refer to any portion of a premium paid for by their employer (and, in one case, former employer as part of a retirement benefits package). Many of the respondents who eventually chose this answer category were hesitant at first—explaining that *both* they and their employer paid for the insurance. In these cases, usually after a re-read of the question, the respondents realized that they could choose more than one answer category and then answered using both the 'self..." and the "employer…" options.

QDRL.8 *Your health insurance premium is the amount you or a family member pays each month or year for health insurance coverage. Do you or a family member pay a premium for your health insurance?*

Across all three rounds, the respondents had a relatively universal interpretation of Question QDRL.8's core construct, understanding a premium to be the amount of money they paid for access to health insurance. A number of respondents conceptualized this payment in terms of frequency. For example, one respondent (who answered "yes" indicated that she was considering, "the monthly amount that I pay [for my plan]." Another respondent explained his "yes" answer by saying that his premium was the "…amount I pay each month for health insurance."

There was some variation in how respondents who had employers who paid for 100% of their health insurance interpreted this question. While most of these respondents understood "premium" to mean any money that the health insurance company receives for his or her coverage (and therefore answered the survey question "yes"), a few others understood this question to only be asking about the portion of the premium they paid—in a way, they understood this question to be asking, "Do you…pay for your health insurance?," or as one of these respondents stated it: "Do *I* actually pay?" All three respondents who answered Q QDRL.8"no" interpreted the question this way, and explained that their employers (or former employers) paid the entire monthly cost of their health insurance plans. For example, one respondent explained that in the time that she left her employer, its benefit structure changed, and people now have to contribute to their insurance, but that she was grandfathered in: "Some of the people I worked with before [at her former employer's], they now have to pay for their premiums."

QDRL.9 *[Round 1 and 2] Do you or a family member receive a benefit from an employer to help pay for a portion of your premium?*

[Round 3] Does your employer help pay for any part of your health insurance?

The first version of Question QDRL.9—given to respondents in Rounds 1 and 2—used the phrase "…receive a benefit from an employer," which caused confusion and a number of both response and interpretation errors. This question was then simplified for the third round of testing.

With the first version of this question, the term "benefits," particularly as related to one's employer, appeared to be a foreign concept to many respondents. While of course some respondents referred to their "benefits package" or something similar, a number of respondents had to ask for the question to be repeated or for the term to be clarified before answering the question. For instance, one respondent—who ended up answering the question "don't know"—seemed to lean towards no when thinking through the question, saying that:

> The way it's [the question] phrased, it's like it's asking about a handout. But I'm putting in the money towards the premium, and the time [at work], so it isn't [a handout] really.

Overall, the interpretation of the core construct "benefit," was split between people who understood it in the technical sense—like a benefits package—and those who interpreted it as the gentlemen above did—a "handout." This second interpretation poses a significant issue during the judgment phase of the response process. During the prior ethnographic work and throughout this cognitive interviewing project, some respondents explained that "taking a handout" was a bad thing, indicating that a person needs help or assistance. Respondents who hold this view are more likely to simply reject the question (and answer "no") out of hand, without fully considering what the question is asking or their circumstances.

The second version of this question—administered in Round 3—simplified this question and eliminated the term "benefits." This change led to a much smaller range of interpretations, with nearly all the respondents thinking about what they called "employer contributions," or "the employer's share." For example, one respondent, who answered the question "no," understood the question to be asking, "does my employer help pay for any part of my health insurance?"

QDRL.10 *Does the amount of your premium depend on income?*

[In Rounds 2 and 3, the respondents received Question QDRL.11 directly after Question QDRL.9, and before Question QDRL.10. In Round 1, the respondents received these questions in numerical order: Q QDRL.9, then Q QDRL.10, followed by Q. QDRL.11. These changes were made as a result of the findings in Round 1, as presented below.]

Respondents answering Question QDRL.10, irrespective of whether it came before or after Question QDRL.11, employed a wide range of interpretations when attempting to determine whether or not their premium was dependent on income. Generally speaking, respondents had very little framing upon which to base their interpretations of this question, and as a result, considered things from Medicaid eligibility to personal choice to actual sliding scales of premium based on one's take-home pay. Table 8 shows the variety of patterns of interpretation for this question across both positions:

Table 7: Patterns of Interpretation Used to Answer Question QDRL.10 by Question Order

	Round 1	Rounds 2 and 3
Ability to choose more plans	•	•
ACA process included questions on income	•	•
ACA tax credits/subsidy	•	•
Graduated or Sliding Scale based on Income	•	•
Medicaid Eligibility	•	•
More family members on a plan changes the cost		•
Self-Identify as having a "low income"	•	

A number of respondents thought that the question was asking about whether they felt like they had more or less ability to choose a variety of plans (and the resulting premiums) because of their income. For example, one woman who initially answered "no," but then switched her answer to "yes" said that she was considering whether or not people with no income could afford certain plans. She explained that only the people who could afford higher premium plans with lower deductible would buy those plans, so income did affect one's premium. Likewise, another respondent (who answered "no" and obtained his insurance through an ACA marketplace) explained that he was thinking about the fact that his income allowed him to shop a large variety of plans:

> It's just like shopping for a regular plan—high premium gives you a low deductible; low premium gives you a high deductible. [Plus there are] old person plans and young person plans…I wanted a low deductible, so I have a high premium…If you make less money, they you will have to pay less.

His logic here was that since he could choose any plan he wanted, his premium did not depend on income. However, someone who could not afford a low deductible plan would *necessarily* have a lower premium because of the intrinsic relationship between premiums and deductibles. One respondent was thinking about a corollary of this—indicating that the more children on her plan, the more the plan would cost. This respondent did not explicitly talk about income, but rather indicated that people with larger families tend to not only have less income, but also have to pay more for insurance.

Other respondents, particularly ones who had experience with healthcare.gov or one of the other ACA vehicles, focused on how the new law might affect people's premiums due to income. Respondents conceptualized the income provisions of the ACA in two ways. First, some respondents simply thought

QDRL.10 *Does the amount of your premium depend on income?*
about the tax credit (though not always using that language) that people could apply to their deductibles. For example, one man who answered “yes” explained his answer by saying:

> I got tax benefits [during the healthcare.gov sign-up process]. Why did I get benefits? Because I didn’t make some level of money.

Other respondents did not specify the exact ways the ACA changed premiums due to income, but rather *deduced* that it did because of the sign up process. These respondents, none of whom remembered receiving a credit, did remember that one of the questions they were asked during the healthcare.gov process had to do with income. Given this, they made the logical leap that since they were asked about income, income must in some way relate to the premiums that they and others have to pay.

A third pathway to approach this question was for respondents to consider whether or not they were eligible for certain programs or rates because of their low income. This manifested in two distinct patterns of interpretation. The first was for the respondent to think about whether or not they were eligible for a specific program designed for low-income individuals, most commonly Medicaid. For example, one respondent noted that she was considering Medicaid, but answered the question “no” because she did not have Medicaid coverage, and that her premiums depended on which specific plan she selected. The second pattern of interpretation dealing with low-income government programs was a more general one. These respondents simply, and perhaps heuristically, decided that the question was asking about whether or not they had low income; since they did not have a low level of income, their answer was automatically “no.”

Finally, a few respondents thought that this question was asking about whether or not their premiums were on a sliding scale based on their income. None of the respondents had any experience with such a concept, they simply deduced that this was what the question was asking about. For example, one respondent thought that the question was asking, “if you make a certain amount of income, will it lower or raise your cost?” She said this wasn’t the case with her, and answered “no.” Another respondent—who had worked in HR previously—thought that the question was asking about “payment bands,” but said that she had never come across them.

QDRL.11 *Do you receive any benefits from the government, such as a tax credit, to help pay for a portion of your premium?*

[In Rounds 2 and 3, the respondents received Question QDRL.11 directly after Question QDRL.9, and before Question QDRL.10. In Round 1, the respondents received these questions in numerical order: Q QDRL.9, then Q QDRL.10, followed by Q. QDRL.11. These changes were made as a result of the findings in Round 1, as presented below.]

Question QDRL.11 carries a strong framing effect: When presented to the respondent after Q QDRL.10, respondents expressed more confusion and employed a wider pattern of interpretation when answering this question than they did when the questions were flipped.

In the initial round of cognitive testing, respondents expressed confusion over how this question differed from the previous question (Q. QDRL.10, about how income affected premiums). These respondents

carried over some of their interpretations from Q QDRL.10 into this question, thinking about whether or not they were eligible for programs such as Medicaid and whether or not they received a tax credit during the ACA sign-up process. One respondent, who answered the question yes, was thinking about whether or not he received a tax refund.

However, in the second and third round of testing, when this question was asked before Q QDRL.10, a much smaller number of interpretation was observed—with all respondents thinking specifically about government benefits applied to health insurance. There was some small variation within this construct—while most respondents thought about the tax credit that was part of the ACA process, others thought about some form of credit they would receive on their tax return at the end of the year.

QDRL.12 *A co-pay is the flat fee you pay for each visit to your doctor or to another health care service provider. Does your health insurance require you to pay a co-pay?*

There was a small amount of variation in the comprehension of Question QDRL.12. While most respondents understood "co-pay" to mean a per-visit fee they owed to their healthcare provider, some few respondents confused co-pay with "co-insurance" (which is a percentage of a service's cost that an insured individual pays, while the insurance pays the remaining percentage). In all three cases where the respondents were thinking about co-insurance instead of co-pays, the respondents answered the question "yes." Upon further probing, only one of these three respondent's plan actually required a *co-pay*. Thus, two of these respondents provided clear false positive responses.

QDRL.13 *Your deductible is the amount you must pay out of your own pocket each year before your health insurance begins paying for health care services. Does your health insurance have a deductible?*

There was almost no variation in the interpretation of Question QDRL.13—with all the respondents but one considering whether or not their insurance began paying for services only after they had paid a certain amount out of pocket. The one exception to this was a respondent who was thinking about her annual out-of-pocket maximum (the total amount of out-of-pocket expenses allowed under a plan before the insurance company will pay for all allowable costs).

A number of respondents explained that they were not sure what a deductible was, but noted that they based their response on the definition provided in the question text. As will be noted below for Question FHI.241 deductible is a relatively confusing concept for respondents—even highly educated ones—indicating that a pithy, easy-to-understand definition is necessary.

FHI.230 *How much do you currently spend for health insurance premiums for your plan? Please include payroll deductions for premiums.*

There was a small amount of variation in how the respondents both comprehended this question and judged their answer. Most respondents understood this question to be asking about how much their plan's premium—or the amount they paid for access to the plan—was. However, some respondents instead understood this question to be asking about the amount they paid for office visits or the total amount they had to spend under the plan—confusing "premiums" with their co-pays and deductibles,

respectively. This was particularly true in the third round of testing, where Question FHI.240 was administered before this question (in order to use the definitional framing of "deductible" provided in Q QDRL.13). This shift meant that respondents received two questions on deductibles before switching back to questions about premiums.

Furthermore, while most respondents only thought about costs associated with their private insurance plan (no respondents in the cognitive interviewing sample had more than one private plan, see Q FHI.171), a few respondents included other plans as well. For instance, one respondent reported both he cost of her private insurance and some supplemental insurance she received through the DC social services office. A couple of respondents also included the cost of their single service plans (dental and vision) in the total amount they reported here.

Across the entire cognitive interviewing sample, only one respondent answered "don't know," explaining that she does not pay attention to the deductions from her pay check. However, about half of the respondents indicated that they were not completely sure of their answers—using words such as "about," "around," or "I think" to qualify the numbers they reported. It is possible that this decreased accuracy could affect the overall validity of the estimates that come from this question.

FHI.231 *How often do you have to pay the premium for this plan?*

1. Once a week
2. Once every 2 weeks
3. Once a month
4. Twice a month
5. Every two months
6. Quarterly (every 3 months)
7. Once a year
8. Twice a year
Refused
Don't know

Question FHI.231 is designed to only be asked in the event that a respondent does not provide a frequency (i.e. "per month" or "per year") in their response to Q FHI.230. All of the respondents provided a frequency in the previous question; therefore there are no cognitive findings available for Q FHI.231.

FHI.235 *Do you know how much the employer or union is paying for your plan?*

All the respondents who received Question FHI.235 understood it to be asking about the amount of their employer's contribution to their premiums. However, none of the 11 respondents who received this question answered "yes." Rather, seven answered "no," and four answered "don't know."

It is important to note that when probed, both the respondents who responded "no" and the respondents who responded "don't know" meant for their answer to indicate the exact same thing: that they were unsure of the amount that their employer contributed to their health insurance. Some respondents

indicated that they could find out, if necessary—by looking at their pay stubs or consulting their medical bills for example. Others, on the other hand, could not think of any way to obtain this information.

One other small point of variation emerged during the probing of Q FHI.235. The question text leaves the format of the respondents' answers unspecified. As a result, during the discussion of this question, some respondents appeared to be trying to think of the dollar amount their employer contributed, while others were thinking about the percentage of the total premium cost.

FHI.237 *How much does the employer or union currently pay for health insurance premiums for your plan?*

Because no respondents answered "yes" to Q FHI.235, no one went on to receive Question FHI.237. No findings are available.

FHI.238 *How often does the employer or union pay the premium for this plan?*

1. Once a week
2. Once every 2 weeks
3. Once a month
4. Twice a month
5. Every two months
6. Quarterly (every 3 months)
7. Once a year
8. Twice a year
Refused
Don't know

Because no respondents answered "yes" to Q FHI.235, no one went on to receive Question FHI.238. No findings are available.

FHI.240 *Is [fill 1] an HMO (Health Maintenance Organization), an IPA (Individual Practice Association), a PPO (Preferred Provider Organization), a POS (Point-Of-Service), fee-for-service or is it some other kind of plan?*

1. HMO/IPA
2. PPO
3. POS
4. Fee-for-service
5. Other
Refused
Don't know

Across all three rounds, the respondents appeared to understand and answer Question FHI.240 in one of two ways: either through a heuristic where they simply knew which kind of health insurance plan they held (or looked at their card to confirm their suspicions), or by matching the characteristics of their plan

with what they understood to be the definitions of the various types of insurance listed in the answer categories.

It should be noted that many respondents noted that they had never heard of Individual Practice Associations, Point of Service or Fee for Service plans. Thus, those respondents who were thinking about their plan's characteristics were really comparing their plan to their understandings of HMOs and PPOs. Furthermore, it is important to note that nearly all the respondents had heard of HMOs and PPOs, but were largely unaware of what these acronyms stood for.

Figure 5 shows the response schema respondents employed while answering Q FHI.240. Note that no respondents answered using the "IPA" or "FFS" answer categories across the entire cognitive interviewing sample.

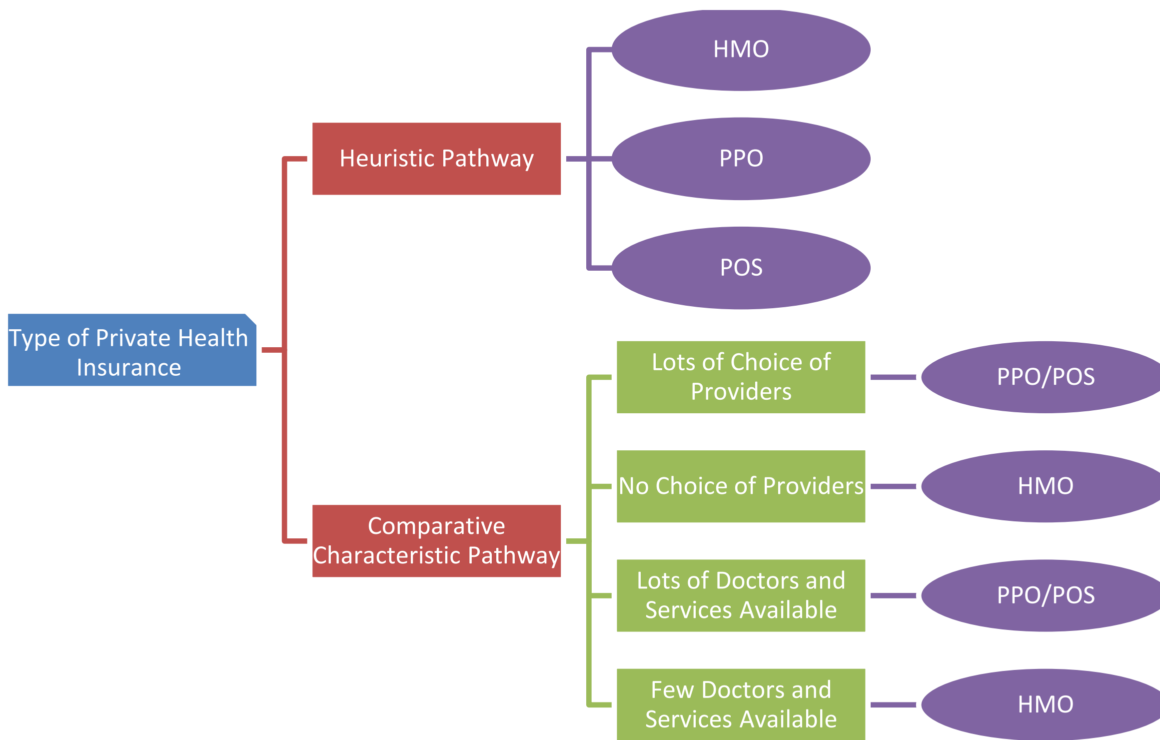

Figure 5: Response Schema for Question FHI.240

The Heuristic Pathway was used mostly by respondents who had recently purchased their insurance and based on their recollection of either the plan name or the materials the health insurance company had sent to them since then. For instance, one respondent who answered the question "HMO" explained that both her employer and her insurance company had continually referred to the plan as an HMO. This respondent explained that he did not know what specially made it an HMO. Other respondents who used the Heuristic Pathway were less sure of their answers. For instance, one respondent who reported having a POS explained that he wasn't "entirely sure," but that he thinks he remembers hearing or reading about a POS somewhere. While a few respondents who were unsure answered Q FHI.240 by saying "don't know," most respondents who indicated a lack of certainty provided an answer anyway.

Most respondents used the Comparative Characteristic Pathway to answer Q FHI.240. In it, respondent first considered characteristics of their own healthcare plan, and then thought about what characteristics a prototypical PPO, POS, or HMO plan would have. Specifically, the respondents all focused on either

their ability to choose their own doctors or on the perceived level of service available to them (which many of them took to mean the number of doctors available who take their plan). All of these respondents understood HMOs to be more limiting than PPOs or POSs. For instance, one respondent who answered "PPO" explained that she has "a booklet and you choose a doctor from that booklet," but if she had an HMO, she would have to go to a specific clinic and would not have that choice. Importantly, respondents did not characterize the distinction between PPOs/POSs and HMOs as "choice versus lack-of-choice." Rather, they were thinking in terms of magnitude, wherein less restrictive plans that afforded them more choice in their providers and care were PPOs or POSs, while the more restrictive plans were HMOs.

FHI.241 *VERSION_A [If only 1 person is covered by the plan]: Is the annual deductible for medical care for this plan less than $1,250 or $1,250 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.*

VERSION_B [If more than 1 person is covered by the plan]: Is the family annual deductible for medical care for this plan less than $2,500 or $2,500 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.

1. Less than [$1,250/$2,500]
2. [$1,250/$2,500] or more
Refused
Don't know

In Rounds 1 and 2 of this cognitive testing project, Question FHI.241 was tested in numerical order, directly following Q FHI.240. However, in Round 3, this question was moved early, and administered directly following Q QDRL.13 (which asks about deductibles).

In Rounds 1 and 2, nearly all of the respondents expressed confusion while answering this question. Some respondents indicated that they forgot or were not sure what a deductible was (even though it was defined for them four to six questions prior, in Q QDRL.13), others thought that this question was double barreled, while others indicated that they did not know how to find out what their deductible was. In particular, a number of respondents clearly had difficulty distinguishing between their health insurance's *premiums* and *deductibles*. For example, one Second Round respondent, who originally answered "$1,250 or more," originally thought that the question was asking her about her total annual premium, which she calculated to be more than $1,250. After probing, she asked for the question to be repeated and realized that the questions was asking not about premiums, but about deductibles. She then asked to switch her answer.

In an effort to temper this confusion between deductibles and premiums, in the Third Round, Q FHI.241 was moved directly following Q QDRL.13, which asks about (and defines) deductibles. This change nearly eliminated the confusion over the terms, and respondents carried their interpretations of deductibles they used in Q QDRL.13 forward to Q FHI.241.

FHI.242 *With this plan, is there a special account or fund that can be used to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and are different from Flexible Spending Accounts.*

Only 12 respondents skipped into Question FHI.242 by answering "$1,250 or more" in Q FHI.241. Of these respondents, it was unclear if they were thinking about HSAs or Flexible Spending Accounts (FSAs). Of the 12 respondents who received this question, only one answered "yes." In explaining her answer, the respondent noted that she was thinking of an account that she can put pre-tax money into, up to a yearly maximum.

FHI.243 *Under this plan, can you choose ANY doctor or MUST you choose one from a specific group or list of doctors?*

1. Any doctor
2. Select from group/list
Refused
Don't know

The respondents' interpretations of Question FHI.243 were largely impacted by which type of private health insurance they held at the time of the interview. Respondents who knew they had HMOs all chose the "select from group/list" answer category, and interpreted this to mean that they were limited to using the doctors within their organization. For instance, one man explained that while he normally goes to one of his HMO's locations in DC, if he is out of the city running errands, he can go to any of their other locations in the suburbs: "as long as I go to a [HMO Name] location, it's their doctors, so it's good."

There was no uniformity in either answer or interpretation across those respondents who had either a PPO or a POS health insurance plan, however. In terms of answering the survey question itself, about half of the PPO/POS respondents answered using the "any doctor" answer category, while the other half used the "select from group/list" answer category. This difference in response appears to stem from whether or not the respondent heard or understood the "must" statement in the question text.

Those respondents who answered "any doctor" noted in most cases that while they were free to choose any doctor they wished, it would be cheaper if they picked one in their network. For instance, one respondent who had a POS and answered "any doctor" explained: "I can go to whomever I want to, but whether I get reimbursed is another question! But yeah, I can go to whomever I want." Likewise, another respondent with a PPO who answered "any doctor" said: "you can go to any doctor you want, but you'll pay more [if you go out of network]."

In addition to this pattern of interpretation, some other PPO/POS respondents who answered "any doctor" used this answer category to indicate they could choose any doctor *in their network.* For example, one gentleman explained his answer by saying: "I can choose any doctor, but they have to be in the [plan name] network." He went on to say how he would call each doctor he was considering and ask if they took his plan before he made an appointment.

Finally, some other PPO/POS respondents chose the "select from group/list" answer category. These respondents all had a similar interpretation as the last example, believing that they had to (or should, for financial reasons) stay within their plan's network—to which they interpreted the "group/list" phrase referred. For example, one woman explained her "select from a group/list" answer by saying that "they [the doctors] have to take my company, my health insurance company." Upon probing, most of these respondents indicated that they did not know what would happen if they went to a non-network doctor—as they had never tried.

Since respondents answer questions based on their experiences, they will tend to answer questions like this and the following ones not about the strict policies of their respective health insurance plans, but rather about how they use their plans and the rules they have deduced from these experiences.

FHI.244 *Do you have the option of choosing a doctor from a preferred or select list at a lower cost?*

By and large, respondents carried their interpretations forward from Q FHI.243 in Question FHI.244. Respondents who answered this question "yes" nearly all were thinking about the fact that if they stay within their plan's network, they'll pay much less than if they go to a doctor who is out of network. These respondents tended to be the ones who responded "any doctor" to the previous question, who interpreted that answer category to mean *any doctor at all*.

On the other hand, respondents who answered Q FHI.243 "any doctor" and were thinking about just the doctors within their network were less consistent in their responses to Q FHI.244. Most answered "no," thinking about a "list-within-a-list"—special providers within their network that would cost less than the other in-network providers. However, one respondent answered "yes," also thinking simply about the fact that the network exists, and (again) it costs less to use an in-network provider than an out of network one. This respondent, by employing nearly identical patterns of interpretation for both Qs FHI.243 and FHI.244, understood these two questions to be asking about the *exact same phenomenon*.

It should be noted that while discussing other questions, a few PPO respondents noted that their networks had "tiers" across which the pricing for services differed. So, for instance, Hospital X might be in Tier 1 and cost $100 for emergency room visits, while Hospital Y might be in Tier 2 and cost $150 for the same visit. While this variability in within-network pricing did appear to exist within the sample, it did not factor into the respondents' answers to this question. While more research is necessary, it seems quite possible that respondents simply do not relate the terms "preferred or select list" to this tiered system.

FHI.246 *If you select a doctor who is not in the plan, will the plan pay for any part of the cost?*

There was almost no variation in the way the respondents understood Question FHI.246, and as such it differentiated respondents who held an HMO from those who held a PPO/POS effectively. All the respondents who answered this question "yes" were PPO/POS holders and understood that while there is a benefit to using an in-network provider, their insurance would pay something if they left the network.

Likewise, all the respondents who responded "no" to this question had HMOs at the time of the interview. These respondents understood their coverage to mean that if they did not use a doctor listed by their HMO, they would not receive any benefits whatsoever.

FHI.248 *When you need to go to a different doctor or place for special care, do you need approval or a referral? Do not include emergency care.*

Respondents used a variety of patterns of interpretation while answering Question FHI.248, particularly those respondents who had PPO or POS coverage at the time of the interview. Respondents who had HMO coverage at the time of the interview all understood this question to be asking whether or not they needed to get a referral from their primary care physician (PCP) for non-primary care services. PPO and POS respondents, on the other hand, understood this question in three distinct ways, as seen below in Figure 6.

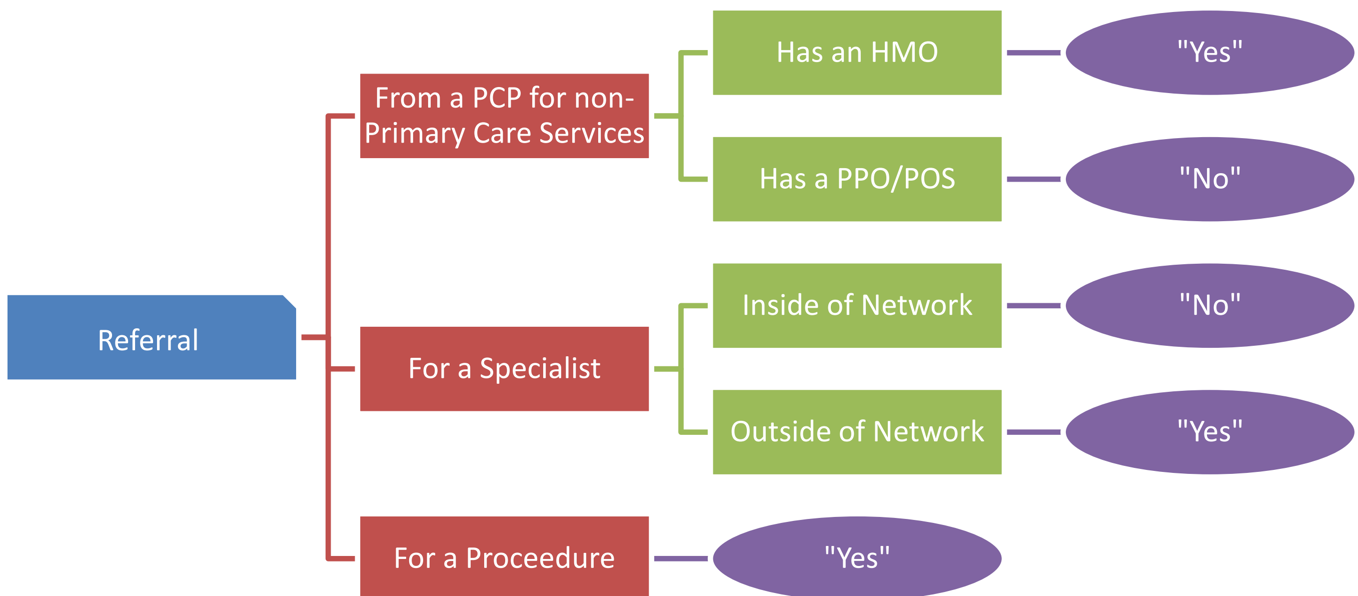

Figure 6: Response Schema for Question FHI.248

Some PPO/POS respondents understood Q FHI.248 to be asking the same thing as the HMO respondents: whether or not they needed permission from their PCP for non-primary care services. All the PPO/POS respondents who interpreted the question in this way responded "no," indicating that they did not need to see their PCP for everything.

Other PPO/POS respondents specifically considered specialists—such as dermatologists and cardiologists—and whether or not they needed "permission" to set up an appointment. These respondents were particularly thinking about what approvals were necessary to ensure that they were reimbursed (or received their maximum benefit) for their visit to the specialist, and their reasoning was largely based on the network status of the specialist. Respondents who were *only* thinking about

specialists within their network generally answered Q FHI.248 “no,” while respondents who were also thinking about specialists outside of their network answered “yes.” For instance, one respondent explicitly tied the fact that she had a PPO to the fact that she did not need a referral within her network. In explaining her “no” answer, this respondent said: “I think that’s why you get a PPO, so you don’t need referrals.” Likewise, another respondent who answered “no” said: “If I determine I need to go see a cardiologist, I’ll go see a cardiologist.” So, PPO/POS respondents who thought this question was asking only about specialist inside their network went on to answer “no,” while others who thought this question was asking about specialists both inside *and* outside of their network went on to answer “yes.”

Finally, a few other PPO/POS respondents considered only whether or not they would need a referral for a medical procedure—such as an x-ray or chemotherapy. These respondents uniformly answered Q FHI.248 “yes,” understanding their answer to mean that they could not simply go and order medical procedures or therapies by themselves—without the input of their PCP—and still receive full reimbursement from their insurer.

FHI.248.5 *Does this plan REQUIRE you to have a primary care doctor or group of doctors for all routine care?*

Question FHI.248.5 was very problematic, with respondents using a large number of patterns of interpretation (some of which are clearly out-of-scope) to answer the question and expressing confusion while doing so. There are three separate aspects of this question that appear to contribute to this confusion: the fact that the question can be understood to be double barreled, variation around the term “require,” and further variation around the phrase “routine care.”

<u>Double Barreled Question</u> A few respondents either expressed confusion over what they believed to be the double barreled nature of the question, or (more commonly) interpreted this question as asking whether they had *both* a PCP *and* a group of doctors for all routine care. This was particularly problematic for those respondents who had interpreted the “select from a group/list” answer category in Q FHI.243 (either four or two questions prior to this one, depending on the skip patterns) to be referring to within-network providers. For instance, one PPO respondent who answered this question “no” explained her response by saying: “No, [I have] just a primary care doctor. Not a group.” Upon probing, this respondent revealed that she did indeed have to go to her PCP for all routine checkups, but because she did not have go to other doctors in her network for routine care, she said “no.”

<u>Interpretation of “Require”</u> Beyond the confusion of what Q FHI.248.5 was specifically asking, there was a lot of variation surrounding the term “require” as it applied to the respondents’ health insurance plans. While many respondents were thinking about the strict policies of the plan, other respondents employed broader interpretations that did not necessarily consider what the plan did or did not dictate. The respondents understood “require” in four separate ways:

1. Must have a PCP/Group of doctors *in order to be insured*
2. Must have a PCP/Group of doctors *in order to receive primary care*
3. *Should have* a PCP/Group of doctors because it is medically the smart thing to do
4. The health insurance company *pressures or asks* you to have a PCP/Group of doctors, but there is no indication that it is required

Each of these four separate patterns led to both “yes” and “no” survey responses, which is problematic because the latter two appear to capture out-of-scope constructs.. This variety of interpretations clearly

stems from the fact that respondents based their answers on their personal experiences with the plans. If a respondent has actually read the policy or has been denied care because he or she did not have a PCP, they would likely employ one of the first two patterns and answer the question "yes." However, if they have not been denied care, they could potentially use all four of the patterns. Furthermore, a few respondents appeared to simply skip over the term "require" in the question text, and understood this question to be asking whether or not they *had* a PCP. For instance, one woman who held PPO coverage answered the question "yes" and explained that she has a PCP that she "goes to for the small things." When probed, this respondent revealed that she had no idea whether or not her plan *required* her to have a PCP, just that she did in fact have one.

Interpretation of "Routine Care" Finally, there was some small variation surrounding the term "routine care." Most respondents thought about check-ups, basic tests (i.e. blood pressure, cholesterol, etc), and care for mild acute illnesses (such as an ear infection or the flu) that they receive at the same doctor's office *routinely*. However, some respondents indicated that they go to their local hospital's emergency department for such procedures, and were unsure how to answer the question. One of these respondents answered "don't know," while another answered "no" because she did not always see the same doctor (even though she always went to the same hospital emergency department for this type of care). Both of these respondents indicated that they knew they could set up a PCP at a place other than the emergency department, but decided not to because they did not want to change their habits, and their insurance companies had not stopped them.

Overall, as seen below in Table 9, this confusion led to a mixed response distribution across the plan types.

Table 8: Question FHI.248.5 Response Distribution by Type of Private Insurance

	Response to Question FHI.248.5		
	Yes	**No**	**Don't Know**
HMO	5	2	0
PPO/POS	6	8	1
Other	0	1	0
Don't Know	2	0	0

While in general, it appears that respondents with HMOs answer the question as expected—with nearly all of them answering "yes"—respondents with PPOs were more or less split between "yes" and "no" responses. This question does not differentiate efficiently between respondents who have HMOs and respondents that have PPOs or POSs: while a "no" response does seem to indicate that a respondents holds a PPO/POS, a "yes" response does not appear to mean anything.

FHI.249.1 *Does the plan pay for any of the costs for medicines prescribed by a doctor?*

All respondents (save one "don't know") responded "yes" to Question FHI.249.1. They uniformly interpreted this question as asking about whether or not their insurance plan covered the costs of drug for which they received a prescription. In particular, most respondent considered the fact that they only paid a co-pay or a fee for medication. For example, one respondent explained her answer by saying:

I think it does because I don't pay that much for prescriptions. Because I have the co-pay, so the plan would pay the other portion.

Likewise, another respondent explained that the question was asking about "prescription drugs." He went to explain that "…there is a co-pay, but they [the insurance company] do their part." Other respondents explained their answer heuristically, simply indicating that they through the question was asking whether or not they had prescription coverage, and that they did.

FHI.249.2 *Does the plan for any of the costs for dental care?*

There was some small variation in how the respondents interpreted Question FHI.249.2 centering upon what counted as "dental care." Respondents considered two different types of dental services when answering this question: routine or preventative dental care (such as cleanings and cavity fillings) and emergency dental care (such as repairing a set of broken teeth after an accident). Overall there were three different pathways a respondent could go down to answer this question:

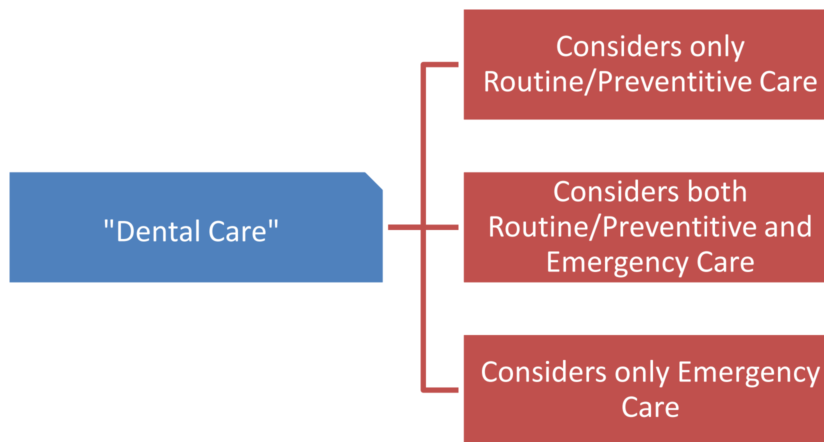

Figure 7: Response Pathways for Question FHI.249.2

Nearly all the respondents used the first pathway, thinking only about whether or not their private health insurance plan covered routine dental care. A couple of respondents, who both answered "yes," indicated that they were thinking about *both* routine and emergency care. Upon probing, both of these respondents indicated that their insurance plans covered costs for both of these types of care.

Finally, one respondent thought only about emergency care, and not about preventative care at all. This respondent, who answered Q FHI.249.2 "yes" revealed after further probing that his plan did not include any coverage for preventative or routine care, but would cover some of the costs if he had an oral emergency—such as "accidents where you lose teeth or have to get reconstruction."

FHI.300 *In the PAST 12 MONTHS, was there any time when you did NOT have ANY health insurance or coverage?*

There was some small variation in both the respondents' interpretations of Question FHI.300—particularly surrounding what it meant to be without insurance or coverage—and in the reference period respondents used to judge their answers.

Most respondents interpreted "any time when you did not have any health insurance or coverage" to be a period of un-insurance, where they had absolutely no health insurance coverage. A few respondents noted that they had transitioned between plans—such as during "open season" periods—but recognized that they had never *lost* insurance, and that their movement from one plan to the next was seamless. However, a few respondents employed different patterns of interpretation. One respondent initially answered "yes," and explained that she had "crappy" coverage—basically a high deductible, low coverage plan. After probing, this respondent asked that her answer be changed to a "no," indicating that she now believed that this low coverage plan counted for the purposes of this question. One other respondent answered "no," but went on to explain that he had actually forgotten to "recertify" his Medicaid, and was technically out of the plan for about a month and a half. However, this respondent noted that he did not need to use any medical services during this period, so he reported "no."

There was also some further variation in the reference periods the respondents used to judge their answers. Nearly all the respondents correctly considered the 12 months prior to the research—though some rounded "up" or "down" to the start of either the current or next month from the date of the interview. Two respondents reported that they considered the previous calendar year, and not the previous 12 months. Both of these interviews were held in March of 2014, and the respondents considered the period from January 2013 to the date of the interview. Probing revealed that this expanded time period did not lead to a response error—both respondents answered "no"—it is clear that such an interpretation error could lead to either false positives or negatives, depending on the date of the interview.

FHI.310 *In the PAST 12 MONTHS, about how many months were you without coverage?*

1. [OPEN RESPONSE]

14 respondents received Question FHI.310 after responding "yes" to Q FHI.300. These respondents all interpreted the question as asking about the length of time they were uninsured during the 12 months prior to the interview. It should be noted that respondents carried forward their interpretations of the reference period "past 12 months" from Q FHI.300 into this question. So, for example, a respondent who was interviewed in mid-March, and "rounded up" their reference period in the last question to include the time between March 2013 and April 2014, considered the same period here in Q FHI.310.

Some respondents rounded their answers to full months, while other did not. For instance, one respondent noted that he lost a job and did not have insurance again until his ACA coverage kicked in—making him uninsured for about 9 weeks. The respondent reported "2 months" in response to this question, explaining that he simply rounded up. Other respondents gave their answers in either fractions of a month—i.e. "3 and a half months"—or in weeks.

FHI.320 *The next question is about money that you have spent out of pocket on medical care. We do NOT want you to count health insurance premiums, over the counter drugs, or costs that you will be reimbursed for. In the PAST 12 MONTHS, about how much did [fill 2: you/your family] spend for medical care and dental care?*

0. Zero
1. Less than $500
2. $500-$1,999
3. $2,000-$2,999
4. $3,000-$4,999
5. $5,000 or more
Refused
Don't know

A number of respondents asked for this question to be repeated or asked for clarification after hearing it. In particular, respondents appeared to have difficulty with the list of exclusions ("…We do NOT want you to count…"), and a few respondents clearly did not hear the word "not"—instead thinking it was a list of *inclusions*. Besides this confusion, respondents largely understood that this question was asking about how much they paid for healthcare that for which they would not be reimbursed over the previous 12 months. The respondents all carried forward their understanding of the 12 month reference period from Qs FHI.300 and FHI.310. However, the largest source of variation in how respondents interpreted and answered Question FHI.320 stems directly from which expenses they judged to be in-scope.

All the respondents included the cost of doctor's visits—copays generally—or prescription drugs when calculating the amount to report. Besides this expense, there was less consistency over what other costs to include. The largest points of discrepancy and confusion were whether to include prescription medication, over the counter medication, and dental costs. Figure 8 shows a Ven Diagram of the various expenses the respondents included while calculating their answer to Q FHI.320.

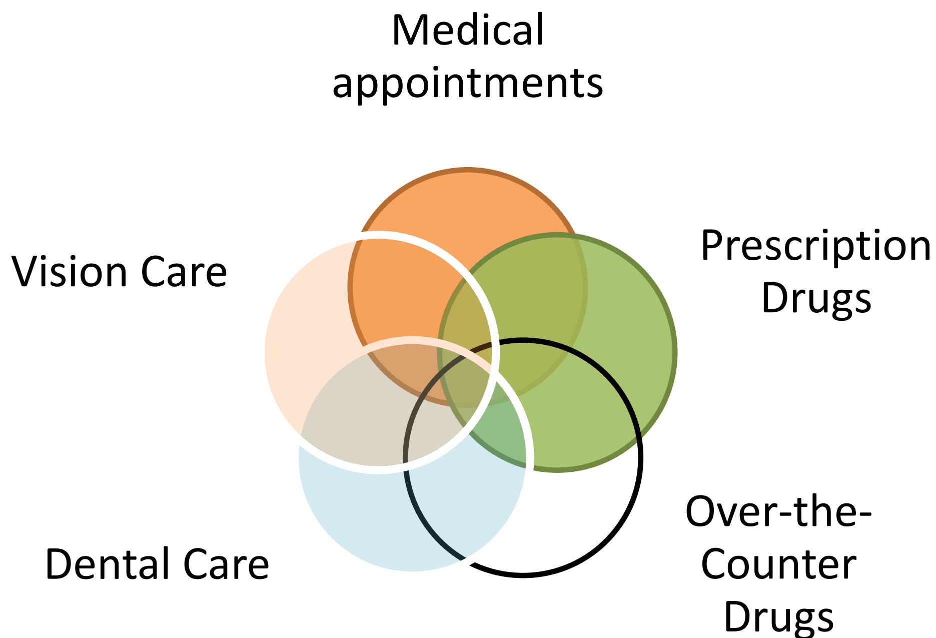

Figure 8: Ven Diagram of Expenses Respondents Considered when Answering Question FHI.320

Medical appointment and prescription drugs (those shaded heavily above) were the only two categories of expenses that respondents considered and reported on by themselves. In other words, some respondents *only* reported on medical appointments, while others *only* reported on prescription drugs. However, respondents only included over-the-counter drugs, dental care, and vision care *in addition to* medical appointments and/or prescription drugs. Over-the-counter drugs, dental, and vision care were included by some respondents in their calculations, and not included by others.

A small number of respondents included the explicitly out-of-scope over-the-counter drug category (represented above by the empty black circle) in their calculations. A larger number considered this category while talking through their calculations, but most either 1) realized that it was out-of-scope, or 2) did not have any over-the-counter drug expenses. The latter of these two patterns of interpretation is a clear interpretation error, which could lead to a response error if the respondent did indeed have costs that they associated with over-the-counter drugs.

No respondents included their insurance premiums when calculating their answer. It is unclear whether the respondents did not include premiums in their calculation because of the explicit instruction in the question text (…We do not want you to count health insurance premiums…), or because respondents do not naturally include premiums in the cognitive domain of "money you have spent out-of-pocket on medical care." The evidence that does exist suggests the latter. First of all, respondents clearly counted (or did not count) other expenses that the question text either explicitly included or excluded (such as out-of-pocket drugs and dental care, respectively). Secondly, when respondents talked through their calculations, very few mentioned premiums at all—either in an exclusionary or inclusionary way.

FHI.325 *In the past 12 months did [fill1: you/anyone in the family] have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home or home care.*

Both the patterns of interpretation, and the responses they led to, were variable across Question FHI.325. At the core of this variability is how the respondents interpreted and judged the phrase "problems paying" medical bills. The response pattern, and the various patterns of interpretation at each decision point, are shown below in Figure 9:

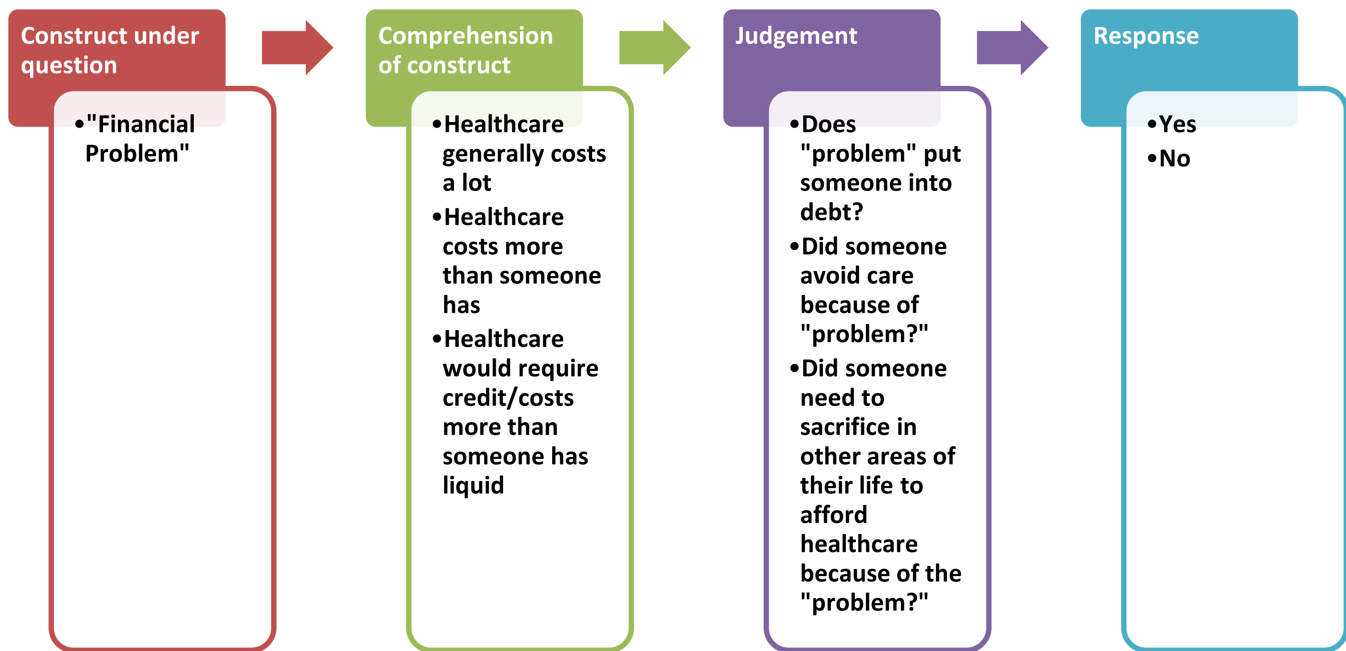

Figure 9: Response Pathway for Question FHI.325

Comprehension The first decision point the respondents came to was how to comprehend and interpret the term "problem:" basically they were answering the question, "what is a financial problem that can occur as a result of healthcare costs?" The patterns of interpretation surrounding this question range from the very general to more specific issues. On the general end of the spectrum, a number of respondents indicated that they were thinking about the fact that healthcare costs are usually relatively high as compared to other household expenses. For example, one respondent (who eventually answered the question "no") explained that he was conceptualizing a problem as:

> …if you have major surgery or were in the hospital and you get the hospital bill months later and it's like thousands of dollars…Or a major dental [operation]. I guess like having all of your teeth pulled out and having new ones put in. Implants. Which costs a lot of money. Or any hospital stay.

Respondents who used this more general pattern of interpretation tended to go on and judge that they did not have a financial problem, and answered the survey question "no."

On the other hand, respondents who were more likely to have had experience dealing with burdensome costs of health care tended to conceptualize problems more specifically than simply thinking about the high cost of health care. Some respondents understood a problem as a healthcare expense that simply costs more than they have. For instance, one respondent explained that she was thinking about a problem in the sense that "you have a health issue, but you just can't afford to go to the doctor." Other respondents were even more specific, and thought about problems as being expenses that would cause them to either dip into savings or use credit—in other words, healthcare expenses that they could not cover with their current liquid financial assets.

Judgment Once a respondent conceptualized a "financial problem," they then had to judge whether or not they *had* one. The first aspect of this is the reference period. Across the cognitive interviewing sample, the respondents all appeared to follow the question text and think about the past 12 months.

However, all the respondents who answered Q FHI.325 “yes” were thinking of financial problems they *currently* had, at the time of the interview.

Beyond the reference period, the respondents employed three different patterns of interpretation to judge whether or not they had a “problem.” The most common patterns of judgment was to think about whether or not healthcare costs had put the respondent into debt. For example, one respondent who answered the question “no” because she “did not have any medical bills [she] could not pay off.” Respondents who employed this pattern of judgment focused on their immediate ability to pay a bill, and approached the judgment in a binary way: “did the expense put me into debt, yes or no?” Respondents who indicated that they were able to pay bills would answer “no,” while those who indicated otherwise would answer “yes.” Importantly, these respondents did not appear to think of the “downstream” consequences of staying out of debt because of a medical expense (such as the medical risk of putting off care), just the simple fact that they were or were not able to pay off a bill.

On the other hand, another group of respondents focused on these downstream consequences more than that simple question of whether or not a bill was paid off. One large group of respondents specifically considered how *knowing* that a medical expense would be too large for them would cause them to simply avoid that care (or put it off longer than they should have) in order to avoid debt. For instance, one woman who answered Q FHI.325 “yes” explained that she has had consistent trouble paying off medical bills, and as a result has had to forgo treatment:

> Did I have problems pay the bills, is that the question? Yes. I’ve had to save or borrow the money in order to see some doctors, and I’ve had to delay treatment…[specifically] mammograms, OB/GYN visits and physical therapy treatments. I’ve had to forgo a lot because I haven’t saved enough.

Interestingly, not all respondents who indicated that they have had to give up or delay medical services because of cost answered this question “yes.” Some few respondents noted that they had delayed treatment, and thus avoided debt—and as a result said that they did not have a problem and consequently answered the question “no.” For example, one respondent who answered “no” spoke about how she had to shift her care during a period of un-insurance:

> During my brief stint with healthcare coverage, I got a bill…for $800. So I put off any more work…unless it was absolutely critical.

This respondent went on to explain that the threshold for a condition to be “absolutely critical” was higher during that period with medical debt than it was later (at the time of the interview) when she had no debt.

In addition to these respondents who thought about whether or not they had to change their healthcare habits because of medical expenses, others thought about other sacrifices or changes to their life they would have to make because of these expenses. One respondent, who answered “no,” noted that she had to dip into her savings to pay for a medical bill, and had to put off her kitchen remodeling. She indicated, however, that this was not too much of a sacrifice to be counted as a problem here, as she was still able to do the remodeling later on after she had rebuilt her savings. Another respondent answered “no,” explaining that while he did have a large number of medical expenses over the previous 12 months, he did not need to change the way he lives his life to pay them: “It [the medical expenses] hurt a little, but I didn’t have to hock anything yet!”

FHI.327 *Do you currently have any medical bills that are being paid off over time? This could include medical bills being paid off with a credit card, through personal loans, or bill paying arrangements with hospitals or other providers. The bills can be from earlier years as well as this year.*

Overall, respondents understood Question FHI.327 to be asking about the current amount of medical debt they were holding at the time of the interview. However, two sources of variation emerged as the respondents were judging which costs to report here: whether or not to include credit card debt, and whether or not to include dentistry.

The credit card question was the more significant source of variation in Q FHI.327, and in fact the sample was nearly split between respondents who included it in their responses, and those who did not include it—even though it is explicitly mentioned in the question text. For example, one respondent who answered the question "no" mentioned that she had no debt, but "was paying off the dentist on my credit card." Other respondents who employed this same pattern of judgment seemed to explain it by saying that the money owed to the healthcare provider was paid, so they did not consider it a debt. For instance, another respondent who was thinking about a large dentist bill they were paying off on credit card answered "no," and explained:

> The dentist got his money. The credit card company pays them, right? I didn't have to ask [the dentist] for a deferred payment.

Similarly, another respondent indicated that not only did he not consider his credit card payments to be a debt because the provider received their money, but also because he nearly always uses his credit card to pay for services: "Nobody pays with cash anymore!" In effect, there appears to be cognitive dissonance between medical debt and credit card debt accrued to pay for medical services.

There was also some slight variation around whether or not to include dentistry in the respondents' medical debt. While most respondents did indeed include any costs due to dental work, a couple of respondents did not. Upon probing, both of these respondents noted that they were paying off dental bills (held by the dentist offices, not by credit card companies) and asked whether or not they should include them in this answer.

FHI.330 *[Rounds 1 and 2] [Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pre-tax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care. With this type of account, any money remaining in the account at the end of the year, following a short grace period, is lost to the employee.*

[Round 3] [Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pre-tax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care.

This question was shortened after Round 2 to decrease respondent burden. The interpretations of this question did not differ between the two versions. Respondents understood Question FHI.300 in a similar way as they did Q FHI.242 about Health Savings Accounts. Most respondents reported that they had heard about such accounts (though only one respondent in the cognitive interviewing sample reporting having a Flexible Spending Account at the time of the interview), though again it is unclear whether they were thinking about FSAs or HSAs.

FHI.050: Are you covered by any kind of health insurance or some other kind of health care plan?

1. Yes
2. No
Don't Know
Refused

[IF NO, and R is >/= to 65 years old, SKIP to FHI.072
IF NO, and R is <65 years old, SKIP to FHI.073]

FHI.070: What kind of health insurance or health care coverage do you have? INCLUDE those that pay for only one type of service (nursing home care, accidents, or dental care). EXCLUDE private plans that only provide extra cash while hospitalized.

1. Private health insurance
2. Medicare
3. Medi-Gap
4. Medicaid
5. SCHIP (CHIP/ Children's Health Insurance Program)
6. Military health care (TRICARE/VA/CHAMP-VA)
7. Indian Health Service
8. State-sponsored health plan
9. Other government program
10. Single service plan (e.g., dental, vision, prescriptions)
11. No coverage of any type
Don't Know
Refused

[IF R is >/= to 65 years old, and FHI.070 ne 2, GO TO FHI.072
IF R is <65 years old, and FHI.070 ne 4, SKIP TO FHI.073
IF FHI.070 = 2, 4, or 10, SKIP TO FHI.120]

FHI.072: Are you covered by Medicare?

1. Yes
2. No
Don't Know
Refused

[SKIP TO FHI.074]

FHI.073: There is a program called Medicaid that pays for health care for persons in need. In this State it is also called (DC/MD/VA =Medical Assistance/Medical Assistance Program, Healthchoice, or REM Program/Virginia Medallion or Medallion 2). Are you covered by Medicaid?

1. Yes
2. No
Don't Know
Refused

FHI.074: Do you have any type of insurance that pays for only one type of service such as dental, vision, or prescriptions?

1. Yes
2. No
Don't Know
Refused

MEDICAID PATHWAY
[GO TO FHI.120 IF FHI.073=1 OR IF FHI.070=4.
ALL OTHERS, SKIP TO FHI.160]

FHI.120: The next questions are about Medicaid coverage. In this State it is also called (DC/MD/VA= Medical Assistance/Medical Assistance Program, Healthchoice, or REM Program/Virginia Medallion or Medallion 2). You are listed as having Medicaid coverage. Can you go to ANY doctor who will accept Medicaid or MUST choose from a book or list of doctors or is a doctor assigned?

1. Any doctor
2. Select from book/list
3. Doctor is assigned
Refused
Don't know

[IF=1, SKIP TO FHI.135
IF=2 SKIP TO FHI.131
IF=3, GO TO FHI.130]

FHI.130: What is the name of the health plan that provided the book or list?

1. [*OPEN RESPONSE*]
2. Refused
3. Don't know

[SKIP TO FHI.135]

FHI.131: What is the name of the health plan that assigned the doctor?

1. [*OPEN RESPONSE*]
2. Refused
3. Don't know

FHI.135: Was your Medicaid obtained through Healthcare.gov or the [DC/MD/VA= Health Insurance Marketplace, such as DC Health Link/ Health Insurance Marketplace, such as Maryland Health Connection/Health Insurance Marketplace]?

1. Yes
2. No
Don't know
Refused

FHI.137_2: Under your Medicaid plan is there an enrollment fee or premium?

1. Yes
2. No
Don't know
Refused

[IF=2,D,or R, SKIP TO FHI.140]

FHI.137_3: Is the premium paid for this Medicaid plan based on income?

1. Yes
2. No
Don't know
Refused

FHI.140: Are you required to sign up with a certain primary care doctor, group of doctors, or certain clinic which you must go to for all of your routine care? Do not include emergency care or care from a specialist you were referred to.

1. Yes
2. No
Don't know
Refused

FHI.150: Under your Medicaid plan, if you to go to a different doctor or place for special care do you need approval or a referral? Do not include emergency care.

1. Yes
2. No
Don't know
Refused

[SKIP TO FHI.300]

PRIVATE PATHWAY

FHI.160: The next questions are about private health insurance plans. These plans can be obtained through work, purchased directly, or through a state or local government program or community program.

It is important that we record the complete and accurate name of each health insurance plan. What is the COMPLETE name of the first plan? Do NOT include plans that only provide extra cash while in the hospital or plans that pay for only one type of service, such as nursing home care, accidents, or dental care.

1. [*OPEN RESPONSE*. ***USE AS FILL1 BELOW***]
Refused
Don't know

FHI.170: Which family members are covered by ***FILL1-n***?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.171: Are there any more private health insurance plans?

1. Yes
2. No
Refused
Don't Know

[IF=1, THEN GO TO FHI.172;
IF=2,D, R, SKIP TO FHI.200]

FHI.172: What is the name of the next plan?

1. [*OPEN RESPONSE*. ***USE AS FILL2-n BELOW***]
Refused
Don't know

[LOOP FHI.170-FHI.172 UNTILL FHI.171=2]

FHI.200: I would like to ask you about [your private plan/Plan X (if multiple plans)]. Health insurance plans are usually obtained in one person's name even if other family members are covered. That person is called the policyholder. In whose name is this plan?

4. Respondent's Name
5. Household member
6. Non-Household member
Refused
Don't Know

[IF FHI.200=1, THEN SKIP TO FHI.204
ELSE CONTINUE TO FHI.2002]

FHI.202: How are you related to the policyholder?

5. Child (including Stepchild)
6. Spouse
7. Former Spouse
8. Some other relationship

Refused
Don't know

FHI.204: Does this plan cover anyone else who does not live here?

1. Yes
2. No

Refused
Don't know

FHI.210: Which one of these categories best describes how this plan was obtained?

1. Through employer
2. Through union
3. Through workplace, but don't know if employer or union
4. Through workplace, self-employed or professional association
5. Purchased directly
6. Through a state/local government or community program
7. Other (specify)

Refused
Don't know

[If FHI.210=1-4, THEN SKIP to FHI.220,
IF FHI.210=5,6,D,R THEN SKIP to FHI.215
IF FHI.210=7, THEN CONTINUE TO FHI.210.1]

FHI.210.1: How was this plan obtained?

1. [*OPEN RESPONSE*]

Refused
Don't know

FHI.215: Was the plan obtained through the Healthcare.gov or the [DC/MD/VA= Health Insurance Marketplace, such as DC Health Link/ Health Insurance Marketplace, such as Maryland Health Connection/Health Insurance Marketplace]?

1. Yes
2. No

Refused

Don't know

BLS.1: Is this policy a platinum, gold, silver, bronze, or catastrophic plan?

6. Platinum plan
7. Gold plan
8. Silver plan
9. Bronze plan
10. Catastrophic plan

Refused
Don't know

FHI.220: Who pays for this health insurance plan? [ALL THAT APPLY]

1. Self or Family (living in the household)
2. Employer or Union
3. Someone outside the household
4. Medicare
5. Medicaid
6. CHIP (SCHIP/Children's Health Insurance Program)
7. State or local government or community program

Refused
Don't know

[IF FHI.220=4-7,R, THEN SKIP TO FHI.240]

QDRL.8: Your health insurance premium is the amount you or a family member pays each month or year for health insurance coverage. Do you or a family member pay a premium for your health insurance?

1. Yes
2. No

Refused
Don't know

[IF QDRL.8=2, THEN SKIP TO QDRL12]

QDRL.9: Do you or a family member receive a benefit from an employer to help pay for a portion of your premium?

1. Yes
2. No

Refused
Don't know

QDRL.10: Does the amount of your premium depend on your family's income?

1. Yes
2. No
Refused
Don't know

QDRL.11: Do you receive any benefits from the government, such as a tax credit, to help pay for a portion of your premium?

1. Yes
2. No
Refused
Don't know

QDRL.12: A co-pay is the flat fee you pay for each visit to your doctor or to another health care service provider. Does your health insurance require you to pay a co-pay?

1. Yes
2. No
Refused
Don't know

QDRL.13: Your deductible is the amount you must pay out of your own pocket each year before your health insurance begins paying for health care services. Does your health insurance have a deductible?

1. Yes
2. No
Refused
Don't know

[IF FHI.220 includes 1, then CONTINUE TO FHI.230;
IF FHI.220 includes 2, but not 1, THEN SKIP TO FHI.235;
ELSE, SKIP TO FHI.240]

FHI.230: How much do you currently spend for health insurance premiums for your plan? Please include payroll deductions for premiums.

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.231: How often do you have to pay the premium for this plan?

1. Once a week

2. Once every 2 weeks
3. Once a month
4. Twice a month
5. Every two months
6. Quarterly (every 3 months)
7. Once a year
8. Twice a year
Refused
Don’t know

[IF FHI.220 includes 2, then CONTINUE TO FHI.235;
ELSE, SKIP TO FHI.240]

FHI.235: Do you know how much the employer or union is paying for your plan?

1. Yes
2. No
Refused
Don't know

[IF FHI.235=2,R,D, THEN SKIP TO FHI.240]

FHI.237: How much does the employer or union currently pay for health insurance premiums for your plan?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.238: How often does the employer or union pay the premium for this plan?

1. Once a week
2. Once every 2 weeks
3. Once a month
4. Twice a month
5. Every two months
6. Quarterly (every 3 months)
7. Once a year
8. Twice a year
Refused
Don’t know

FHI.240: Is [fill 1] an HMO (Health Maintenance Organization), an IPA (Individual Practice Association), a PPO (Preferred Provider Organization), a POS (Point-Of-Service), fee-for-service or is it some other kind of plan?

1. HMO/IPA
2. PPO

3. POS
4. Fee-for-service
5. Other
Refused
Don't know

[IF only 1 person is covered by the plan, ASK FHI.241_VERSION_A;
IF more than 1 person is covered by the plan, ASK FHI.241_VERSION_B]

FHI.241: VERSION_A [If only 1 person is covered by the plan]: Is the annual deductible for medical care for this plan less than $1,250 or $1,250 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.

VERSION_B [If more than 1 person is covered by the plan]: Is the family annual deductible for medical care for this plan less than $2,500 or $2,500 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.

1. Less than [$1,250/$2,500]
2. [$1,250/$2,500] or more
Refused
Don't know

[IF FHI.241=1,R,D, THEN SKIP TO FHI.243]

FHI.242: With this plan, is there a special account or fund that can be used to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and are different from Flexible Spending Accounts.

1. Yes
2. No
Refused
Don't know

FHI.243: Under this plan, can you choose ANY doctor or MUST you choose one from a specific group or list of doctors?

1. Any doctor
2. Select from group/list
Refused
Don't know

[IF FHI.243=2,R,D, THEN SKIP to FHI.246]

FHI.244: Do you have the option of choosing a doctor from a preferred or select list at a lower cost?

1. Yes
2. No
Don't Know
Refused

[SKIP TO FHI.248]

FHI.246: If you select a doctor who is not in the plan, will the plan pay for any part of the cost?

1. Yes
2. No
Refused
Don’t know

FHI.248: When you need to go to a different doctor or place for special care, do you need approval or a referral? Do not include emergency care.

1. Yes
2. No
Don't Know
Refused

FHI.248.5: Does this plan REQUIRE you to have a primary care doctor or group of doctors for all routine care?

1. Yes
2. No
Don't Know
Refused

FHI.249.1: Does the plan pay for any of the costs for medicines prescribed by a doctor?

1. Yes
2. No
Don't Know
Refused

FHI.249.2: Does the plan for any of the costs for dental care?

1. Yes
2. No
Don't Know
Refused

COVERAGE HISTORY PATHWAY

FHI.300: In the PAST 12 MONTHS, was there any time when you did NOT have ANY health insurance or coverage?

1. Yes
2. No
Don't Know
Refused

[IF FHI.300=2,R,D, THEN SKIP TO FHI.320]

FHI.310: In the PAST 12 MONTHS, about how many months were you without coverage?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.320: The next question is about money that you have spent out of pocket on medical care. We do NOT want you to count health insurance premiums, over the counter drugs, or costs that you will be reimbursed for. In the PAST 12 MONTHS, about how much did [fill 2: you/your family] spend for medical care and dental care?

0. Zero
1. Less than $500
2. $500-$1,999
3. $2,000-$2,999
4. $3,000-$4,999
5. $5,000 or more
Refused
Don’t know

FHI.325: In the past 12 months did [fill1: you/anyone in the family] have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home or home care.

1. Yes
2. No
Refused
Don't know

FHI.327: Do you currently have any medical bills that are being paid off over time? This could include medical bills being paid off with a credit card, through personal loans, or bill paying arrangements with hospitals or other providers. The bills can be from earlier years as well as this year.

1. Yes
2. No
Refused
Don't know

FHI.330: [Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pre-tax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care. With this type of account, any money remaining in the account at the end of the year, following a short grace period, is lost to the employee.

1. Yes
2. No

FHI.050: Are you covered by any kind of health insurance or some other kind of health care plan?

1. Yes
2. No

Don't Know
Refused

[IF NO, and R is >/= to 65 years old, SKIP to FHI.072
IF NO, and R is <65 years old, SKIP to FHI.073]

FHI.070: What kind of health insurance or health care coverage do you have? INCLUDE those that pay for only one type of service (nursing home care, accidents, or dental care). EXCLUDE private plans that only provide extra cash while hospitalized.

1. Private health insurance
2. Medicare
3. Medi-Gap
4. Medicaid
5. SCHIP (CHIP/ Children's Health Insurance Program)
6. Military health care (TRICARE/VA/CHAMP-VA)
7. Indian Health Service
8. State-sponsored health plan
9. Other government program
10. Single service plan (e.g., dental, vision, prescriptions)
11. No coverage of any type

Don't Know
Refused

[IF R is >/= to 65 years old, and FHI.070 ne 2, GO TO FHI.072
IF R is <65 years old, and FHI.070 ne 4, SKIP TO FHI.073
IF FHI.070 = 2, 4, or 10, SKIP TO FHI.120]

FHI.072: Are you covered by Medicare?

1. Yes
2. No

Don't Know
Refused

[SKIP TO FHI.074]

FHI.073: There is a program called Medicaid that pays for health care for persons in need. In

this State it is also called (DC/MD/VA =Medical Assistance/Medical Assistance Program, Healthchoice, or REM Program/Virginia Medallion or Medallion 2). Are you covered by Medicaid?

1. Yes
2. No
Don't Know
Refused

FHI.074: Do you have any type of insurance that pays for only one type of service such as dental, vision, or prescriptions?

1. Yes
2. No
Don't Know
Refused

MEDICAID PATHWAY
[GO TO FHI.120 IF FHI.073=1 OR IF FHI.070=4.
ALL OTHERS, SKIP TO FHI.160]

FHI.120: The next questions are about Medicaid coverage. In this State it is also called (DC/MD/VA= Medical Assistance/Medical Assistance Program, Healthchoice, or REM Program/Virginia Medallion or Medallion 2). You are listed as having Medicaid coverage. Can you go to ANY doctor who will accept Medicaid or MUST choose from a book or list of doctors or is a doctor assigned?

1. Any doctor
2. Select from book/list
3. Doctor is assigned
Refused
Don’t know

[IF=1, SKIP TO FHI.135
IF=2 SKIP TO FHI.130
IF=3, GO TO FHI.131]

FHI.130: What is the name of the health plan that provided the book or list?

1. [*OPEN RESPONSE*]
2. Refused
3. Don’t know

[SKIP TO FHI.135]

FHI.131: What is the name of the health plan that assigned the doctor?

1. [*OPEN RESPONSE*]
2. Refused
3. Don’t know

FHI.135: Was your Medicaid obtained through Healthcare.gov or the [DC/MD/VA= Health Insurance Marketplace, such as DC Health Link/ Health Insurance Marketplace, such as Maryland Health Connection/Health Insurance Marketplace]?

1. Yes
2. No

Don't know
Refused

FHI.137_2: Under your Medicaid plan is there an enrollment fee or premium?

1. Yes
2. No

Don't know
Refused

[IF=2,D,or R, SKIP TO FHI.140]

FHI.137_3: Is the premium paid for this Medicaid plan based on income?

1. Yes
2. No

Don't know
Refused

FHI.140: Are you required to sign up with a certain primary care doctor, group of doctors, or certain clinic which you must go to for all of your routine care? Do not include emergency care or care from a specialist you were referred to.

1. Yes
2. No

Don't know
Refused

FHI.150: Under your Medicaid plan, if you to go to a different doctor or place for special care do you need approval or a referral? Do not include emergency care.

1. Yes
2. No

Don't know
Refused

[SKIP TO FHI.300]

PRIVATE PATHWAY

FHI.160: The next questions are about private health insurance plans. These plans can be obtained through work, purchased directly, or through a state or local government program or community program.

It is important that we record the complete and accurate name of each health insurance plan. What is the COMPLETE name of the first plan? Do NOT include plans that only provide extra cash while in the hospital or plans that pay for only one type of service, such as nursing home care, accidents, or dental care.

1. [*OPEN RESPONSE.* ***USE AS FILL1 BELOW***]
Refused
Don't know

FHI.170: Which family members are covered by ***FILL1-n***?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.171: Are there any more private health insurance plans?

1. Yes
2. No
Refused
Don't Know

[IF=1, THEN GO TO FHI.172;
IF=2,D, R, SKIP TO FHI.200]

FHI.172: What is the name of the next plan?

1. [*OPEN RESPONSE.* ***USE AS FILL2-n BELOW***]
Refused
Don't know

[LOOP FHI.170-FHI.172 UNTILL FHI.171=2]

FHI.200: I would like to ask you about [your private plan/Plan X (if multiple plans)]. Health insurance plans are usually obtained in one person's name even if other family members are covered. That person is called the policyholder. In whose name is this plan?

7. Respondent's Name
8. Household member
9. Non-Household member
Refused

Don’t Know

[IF FHI.200=1, THEN SKIP TO FHI.204
ELSE CONTINUE TO FHI.2002]

FHI.202: How are you related to the policyholder?

9. Child (including Stepchild)
10. Spouse
11. Former Spouse
12. Some other relationship
Refused
Don't know

FHI.204: Does this plan cover anyone else who does not live here?

3. Yes
4. No
Refused
Don't know

FHI.210: Which one of these categories best describes how this plan was obtained?

1. Through employer
2. Through union
3. Through workplace, but don't know if employer or union
4. Through workplace, self-employed or professional association
5. Purchased directly
6. Through a state/local government or community program
7. Other (specify)
Refused
Don't know

[If FHI.210=1-4, THEN SKIP to FHI.220,
IF FHI.210=5,6,D,R THEN SKIP to FHI.215
IF FHI.210=7, THEN CONTINUE TO FHI.210.1]

FHI.210.1: How was this plan obtained?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.215: Was the plan obtained through the Healthcare.gov or the [DC/MD/VA= Health Insurance Marketplace, such as DC Health Link/ Health Insurance Marketplace, such as Maryland Health Connection/Health Insurance Marketplace]?

1. Yes

2. No
Refused
Don't know

BLS.1: Is this policy a platinum, gold, silver, bronze, or catastrophic plan?

11. Platinum plan
12. Gold plan
13. Silver plan
14. Bronze plan
15. Catastrophic plan
Refused
Don't know

FHI.220: Who pays for this health insurance plan? [ALL THAT APPLY]

1. Self or Family (living in the household)
2. Employer or Union
3. Someone outside the household
4. Medicare
5. Medicaid
6. CHIP (SCHIP/Children's Health Insurance Program)
7. State or local government or community program
Refused
Don't know

[IF FHI.220=4-7,R, THEN SKIP TO FHI.240]

QDRL.8: Your health insurance premium is the amount you or a family member pays each month or year for health insurance coverage. Do you or a family member pay a premium for your health insurance?

1. Yes
2. No
Refused
Don't know

[IF QDRL.8=2, THEN SKIP TO QDRL12]

QDRL.9: Do you or a family member receive a benefit from an employer to help pay for a portion of your premium?

1. Yes
2. No
Refused
Don't know

QDRL.11: Do you receive any benefits from the government, such as a tax credit, to help pay for a portion of your premium?

1. Yes
2. No
Refused
Don't know

QDRL.10: Does the amount of your premium depend on your family's income?

1. Yes
2. No
Refused
Don't know

QDRL.12: A co-pay is the flat fee you pay for each visit to your doctor or to another health care service provider. Does your health insurance require you to pay a co-pay?

1. Yes
2. No
Refused
Don't know

QDRL.13: Your deductible is the amount you must pay out of your own pocket each year before your health insurance begins paying for health care services. Does your health insurance have a deductible?

1. Yes
2. No
Refused
Don't know

[IF FHI.220 includes 1, then CONTINUE TO FHI.230;
IF FHI.220 includes 2, but not 1, THEN SKIP TO FHI.235;
ELSE, SKIP TO FHI.240]

FHI.230: How much do you currently spend for health insurance premiums for your plan? Please include payroll deductions for premiums.

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.231: How often do you have to pay the premium for this plan?

1. Once a week
2. Once every 2 weeks
3. Once a month
4. Twice a month
5. Every two months
6. Quarterly (every 3 months)
7. Once a year
8. Twice a year
Refused
Don't know

[IF FHI.220 includes 2, then CONTINUE TO FHI.235;
ELSE, SKIP TO FHI.240]

FHI.235: Do you know how much the employer or union is paying for your plan?

1. Yes
2. No
Refused
Don't know

[IF FHI.235=2,R,D, THEN SKIP TO FHI.240]

FHI.237: How much does the employer or union currently pay for health insurance premiums for your plan?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.238: How often does the employer or union pay the premium for this plan?

1. Once a week
2. Once every 2 weeks
3. Once a month
4. Twice a month
5. Every two months
6. Quarterly (every 3 months)
7. Once a year
8. Twice a year
Refused
Don't know

FHI.240: Is [fill 1] an HMO (Health Maintenance Organization), an IPA (Individual Practice Association), a PPO (Preferred Provider Organization), a POS (Point-Of-Service), fee-for-service or is it some other kind of plan?

1. HMO/IPA
2. PPO
3. POS
4. Fee-for-service
5. Other
Refused
Don’t know

[IF only 1 person is covered by the plan, ASK FHI.241_VERSION_A;
IF more than 1 person is covered by the plan, ASK FHI.241_VERSION_B]

FHI.241: VERSION_A: Is the annual deductible for medical care for this plan less than $1,250 or $1,250 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.

VERSION_B: Is the family annual deductible for medical care for this plan less than $2,500 or $2,500 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.

1. Less than [$1,250/$2,500]
2. [$1,250/$2,500] or more
Refused
Don’t know

[IF FHI.241=1,R,D, THEN SKIP TO FHI.243]

FHI.242: With this plan, is there a special account or fund that can be used to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and are different from Flexible Spending Accounts.

1. Yes
2. No
Refused
Don’t know

FHI.243: Under this plan, can you choose ANY doctor or MUST you choose one from a specific group or list of doctors?

1. Any doctor
2. Select from group/list
Refused
Don’t know

[IF FHI.243=2,R,D, THEN SKIP to FHI.246]

FHI.244: Do you have the option of choosing a doctor from a preferred or select list at a lower cost?

1. Yes
2. No
Don't Know
Refused

[SKIP TO FHI.248]

FHI.246: If you select a doctor who is not in the plan, will the plan pay for any part of the cost?

1. Yes
2. No
Refused
Don’t know

FHI.248: When you need to go to a different doctor or place for special care, do you need approval or a referral? Do not include emergency care.

1. Yes
2. No
Don't Know
Refused

FHI.248.5: Does this plan REQUIRE you to have a primary care doctor or group of doctors for all routine care?

1. Yes
2. No
Don't Know
Refused

FHI.249.1: Does the plan pay for any of the costs for medicines prescribed by a doctor?

1. Yes
2. No
Don't Know
Refused

FHI.249.2: Does the plan pay for any of the costs for dental care?

1. Yes
2. No
Don't Know
Refused

COVERAGE HISTORY PATHWAY

FHI.300: In the PAST 12 MONTHS, was there any time when you did NOT have ANY health insurance or coverage?

1. Yes
2. No
Don't Know
Refused

[IF FHI.300=2,R,D, THEN SKIP TO FHI.320]

FHI.310: In the PAST 12 MONTHS, about how many months were you without coverage?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.320: The next question is about money that you have spent out of pocket on medical care. We do NOT want you to count health insurance premiums, over the counter drugs, or costs that you will be reimbursed for. In the PAST 12 MONTHS, about how much did [fill 2: you/your family] spend for medical care and dental care?

0. Zero
1. Less than $500
2. $500-$1,999
3. $2,000-$2,999
4. $3,000-$4,999
5. $5,000 or more
Refused
Don’t know

FHI.325: In the past 12 months did [fill1: you/anyone in the family] have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home or home care.

1. Yes
2. No
Refused
Don't know

FHI.327: Do you currently have any medical bills that are being paid off over time? This could include medical bills being paid off with a credit card, through personal loans, or bill paying arrangements with hospitals or other providers. The bills can be from earlier years as well as this year.

1. Yes
2. No

Refused
Don't know

FHI.330: Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pre-tax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care. With this type of account, any money remaining in the account at the end of the year, following a short grace period, is lost to the employee.

1. Yes
2. No

FHI.050: Are you covered by any kind of health insurance or some other kind of health care plan?

1. Yes
2. No

Don't Know
Refused

[IF NO, and R is >/= to 65 years old, SKIP to FHI.072
IF NO, and R is <65 years old, SKIP to FHI.073]

FHI.070: What kind of health insurance or health care coverage do you have? INCLUDE those that pay for only one type of service (nursing home care, accidents, or dental care). EXCLUDE private plans that only provide extra cash while hospitalized.

1. Private health insurance
2. Medicare
3. Medi-Gap
4. Medicaid
5. SCHIP (CHIP/ Children's Health Insurance Program)
6. Military health care (TRICARE/VA/CHAMP-VA)
7. Indian Health Service
8. State-sponsored health plan
9. Other government program
10. Single service plan (e.g., dental, vision, prescriptions)
11. No coverage of any type

Don't Know
Refused

[IF R is >/= to 65 years old, and FHI.070 ne 2, GO TO FHI.072
IF R is <65 years old, and FHI.070 ne 4, SKIP TO FHI.073
IF FHI.070 = 2, 4, or 10, SKIP TO FHI.120]

FHI.072: Are you covered by Medicare?

1. Yes
2. No

Don't Know
Refused

[SKIP TO FHI.074]

FHI.073: There is a program called Medicaid that pays for health care for persons in need. In

this State it is also called (DC/MD/VA =Medical Assistance/Medical Assistance Program, Healthchoice, or REM Program/Virginia Medallion or Medallion 2). Are you covered by Medicaid?

1. Yes
2. No
Don't Know
Refused

FHI.074: Do you have any type of insurance that pays for only one type of service such as dental, vision, or prescriptions?

1. Yes
2. No
Don't Know
Refused

MEDICAID PATHWAY
[GO TO FHI.120 IF FHI.073=1 OR IF FHI.070=4.
ALL OTHERS, SKIP TO FHI.160]

FHI.120: The next questions are about Medicaid coverage. In this State it is also called (DC/MD/VA= Medical Assistance/Medical Assistance Program, Healthchoice, or REM Program/Virginia Medallion or Medallion 2). You are listed as having Medicaid coverage. Can you go to ANY doctor who will accept Medicaid or MUST choose from a book or list of doctors or is a doctor assigned?

1. Any doctor
2. Select from book/list
3. Doctor is assigned
Refused
Don't know

[IF=1, SKIP TO FHI.135
IF=2 SKIP TO FHI.130
IF=3, GO TO FHI.131]

FHI.130: What is the name of the health plan that provided the book or list?

1. [*OPEN RESPONSE*]
2. Refused
3. Don't know

[SKIP TO FHI.135]

FHI.131: What is the name of the health plan that assigned the doctor?

1. [*OPEN RESPONSE*]
2. Refused
3. Don’t know

FHI.135: Was your Medicaid obtained through Healthcare.gov or a state Health Insurance Marketplace?

1. Yes
2. No
Don't know
Refused

FHI.137_2: Under your Medicaid plan is there an enrollment fee or premium?

1. Yes
2. No
Don't know
Refused

[IF=2,D,or R, SKIP TO FHI.140]

FHI.137_3: Is the premium paid for this Medicaid plan based on income?

1. Yes
2. No
Don't know
Refused

FHI.140: Are you required to sign up with a certain primary care doctor, group of doctors, or certain clinic which you must go to for all of your routine care? Do not include emergency care or care from a specialist you were referred to.

1. Yes
2. No
Don't know
Refused

FHI.150: Under your Medicaid plan, if you to go to a different doctor or place for special care do you need approval or a referral? Do not include emergency care.

1. Yes
2. No
Don't know
Refused

[SKIP TO FHI.300]

PRIVATE PATHWAY

FHI.160: The next questions are about private health insurance plans. These plans can be obtained through work, purchased directly, or through a state or local government program or community program.

It is important that we record the complete and accurate name of each health insurance plan. What is the COMPLETE name of the first plan? Do NOT include plans that only provide extra cash while in the hospital or plans that pay for only one type of service, such as nursing home care, accidents, or dental care.

1. [*OPEN RESPONSE*. ***USE AS FILL1 BELOW***]
Refused
Don't know

FHI.170: Which family members are covered by ***FILL1-n***?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.171: Are there any more private health insurance plans?

1. Yes
2. No
Refused
Don't Know

[IF=1, THEN GO TO FHI.172;
IF=2,D, R, SKIP TO FHI.200]

FHI.172: What is the name of the next plan?

1. [*OPEN RESPONSE*. ***USE AS FILL2-n BELOW***]
Refused
Don't know

[LOOP FHI.170-FHI.172 UNTILL FHI.171=2]

FHI.200: I would like to ask you about [your private plan/Plan X (if multiple plans)]. Health insurance plans are usually obtained in one person's name even if other family members are covered. That person is called the policyholder. In whose name is this plan?

10. Respondent's Name
11. Household member
12. Non-Household member
Refused
Don't Know

[IF FHI.200=1, THEN SKIP TO FHI.204
ELSE CONTINUE TO FHI.2002]

FHI.202: How are you related to the policyholder?

13. Child (including Stepchild)
14. Spouse
15. Former Spouse
16. Some other relationship
Refused
Don't know

FHI.204: Does this plan cover anyone else who does not live here?

5. Yes
6. No
Refused
Don't know

FHI.210: Which one of these categories best describes how this plan was obtained?

1. Through employer
2. Through union
3. Through workplace, but don't know if employer or union
4. Through workplace, self-employed or professional association
5. Through Healthcare.gov, or the Affordable Care Act, sometimes known as Obamacare
6. Purchased directly
7. Through a state/local government or community program
8. Other (specify)
Refused
Don't know

[If FHI.210=1-4, THEN SKIP to FHI.220,
IF FHI.210=5, then skip to BLS 1
IF FHI.210=6,7,D,R THEN SKIP to FHI.215
IF FHI.210=8, THEN CONTINUE TO FHI.210.1]

FHI.210.1: How was this plan obtained?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.215: Was the plan obtained through the Healthcare.gov or the [DC/MD/VA= Health Insurance Marketplace, such as DC Health Link/ Health Insurance Marketplace, such as Maryland Health Connection/Health Insurance Marketplace]?

1. Yes
2. No
Refused
Don't know

[IF FHI.215=2,D,R, THEN SKIP TO FHI.220
IF FHI.215=1, THEN CONTINUE TO BLS.1]

BLS.1: Is this policy a platinum, gold, silver, bronze, or catastrophic plan?

16. Platinum plan
17. Gold plan
18. Silver plan
19. Bronze plan
20. Catastrophic plan
Refused
Don't know

FHI.220: Who pays for this health insurance plan? [ALL THAT APPLY]

1. Self or Family (living in the household)
2. Employer or Union
3. Someone outside the household
4. Medicare
5. Medicaid
6. CHIP (SCHIP/Children's Health Insurance Program)
7. State or local government or community program
Refused
Don't know

[IF FHI.220=4-7,R, THEN SKIP TO FHI.240]

QDRL.8: Your health insurance premium is the amount you or a family member pays each month or year for health insurance coverage. Do you or a family member pay a premium for your health insurance?

1. Yes
2. No
Refused
Don't know

[IF QDRL.8=2, THEN SKIP TO QDRL12]

QDRL.9: Does your employer help pay for any part of your health insurance?

1. Yes

2. No
Refused
Don't know

QDRL.11: Do you receive any benefits from the government, such as a tax credit, to help pay for a portion of your premium?

1. Yes
2. No
Refused
Don't know

QDRL.10: Does the amount of your premium depend on income?

1. Yes
2. No
Refused
Don't know

QDRL.12: A co-pay is the flat fee you pay for each visit to your doctor or to another health care service provider. Does your health insurance require you to pay a co-pay?

1. Yes
2. No
Refused
Don't know

QDRL.13: Your deductible is the amount you must pay out of your own pocket each year before your health insurance begins paying for health care services. Does your health insurance have a deductible?

1. Yes
2. No
Refused
Don't know

[IF only 1 person is covered by the plan, ASK FHI.241_VERSION_A;
IF more than 1 person is covered by the plan, ASK FHI.241_VERSION_B]

FHI.241: VERSION_A: Is the annual deductible for medical care for this plan less than $1,250 or $1,250 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.

VERSION_B: Is the family annual deductible for medical care for this plan less than $2,500 or $2,500 or more? If there is a separate deductible for prescription drugs, hospitalization, or out-of-network care, do not include those deductible amounts here.

1. Less than [$1,250/$2,500]
2. [$1,250/$2,500] or more
Refused
Don't know

[IF FHI.241=1,R,D, THEN SKIP TO FHI.230]

FHI.242: With this plan, is there a special account or fund that can be used to pay for medical expenses? The accounts are sometimes referred to as Health Savings Accounts (HSAs), Health Reimbursement Accounts (HRAs), Personal Care accounts, Personal Medical funds, or Choice funds, and are different from Flexible Spending Accounts.

1. Yes
2. No
Refused
Don't know

[IF FHI.220 includes 1, then CONTINUE TO FHI.230;
IF FHI.220 includes 2, but not 1, THEN SKIP TO FHI.235;
ELSE, SKIP TO FHI.240]

FHI.230: How much do you currently spend for health insurance premiums for your plan? Please include payroll deductions for premiums.

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.231: How often do you have to pay the premium for this plan?

1. Once a week
2. Once every 2 weeks
3. Once a month
4. Twice a month
5. Every two months
6. Quarterly (every 3 months)
7. Once a year
8. Twice a year
Refused
Don't know

[IF FHI.220 includes 2, then CONTINUE TO FHI.235;
ELSE, SKIP TO FHI.240]

FHI.235: Do you know how much the employer or union is paying for your plan?

1. Yes
2. No
Refused
Don't know

[IF FHI.235=2,R,D, THEN SKIP TO FHI.240]

FHI.237: How much does the employer or union currently pay for health insurance premiums for your plan?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.238: How often does the employer or union pay the premium for this plan?

1. Once a week
2. Once every 2 weeks
3. Once a month
4. Twice a month
5. Every two months
6. Quarterly (every 3 months)
7. Once a year
8. Twice a year
Refused
Don't know

FHI.240: Is [fill 1] an HMO (Health Maintenance Organization), an IPA (Individual Practice Association), a PPO (Preferred Provider Organization), a POS (Point-Of-Service), fee-for-service or is it some other kind of plan?

1. HMO/IPA
2. PPO
3. POS
4. Fee-for-service
5. Other
Refused
Don't know

FHI.243: Under this plan, can you choose ANY doctor or MUST you choose one from a specific group or list of doctors?

1. Any doctor
2. Select from group/list

Refused
Don’t know

[IF FHI.243=2,R,D, THEN SKIP to FHI.246]

FHI.244: Do you have the option of choosing a doctor from a preferred or select list at a lower cost?

1. Yes
2. No
Don't Know
Refused

[SKIP TO FHI.248]

FHI.246: If you select a doctor who is not in the plan, will the plan pay for any part of the cost?

1. Yes
2. No
Refused
Don’t know

FHI.248: When you need to go to a different doctor or place for special care, do you need approval or a referral? Do not include emergency care.

1. Yes
2. No
Don't Know
Refused

FHI.248.5: Does this plan REQUIRE you to have a primary care doctor or group of doctors for all routine care?

1. Yes
2. No
Don't Know
Refused

FHI.249.1: Does the plan pay for any of the costs for medicines prescribed by a doctor?

1. Yes
2. No
Don't Know
Refused

FHI.249.2: Does the plan pay for any of the costs for dental care?

1. Yes
2. No
Don't Know
Refused

COVERAGE HISTORY PATHWAY

FHI.300: In the PAST 12 MONTHS, was there any time when you did NOT have ANY health insurance or coverage?

1. Yes
2. No
Don't Know
Refused

[IF FHI.300=2,R,D, THEN SKIP TO FHI.320]

FHI.310: In the PAST 12 MONTHS, about how many months were you without coverage?

1. [*OPEN RESPONSE*]
Refused
Don't know

FHI.320: The next question is about money that you have spent out of pocket on medical care. We do NOT want you to count health insurance premiums, over the counter drugs, or costs that you will be reimbursed for. In the PAST 12 MONTHS, about how much did [fill 2: you/your family] spend for medical care and dental care?

0. Zero
1. Less than $500
2. $500-$1,999
3. $2,000-$2,999
4. $3,000-$4,999
5. $5,000 or more
Refused
Don’t know

FHI.325: In the past 12 months did [fill1: you/anyone in the family] have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home or home care.

1. Yes
2. No
Refused
Don't know

FHI.327: Do you currently have any medical bills that are being paid off over time? This could include medical bills being paid off with a credit card, through personal loans, or bill paying arrangements with hospitals or other providers. The bills can be from earlier years as well as this year.

1. Yes
2. No
Refused
Don't know

FHI.330: [Do you/Does anyone in your family] have a Flexible Spending Account for health expenses? These accounts are offered by some employers to allow employees to set aside pre-tax dollars of their own money for their use throughout the year to reimburse themselves for their out-of-pocket expenses for health care.

1. Yes
2. No
Refused
Don't Know