Final Interim Report
Utah State Planning Grant

Utah Department of Health

Prepared for:
Secretary Tommy G. Thompson, U.S. Department of Health and Human Services

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Executive Summary

The state of Utah is currently conducting a number of activities as part of the State Planning Grant process. The activities we have undertaken reflect the goals of the project.

The project goals are:

? Gain a greater understanding of the uninsurance problem in the state of Utah
? Develop proposals for addressing the problem of the uninsured
? Develop recommendations for Federal action to support State efforts to provide health insurance for the uninsured

Current efforts to better understand the extent of the uninsurance problem in the state of Utah include a review of currently available data including the 1996 Utah Health Status Survey (UHSS), and the Current Population Survey data for Utah as well as the nation. Several new questions about insurance coverage and access to health care were added to the 2001 version of the UHSS. Data from the UHSS will be available in December 2001.

Many new data collection efforts have also been undertaken by the Utah State Planning Grant project. A survey of Utah small employers is currently underway. This survey will provide previously unavailable information comparing the characteristics of those companies presently offering coverage to those companies that do not offer health care coverage to their employees. This survey will also provide valuable information about the factors effecting an employer's decision to offer health care coverage.

One of the more unique data collection efforts of the project is a discrete choice analysis. Discrete choice analysis uses advanced modeling techniques to provide a better understanding of the values and preferences of a target population. Individuals with and without health care coverage as well as small employers are being surveyed using the discrete choice technique. The results of the discrete choice analysis will help us to identify key factors effecting the decision to take up a specific benefits package across a range of price points. Discrete choice will also be used to ensure that the proposals are designed to minimize crowd out by asking insured respondents to "choose" between their present coverage and several proposed options.

Qualitative data is being collected through the use of employer and individual focus groups. The focus groups will be targeted at urban and rural regions as well as a number of income categories and industry sectors. Key informant interviews are also being planned for health care industry representatives across the state.

The project has organized a number of efforts to develop viable policy options for the state of Utah. The project steering committee has played a key role in this process by authoring the projects guiding principles. The steering committee will also be responsible for evaluating the proposals developed by our project workgroups.

A number of community representatives have participated in the project workgroups. The workgroups were charged with developing viable proposals that were brought before, and evaluated by, the steering committee.

Several of the proposals evaluated by the steering committee shared key components. The committee recommended that we move forward with two key proposals combining these proposals with elements taken from the other proposals in an attempt to fashion a more comprehensive solution.

The workgroup members and small "Consultation Teams" are now working to fashion the proposals in a manner that would allow then to be implemented in a stepped or graduated fashion.

The specific proposals presently under consideration include the following:

1. Primary Care Net work Proposal (1115 waivers)
2. CHIP Expansion to Parents (1115 waiver)
3. 1931 Expansion of Medicaid to Parents
4. Employer Cost Sharing Model

The Primary Care Network proposal would offer a primary care benefit package to a newly eligible population of adults who do not qualify for Medicaid. This model is akin to a "family physician" model. This Primary Care Network program will provide basic and general health care services to people seeking assistance for screenings to identify or prevent illness and disease or needing treatment for common illness or injury. It will also provide care for the management of chronic disease. The Primary Care Network proposal would be made available to all adults earning up to 200% of Federal Poverty Level (FPL).

We are soon to begin work on developing an outline of possible proposals to expand CHIP coverage to parents earning up to 200% of FPL (1115 waiver) or to expand Medicaid coverage to parents earning up to 100% of FPL (1931 waiver). The most significant barrier to these two proposals is funding.

Finally, we are looking at the cost-sharing model currently in use by Muskegon County Michigan as a possible adjunct to our PCN proposal. The cost sharing model uses an equally distributed three-way cost share between state, employer and employees to bring insurance coverage to within the reach of businesses that employee a disproportionate number of low income workers.

Regarding Federal action to support state efforts to provide health insurance for the uninsured, recommendations will be included as part of our Final project report. These recommendations will be more specific and meaningful after we have had an opportunity to more fully develop our proposals and to review the data we are presently collecting.

Section 1. Summary of Findings: Uninsured Individuals and Families

The purpose of this section is to describe (1) who the uninsured are in your State; (2) what strategy was used to obtain this information; and (3) how these findings are reflected in the coverage options that your State has selected or is currently considering. In discussing your survey findings, please be sure to link the results directly to your State's coverage expansion strategy.

More detailed survey findings (reports, spreadsheets, etc.), as well as survey instruments and other descriptions of the research methodology, should be referenced in Appendix II.

Questions 1.1 through 1.3 focus on the ***quantitative*** *research work conducted by the State. If possible, please use the Current Population Survey definitions and data breaks, even if alternate data sources are used. This will allow comparisons across all states in the summary report.*

1.1 What is the overall level of uninsurance in your State?

The Utah Department of Health released a report in June 2001 entitled Estimating Utah's Uninsured (Office of Public Health Assessment). Since that report was published, the U.S. Bureau of the Census has released additional estimates for population counts and percentage uninsured. The information presented below reflects the up-to-date information on the number of Utahns uninsured and their reasons for being uninsured.

How Many Utahns are Uninsured?

The most precise information on Utahns comes from the Utah Health Status Survey. The survey has been conducted every five years since 1986, and has a much larger sample size than national surveys on the subject. As of this writing, the 2001 Utah Health Status Survey data are still being collected and results will be available later this year.

We can use the 1996 Utah Health Status Survey as a baseline, and project it forward using the trend information available from the Current Population Survey (CPS), conducted each year by the U.S. Bureau of the Census.[1] The CPS is not directly comparable with the Health Status Survey and the CPS produces higher percentages of uninsured (13.4% of Utahns, 296,000 persons). Although these estimates are the best we have right now, we will have more confidence in our estimates from the 2001 Health Status Survey.

1996 Utah Health Status Survey (HSS) Estimate for Persons Without Insurance Coverage, Projected Forward Using CPS Trend Information, Utah 1996-2000[2]

	Percentage Uninsured	Number of Persons # Insured	# Uninsured	Population
2000	11.0%	1,987,608	**245,561**	2,233,169
2000	11.0%	1,964,317	**242,683**	2,207,000
1999	10.9%	1,897,862	**231,974**	2,129,836
1998	10.6%	1,877,239	**223,323**	2,100,562
1997	10.1%	1,857,453	**207,944**	2,065,397
1996	9.5%	1,829,532	**192,721**	2,022,253

Population estimate from 2000 U.S. Census

Population estimates & projections from U.S. Census Bureau prior to 2000 decennial census

How Many Children Are Uninsured?

Here again, the CPS produces estimates that are higher than those produced by Utah Department of Health surveys (11.1% and 10.0% in 1996 and 2000 compared with 8.6% and 6.5% as measured by the UHSS surveys in the same years). However, UDOH epidemiologists and survey methodologists believe that the "point in time" method used by the Department produces more valid results than the method used by the CPS. Also worth repeating, is that although these estimates are the best we have right now, we will have more confidence in our estimates from the 2001 Health Status Survey. The table, below, is one reproduced from Estimating Utah's Uninsured, June 2001.

Estimates of the Percentage and Number of Children Who Lacked Health Insurance Coverage by Poverty Level of Child's Household, Utah Children Age 0-18, 2000[3]

Poverty Level of Child's Household	Total, All Children Age 0-18	Percentage of Children Who Lacked Insurance Coverage
At or Below 200% of Poverty	36.7% 283,400	12.9% 36,600
201% or Above	63.4% 489,900	2.5% 12,400
Total, All Children Age 0-18	100% 773,285	6.5% 50,500

At present, data for the 2001 UHSS has been collected from a total of 7125 households. The projected goal of the 2001 UHSS is 7250 households. Data for the 2001 survey should be available in December 2001.

1.2 What are the characteristics of the uninsured?

Income:

The 1996 UHHS examined annual household income and discovered that those earning between $25,000 and $35,000 annually represented the largest group in Utah's uninsured population (27% of the uninsured). The following table portrays Utah's uninsured in 1996 by annual household income.

1996 Uninsured by Annual Household Income		
Annual Household Income	Percent Who Are Uninsured	Distribution of Uninsured
Under $15,000	23.9%	17%
15,000 - 25,000	17.4%	23%
25,000 - 35,000	15.5%	27%
35,000 - 45,000	7.1%	14%
45,000 - 55,000	5.4%	8%
Over $55,000	3.7%	11%
Total	9.53%	100%

Age:

The 18-34 age group represented the largest group of Utah's uninsured at 43 percent, followed by those under 18 at 29 percent, 35-49 years of age at 20 percent, 50- 64 years of age at 7 percent, and lastly those over 64 represented 1 percent of the uninsured in the state.

1996 Uninsured by Age		
Age range	Percent Who Are Uninsured	Distribution of Uninsured
Under 18	8.6%	29.3%
18-34	14.9%	42.5%
35-49	9.5%	20.1%
50-64	6.1%	6.8%
Over 64	1.2%	1.2%
Totals	9.5%	100%

Gender:

In the 1996 UHSS, males were somewhat more likely to be uninsured than females.

1996 Uninsured by Gender		
Gender	Percent Who Are Uninsured	Distribution of Uninsured
Male	10.2%	53.4%
Female	8.9%	47.0%
Totals	9.5%	100.0%

Family composition:

The 1996 UHSS found that respondents who had "Never Married" were most likely to be uninsured (14.4%), followed by those who were "Divorced, Separated, Widowed" (12.5%). Respondents who were "Married, living as married" were the least likely to be uninsured (8.4%). However, because of the large percentage of people belonging to the "Married, living as married" category, this group accounted for 57.4% of all the uninsured in the state.

1996 Uninsured by Marital Status of Utah Adults		
Marital Status (age 18 and over)	Percent Who Are Uninsured	Distribution of Uninsured
Married, living as married	8.4%	57.4%
Divorced, Separated, Widowed	12.5%	16.8%
Never Married	14.4%	25.8%
Totals	9.8%	100.0%

Health status:

The 1996 UHSS found that respondents who reported being in "Fair/Poor" health were more likely to be uninsured (11.9%) than those reporting to be in "Good/Very Good/Excellent" health (9.4%).

1996 Uninsured by Health Status		
Health Status	Percent Who Are Uninsured	Distribution of Uninsured
Fair/Poor	11.9%	10.7%
Good/Very Good/Excellent	9.4%	89.3%
Totals	9.5%	100.0%

Employment status (including seasonal and part-time employment and multiple employers):

The 1996 UHSS found that respondents who reported being "Unemployed/Other" were the most likely to be uninsured (18.7%). Part-time workers (13.6% uninsured) and homemakers (12.0% uninsured) were the next most likely to be uninsured, followed by fulltime workers (9.7%) and students (8.7%). Retirees were the least likely to be uninsured (2.2%). Because of the large percentage of people working full time, this group accounted for 55.3% of all the uninsured in the state.

Information is being collected for the 2001 UHSS to address questions of seasonal employment as well as those working for multiple employers and their access to health care coverage.

1996 Uninsured by Employment Status		
Employment Status	Percent Who Are Uninsured	Distribution of Uninsured
Full Time	9.7%	55.3%
Part Time	13.6%	18.5%
Retired	2.2%	3.0%
Homemaker	12.0%	11.6%
Student[4]	8.7%	3.3%
Unemployed/Other	18.7%	8.4%
Totals	9.8%	100.0%

Availability of private coverage (including offered but not accepted):

Information about the overall availability of private coverage, including the refusal of coverage that was offered, is being collected with the 2001 UHSS and our employer surveys.

Availability of public coverage:

Information about the overall availability of public coverage is being collected with the 2001 UHSS and our employer surveys.

Race/ethnicity:

Data from the 1996 UHSS were insufficient to estimate insurance coverage for racial and ethnic minorities. This problem will be partially addressed by a Spanish language version of the Behavioral Risk Factor Surveillance Survey (BRFSS) that is presently being administered in the state. Data is available that shows Hispanic residents are more than twice as likely to be uninsured (21.4%) than Non-Hispanic residents of the state (8.8%).

1996 Percentage of Persons Who Were Uninsured By Hispanic Status			
	Percent of Utah Population	Percent Who Are Uninsured	Distribution of Uninsured
Hispanic	5.79%	21.4%	13.0%
Non-Hispanic	94.21%	8.8%	87.0%
Total	100%	9.5%	100%

Immigration status:

This information has not yet been summarized.

Geographic location (as defined by State -- urban/suburban/rural, county-level, etc.):

Over 77% of the population of Utah lives along the Wasatch Front. The Wasatch Front is a 100-mile corridor comprised of several urban areas including Salt Lake City, Ogden, Orem, and Provo.

Sampling methods used in the CPS do not permit sub-state estimates. The most recent evidence we have for urban and rural differences comes from the 1996 Utah Health Status Survey and the 2000 Child Health Survey. The Utah Health Status Survey found the highest percentages of persons without health insurance coverage in frontier areas of the state, but the 2000 Child Health Survey found no urban/rural differences.

Survey Estimates for Number And Percentage Uninsured by Local Health District, 1996 Utah Health Status Survey.

Health District	Total Population	Insured Persons	Uninsured Persons	% Without Health Insurance Coverage
Urban Districts				
Davis County	219,915	209,161	10,754	4.89%
Salt Lake	823,411	743,622	79,789	9.69%
Utah County	316,160	285,587	30,573	9.67%
Weber-Morgan	186,609	170,486	16,123	8.64%
Rural Districts				
Bear River	122,319	113,059	9,260	7.57%
Central	58,640	50,577	8,063	13.75%
Southeast	53,533	47,302	6,231	11.64%
Southwest	111,139	93,790	17,349	15.61%
Summit	22,414	20,823	1,591	7.10%
Tooele	16,934	15,513	1,421	8.39%
Uintah	38,523	32,101	6,422	16.67%
Wasatch	12,214	10,643	1,571	12.86%
State Total	1,991,811	1,801,991	189,820	9.53%

Utahns living along the more urban Wasatch Front were less likely to be uninsured (8.9%) compared to Utahns living in the more rural areas of Utah (11.6%).

1996 Percentage of Persons Who Were Uninsured By Residence in Wasatch Front Counties			
	Percent of Utah Population	Percent Who Are Uninsured	Distribution of Uninsured
Wasatch Front (Urban)	77.29%	8.9%	72.4%
Non-Wasatch Front (Rural)	22.71%	11.6%	27.6%
Total	100%	9.5%	100%

Duration of uninsurance:

Data from the 1996 UHSS indicates that the majority of uninsured in Utah fall into two categories, those that have been uninsured for less than six months (25.1%) and those that have been without insurance for four years or longer (37.5%).

Duration of Uninsurance	
Duration Uninsured	Percentage Distribution of Households (with uninsured members)
< 6 Months	25.1%
6 months - < 1 year	10.5%
1 year - < 2 years	12.8%
2 years - < 3 years	6.2%
3 years - < 4 years	7.9%
>= 4 years	37.5%
Totals	100%

Other(s):

Why Are Utahns Uninsured?

Here again, the best information we have is from our state-based surveys. The top two reasons in the two tables, below, were "Can't afford insurance," and "Employer doesn't offer insurance." Note that the percentages in the two tables are not directly comparable. Respondents to the 1996 Health Status Survey were allowed to choose only one, primary, reason, whereas respondents to the 2000 Child Health Survey were allowed to choose all reasons that applied to them.

Reasons Respondents Gave That a Household Member Lacked Health Insurance Coverage: 1996 Utah Health Status Survey

Could Not Afford Premium	40.86%
Employer Offers No Insurance	16.22%
Uninsurable	13.73%
Unemployed	8.59%
Don't nNeed/Don't Want	4.97%
Not on Job Long Enough	4.04%
Other	11.59%

Note: Respondents were allowed to choose only ONE, primary, reason for lack of insurance coverage.

Reasons Parents Gave That a Child Lacked Health Insurance Coverage: 2000 Utah Child Health Survey

Could Not Afford Premium	58.60%
Employer Offers No Insurance	35.30%
Lost or Changed Job	28.50%
Child's Good health	21.60%
Part Time Employment	13.40%
Lost Medicaid/CHIP Eligibility	12.30%
Uninsurable	3.10%

Note: Parents were allowed to choose as MANY reasons as applied to them.

In addition to the information provided above, we have augmented the 2001 UHSS with a number of insurance specific items. First, we have enhanced the 2001 version of the UHSS in the following ways:

- We are collecting information on the type of coverage for every person in the household (in 1996, we got insurance status for each person, but only primary type of insurance for the head of the household).
- We are using CPS-type classification for type of insurance (e.g., private/employer, Medicaid, Medicare).
- We are recording all types of insurance coverage for each person (not just primary type of coverage).
- For those who respond "no" to the insurance screener question, indicating that they do not have insurance, we are asking a follow-up question that lists all possible sources of insurance, and verifies that none of them is relevant in the household.
- We are asking specifically about CHIP, and include a question "preamble" that says that CHIP is a government-sponsored program for children of low-income working parents.
- We are asking two verification questions (insurance card size and frequency) to correctly classify whether persons are covered by Medicaid.

- We are asking whether the insurance plan(s) covering persons in the household cover ONLY special conditions, such as diabetes or breast cancer. This is done to distinguish these plans from more comprehensive plans, and get a better measure of overall health insurance coverage.
- For those who lack health insurance, we are asking about each of several reasons why they may not be covered. That is, instead of reciting the list and asking for the primary reason, we ask each reason separately, for each person in the household, and ask whether that reason applies to them.
- Several questions have been added that improve our ability to measure 1) access to medical, mental health, and dental care, 2) employment status, 3) employee take up of insurance plans offered at work, 4) ability to afford prescription medicines, and 5) fear that seeking health care or government assistance would jeopardize US residency status.
- Finally, our measure of household income has been improved in three ways that will improve (decrease) measurement error for poverty status: 1) smaller income categories, 2) an additional question about whether income was steady over the past year, and 3) an additional follow-up question about last month's income for persons whose annual income is not steady over the course of the year (we did this because we have problems with agreement with Medicaid's estimates of percentage of persons in poverty at any given time).

Perhaps the most unique aspect of our data collection efforts is the discrete choice analysis that we are conducting for both individuals and employers in Utah. Discrete Choice modeling uses sophisticated mathematics, theories in human choice behavior, and scientific design technologies. It involves collecting data from a carefully controlled sample to examine the influence that various factors have on the choices people make. This information will be used to build simulations that identify target groups who react differently to changes in various insurance product packages and predict how changes in key factors (i.e. benefit packages, cost sharing, provider availability, etc.) will influence future choices (uptake rates).

In our case, product packages would refer to various possible solutions for providing health care to the presently uninsured. Target groups we are interested in include individuals and employers. Discrete choice analysis will measure how each group might respond to a range of possible private insurance and publicly administered health care products. Individual respondents will be stratified and grouped by income level, employment status, rural versus urban residence, health status, and parental status. Employer respondents will be stratified and grouped by number of employees, urban or rural location, and industry.

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

Based on the 1996 UHSS, sub-populations with higher percentages of people without health insurance were:

1. Young adults age 18-34 years old (15 percent without health insurance)
2. Adults without a high school education (26 percent)
3. Persons in households with incomes less than $15,000 a year (24 percent)
4. Unemployed adults (19 percent)
5. Persons of Hispanic ethnicity (21 percent)[5]
6. Persons living outside the urban Wasatch Front (12 percent)
7. Residents of several more rural health districts (e.g., Tricounty and Southwest Utah Health Districts, 17 and 16 percent, respectively)
8. Persons who reported fair or poor health status (12 percent)

In brief, the expansion options chosen by our steering committee for continued review were evaluated according to a set of guiding principles developed by the committee at their first meeting. The target population of the uninsured earning less than 200% FPL was selected for reasons related to cost, need, and ability to pay.

The project's guiding principles are:

- Make Health Care Accessible to the Most People Possible, under 200%FPL
- Achieve Political and Fiscal Viability
- Cover Greatest Need First
- Preserve private sector investment in the financing of health care
- Promote individual responsibility for the cost of health care
- Solutions are workable and acceptable to target population

As more current data become available proposals that are currently under consideration will be modified to address the most urgent needs.

*Questions 1.4 through 1.13 focus primarily on the **qualitative** research work conducted by the State:*

1.4 What is affordable coverage? How much are the uninsured willing to pay?

The primary means by which we address the questions of affordable coverage and willingness/ability to pay for coverage include focus groups, discrete choice analysis and numerous meetings with a range of community advocates as well as business and community representatives. Discrete choice analysis will provide us with information about price elasticity for various benefits packages when offered to the uninsured. This information will be available for the final report.

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Similar to question 1.4, we are addressing the questions of non-participation in public programs through the use of focus groups, discrete choice analysis and numerous meetings with a range of community advocates as well as business and community representatives. This information will be available for the final report.

1.6 Why do uninsured individuals and families disenroll from public programs?

Information on disenrollment from public programs will be gathered through focus groups with individuals and employers.

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

Information on non-participation in employer sponsored plans will be gathered through focus groups with individuals and employers.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

The primary avenue for collecting information on the role individuals would like for their employers to play will be our focus groups. Some information will also be available from our discrete choice analysis.

1.9 How likely are individuals to be influenced by:

Availability of subsidies?:
Tax credits or other incentives?:

Data on the influence of subsidies, tax credits, or other incentives would be collected through the use of focus groups.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

This question is being addressed through focus groups as well as items on the 2001 UHSS.

1.11 How are the uninsured getting their medical needs met?

Focus groups, low income advocates and providers (including hospitals) are our primary sources of data to answer this question. We will also be collecting information with the 2001 UHSS that will help to address this question.

1.12 What is a minimum benefit?

Focus groups, low income advocates and providers are contributing a significant amount of input on this question. Our discrete choice analysis will also be a rich source of information as various combinations of benefit packages will be compared according to their attractiveness (predicted take up rates) to both employers and individuals.

1.13 How should underinsured be defined? How many of those defined as "insured" are underinsured?

This is a question that is currently being debated by our steering committee. Input is also being sought from community advocates and providers.

Section 2. Summary of Findings: Employer-based Coverage

The purpose of this section is to document your State's research activities related to employer-based coverage: (1) what is the state of employer-based coverage? (2) how was the information obtained (surveys, focus groups, etc.)?; and (3) how are the findings reflected in the coverage options that have been selected (or are being considered) by the State?

*Questions within 2.1 focus on the **quantitative** research work conducted by the State:*

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

In addition to information regarding whether or not the company offers healthcare coverage, our employer survey will allow a comparison of companies that offer insurance versus those that do not by the following background information:

- How long the company has been in business
- Gross payroll amount
- Rural- or urban-based
- Percent of employees on the job for: < 1 year; 1-5 years; 6-10 years; >10 years
- Employee profile by age
- Whether or not the company offers a range of other benefits including Disability coverage, Retirement plans, Flexible Spending Accounts for health care, paid sick leave, paid vacations, Wellness Programs or exercise facilities, Term Life Insurance, and Medicare Supplemental coverage.

- Number/percentage of full-time, part-time, and seasonal or temporary workers:
- Industry sector (by SIC code and through self report)
- Employee wages
- Geographic location (urban versus rural)

For those employers offering coverage, please discuss the following:

Cost of policies:

Companies offering employee health care coverage are asked to provide information for up to three company plans. Companies with more than three plans are asked to provide information for the three with the highest employee enrollment.

The employer survey asks the following questions:

What is the total premium for an employee with employee-only coverage?
What is the total premium for an employee with family (employee, spouse, and dependents) coverage?

Level of contribution:

Employers are also asked to report the following:

How much of the total premium for employee-only coverage is paid for by the employee?
How much of the total premium for family coverage is paid for by the employee?

Percentage of employees offered coverage who participate:

The following items on the employer survey address the question of employee participation in employer offered plans:

How many employees are currently **eligible** for this plan?

Full-time employees	_____
Part-time employees	_____
Temporary or seasonal employees	_____
COBRA	_____
Retirees age 65 and over	_____
Retirees under age 65	_____

How many employees are currently **enrolled** in this plan?

Full-time employees	_____
Part-time employees	_____
Temporary or seasonal employees	_____
COBRA	_____
Retirees age 65 and over	_____
Retirees under age 65	_____

*Questions 2.2 through 2.7 focus primarily on the **qualitative** research work conducted by the State:*

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

Information addressing the factors influencing employers' decisions to offer coverage is being collected through our employer focus groups, discrete choice analysis, and the following items on our employer survey:

- Approximately how many of your competitors offer healthcare coverage for their workers?
- On a scale of 1 to 7 where 1 is not important and 7 is extremely important, how important do you think is it for all working Utahns and their families to have healthcare coverage?
- In your opinion, what percentage of a worker's health insurance premiums should be paid by the employer?
- In your opinion, what percentage of a worker's health insurance premiums should be paid by the individual worker?
- For each of the following statements, indicate whether you strongly agree, somewhat agree, are unsure, somewhat disagree, or strongly disagree:
  - Providing health insurance to more Utahns would make financial sense overall.
  - Businesses pay in other ways if they don't provide healthcare coverage for their employees.
  - Employees see healthcare coverage as part of their compensation.
  - Uninsured workers get the same quality of healthcare as those with healthcare coverage.
  - The benefits of early intervention and better management of chronic and acute health problems outweigh the costs of health insurance.
  - In general, health insurance is not a good value for what it costs.
  - Workers without healthcare coverage have more absenteeism and are less productive than those who have health care coverage.
  - Money spent on health coverage for employees reduces other costs.
  - Employers would be more likely to offer employee health benefits if they had some control over costs.

Employers who do not offer healthcare coverage are asked to indicate how each of the following are reflected in the decision not to offer coverage:

- Setting up a plan is too complicated and time consuming
- Revenue is too uncertain to commit to a plan
- Employees cannot afford it
- Employees are healthy and do not need it
- Employees have coverage elsewhere
- Employees prefer wages and/or other benefits
- My/our business does not need to offer health insurance in order to recruit and retain good workers
- A large portion of my/our workers are seasonal, part–time, or high turnover
- The company has had an adverse experience with employee healthcare coverage
- Administration?
- The company was denied coverage
- Don't have enough information to make a decision about benefits
- Costs of employee health benefits are too difficult to control
- Other reason why your business does not offer a health plan

2.3 What criteria do offering employers use to define benefit and premium participation levels?

This is an item that will be primarily addressed though our employer focus groups.

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

This is also an item that will be primarily address though our employer focus groups.

2.5 What employer and employee groups are most susceptible to crowd-out?

In addition to information collected through our employer and individual focus groups, our discrete choice analysis will provide unique information about the likeliness of crowd out across a range of benefit packages when offered at numerous price points. This will be achieved by presenting presently insured individuals and employers who currently offer coverage to their employees with choice tasks that allow them to choose between the coverage they currently have and the options currently under consideration by the project.

2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?:

Individual or employer subsidies?:

Additional tax incentives?:

These questions will be addressed by a combination of employer focus groups, input from employers that participated in our community workgroups, and input from members of our project steering committee. We are also reviewing Utah's experience with a previous (failed) small business purchasing pool.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Similar to item 2.6, the questions of other alternatives to motivate employers will be addressed by a combination of employer focus groups, input from employers that participated in our community workgroups, and input from members of our project steering committee.

Section 3. Summary of Findings: Health Care Marketplace

The purpose of this section is to document your State's research activities related to the State's health care marketplace. The State should discuss (1) findings relating to the marketplace; (2) how the information was obtained; and (3) how the findings affected policy deliberations in the State.

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?

This is a question that is currently being debated by our steering committee. Input is also being sought from community advocates and providers.

The following is a definition of adequate insurance that was present to the project for consideration.

When defining "adequate" the value of adequacy has to be separated by how it is parochially defined by the insured, the health provider, and the insurance institution. What is adequate to one may not be adequate to the others. Based on this definition, the likelihood of an insurance product being adequate for the insured, provider, or insurance company significantly decreases as the medical condition goes from routine, to emergency, or to chronic.

For most insured individuals, an adequate health coverage plan will enable them to receive medical care comparable to others within her/his socio-economic status.

How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions?

Publicly Insured (Medicaid/CHIP/Medicare)
· Based on the definition of adequate, public insurance products are adequate for the insureds' needs, provider reimbursements (with the exception of dental provider reimbursement), and insurance profits.
· Changing one of the player's perceived level of adequacy, the adequacy requirements for the other two players also changes.
· The public system's major breakdown happens when the insured does not understand the playing field and is not able to maneuver within the system.
· Preexisting conditions are accepted as covered, reimbursable, and allowable benefits and costs within the public system.

No Insurance (Safety Net)
· Without insurance or public coverage, individuals primarily rely on the Federal government for health care options. The Community Health Centers (i.e., FQHCs) provide adequate primary care for those already in this public system. For those outside this system, there is not a public safety net that provides reliable or adequate health coverage.
- Secondary or tertiary care is not adequate for this population. Diagnosed problems which cannot be resolved within the safety net require the uninsured's limited disposable and non-disposable income to pay for the high cost treatment(s).

Privately Insured
- Private insurance products are generally adequate. The cost of private products, however, prohibit lower-income families (under 200% FPL) to afford coverage.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

This question will be addressed in part by our employer survey. In addition, we are working with the Utah Department of Insurance which is currently collecting information on the number of insured members and groups sizes for comprehensive health insurance plans. This information will be available later this year.

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

We are presently attempting to collect this information with the aid of the Utah Department of Labor. The Utah Department of Insurance provided a "very gross estimate" of the percentage of employer group plans that are self-funded at 50 percent.

Data on the impact of self-funded employer group plans is not presently available.

3.4 What impact does your State have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

This question may be addressed as part of our actuarial analysis. We are also working with the Utah Department of Health's Health Care Finance division to assess this impact.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

We are currently investigating the possibility of an actuarial study of a "single payer plan" as one possible avenue to achieve universal coverage. Whether or not this study will be undertaken is dependent upon the project budget as it was not assigned the highest priority by our project steering committee.

3.6 How would universal coverage affect the financial status of health plans and providers?

This question will be addressed if we are able to move forward with the actuarial review of a single payer plan.

3.7 How did the planning process take safety net providers into account?

Safety net providers have been heavily involved in all aspects of the grant activities. A range of safety net providers are presently represented on the project steering committee, the project workgroups, and in the project "Consultation Teams" as described in section five. The project staff has compiled a comprehensive directory of all safety net providers in Utah

3.8 How would utilization change with universal coverage?

This is also a question that will be addressed if we are able to move forward with the actuarial review of a single payer plan.

3.9 Did you consider the experience of other States with regard to:

Expansions of public coverage?:

Public/private partnerships?:

Incentives for employers to offer coverage?:

Regulation of the marketplace?:

The project's four original workgroups were presented with a large amount of data on all aspects of other states' experience. We compiled a library of information on all topics related to the uninsured that is accessible through our web-site (http://168.179.113.242/resources.html). Workgroup participants were also encouraged to supplement our database with any additional relevant information. Elements of programs currently being offered in other states are evident in many of the proposals presented by the workgroups to our project steering committee.

Section 4. Options for expanding coverage

The purpose of this section is to provide specific details about the policy options selected by the State. Those states that have not reached a consensus on a coverage expansion strategy may answer questions 4.1 through 4.15 as applicable, but should focus primarily on questions 4.16, 4.18, and 4.19.

4.1 Which coverage expansion options were selected by the State (e.g., family coverage through SCHIP, Medicaid Section 1115, Medicaid Section 1931, employer buy-in programs, tax credits for employers or individuals, etc.)?

The study had originally planned to have the workgroups develop four competing proposals that would them be reviewed by the project steering committee who would select three of the four proposals for inclusion in the project's final report.

In all, the workgroups presented a total of ten proposals to the steering committee, many of which contained similar or "overlapping features". Most of these proposals were targeted at specific sub-groups within the overall population of uninsured Utahns. After listening to the workgroup chairpersons present their proposals, studying papers prepared by the workgroups for the steering committee, and two steering committee meetings, the committee recommended that the project focus on a combination of proposals that could be implemented in a graduated manner.

There was broad support for two of the proposals with some key caveats. First, there was general agreement that the Primary Care Network (PCN) model (the 1115 waiver), as proposed by the Utah Department of Health, would provide coverage to a significant portion of the target population under 200% of the FPL. However, concerns were voiced in three areas: 1) the ability of the current safety net of primary care providers to absorb the increased demands that the PCN would likely create; 2) the absence of a more formalized system for providing access to inpatient hospital and specialty care; and 3) the lack of an employer component.

The second “proposal” receiving broad support was actually a combination of a 1931 expansion and an 1115 CHIP waiver for parents. Either of these two options, combined with the DOH’s PCN could provide coverage for a large segment of the target population.

Many steering committee members stressed the need to maximize employer participation. Several of the proposals dealt directly with this type of coverage. However, there was general agreement that none of these proposals on their own could be fashioned in a manner that would

provide coverage for a significant percentage of the unemployed and lower wage uninsured (below 125-150% FPL). The steering committee recommended that the project continue to investigate the cost-sharing model (Muskegon County's Access Health Program) and the viability of a CHIP buy-in program for employers.

Prior to being awarded this State Planning Grant, the Utah Department of Health had worked for a significant period of time with the office of Health and Human Services Secretary Tommy G. Thompson to develop the Primary Care Network (PCN) proposal.

As described in section five of this report, the project steering committee studied this proposal and two of the workgroups adopted variations of the proposal, commenting upon the strengths and weaknesses of the PCN as they perceived them. The decision of the project steering committee to further pursue the PCN as a possible proposal to be presented in the project's final report was a recognition of the PCN proposal's strengths (offering coverage to a broad group of people who presently had no coverage) and the need for a more formalized mechanism by which the community could comment upon and effect the final form of the PCN.

Many of the details of the proposal remain to be worked, however, the following is a description of the key elements of the PCN proposal as it stands at this time.

The proposal would offer a primary care benefit package to only the new eligible population of adults who do not qualify for Medicaid. This is akin to a “family physician” model. This Primary Care Network program will provide basic and general health care services to people seeking assistance for screenings to identify or prevent illness and disease or needing treatment for common illness or injury. It will also provide care for the management of chronic disease.

Utah has experience with this benefit alternative and we estimate that since we will be paying for actual services used, rather than prepaying “actuarial use” as an insurance product, the cost will be relatively low. The population of adults above categorical income threshholds is generally healthier as well, which will contribute to keeping the cost low. Utah experienced this phenomena with the SCHIP population. The cost of SCHIP children is 25% below the cost of Medicaid children, in part because we created a plan that was similar to the State employee plan with a separate actuarial pool. The separate actuarial pool kept the SCHIP plan from being co-mingled with Medicaid and losing its identify for cost predicting purposes. We also have experienced significantly lower costs for the adult population in transitional Medicaid, as well as those served through Utah’s Primary Care Grant program.

SPECIFIC PROGRAM COMPONENTS:

1. Eligibility Processes:

   For those eligible under the existing family related program, there will be no change in current eligibility criteria. For the new eligibility group, the eligibility process will be CHIP-like in design. Specific components include:

   ? Income based only - no asset test

- ? No retroactive eligibility
- ? Annual eligibility determination and re-determinations
- ? Cap on enrollment if needed
- ? IT support added to Utah's FAMIS system
- ? ID card issued once per year
- ? A low enrollment fee for new applications and annual re-certifications

2. Benefit Design:

The benefit design will be a primary care package focusing on prevention. Specific services will include: physician, pharmacy, lab and x-ray, supplies, emergency services, health education, transportation required for patient care and preventative dental.

- ? Pharmacy will be set up similar to Utah's SCHIP program with higher co-pays for non-generic drugs and other expensive alternatives to less costly equivalent drugs.
- ? Some inpatient services will be donated by Utah's hospitals based on a capped aggregate value on the contribution of services.

3. Cost Sharing:

Cost sharing will be equivalent to approximately one-half of what is required under the State employees health plan to reflect the lower income status of this group. There will also be a low annual enrollment fee. This will apply to both the TANF related adults as well. Exception: American Indians utilizing either the IHS or Tribal systems will not be required to make co-payments within these delivery systems. This includes services received under contract or through referral from these systems. Additionally, no enrollment fee will be required for those eligible for IHS services.

4. Claims Processing:

Claims processing will be MMIS based with point of sale eligibility confirmation and electronic claims transmission.

5. Delivery System:

The delivery network will consist of a state-wide coalition of private providers. Members of the network must guarantee a level of capacity to meet the needs of this new population. Payment will be made on a fee-for-service encounter basis.

FINANCING AND COST NEUTRALITY:

1. We estimate that we can capture $25 million annually in revenues to fund this waiver plus $8 million of on-going free hospital care donated by Utah's hospitals for a total of $33 million.

2. Current program savings would be generated by modifying the Medicaid benefits for non-aged, non-disabled, non-institutionalized Medicaid adults to that comparable to what Utah State employees receive, and in recognition of their low income status imposing cost-sharing at approximately 50% of the level required by the State employee plan. We would also roll the State-funded program for non-categorical adults into the waiver program.

3. Utah has a lot of experience with this benefit alternative and it is estimated that since we are only paying for actual services used rather than prepaying "actuarial use" as in an insurance product, the cost would be about $50 per person per month. The population of adults above categorical income thresholds is generally healthier as well, which is another contributing factor to keeping this cost low. As noted above, Utah experienced this phenomena with the CHIP population and a PEHP style benefits plan. The use of a separate actuarial pool prevented the CHIP program from being co-mingled with Medicaid and losing its identify for cost predicting purposes. Our experience with the Utah primary care grant program indicates that we could expect to see a range of about 2.5 to 3.5 encounters per year from this new population. Cost per encounter has ranged from $63 to $80.

4. With the $25 million, at $50 per person per month, we could serve 41,000 uninsured adults, potentially more, depending on the subsidy. The per capita cost is substantially below the current cost of a TANF related adult, which is closer to $300 per month.

AREAS OF THE PCN THAT WOULD NEED WAIVERS:

- Restricting Benefit Package
- Eliminating Categorical Requirements
- Co-payments/Premiums
- No Retroactive Eligibility for New Primary Care Network Enrollees
- Enrollment Cap
- Eliminate Current Cost Based Reimbursement Methodology for New Primary Care Network Enrollees
- Comparability

4.2 What is the target eligibility group under the expansion?

In addition to the target eligibility group described above for the PCN proposal, the other proposals under consideration are targeted at the following populations:

PROPOSAL	**TARGET POPULATION**
Expand CHIP to families (1115 waiver)	Parents earning 200% of the FPL or less
1931 Expansion	Parents Earning 100% of the FPL or less
Cost Sharing Model	Working uninsured employed by companies meeting an average wage requirement. Crowd out guidelines to be determined

Because of a very narrow window for input from the community on the PCN proposal, our present efforts have been focused on that proposal. Items 4.3 through 4.16 will be addressed in detail for each of the proposals prior to the conclusion of the project.

4.3 How will the program be administered?

4.4 How will outreach and enrollment be conducted?

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

4.6 What will the benefits structure be (including co-payments and other cost-sharing)?

4.7 What is the projected cost of the coverage expansion? How was this estimate was reached? (Include the estimated public and private cost of providing coverage.)

4.8 How will the program be financed?

4.9 What strategies to contain costs will be used?

4.10 How will services be delivered under the expansion?

4.11 What methods for ensuring quality will be used?

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

4.13 How will crowd-out will be avoided and monitored?

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

4.15 How (and how often) will the program will be evaluated?

4.16 For each expansion option selected (or currently being given strong consideration), discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g., financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the State to consensus on each of these approaches?

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered or passed), and the remaining challenges.

Discussions between the Utah Department of Health and the Centers for Medicare & Medicaid Services as well as Secretary Thompson's office are presently on going with regard to the PCN proposal.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice? What were the primary factors that ultimately led to the rejection of each of these approaches (e.g., cost, administrative burden, Federal restrictions, constituency/provider concerns)?

Elements of most the workgroup proposals exist in the proposals that continue to be investigated. Two proposals are no longer being investigated, an Insurance Pool/Voucher Approach and a New Insurance Product proposal.

Insurance Pool/Voucher Approach To GAPs In Coverage (100% to 200% of FPL)

This proposal was tabled. The primary reason was state costs and the lack of matching Federal dollars. The workgroup is now focusing on a CHIP buy-in for employers and the Muskegon cost-sharing model.

Proposal Overview

This proposal attempted to address possible/likely gaps in insurance coverage and benefits after CHIP and Medicaid expansions are developed. The approach developed from the notion that some individuals could get health insurance by providing access to existing insurance pools. The proposed solution quickly transformed into a voucher approach. The group concluded that almost all Utahns have access to health insurance. The issue for many, however, is affordability and how much the individual should contribute to their own coverage.

These existing pools might include Utah Comprehensive Health Insurance Pool (HIPUtah), PEHP, and IHC's and Regence's individual insurance programs. Affording individuals access to existing pools has many advantages. Existing pools offer the advantages of sound actuarial data, administrative costs spread over a large number of enrollees, existing programs and already developed networks. For example, PEHP is noted for sound administration, good cost predictability and an excellent network.

The key to the success of this approach is protecting the players from risk. Adding a large number of high utilizers, enrollees with unmet need for services, or the unhealthy would increase the costs to other pool enrollees. Group pools such as PEHP are expensive since they include those who have high cost health conditions. Additionally, allowing open access to the expensive HIPUtah program would offer little to low-income individuals. Finally, the question of pre-existing health and maternal conditions must be addressed. Individual policies almost always limit coverage for these categories.

Specifically the concern is for childless couples and individuals who are in the 133%- 200% of poverty level. This gap group will not be uniform. It will include young couples and individuals with entry-level jobs or with multiple part-time jobs. They frequently, make economic decisions that health insurance is not necessary (the "bullet proof"). An additional target would be divorced and underemployed "empty nest" women. Finally, many individuals are unemployed or have limited employment due to health condition. The private individual market does not serve them.

The 2001 200% FPL for individuals is $17,180 and $23,220 for couples. With this limited income, the important policy question of individual financial responsibility must be addressed. With a CHIP-like guideline of 5% of income, these individuals should spend about $850 annually on health insurance (an amount unaffordable for some). The least expensive individual plan for the healthy is about $1570 with a $250 deductible. Thus affordability is clearly an issue with this group who will experience shortfalls of no less than $750 per year.

For those uninsurable due to health condition, enrollment in HIPUtah costs about $4100 annually with a $500 deductible. This represents only the enrollee's cost. Utah currently subsidizes almost $1700 for each enrollee through appropriations and pool investment returns.

Populations and Number Served

The 1115 Waiver group estimates that there are about 18,100 childless adults at the 100- 200% of the FPL. The Utah Comprehensive Health Insurance Pool estimated that there are about 20,000 uninsured and uninsurable Utahns. Of these, the program estimates about 25-40% are under the 200% FPL. This means about 5,000 uninsurables under the 200% FPL. These two estimates are substantially duplicated and should be refined.

Cost Estimates

Currently, any voucher support would be from Utah State or local private sources since Federal match does not appear available for vouchers. With very little work a reasonable estimate of multi-year costs can be developed. Future costs must be estimated since legislatures are unwilling to commit to future expenditures without these estimates. The cost estimate would be based on:

- Accurate projections of the number uninsured and uninsurable to be covered;
- Estimated proportion of each group who will seek coverage;
- Age/sex analysis of those to be covered;
- Development of the benefit plan;
- Whether pre-existing and maternal conditions are covered;
- Actuarial estimated of utilization.

Financing Possibilities

To be determined. The current HIPUtah approach is that costs are covered through premium (60%), investment income (10%), and general fund appropriations (30%). HIPUtah will

implement a premium subsidy program for low-income uninsurables. However, as designed, this program will still be expensive for the under 200% of FPL group.

Benefit Package and Co-pay Options

The benefit package should be similar to Utah's current HIPUtah's benefit package or the Utah Basic Health Plan. They offer comprehensive but not rich coverage and include standard health and mental health services, pharmacy, and home health and supplies. However, HIPUtah costs are moderated by not covering transplants or neonatal care. Costs are also limited with high deductibles, 20% coinsurance and pre-existing condition limits. Each of these cost-saving features must be carefully evaluated before inclusion in this safety net approach. The HIPUtah and private sector individual programs also include standard managed care functions such as referral, pre-authorization and contracted networks.

Crowd-out Provisions

This issue must be carefully evaluated to allow coverage expansion without substituting for current employer or community based care.

- For uninsurable: must prove uninsurabilty through presumptive health condition or a letter of denial from a licensed insurance company or HMO.
- Initial pre-existing condition feature for low cost health service, but risk protection for the individual from catastrophic events
- Reduced scope of benefits from those typically offered in group or public programs. For example, HIPUtah mental health benefits are not subject to legislated parity.
- Limit enrollment to previously uninsured or those with terminated coverage.
- Evaluate residency requirement to prevent individuals moving from other states to access Utah supported programs.

Individual Responsibility Component

The group supported legislated individual responsibility for healthcare. It would function very much like requirements for maintaining liability auto insurance. That is, all Utahns would be required to have some means for covering catastrophic or major health problems. This could include group coverage, public coverage, subsidized or unsubsidized individual coverage, a specific asset level or family support.

Rationale

- Adults <100%-200% FPL generally cannot afford insurance on their own
- Uninsured people suffer from poorer health than the insured. Although clinics and other safety net programs offer some care, the uninsured lack access to care. They are less likely to have a regular source of care, more likely to delay seeking needed care, and more likely to go without needed care. Overall, uninsureds have a 25% higher risk of death than the insured.
- Supports independence and self-sufficiency. With an adequate benefits package, the target population will be more stable in the workforce, thus less likely to need public assistance down the road.

- Access to insurance in low-wage jobs may worsen. Utah's job forecast for 2000-2005 predicts that *most* of Utah's job growth will occur in low-skill and low-paying jobs. Typically these jobs are part-time, temporary, offering little or no opportunity for advancement, and do not include benefits.
- Supports those moving from welfare to work. With an adequate benefits package, the target population will be more stable in the workforce and less likely to need future public assistance.
- Provides greater access to care for the uninsurable.

A New Insurance Product

This proposal involved development of a combination high deductible and catastrophic coverage plan for employees of small businesses (less than or equal to 15 employees) and individuals who do not currently have access to affordable health insurance. This proposal was not selected for continued review. The primary reason was that many on the committee felt that similar products were already available in the form of Medical Savings Account (MSA) products and that those products have received little interest from employers and consumers.

Target population:

- Small employers who want to participate in employee health benefit plans.
- Uninsured individuals, up to 200% above FPL.

Services to be Provided

Overall, this insurance plan would include most of the benefits now available and being purchased by employer plans:

- Basic and preventive health care
- Maternity not likely
- Limited formulary (with possibility of separate deductible for Rx)
- Allergies not likely
- Infertility not likely

But it could require exemptions from certain state-mandated benefits:

- Home health care
- Chiropractic care
- Outpatient alcohol and substance abuse treatment
- Some mental health coverages

Catastrophic Coverage Provisions

The proposed approach to covering the uninsured includes a high-deductible (around $2000) annually that would have to be met before any benefits were paid. The first $1000 (approximate

figures here) of the deductible would be paid by the employer. For example, an employee might incur an eligible health expense and be billed $125. Under the fee schedule agreed upon by the provider and employer, the fee might be $85. The employer would pay the provider directly, $85. Once the employee's covered expenses reached a maximum employer contribution level, say $1000, the employee would be expected to pay their own (or their family member's) eligible expenses up to the maximum deductible (for example, for a $2000 deductible, the employee would be responsible for the second $1000 spent on medical care). Very low income (to be defined) individuals might receive a subsidy. Once the deductible level was met, the provider would provide coverage—up to some lifetime maximum, say $2,000,000.—or alternatively with no lifetime maximum.

For low-income individuals without access to employer-based coverage, the first $1000 would be paid through some state funding mechanism, the individual would be responsible for the next $1000, and the health insurance package described above would begin to cover claims beyond the value of the deductible.

Barriers/Potential difficulties with the proposal that will have to be worked out, pending more information, time to examine existing conditions, etc.

- ? Could the target population actually afford this?
- ? Right now HMO's can't sell this kind of product or only offer it to certain groups.
- ? The source of funding needs to be identified.

A. Other considerations:

- ? Insurance coverage would be mandatory. Individuals and eligible employers would be automatically enrolled unless otherwise covered. Proof of other coverage would be required in order to waive automatic enrollment.
- ? The group is discussing how Medical Savings Accounts might fit into this plan, as a way for employees to contribute pre-tax dollars to their share of the coverage costs.
- ? Self-employed individuals would probably be treated as individuals, described above.

Single Payer Proposal

Finally, much discussion centered around the Single Payer proposal. There were many steering committee members who felt it important to stress that none of the other proposals presented by the workgroups comprised a permanent or complete solution for meeting the needs of the uninsured. In addition, some steering committee members questioned the primacy of the Guiding Principle that proposals "Achieve Political and Fiscal Viability". We would like to suggest that the importance of this particular Guiding Principle rests upon the goals of the project. The DOH clearly stated that one goal of this project is to develop proposals that could be implemented in the state of Utah within the short timeline of 1-3 years.

There was agreement that Single Payer is not a viable option in the near future and that it is very unlikely to be unilaterally implemented by the State of Utah. However, we do feel that the potential exists for a limited study of this proposal as long as it does not compromise the project's ability to fully study those proposals that do meet the Guiding Principles as viewed in light of the DOH's goals for the Covering the Uninsured Project. We are presently investigating the possibility of conducting an actuarial study of a Single Payer proposal similar to that conducted for the state of Vermont by the Lewin group[6].

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

This also an issue that will be dealt with as the project's proposals are further developed.

Section 5. Consensus building strategy

5.1 What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

The primary governance structure of our project is the project steering committee. The steering committee is composed of community leaders who have volunteered to representing the following organizations:

Organization
Rural Health Providers
Utah Department of Health
Ethnic Health Agencies
Utah Health Insurance Association
Small Employers - Natl. Federation of Independent Business
Utah Issues - Low Income Advocates
Utah Medical Association
University Health Policy Center
Local Health Departments / Utah County Health Department
University of Utah Health Sciences Center
Utah Hospital Association
Native American Health

The steering committee has two primary functions. First, the steering committee created the project's guiding principles. The guiding principles are listed below:

- Make Health Care Accessible to the Most People Possible, under 200%FPL
- Achieve Political and Fiscal Viability
- Cover Greatest Need First
- Preserve private sector investment in the financing of health care

- ? Promote individual responsibility for the cost of health care
- ? Solutions are workable and acceptable to target population

The second primary function of the steering committee is to evaluate the proposals that were developed and presented by the project workgroups. Proposal evaluation includes commenting upon specific aspects of the proposals and select proposals for continued review.

5.2 What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?

Early in the project (June 18, 2001), a "Partnership Summit" was held for all interested parties. Invitations were mailed to over 600 people representing a wide range organizations and interests. In addition, many groups were encouraged to invite their members as well as any other interested parties.

The first half of the summit agenda included the following:

- ? An Overview of the HRSA Grant
- ? A review of Health Insurance Coverage in Utah
- ? An overview of Utah's Safety Net
- ? Structure of *Covering the Uninsured 2002* Project (timeline and guiding principles)
- ? An overview of the workgroup's role

The second half of the summit consisted of the summit attendees organizing into four workgroups according to their own interests. Workgroups were charged with developing proposals for covering the uninsured that would be presented to the project steering committee after a period of about eight weeks. Workgroups elected their own chairperson at the Partnership Summit.

Workgroups were originally structured as follows:

<u>Public workgroup</u>

- ? Expansion Programs
  - Chip (present program in Utah is not solely public)
  - Medicaid (present program in Utah is not solely public)
- ? Single Payer
- ? "Direct" provision of care

<u>Private workgroup</u>

- ? Employer Based
- ? Tax Incentives
- ? Subsidies
- ? Medical Savings Account
- ? Reinsurance/stop loss

Public/Private workgroup

- ? Expansion Programs
  - Chip
  - Medicaid
- ? High Risk Pool

Community-wide workgroup

- ? Combine elements from other workgroups to provide coverage

In addition to the workgroups, several surveys are presently being conducted (Individual, employer and discrete choice), individual and employer focus groups are being planned, and several small "Consultation Teams" have been formed as mechanisms for community advocates, providers, employers, and health care industry interests to provide input to the grant.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

We have developed a web-site where many of our grant activities are posted (http://www.health.state.ut.us). We have included meeting schedules and minutes on the web-site as well as a "med-line" style database containing a searchable database of health care coverage related literature.

Recently, we partnered with ***The Matheson Center For Health Care Studies*** at the University of Utah to host a two day conference on the appropriateness of a cost-sharing model approach (similar to the program presently offered in Muskegon County Michigan[7]) for Utah. We have invited Vondie Woodbury, Director of the Muskegon Community Health Project to present at this conference. Break out sessions are planned for members of Utah's Legislative Task force for Access to Health Care, employers, insurance industry representatives, community advocates, providers, and our steering committee. The conference will conclude with a roundtable/lunch where community representatives will discuss the strengths and weaknesses of such a model for Utah.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.

The impact of the planning effort has yet to become fully apparent. Having a wide range of community members work on this project appears to have had the effect of generating a broader sense of understanding amongst all parties with regard to the obstacles that exist to providing access to health care for all Utahns.

Section 6. Lessons Learned and recommendations to States

6.1 How important was State-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

As our data collection activities are not yet complete and at present we do not have access to any results, the impact of the improved state specific data is not yet discernable.

6.2 Which of the data collection activities were the most effective relative to resources expended in conducting the work?

As our data collection activities are not yet complete and we do not have access to any results, the impact of the improved state specific data is not yet discernable. We are looking forward to the unique data to be supplied by our discrete choice analysis. The discrete choice results should be available in late January/mid-February, 2002.

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

At this time it is anticipated that all proposed data collection activities will be completed prior to the conclusion of this project.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rates)?

This has yet to be determined.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under HRSA grant? Does the State have plans to conduct that research?

We will know more about this once we have had a chance to look at the data that we are presently collecting.

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

There are no proposed changes to health care programs or their coordination as a result of the HRSA planning effort at this time. We would address any possible organizational or operational lessons closer towards the end of the planning grant process.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

Key lessons about the insurance market and employer communities are still being assessed, as is the health plans response to our proposed expansion mechanisms. We have found that involving the employer community is difficult due primarily to limited availability resulting from the demands of simply running a business faced by most employers. It does appear, from the preliminary results of our employer insurance survey, that employers are willing to provide information when questions are asked in a succinct and informed manner.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

The response to this question will most likely change with the benefit of hindsight but at this time a key point would be to get all of the key players involved early in the process.

Section 7. Recommendations to the Federal Government

7.1 What coverage expansion options selected require Federal waiver authority or other changes in Federal law (e.g., SCHIP regulations, ERISA)?

The PCN proposal would require waivers in the following areas:

1. Restricting Benefit Package
2. Eliminating Categorical Requirements
3. Co-payments/Premiums
4. No Retroactive Eligibility for New Primary Care Network Enrollees
5. Enrollment Cap
6. Eliminate Current Cost Based Reimbursement Methodology for New Primary Care Network Enrollees
7. Comparability

An 1115 waiver would also be needed to expand CHIP coverage to parents earning up to 200% of FPL.

The necessity of other Federal waivers or changes in federal law are being investigated. Implementation of a single payer plan would likely require the most significant changes in Federal law. A detailed list of the required changes is being compiled at this time.

7.2 What coverage expansion options not selected require changes in Federal law? What specific Federal actions would be required to implement those options, and why should the Federal government make those changes?

A list of these changes has not been compiled at this time.

7.3 What additional support should the Federal government provide in terms of surveys or other efforts to identify the uninsured in States?

This question will be best answered after we have assessed the information collected for the 2001 UHSS, our employer survey, the discrete choice analysis, and our focus groups; as well as reviewed of data already collected by agencies with goals similar to those of the project.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

The response to this question is similar to the response given to item 7.3. A more informed and comprehensive response will be possible after we have assessed the results of our data collection efforts.

Appendix I: Baseline Information

Please provide the following baseline information about your State (if possible). Also include any additional baseline information especially relevant to your coverage expansion strategies:

Population:

According to the 2000 U.S. census, the population of Utah is 2,233,169

Number and percentage of uninsured (current and trend):

As mentioned in section one, the 1996 Utah Health Status Survey estimated that 9.5 percent of the Utah population was without any kind of health insurance. The 1991 and 1996 versions of the UHSS showed no change in coverage rates between these years. In addition, the CPS showed no significant change in the rate of uninsurance from 1998 through 2000. Assuming that the UHSS more accurately reflects the rate of uninsurance in Utah and that rate of uninsurance has remained relatively close to 9.5%, there would have been 212,251 Utahns without health insurance in 2000.

It should be noted that Current Population Survey (CPS) data for the year 2000 estimates Utah's uninsured population at 13.4%. More importantly, CPS data from the last three years shows that the percentage of Utah residents without health insurance has remained relatively stable (three year average of 13.2%).

Average age of population:

Average age is not an appropriate measure of central tendency for this state. Median age is 27.1 years, with 36.3% of the population 19 years or younger and 8.5% of the population 65 years or older.

Percent of population living in poverty (<100% FPL):

9.1% of the state's residents live at or below 100% FPL

Primary industries:

Industry type	Number of employees	Annual payroll
Manufacturing	119,140	3,726,130
Retail trade	114,474	1,856,875
Accommodation/Food Service	74,481	650,041
Administrative / Support / Waste management / Remediation Services	68,232	1,147,169
Construction	55,801	1,578,334
Healthcare/Social Assistance	46,989	1,226,744
Wholesale trade	44,312	1,420,376
Finance/Insurance	39,603	1,228,769

Number and percent of employers offering coverage:
Number and percent of self-insured firms:
Payer mix:
Provider competition:

With assistance from the Utah Department of Insurance, the Utah Department of Labor and through the use of our employer survey, we are presently attempting to collect information on the percentage of employers offering coverage, the prevalence of self-insured firms, payer mix, and provider competition.

Insurance market reforms:

We are presently attempting to collect that information with the assistance of the DOI.

Eligibility for existing coverage programs (Medicaid/SCHIP/other):

The following table represents the primary categories of Medicaid coverage in Utah:

	Incoming Eligibility (percent FPL)	Other Criteria:
People with disabilities	100.0% - non-working 250% - working	SSI criteria or 12 months total actual or projected by M.D.
Pregnant Women	133.0%	
Blind	72.0%	
Aged	100.0%	
Medically Needy	53.4%	Does not meet income criteria but qualifies via "spend down". Must be categorically eligible.
Adult Parents	53.4%	
Transitional Medicaid	185.0 %	If income increased due to employment, extended for 12 months. If income increased due to child support payment, extended for 4 months.
Children under 6	133.0%	
Children 6 - 18 years of age	100.0%	

The following is a detailed summary of the medical assistance programs in Utah:

MEDICAID PROGRAMS

1931 Family Medicaid (FM-O)

1931 Family Medicaid provides coverage for low income families with dependent children. Families must meet a deprivation of support requirement. This means the children must be deprived of parental support due to the death, absence, or incapacity or a parent. Families in which the primary wage earner parent is unemployed or employed less than 100 hours per month also meet the deprivation of support requirement. The household must pass two specific income tests. 1931 FM-O households may qualify for a 12 month earned income disregard when the earned income of a parent exceeds the income limit. Additionally 1931 households may qualify for 4 or 12 month Transitional Medicaid when they loose eligibility for 1931FM-O due to child support collections or earnings of a parent.

Family Size	First Test	Second Test
1	$623.00	$382.00
2	$866.00	$468.00
3	$1,079.00	$583.00
4	$1,262.00	$682.00
5	$1,437.00	$777.00
6	$1,584.00	$857.00

Deductions: No deductions are allowed in the first income test. Second test, $90.00 work allowance, a $30 and 1/3 disregard*, child care ($200 maximum

per child under age two, $175 over age two), some medical bills, from earned income. *Each individual with the earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Not allowed.

Asset Limit: 1 person - $2,000 2 people - $3,000 Each additional person add $25

Retroactive coverage: Allowed.

Regular Family Medicaid

This program provides Medicaid coverage to low income families who do not qualify for 1931 FM-O because of income or other household circumstances. A household must meet the same deprivation of support requirement as the 1931 FM-O program described above. The difference between 1931 FM-O and regular FM program is that regular FM households do not have to meet the gross income test, and they may spend down to the income limit to be eligible. Regular FM households may also voluntarily choose to leave children out of the coverage that do not meet deprivation of support or when they do not want to count the child's income in determining eligibility.

Household Size	Income Limits	Household Size	Income Limits
1	$382.00	4	$682.00
2	468.00	5	777.00
3	583.00	6	857.00

Deductions: $90.00 work allowance, a $30 and 1/3 disregard*, child care ($200 maximum per child under age two, $175 over age two), some medical bills, from earned income. *Each individual with the earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Allowed.

Asset Limit: 1 person - $2,000 2 people - $3,000 Each additional person add $25

Retroactive coverage: Allowed.

Transitional Medicaid

Families who become ineligible for Family Employment Program (FEP) cash assistance or 1931 Family Medicaid, may receive additional months of Medicaid coverage depending on the reason they became ineligible. Families who are no longer eligible for FEP or 1931 Family Medicaid because of child support can receive Medicaid for 4 additional months. Families who are no longer eligible for 1931 Family Medicaid because of earnings or hours of employment of the parent or non-parent specified relative, or because of the loss of 1931 Family Medicaid time limited income disregards can receive up to 12 months of continued Medicaid coverage. Families who are no longer eligible for FEP because of earnings of the parent or non-parent specified relative can receive up to 12 months of continued Medicaid coverage. A household must meet certain income and reporting requirements to qualify for transitional Medicaid.

Non-Parent Caretaker Relative (FM)

An adult who is caring for a relative child, but who is not the parent of the child may qualify to receive Medicaid. The adult must meet the Family Medicaid eligibility criteria except for deprivation. The caretaker relative's spouse and dependent children cannot be included on the program unless they meet deprivation. Income and assets of the excluded spouse of a caretaker relative must be counted. A different income calculation is used to determine countable income. Spenddown is allowed.

Prenatal Program (PN)

The Prenatal program provides full Medicaid coverage to pregnant women. The income limit for this program is 133% of the Federal Poverty Level for the household size. The program covers the mother from application through 60 days after the birth. Once eligible, the woman remains eligible for the entire period. The mother does not have comply with Duty of Support requirements while she is pregnant or for the 60 day postpartum period. **Children born to women on this program can receive Medicaid through the month of their first birthday under the Postnatal program**.

Household Size	Prenatal Income Limits	Household Size	Prenatal Income Limits
1	$ 953.00	4	$1,957.00
2	1,287.00	5	2,291.00
3	1,622.00	6	2,626.00

Deductions: Same as Family Medicaid. Thirty and one-third disregard from earned income may be allowed only if a client received Diversion or 1931 Medicaid in one of the previous four months.

Asset limits: $5,000 for free coverage. Household's whose assets exceed $5,000 limit may pay a co-payment equal to 4% of the **total** assets. Maximum co-payment is $3,367.

Retroactive coverage: Allowed.

Pregnant Women (PG)

A Medicaid program for pregnant women who do not meet the income limits for the Prenatal program. The advantage of the PG program is that a woman may pay a spend down and receive the coverage. Eligibility follows the regular FM program except that the household does not have to meet deprivation of support requirements.

The woman may receive 60 day postpartum coverage if she applies for benefits before the birth of the child. The spenddown must be met for each month of coverage including the 60 day postpartum period. The mother does not have to comply with Duty of Support requirements while she is pregnant or for the 60 postpartum period. The child will qualify for Medicaid for the first year under the Postnatal program with no spenddown.

Postnatal (PN+)

This program covers the newborn from birth to twelve months and the mother for the 60 day postpartum period. If the mother qualifies for the PN program, the 60 day postpartum coverage for the mother and child is automatic. Mothers who were not on Medicaid when the baby was born may receive the 60

postpartum coverage and the baby may receive the year's coverage if the mother qualifies for the PN program in a retroactive month that covers the date of the birth.

At the end of the 60 day postpartum period, the household must provide verification of the birth and information about any possible insurance coverage. Application for a Social Security card will be requested, but isn't required.

A child can only receive Postnatal coverage if the mother was eligible for Medicaid for the month of birth. If the mother did not qualify for Medicaid for the month of birth, the child may be eligible for the Newborn program.

Newborn Medicaid (NB)

This program provides Medicaid coverage for children from birth through age 5. Children do not have to be deprived of parental support as in the 1931 FM and regular FM programs. A child does not have to reside with the birth mother or other relative to receive coverage.

Income Limit: 133% of the Fedearl Poverty Level.
Deductions: Same as Family Medicaid.
Spend down: Not allowed.
Asset limits: None.
Retroactive coverage: Allowed.

Newborn Plus Medicaid (NB+)

Medicaid coverage for children from age 6 through 19*. Children do not have to be deprived of parental support and do not have to reside a specified relative to receive coverage.

Household Size	Income Limits (100% of Poverty)	Household Size	Income Limits (100% of Poverty)
1	$ 716.00	4	$1,471.00
2	968.00	5	1,723.00
3	1,220.00	6	1,975.00

*Children who turned 18 prior to October 1, 2001 are eligible only through the month of their 18th birthday.

Deductions: Same as Family Medicaid.
Spend down: Not allowed.
Asset limits: Same as FM.
Retroactive coverage: Allowed.

Medically Needy Child (CM)

Households who do not meet the FM deprivation of support requirements and whose income exceeds the NB Medicaid limit, may be eligible for CM Medicaid for children under age 18 or for children between age 18 and 19 who are in school and will graduate before turning 19. Children do not have to be living with a specified relative and the income and assets of adult household members who are not the parents of

the child are not counted. All other eligibility factors follow the guidelines under the regular Family Medicaid program. Spend down is allowed.

Refugee Medical Assistance (RMA)

Refugees entering the United States are eligible to apply for Medicaid for 8 months after their date of entry. The same income and resource standards apply as for FM Medicaid. Refugee Financial Assistance automatically provides eligibility for RMA.

Medicaid Cancer Program

The Medicaid Cancer Program provides full Medicaid benefits to uninsured women under age 65 who are identified through CDC (Center for Disease Control) providers and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. The UCCP (Utah Cancer Control Program) is the CDC provider that will complete screening. If a woman has another type of cancer but the primary cancer is breast or cervical cancer, they may still meet the requirement.

A woman must meet the general Medicaid requirements along with the following requirements:

- ? Screened by the CDC
- ? Need treatment for breast or cervical cancer
- ? Cannot have coverage under a group health plan or other health insurance coverage plan which would cover the treatments needed for breast or cervical cancer
- ? Must be under the age of 65

Income: There are no income limits after meeting the screening by CDC.
Asset limits: None.
Retroactive coverage: Allowed, but not before July 1, 2001.

Aged, Blind, Disabled Medical (A, B, D)

Provides a Medicaid card for individuals who are Aged (65+), Blind, or Disabled. People who want to qualify on the basis of disability must meet the Social Security criteria for being disabled. If disability is denied by Social Security due to Substantial Gainful Activity (SGA), the Medicaid Medical Review Board may still look at disability without considering SGA.

Receipt of SSI or SSA disability benefits meets the criteria for disability. If the person receives SSI, we do not count income of a spouse or parent; assets of a spouse or parent will be counted. The SSI person's income doesn't count toward the income limit except for nursing home or Home and Community Based Waiver clients. Some individuals who lose their SSI payments may still qualify without a spenddown under a protected group.

Household Size	Income Limits
1	$382.00
2	468.00

Deductions: $20.00 general income exclusion, health insurance premiums, $65.00 and ½ of the remaining gross earned income, impairment related work expenses, medical bills.
Spend down: Allowed.
Asset limits: 1 person - $2,000 2 people - $3,000 Each additional person add $25
Retroactive coverage: Allowed.

Aged and Disabled Poverty Level Medical (A, D)

Provides a medical card for people 65 years of age or older, or disabled according to Social Security disability criteria, who have income at or below 100% of the federal poverty limit. People who qualify under this coverage group do not have to pay for their medical card. Income of a spouse or parent is countable to the eligible person. This coverage group is not available to person's whose only impairment is legal blindness.

Household Size	Net Income Limit (100% of poverty)
1	$716
2	$968

Resource Limit: 1 person - $2,000 2 people - $3,000
Deductions: $20.00 general income disregard. $65.00 of earned income and one-half of the remaining earned income is not counted. **No** deductions for health insurance premiums or medical bills.
Spenddown: Not allowed
Retroactive coverage: Allowed.

Medicaid Work Incentive Program (DM)

A Medicaid program for disabled individuals with earned income. The household income limit is 250% of the federal poverty level. If household net income does not exceed 100% of poverty, the individual will not have any cost sharing responsibilities (buy-in premium). If household net income is above 100% of poverty but below the 250% income limit, the individual will pay a buy-in premium equal to 20% of their net countable income.

Basic Qualifying Factors:
Income limits and household size:
The following people will be counted in the household size: the client, a spouse living in the home, parents of a minor child, minor children and children up to age 21 who are full-time students, and siblings (up to age 21 who are full-time students) of a minor client. Only the income of the client, a spouse living in the home and income of parents of a minor client will be counted and compared to the 250% of poverty limit.

HH Size	250% Poverty
1	$1790
2	$2419
3	$3048
4	$3678
5	$4307
6	$4936

Deductions:	$20 General income disregard; the first $65 of earned income and ½ of the remaining; impairment related work expenses. Allocations for children or parents are not allowed. A spouse's income does not have to exceed the allocation to be counted in the 250% test.
Buy-In Premium:	Equal to 20% of the eligible individual's net countable income. Must be paid in cash; medical bills are not allowed to meet the buy-in premium.
Asset Limit:	$15,000 for all household sizes.
Retroactive Coverage:	Allowed (3 months prior to the date of application) but not to start before July 1, 2001. Must meet all eligibility factors each month**.**

MEDICARE COST-SHARING PROGRAMS

There are four related programs available to individuals with Part A Medicare benefits. These programs help cover some of the recipient's costs for Medicare services. They are not Medicaid programs, but a Medicaid recipient who is eligible for Part A Medicare may be eligible for both Medicaid and either QMB or SLMB coverage. Qualifying Individuals (QI) benefits are only available to people who are not receiving Medicaid. Poverty limits change in April of each year.

Qualified Medicare Beneficiaries Program (QMB)

The QMB program picks up costs for low-income **Medicare** recipients which go along with their Medicare cards. People who receive or are eligible to receive Part A Medicare may apply for QMB. QMB pays Medicare Part B premiums and deductibles, the 20% co-payment of Medicare-approved amounts, and co-payments for Medicare-approved, skilled nursing home. It can also pay Part A premiums. It takes about three months after you become eligible for QMB for your Social Security check to increase. You will also be reimbursed by Social Security, at that time, for each month of eligibility. Income from a non-eligible spouse is countable. Coverage begins the first of the month after you are determined eligible. A card will be issued each month. If you do not have Medicaid, the card will read "MEDICARE COST-SHARING ONLY."

Income limits:	100% of poverty. 1 person -$716 2 people -$968
Deductions:	$20.00; $65 of earned income and ½ of remaining earned income is counted.
Spend down:	Not allowed.
Asset limits:	1 person - $4000 2 people - $6000
Retroactive Coverage:	Not allowed.

Specified Low-Income Medicare Beneficiaries (SLMB)

The SLMB program pays the Part B Medicare premium only. Part B Medicare covers a person's physician care, and a variety of out-patient services including out-patient hospital services. The charge is $50.00 per month for 2001. Applicants must pass all the QMB rules, except that their income exceeds 100% of poverty and does not exceed 120% of poverty. The only benefit on this program is the payment of the Part B premium. It takes about three months after you become eligible for SLMB for your Social Security check to increase. You will also be reimbursed by Social Security, at that time, for each month

of eligibility. No card is issued for the SLMB program. An individual may be eligible for both Medicaid and SLMB.

Income limits:	1 person - $859.00	2 people - $1,161.00
Asset limits:	1 person - $4000	2 people - $6000
Retroactive Coverage:	Allowed.	

Qualifying Individuals (QI)

The QI programs pay either all or a part of the Part B Medicare premium. There are two different groups of Qualifying Individuals--Group 1 and Group 2. The criteria is exactly the same as the SLMB program except that the income limits are higher, and the individual **cannot** be eligible for Medicaid coverage. This is not an entitlement program. States have been granted a set amount of federal money to cover the benefits paid by the QI program. When funds have been allocated for a calendar year, no new applicants will receive any benefits. No card is issued for the QI programs.

QI-Group 1
The income limit for QI-Group 1 is from 120% to 135% of poverty. The benefit individuals qualifying under Group 1 will receive is payment of their monthly Part B premium. It takes about three months after you become eligible for QI-Group 1 for your Social Security check to increase. You will also be reimbursed by Social Security, at that time, for each month of eligibility.

QI-Group 2
The income limit for QI-Group 2 is from 135% to 175% of poverty. Individuals who qualify under Group 2 will only have a small portion of their Part B premium paid. The amount of the monthly benefit is $3.09 in 2001. This amount will be multiplied by the number of months a person is eligible during a year and will be paid to Group 2 recipients in the form of a 'refund' check from the Department of Health after the end of the calendar year.

Funding is limited for these groups. When funds are used up, new applicants will be denied coverage. Eligibility in future calendar years is not guaranteed.

Income limits:	Group 1 individuals--1 person = $ 967; 2 persons = $1,307.
	Group 2 individuals--1 person = $1,307; 2 persons = $1,694.
Asset limits:	1 person - $4000 2 people - $6000
Retroactive Coverage:	Allowed.

MEDICAID FOR LONG-TERM CARE

To get Medicaid to pay for long term care people must be financially and medically eligible. The individual may enter a medical facility such as a nursing home, or in some cases may be able to receive care in his or her own home under one of the home and community based waivers.

Nursing Home (NH)

Nursing home Medicaid will pay for nursing home and other medical costs. Some different income and asset rules apply for married couples. The patients doctor and the nursing home must give facts about how ill the patient is to see if the patient qualifies medically for Medicaid.

Income limits:	Complicated. For single people short term (less than 6 months) eligibility is different than long term stay. The nursing home resident is able to keep $45 of monthly income for personal needs such as a permanent or hair cut. The rest of the money, in most cases, must be paid to the nursing home
Supplemental income:	SSI recipients in nursing homes receiving $30 a month plus a state supplemental payment of $15.
Deductions:	Complex. Under Spousal Impoverishment lae, a spouse at home is allowed to keep a portion of total income for living expenses. Medical insurance is a deduction.
Spend down:	Allowed. It is considered a contribution to care and is paid to the nursing home.
Asset limits:	Complex. Under Spousal Impoverishment law, the nursing home client is allowed $2,000.00. The spouse at home may keep ½ the total amount of countable assets. There are some exceptions. The spouse at home may keep a minimum of $17,400 of the assets the couple owned when the patient entered the nursing home, but no more than a maximum of $87,000. These amounts go up January 1st of each year.
Transfer of Assets:	Transfers of assets for less than the fair market value can result in the person being ineligible (i.e., sanctioned) for nursing home Medicaid services for a period of time. When an application for Medicaid is made, the eligibility worker will request information from the prior 36 months about what the person has done with assets. This is called the look-back period. The look-back period is 60 months for assets in trusts.
Retroactive Coverage:	Allowed for nursing home charges only from the date the patient is determined medically eligible. Ancillary (non nursing home) charges are allowed. For more information request the pamphlet "Nursing Home Information, May we be of service to you" BES PM 969. For Married couples also request, "Assessment of Assets" BES PM 992.

Aging Home and Community Based Waiver

A special program for clients who would be medically appropriate for institutional care. This program offers incentives for clients to remain in their own home. These clients are eligible for medical services that are not generally available to Medicaid recipients, such as day treatment programs, lifeline, and in-home respite care. To be eligible for this program recipients must be at least 65 years old. The referral process begins with the Area Agency on Aging (AAA). A case manager from AAA must complete an evaluation of the individual's appropriateness for the waiver.

Income limits:	100% of poverty (adjusted annually). Only the waiver client's income counts.
Deductions:	$125 earned income deduction, spousal and family allowance, health insurance premiums medical expenses, some shelter costs.
Spend Down:	Allowed
Asset Limits:	Complex. $2000, spousal impoverishment applies.
Transfer of Assets:	Same as Nursing Home. Waiver services will not be paid during a sanction period.

Retroactive coverage: Allowed. Waiver services allowed only back to the date the person met the medical criteria as certified by the AAA worker.

DD/MR Home and Community Based Waiver

A special program which helps severely disabled people of any age remain in their own homes rather than being institutionalized. Space is limited in this program. Applications are taken through the Division of Services for People with Disabilities (DSPD). One advantage of this program is that none of the parent's income or assets are counted towards a minor child's eligibility. Also, an intensive service plan is drawn up for the client. All services are paid for by Medicaid. To be eligible for this program, clients must have been disabled before age twenty-two.

Income limits: 100% of poverty (adjusted annually)
Deductions : $740 earned income deduction, health insurance premiums, medical bills, and deduction for a dependent spouse or children.
Spend down: Allowed.
Asset limits: Complex. $2000, spousal impoverishment applies.
Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.
Retroactive Coverage: **A**llowed. Waiver services allowed only back to the date the client met the medical criteria as certified by DSPD.

Technology Dependent Children Waiver

A special program which helps medically fragile children remain in their own homes rather than being institutionalized. Space is limited in this program. Children can qualify for this waiver through the month in which the they turn 21. Recipients 21 and older who are admitted to the waiver prior to their 21st birthday may receive ongoing benefits. Applications are taken through the Division of Family Health Services. One advantage of this program is that none of the parent's income or assets are counted towards the child's eligibility. Also, an intensive service plan is drawn up for the client. Parents receive specialized training to learn how to provide some of the care the child needs. Families usually receive private-duty nursing services due to the complex medical condition of these children. All services are paid for by Medicaid. To be eligible for this program, clients must meet specific medical criteria.

Income limits: 100% of poverty (adjusted annually)
Deductions : $125 earned income deduction, health insurance premiums, medical bills, and deduction for a dependent spouse or children.
Spend down: Allowed.
Asset limits: Complex. $2000, spousal impoverishment applies.
Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.
Retroactive Coverage: Allowed. Waiver services allowed only back to the date the client met the medical criteria as certified by the Family Health Services worker.

Brain Injury Waiver

A special program for clients who have a brain injury and would be medically appropriate for institutional care. This program offers incentives for the client to remain in their own home. These clients are eligible for medical services that are not generally available to Medicaid recipients, such as supported employment, day treatment programs, behavioral training, and in-home respite care. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits:	100% of poverty (adjusted annually) Only the waiver client's income is counted.
Deductions :	$125 earned income deduction, some shelter expenses, health insurance premiums, medical bills, and deduction for a dependent spouse or children.
Spend down:	Allowed.
Asset limits:	Complex. $2000, spousal impoverishment applies.
Transfer of Assets:	Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.
Retroactive Coverage:	Allowed. Waiver services allowed only back to the date the client met the medical criteria as certified by the DSPD worker.

Physical Disabilities Waiver

Clients who are eligible for this waiver would be medically appropriate for institutional care. These clients are eligible for medical services that are not generally available to Medicaid recipients. Additional services available include, personal care assistance, consumer training, and personal emergency response services. Policy follows the institutional policy except that the client is allowed a higher income deduction.

Income limits: 300% of the SSI rate. This rate, which is adjusted annually, is $1,590.00 for 2001. If income exceeds 300% the person must spend down to $382.00 and follow DM income policy. Only the waiver client's income is counted.

Deductions :	All income deducted up to 300% of the SSI rate.
Spend down:	Allowed, If income is over 300% of SSI.
Asset limits:	Complex. $2000, spousal impoverishment applies.
Transfer of Assets:	Same as Nursing Home Medicaid. Waiver services will not be paid during a sanction period.
Retroactive coverage:	Allowed. Waiver services allowed only back to the date the client met the medical criteria as certified by the DSPD worker.

OTHER MEDICAL ASSISTANCE PROGRAMS

Utah Medical Assistance Program (UMAP)

A State sponsored program for adults between age 18 and 65 who need medical attention and do not qualify for any Medicaid program. The individual must meet the same U.S. Citizen or qualified alien

requirements required under the Medicaid program. At application, countable income from the previous 12 months is averaged. If the averaged income is equal to or less than the UMAP income limit then current income is used to determine eligibility. If the averaged income is greater than the UMAP limit, there is no eligibility regardless of current income. The resource and income limits are low compared to other programs. The services are also limited to mostly acute care services.

Household Size	Income Limits	Asset Limit
1	$337.00	1 person - $500
2	413.00	2 or more people - $750
3	516.00	
4	602.00	
5	686.00	
6	756.00	

Spend down: Cash only up to $50.00.
Deductions: Health insurance, taxes on earned income.
Retroactive Coverage: UMAP allows a 4 day grace period.

Children's Health Insurance Program (CHIP)

- 200% of FPL and down (all parental income excluding social security and child support that goes to a child)
- Under 19 years of age
- Child must be Legal resident or US citizen
- Currently not insured (if voluntarily dis-enrolled from previous insurance - 90 day waiting period)

CHIP is administered in two tiers, for those families earning less than 150% FPL, there are reduced co-pays for most services and no co-insurance for labs, x-rays, and hospital visits. Families earning more than 150% FPL are required to pay slightly higher co-pays for most services and up to a 20% co-insurance for hospital visits, labs, x-rays, medical equipment, and supplies.

As of October 26, 2001, CHIP enrollment was 25,988 children. According to Chad Westover, CHIP program Director, the total number of children eligible for CHIP in Utah is estimated at just over 36,000. A projected take up rate of 80% would result in 29,000 children covered by CHIP in Utah.

Use of Federal waivers:

The state of Utah currently has two 1915(b) Freedom of Choice waivers.

THE STATE OF UTAH 1915(b) PROGRAM - Choice of Health Care Delivery Program

Proposal Renewal Approval: July 23, 2001
Proposal Renewal Expiration: July 23, 2003

PROGRAM SUMMARY:

The State of Utah submitted a renewal proposal under Section 1915(b) of the Social Security Act (the Act) authority to provide Medicaid clients managed care services in the urban areas of Weber, Davis, Salt Lake and Utah counties. In the rural areas choosing a primary care provider or MCO is voluntary and Medicaid clients may remain with traditional fee for service.

The waiver operates in the following Counties: Weber, Davis, Salt Lake, and Utah. Since July 1, 1996 96% of Medicaid urban clients have been enrolled in MCOs. The program is administered by the Utah Department of Health, Division of Health Care Financing.

The uniqueness of the waiver is that it requires Medicaid clients living in urban counties to select an MCO that provides , through ongoing patient/physician relationship, primary care services and referral for all necessary specialty services.

In the rural areas of Utah Medicaid clients are offered the selection of a Primary Care Provider (PCP) or MCO, when available; traditional fee for service remains an option, as well. Enrollment is voluntary in the rural areas.

The State arranges for an annual independent, external review of the quality of services delivered under each MCO contract with the State. The entity which provides the annual external quality review is not part of the State government, and is not a managed care organization or an association of managed care organizations. The entity is HealthInsight, the federally-designated Peer Review Organization for Utah.

THE STATE OF UTAH 1915(b) PROGRAM - Utah Non-Emergency Transportation Waiver Program (UT06)

Approval: September 19, 2000
Expiration: September 18, 2002

PROGRAM SUMMARY:

The purpose of the waiver is to control costs through the selection of a Statewide non-emergency transportation broker who will be paid a monthly capitation rate based on the average number of eligibles for each month. The waiver program is operated directly by the state Medicaid agency. The State was and will continue to claim transportation as a service under the waiver.

The waiver was approved under 1915(b)(4) authority to allow the State to utilize a single broker statewide. A waiver of 1902(a)(23) was also granted to allow the State in order to constrain beneficiary freedom of choice to selected providers, in this case to the broker or subcontractors selected by the broker. The single broker will be selected through a competitive request for proposal (RFP) process.

The waiver will cover all Medicaid beneficiaries (TANF, SSI, and related populations) who have no personal transportation, have no access to public transportation, or have access to but cannot reasonably use public transportation due to a precluding disability or medical condition. Enrollment for eligible individuals will be mandatory. Populations excluded from this waiver are

those residing in a nursing facility or an ICF/MR or those who have access to and are capable of using public transportation.

The state of Utah currently has the following 1915(c) Home and Community-Based Services Regular Waivers and 1915(c) Home and Community-Based Services Model Approved Waivers.

Utah Home and Community-Based Services Regular Waivers as of *10/04/2001*

WAIVER	DESCRIPTION	STATUS	EFFECTIVE DATE
0158.90.R2	Provides Intermediate care facility for the mentally retarded, services include support coordination, community living, personal assistance, PERS, environmental accessibility adaptations, Chore and homemaker, supported employment, site and non-site-based day, senior supports, transportation, latch key, family assistance and support, respite, self-directed, educational, spec. medical equipment/supplies/assistive tech., and specialized supports. (Replaces 0158.90.R1 which expires 6/30/00)	Approved 6/30/00	07/01/2000
0158.90.R2.01	Waiver mod to 0158.90.R2 to accommodate the dual diagnosis pilot project.	Pending 6/29/01	
0158.90.R2.02	Waiver mod to 0158.90.R2 to decrease factor C for FY2002 from 3,755 to 3,564.	Pending 7/19/01	
0247.90.R1	To provide case management, homemaker, in-home respite, supportive maintenance, adult day care, PERS, non-medical transportation, home delivered meals and companion services. (Replaces 0247.90 which expires 6/30/00)	Approved 6/30/00	07/01/2000
0292.90	Provide case management, homemaker, respite, habilitation, supported employment, specialized medical equipment and supplies, PERS, companion, family training, transportation, structured day programming, community supported	Approved 9/30/99	07/01/1999

	living, and counseling to TBI age 18 and over. (Replaces 0292)		
0292.90.01	Waiver mod to 0292.90 to increase factor C from 59 to 82 for FY 2002.	Pending 7/19/01	
0331	To provide attendant care, personal emergency response systems, personal assistance services, and consumer preparation services to individuals with physical disabilities.	Approved 6/1/98	07/01/1998
0331.01	Waiver mod. to 0331 to change effective date and state contact person, amend provider qualifications for consumer prep. services and clarify the divisions which will enter into provider	Approved 4/2/99	07/01/1998
0331.02	Waiver mod to 0331 to add a new waiver service, Local Area Support Coordination Liaison and to amend the waiver's approved plan of care document.	Approved 12/26/00	07/01/2000
0331.90	To provide attendant care, PERS, local area support coordination liaison, consumer prep., nursing facility level of care.	Pending 7/2/01	

Utah Home and Community-Based Services Model Approved Waivers as of *10/04/2001*

WAIVER	DESCRIPTION	STATUS	EFFECTIVE DATE
40183.90	To provide respite, in-home respiratory care, nutritional evaluation and in-home based treatment, in-home family counseling, portable oxygen for non-medical transportation and activities to technology dependent/medically fragile under 21. (Replaces 40183 which expired 6/30/98) 7/15/98	Approved	07/01/1998
40183.90.01	Waiver mod to 40183.90 to change age criteria to over 21 years of age and older who were admitted t the waiver prior to their 21 birthday. 7/6/99	Approved	07/01/1998

40183.90.02	Waiver mod to 40183.90 to increase the number of individuals served for years 3, 4 and 5. 12/5/00	Approved	07/01/2000

Appendix II: Links to Research Findings and Methodologies

Indicate the Web site addresses for any additional sources of information regarding your State's research work, including detailed data spreadsheets, cross-tabs, focus group and key informant interview summary reports, survey instruments, and summaries of research methodology.

This information will be made available once our data collection efforts are complete. Results of the 1996 Utah Health Status Survey along with numerous other Utah Department of Health publications is available at: http://www.health.state.ut.us/action2000/. Results of studies completed by the Utah State Planning Grant will be posted on the project web-site at: http://www.health.state.ut.us/cu2002.

Copies of the 2001 Utah Health Status Survey, Utah Employer Health Insurance Survey, Individual Discrete Choice Survey Materials, and Employer Discrete Choice Survey Materials are attached. Please note that the attached versions of the discrete choice instruments are representative of the instruments used. Actual surveys depict hundreds of variations across a range of available plans, benefit packages, and cost-sharing combinations.

[1] The CPS uses a different methodology than that used in the Utah Health Status Survey, so the two are not directly comparable. The CPS does, however, provide annual rates that can be used to assess trends and in comparing Utah to other states.
[2] The number of Utahns who were uninsured was estimated by multiplying the estimated number of persons in the population by the estimate for percentage uninsured. Estimates of the percentage of persons who were uninsured was derived by adjusting the 1996 Utah Health Status Survey estimate by the percentage change in the 3-year moving average of the Current Population Survey, U.S. Census Bureau.
[3] Data sources: Estimates of the percentage of Utah children in poverty and percentage uninsured were from the 2000 Utah Child Health Survey. US Census population estimates by age group had not been released as of the publication date of this report. The GOPB population projection for this age group was modified by the ratio of the 2000 GOPB estimate: 2000 US Census estimate for the total population.
[4] Includes only persons whose primary status is "student."
[5] Data were insufficient to estimate insurance coverage for racial and ethnic minorities.
[6] Analysis of the Costs and Impact of Universal Health Care Coverage Under a Single Payer Model for the State of Vermont; August 2001. Prepared for: HRSA State Planning Grant, Office of Vermont Health Access.
[7] Information about Muskegon county's Access Health program can be found at http://www.access-health.org

2001 Utah Health Status Survey Questionnaire
Office of Public Health Assessment
Utah Department of Health

Tuesday, May 15, 2001

I.D.#:_____

AREA CODE AND TELEPHONE NUMBER:_____-_____-_____

INTERVIEW TIME:

S1a. REGION (Local Health District)

1...BEAR RIVER	2...CENTRAL	3...DAVIS
4...SALT LAKE	5...SOUTHEAST	6...SOUTHWEST
7...SUMMIT	8...TOOELE	9...UINTAH
10...UTAH	11...WASATCH	12...WEBER/MORGAN

INTRODUCTION

Hello, this is _____ calling from PEGUS Research of Salt Lake City. The Utah Department of Health has commissioned us to conduct a research study about the health of people in your state. Your telephone number has been randomly chosen to be included in the study and we'd like to ask some questions about the health of people living in your household to guide state health policies. **(If necessary, read:)** The information will be used by state lawmakers, public health programs and by your local health department in setting the public health agenda for the next five years. In order for the study to truly represent all Utahns, it is extremely important that we conduct an interview with every randomly selected household. **(If respondent wants to verify survey legitimacy, give out phone number (800) xxx-xxxx)**

1 . . . AVAILABLE **(CONTINUE)**
7 . . . NOT AVAILABLE **(SET TIME TO CALL BACK)**

S1b. Is this a residential number in the state of Utah?
1 . . . YES **(CONTINUE)**
2 . . . NO **(THANK AND TERMINATE)**
3 . . . (DK) **(THANK AND TERMINATE)**
4 . . . (REFUSED)**(THANK AND TERMINATE)**

S1c. Is this (xxx)xxx-xxxx?

Interviewer Note: If they ask how you got their number, state that the phone number was randomly generated by computer.

S3. May I please speak to the adult in the household, age 18 or older, who has had the most recent birthday?

Interviewer Note: This would be the adult in the household who celebrated the last birthday, not the person with the birthday closest to today.

CONSENT. All of your answers and your phone number will remain completely confidential. Also, if there is any question you do not want to answer just let me know and we'll go on to the next one. If it is alright with you my supervisor may listen to all or part of this call to monitor my performance. (45 CFR 46.116, Title 21 CFR Part 56.116)

1. CONTINUE WITH THE SURVEY
2. NOT A GOOD TIME RIGHT NOW/ CALLBACK
3. REFUSAL

S2. In what county is this household located? (Open ended and code to FIPS code)
001 . . . BEAVER TO 057 . . . WEBER (RECODED 1-29)

S3a. We need to know how many people are in your household so that we can ask you relevant questions. Please tell me how many people, age 18 or older live in your household, including yourself? (Open ended **and code actual number)** **(If not sure, ask:)** Is this CURRENTLY his/her primary residence? **(For students living away from home and for LDS missionaries, the answer should be "No")**

00 . . . NONE
01 . . . ONE
02-11... ENTER # OF PEOPLE
12..... 12 OR MORE
98 . . . (DK) **(THANK AND TERMINATE)**
99 . . . (REFUSED) **(THANK AND TERMINATE)**

S4. How many members of your household are children under 18 years of age? (Open ended **and code actual number)**

00 . . . NONE
01 . . . ONE
02-11... ENTER # OF PEOPLE
12..... 12 OR MORE
98 . . . (DK)
99 . . . (REFUSED)

(If code "01" in S3a, Skip to S6; Otherwise, Continue)

S9a. Thinking about ALL the adults in your household who are age 18 or older, who would know the MOST about EVERYONE'S health in your household? Would that be you, or some other household member?

1..... RESPONDENT **(CONTINUE)**
2..... RESPONDENT & SOMEONE ELSE EQUALLY **(CONTINUE)**
3..... SOME OTHER HOUSEHOLD MEMBER **(CONTINUE)**
4..... (DK) **(SKIP TO S10)**
5..... (REFUSED) **(SKIP TO S10)**

(If code "3" in S9a, read:) Thank you. That information will help us compare these survey results with other health surveys we've conducted in the past. For this survey I need to interview you because you were the one randomly selected.

(Variables S6 through STATUS will be asked of the respondent first. After that they will cycle through for each individual in the household, then continue onto HISPANIC for the respondent.)

S6a-z. What is your first name? **Note:** If they don't want to give you a name, ask for initials. This in ONLY to help you keep track of who you are talking to/about during the survey.

Not including yourself, of those 4 people in your household, who is the next oldest? What is their first name?

HOUSEHOLD MEMBER DEMOGRAPHIC CHARACTERISTICS

GENDER: **(Autocode respondent's … Adults a-f = male, Adults g-l=female)**
Thinking about the (next) oldest person in the household, (**response in S6a-z)**, is this individual a male or a female?

1..... MALE
2..... FEMALE

RELASHIP: **(will not be asked of respondent)**

00..... RESPONDENT
01..... SPOUSE
02..... SON
03..... DAUGHTER
04..... SON-IN-LAW (OF RESP OR SPOUSE)
05..... DAUGHTER-IN-LAW (OF R OR SPOUSE)
06..... FATHER (OF RESPONDENT OR SPOUSE)
07..... MOTHER (OF RESPONDENT OR SPOUSE)
08..... BROTHER (OF RESP OR SPOUSE)
09..... SISTER (OF RESPONDENT OR SPOUSE)
10..... OTHER RELATIVE
11..... NON RELATIVE
12..... (DK)
13..... (REFUSED)

(If S4<1, skip to AAGE;
otherwise, continue)

ADOPT Are any children under age 18 living in the household adopted? We are interested in adopted children who do not live with either biological parent.

1..... YES
2..... NO
3 (DK)
4..... (REFUSED)

(READ:)..... If there are any questions about other household members that you're not sure how to answer, feel free to confer with other people in the household.

AAGEa-l: How old were you (was [fill person's name]) on your (his/her) last birthday? (Open ended **and code actual age in years)**

ENTER # OF YEARS, _____ 18-96
97..... 97 OR MORE YEARS
98..... DK
99..... REFUSED

CAGEm-x: How old is [fill person's name]? (Open ended)

ENTER # GIVEN, _____
98..... DK
99..... REFUSED

CAGE2m-x: Is that in weeks, months, or years?

01…… WEEKS
02…… MONTHS
03…… YEARS

98..... (DK)
99..... (REFUSED)

HEALTH. In general, would you say your (your/that **response in RELASHIP**) health is excellent, very good, good, fair, or poor?

1..... EXCELLENT
2..... VERY GOOD
3..... GOOD
4..... FAIR
5..... POOR
6..... (DK)
7..... (REFUSED)

(If age <18, skip to next respondent question)

HEIGHT. About how tall are you (is your/that **response in RELASHIP**) without shoes? (Open ended **and code actual height)** **(Round to the nearest inch, 1/4 rounds down; 2 or 3/4 round up)**

_____ FEET _____ INCHES
9.98..... (DK)
9.99..... (REFUSED)

WEIGHT. About how much do you (does your/that **response in RELASHIP**) weigh, without clothes and shoes? (Open ended **and code actual weight)**

998..... (DK)
999..... (REFUSED)

EDUCAT. What is the highest year or grade of education you have (your/that **response in RELASHIP** has) completed? (Open ended and code)

1..... SOME HIGH SCHOOL OR LESS
2..... HIGH SCHOOL GRADUATE/GED
3..... SOME COLLEGE OR VOCATIONAL SCHOOL
4..... TECH./VOCATIONAL SCHOOL GRAD/ASSOC. DEGREE
5..... COLLEGE GRADUATE (4-YEAR COLLEGE DEGREE)
6..... SOME POSTGRADUATE COURSES
7..... POSTGRADUATE/PROFESSIONAL DEGREE
(MA, MS, PHD, JD, MD, ETC.)
8..... (DK)
9..... (REFUSED)

EMPLOYEDa-l. Thinking about the last 12 months, were you (was your/that **response in RELASHIP**) employed, that is, working for pay, during MOST of that time?

1..... YES **(CONTINUE)**
2..... NO **(SKIP TO JOBSTATA-L)**
3..... (DK) **(SKIP TO STATUS)**
4..... (REFUSED) **(SKIP TO STATUS)**

HOURSWKD. **(If code "1" in EMPLOYEDa-l, ask:)** Counting hours from all jobs, how many hours did you (he/she) work for pay during a TYPICAL WEEK last year? (Open ended **and code actual number)**

98..... (DK)
99..... (REFUSED)

EMPCSELF.... **(If code "01" in S3a, ask:)** Are you/they self-employed?

1..... YES
2..... NO
3..... (DK)

4..... (REFUSED)

JOBSTATa-l. **(If code "2" in EMPLOYED, ask:)** Were you primarily **(read 1-6)**?

1..... RETIRED **(SKIP TO STATUS)**
2..... KEEPING HOUSE **(CONTINUE)**
3..... A FULL TIME STUDENT **(SKIP TO STATUS)**
4..... TEMPORARILY NOT AT WORK **(SKIP TO STATUS)**
5..... UNEMPLOYED AND LOOKING FOR WORK,
OR**(SKIP TO STATUS)**
6..... UNABLE TO WORK **(SKIP TO STATUS)**
7..... [OTHER (DO NOT LIST)] **(SKIP TO STATUS)**
8..... (DK) **(SKIP TO STATUS)**
9..... (REFUSED) **(SKIP TO STATUS)**

STATUS. Are you (is that/your **response in RELASHIP**) currently **(read 1-5)**?

(If respondent says, "DK" or "living as married", probe:) What category do you think you fall into?

1..... MARRIED
2..... DIVORCED
3..... WIDOWED
4..... SEPARATED, OR
5..... NEVER MARRIED
6..... (DK)
7..... (REFUSED)

HOFH……..Of the adults living in your house, who would you say is the head of the household?

Interviewer Note: If respondent has trouble answering this question because they are unsure who the Head of Household is, tell them that for our purpose the HofH if the person who's job is most likely to provide health insurance. If that does not work tell them that it is up to them.

HISPANIC….. Are you (is your/that **response in RELASHIP**) of Spanish, Hispanic, or Latino origin or descent?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

(If code "01" in S3a AND code "00" in S10, Skip to RACEa-x;
Otherwise, Continue)

HISPAN2. Are any other household members of Spanish, Hispanic, or Latino origin?

1..... YES, ALL
2..... YES, SOME
3..... NO, NO ONE ELSE IS
4..... (DK)
5..... (REFUSED)

(If code "02" in HISPAN2, continue;
Otherwise, skip to RACEa)

HISPAN3b-l. Will you please list which other household members are of Spanish, Hispanic, or Latino origin?

1..... [FILL PERSON 1]
2..... [FILL PERSON 2]
3..... [FILL PERSON 3]
4..... [FILL PERSON 4]
5 ETC ……..

(READ)……. The next few questions ask about race.

RACE1…….. Do you consider yourself to be BLACK or AFRICAN AMERICAN?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

RACE2..... Do you consider yourself to be ASIAN?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

RACE3..... Do you consider yourself to be NATIVE HAWAIIAN or OTHER PACIFIC ISLANDER?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

RACE4..... Do you consider yourself to be AMERICAN INDIAN or ALASKA NATIVE?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

RACE5……..Do you consider yourself to be WHITE?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

RACE6..... Do you consider yourself to be SOMETHING ELSE, other than what I have already mentioned?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

RACE7.....What race do you consider yourself to be? **(Type In Exactly What The Respondent Says)**

(If code "88" or "99" in RACEa-x, Continue to RACEBESTb-x;
(If code "01" in S3a AND code "00" in S10, Skip to SF2;
Otherwise, skip to RACEALL)

RACEBESTb-x. Which one of these groups would you say **BEST** describes your race **(uses same categories and questions as RACE1 -7 above)?**

(If code "01" in S3a AND code "00" in S10, Skip to RACEBESTb-x;
If code "08-09" in RACEa, Skip to SF2;
Otherwise, Continue)

RACEALL…. Is everyone else in the household **(response in RACE)**?
1..... YES, ALL
2..... YES, SOME
3..... NO
4..... (DK)
5..... (REFUSED)

(if code "3" in RACEALL go to RACEb-x (for each person in household)

MEDICAL OUTCOMES STUDY, SF-12

[Question HEALTH, "In general, would you say your health is excellent, very good, good, fair or poor?" is the first item in the SF12 scale.]

SF2. The next few questions ask about activities you might do during a typical day. Does YOUR HEALTH NOW LIMIT YOU IN MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling or playing golf? Would you say you are limited a lot, a little, or not at all?

1..... A LOT
2..... A LITTLE
3..... NOT AT ALL
4..... (DK)
5..... (REFUSED)

SF3. How about CLIMBING SEVERAL FLIGHTS OF STAIRS? Would you say your health limits you a lot, a little, or not at all?

1..... A LOT
2..... A LITTLE
3..... NOT AT ALL
4..... (DK)
5..... (REFUSED)

During the past 4 WEEKS, how much of the time have you had any of the following problems with your work or regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?

SF4. How much of the time have you ACCOMPLISHED LESS than you would like? Would you say …

1..... ALL OF THE TIME
2..... MOST OF THE TIME
3..... SOME OF THE TIME
4..... A LITTLE OF THE TIME, OR
5..... NONE OF THE TIME
7..... (DK)
8..... (REFUSED)

SF5. How much of the time were you limited in the KIND of work or other activities you could do?

1..... ALL OF THE TIME
2..... MOST OF THE TIME
3..... SOME OF THE TIME
4..... A LITTLE OF THE TIME, OR
5..... NONE OF THE TIME
7..... (DK)
8..... (REFUSED)

During the past 4 WEEKS, how much of the time have you had any of the following problems with your work or other daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS, such as feeling depressed or anxious.

SF6. How much of the time have you ACCOMPLISHED LESS than you would like?

1..... ALL OF THE TIME
2..... MOST OF THE TIME
3..... SOME OF THE TIME
4..... A LITTLE OF THE TIME, OR
5..... NONE OF THE TIME

7..... (DK)
8..... (REFUSED)

SF7. How much of the time did you have trouble doing work or other activities as CAREFULLY as usual?

1..... ALL OF THE TIME
2..... MOST OF THE TIME
3..... SOME OF THE TIME
4..... A LITTLE OF THE TIME, OR
5..... NONE OF THE TIME
7 (DK)
8..... (REFUSED)

SF8. During the past four weeks, how much did PAIN interfere with your normal work including both work outside the home and housework, would you say **(read 1-5)**?

1..... NOT AT ALL
2..... A LITTLE BIT
3..... MODERATELY
4..... QUITE A BIT, OR
5..... EXTREMELY
6..... (DK)
7..... (REFUSED)

SF9. The next three questions ask about how you feel and how things have been with you DURING THE PAST FOUR WEEKS. How much of the time during the past four weeks have you felt calm and peaceful? Would you say **(read 1-6)**?

1..... ALL OF THE TIME
2..... MOST OF THE TIME
3..... SOME OF THE TIME
4..... A LITTLE OF THE TIME, OR
5..... NONE OF THE TIME
7..... (DK)
8..... (REFUSED)

SF10. How much of the time during the PAST FOUR WEEKS did you have a lot of energy? Would you say **(read 1-6)**?

1..... ALL OF THE TIME
2..... MOST OF THE TIME
3..... SOME OF THE TIME
4..... A LITTLE OF THE TIME, OR
5..... NONE OF THE TIME
7..... (DK)
8..... (REFUSED)

SF11. How much of the time during the past four weeks have you felt downhearted and blue? **(If necessary, read 1-6)**

1..... ALL OF THE TIME
2..... MOST OF THE TIME
3..... SOME OF THE TIME
4..... A LITTLE OF THE TIME, OR
5..... NONE OF THE TIME
7..... (DK)
8..... (REFUSED)

SF12. During the last four weeks, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities, like visiting with friends, relatives, etc.? **(If necessary, read 1-6)**

1..... ALL OF THE TIME
2..... MOST OF THE TIME
2..... SOME OF THE TIME
4..... A LITTLE OF THE TIME, OR
5..... NONE OF THE TIME
7..... (DK)
8..... (REFUSED)

HELP1. During the PAST 12 MONTHS, did you seek help from a therapist, counselor, or other mental health professional for any personal or emotional problems?

1..... YES ..... **(SKIP TO DIAB1)**
2..... NO ..... **(CONTINUE)**
3..... (DK) .. **(CONTINUE)**
4..... (REFUSED) **(CONTINUE)**

(If code "1 or 2" in SF6 OR If code "1 or 2" in SF7 OR If code "3-6" in SF9 OR If code "4-6" in SF10 OR If code "1-4" in SF11 OR If code "1-4" in SF12, Continue; Otherwise, Skip to DIAB1)

HELP2. Did you CONSIDER seeking help for any personal or emotional problems during the past 12 months?

1..... YES .... **(CONTINUE)**
2..... NO ..... **(SKIP TO DIAB1)**
3..... (DK) ... **(SKIP TO DIAB1)**
4..... (REFUSED) **(SKIP TO DIAB1)**

HELP3. **(If code "1" in HELP2, ask:)** What was the primary reason you did NOT seek help? (Open ended)

01..... OTHER (LIST)
02..... (DK)
03..... (REFUSED)
04..... HOLD
05..... HOLD

MEDICAL CONDITIONS

(READ:) Now I am going to ask about some medical conditions.

Diabetes

DIAB1. ..... Has a medical DOCTOR or other health professional ever told anyone currently living in your household that they have ANY KIND OF DIABETES? **(If respondent indicates diabetes while pregnant (gestational), code as "1")**

1..... YES . ..... **(CONTINUE)**
2..... NO..... ..... **(SKIP TO ASTH1)**
3..... (DK) ... . **(SKIP TO ASTH1)**
4..... (REFUSED)..... **(SKIP TO ASTH1)**

DIAB2. ..... **(If code "1" in DIAB1, ask:)** I need to list all household members who have been told by a doctor they have diabetes starting with the oldest? **(Probe:)** Any others? Who is the next oldest household member? (Open ended and code)

01 ..... **(RESPONSE IN S6-A)**
02..... **(RESPONSE IN S6-B)**
03..... **(RESPONSE IN S6-C)**
04..... **(RESPONSE IN S6-D)**
05..... **(RESPONSE IN S6-E)**
06..... **(RESPONSE IN S6-F)**
07..... **(RESPONSE IN S7-A)**
08..... **(RESPONSE IN S7-B)**
09..... **(RESPONSE IN S7-C)**
10..... **(RESPONSE IN S7-D)**
11..... **(RESPONSE IN S7-E)**
12..... **(RESPONSE IN S7-F)**
13..... **(RESPONSE IN S11-A)**
14..... **(RESPONSE IN S11-B)**
15..... **(RESPONSE IN S11-C)**
16..... **(RESPONSE IN S11-D)**
17..... **(RESPONSE IN S11-E)**
18..... **(RESPONSE IN S11-F)**
19..... **(RESPONSE IN S11-G)**
20..... **(RESPONSE IN S11-H)**
21..... **(RESPONSE IN S11-I)**
22..... **(RESPONSE IN S11-J)**
23..... **(RESPONSE IN S11-K)**
24..... **(RESPONSE IN S11-L)**
25..... NONE OF THESE
26..... (DK)
27..... (REFUSED)

(If response in DIAB1 = 1 and if response in DIAB2 = GENDER '2' [FEMALE] ask:)

DIAB3. ..... Did **(read A-F)**'s diabetes occur only during pregnancy, or has she also been diagnosed with diabetes while not pregnant?

1..... ONLY DURING PREGNANCY
2..... HAS BEEN DIAGNOSED WHILE NOT PREGNANT
3..... (DK)
4..... (REFUSED)

Asthma

ASTH1. …. Is anyone living in your household currently under medical care for ASTHMA?

1..... YES ... . **(CONTINUE)**
2..... NO..... ..... **(SKIP TO OPD1)**
3..... (DK) ... . **(SKIP TO OPD1)**
4..... (REFUSED)..... **(SKIP TO OPD1)**

ASTH2. ..... **(If code "1" in ASTH1, ask:)** I need to list all household members under medical care for asthma starting with the oldest? **(Probe:)** Any others? Who is the next oldest household member? (Open ended and code)

01 ..... **(RESPONSE IN S6-A)**
02..... **(RESPONSE IN S6-B)**
13..... **(RESPONSE IN S11-A)**
14..... **(RESPONSE IN S11-B)**

03..... **(RESPONSE IN S6-C)**
04..... **(RESPONSE IN S6-D)**
05..... **(RESPONSE IN S6-E)**
06..... **(RESPONSE IN S6-F)**
07..... **(RESPONSE IN S7-A)**
08..... **(RESPONSE IN S7-B)**
09..... **(RESPONSE IN S7-C)**
10..... **(RESPONSE IN S7-D)**
11..... **(RESPONSE IN S7-E)**
12..... **(RESPONSE IN S7-F)**
15..... **(RESPONSE IN S11-C)**
16..... **(RESPONSE IN S11-D)**
17..... **(RESPONSE IN S11-E)**
18..... **(RESPONSE IN S11-F)**
19..... **(RESPONSE IN S11-G)**
20..... **(RESPONSE IN S11-H)**
21..... **(RESPONSE IN S11-I)**
22..... **(RESPONSE IN S11-J)**
23..... **(RESPONSE IN S11-K)**
24..... **(RESPONSE IN S11-L)**
25.....NONE OF THESE
26.....(DK)
27.....(REFUSED)

Obstructive Pulmonary Disease

OPD1 . .....Is anyone living in your household currently under medical care for OBSTRUCTIVE PULMONARY DISEASE, such as CHRONIC BRONCHITIS or EMPHYSEMA?

1..... YES . .....**(CONTINUE)**
2..... NO..... .....**(SKIP TO STROKE1)**
3..... (DK)... .....**(SKIP TO STROKE1)**
4..... (REFUSED).....**(SKIP TO STROKE1)**

OPD2 . ..... **(If code "1" in OPD1, ask:)** I need to list all household members under medical care for obstructive pulmonary disease starting with the oldest? **(Probe:)** Any others? Who is the next oldest household member? (Open ended and code)

01 ..... **(RESPONSE IN S6-A)**
02..... **(RESPONSE IN S6-B)**
03..... **(RESPONSE IN S6-C)**
04..... **(RESPONSE IN S6-D)**
05..... **(RESPONSE IN S6-E)**
06..... **(RESPONSE IN S6-F)**
07..... **(RESPONSE IN S7-A)**
08..... **(RESPONSE IN S7-B)**
09..... **(RESPONSE IN S7-C)**
10..... **(RESPONSE IN S7-D)**
11..... **(RESPONSE IN S7-E)**
12..... **(RESPONSE IN S7-F)**
13..... **(RESPONSE IN S11-A)**
14..... **(RESPONSE IN S11-B)**
15..... **(RESPONSE IN S11-C)**
16..... **(RESPONSE IN S11-D)**
17..... **(RESPONSE IN S11-E)**
18..... **(RESPONSE IN S11-F)**
19..... **(RESPONSE IN S11-G)**
20..... **(RESPONSE IN S11-H)**
21..... **(RESPONSE IN S11-I)**
22..... **(RESPONSE IN S11-J)**
23..... **(RESPONSE IN S11-K)**
24..... **(RESPONSE IN S11-L)**
25.....NONE OF THESE
26.....(DK)
27.....(REFUSED)

Arthritis

ARTH1 .....Has anyone living in your household ever been told by a doctor that they have some form of ARTHRITIS, Rheumatoid Arthritis, gout, lupus, or fibromyalgia ?

1..... YES ... . **(CONTINUE)**
2..... NO..... .....**(SKIP TO STROKE1)**
3..... (DK)... .....**(SKIP TO STROKE1)**
4..... (REFUSED).....**(SKIP TO STROKE1)**

ARTH2.....**(If code "1" in ARTH1, ask:)** I need to list all household members who have ever been told by a doctor that they have some form of arthritis starting with the oldest? **(Probe:)** Any others? Who is the next oldest household member? (Open ended and code) **(Probe for six responses)**

01 ..... **(RESPONSE IN S6-A)**
02..... **(RESPONSE IN S6-B)**
03..... **(RESPONSE IN S6-C)**
04..... **(RESPONSE IN S6-D)**
05..... **(RESPONSE IN S6-E)**
06..... **(RESPONSE IN S6-F)**
07..... **(RESPONSE IN S7-A)**
08..... **(RESPONSE IN S7-B)**
09..... **(RESPONSE IN S7-C)**
10..... **(RESPONSE IN S7-D)**
11..... **(RESPONSE IN S7-E)**
12..... **(RESPONSE IN S7-F)**
13..... **(RESPONSE IN S11-A)**
14..... **(RESPONSE IN S11-B)**
15..... **(RESPONSE IN S11-C)**
16..... **(RESPONSE IN S11-D)**
17..... **(RESPONSE IN S11-E)**
18..... **(RESPONSE IN S11-F)**
19..... **(RESPONSE IN S11-G)**
20..... **(RESPONSE IN S11-H)**
21..... **(RESPONSE IN S11-I)**
22..... **(RESPONSE IN S11-J)**
23..... **(RESPONSE IN S11-K)**
24..... **(RESPONSE IN S11-L)**
25.....NONE OF THESE
26.....(DK)
27.....(REFUSED)

Stroke

STROKE1.....Has a medical DOCTOR or other health professional ever told anyone currently living in your household that they had a STROKE?

1..... YES .. .. **(CONTINUE)**
2..... NO..... .....**(SKIP TO HD1)**
3..... (DK)... .....**(SKIP TO HD1)**
4..... (REFUSED).....**(SKIP TO HD1)**

STROKE2..... **(If code "1" in STROKE1, ask:)** I need to list all household members who have been told by a doctor they have had a stroke starting with the oldest? **(Probe:)** Any others? Who is the next oldest household member? (Open ended and code)

01 ..... **(RESPONSE IN S6-A)**
02..... **(RESPONSE IN S6-B)**
03..... **(RESPONSE IN S6-C)**
04..... **(RESPONSE IN S6-D)**
05..... **(RESPONSE IN S6-E)**
06..... **(RESPONSE IN S6-F)**
07..... **(RESPONSE IN S7-A)**
08..... **(RESPONSE IN S7-B)**
09..... **(RESPONSE IN S7-C)**
10..... **(RESPONSE IN S7-D)**
11..... **(RESPONSE IN S7-E)**
12..... **(RESPONSE IN S7-F)**
13..... **(RESPONSE IN S11-A)**
14..... **(RESPONSE IN S11-B)**
15..... **(RESPONSE IN S11-C)**
16..... **(RESPONSE IN S11-D)**
17..... **(RESPONSE IN S11-E)**
18..... **(RESPONSE IN S11-F)**
19..... **(RESPONSE IN S11-G)**
20..... **(RESPONSE IN S11-H)**
21..... **(RESPONSE IN S11-I)**
22..... **(RESPONSE IN S11-J)**
23..... **(RESPONSE IN S11-K)**
24..... **(RESPONSE IN S11-L)**
25.....NONE OF THESE
26.....(DK)
27.....(REFUSED)

Heart Disease

HD1....Has a medical DOCTOR or other health professional ever told anyone currently living in your household that they have HEART DISEASE, such as angina, congestive heart failure, or heart attack?

1..... YES .. .. **(CONTINUE)**
2..... NO..... .....**(SKIP TO COV1)**
3..... (DK)... .....**(SKIP TO COV1)**
4..... (REFUSED).....**(SKIP TO COV1)**

HD2 ... **(If code "1" in HD1, ask:)** I need to list all household members who have been told by a doctor they have heart disease starting with the oldest? **(Probe:)** Any others? Who is the next oldest household member? (Open ended and code)

01 ..... **(RESPONSE IN S6-A)**
02..... **(RESPONSE IN S6-B)**
03..... **(RESPONSE IN S6-C)**
04..... **(RESPONSE IN S6-D)**
05..... **(RESPONSE IN S6-E)**
06..... **(RESPONSE IN S6-F)**
07..... **(RESPONSE IN S7-A)**
08..... **(RESPONSE IN S7-B)**
09..... **(RESPONSE IN S7-C)**
10..... **(RESPONSE IN S7-D)**
11..... **(RESPONSE IN S7-E)**
12..... **(RESPONSE IN S7-F)**
13..... **(RESPONSE IN S11-A)**
14..... **(RESPONSE IN S11-B)**
15..... **(RESPONSE IN S11-C)**
16..... **(RESPONSE IN S11-D)**
17..... **(RESPONSE IN S11-E)**
18..... **(RESPONSE IN S11-F)**
19..... **(RESPONSE IN S11-G)**
20..... **(RESPONSE IN S11-H)**
21..... **(RESPONSE IN S11-I)**
22..... **(RESPONSE IN S11-J)**
23..... **(RESPONSE IN S11-K)**
24..... **(RESPONSE IN S11-L)**
25.....NONE OF THESE
26.....(DK)
27.....(REFUSED)

HEALTH INSURANCE STATUS

Coverage Status

COV1. The next few questions ask about health insurance. By health insurance I mean private and employer plans, prepaid plans such as HMOs, and government plans, such as Medicare. Are any of the members of your household currently covered by health insurance?

1. YES
2. NO
3. DON'T KNOW
4. REFUSED

If COV1=Yes, then skip to COV2
If COV1=No, then continue

COV3. There are some types of plans you many not have considered, are any of the members of your household currently covered by…
[Read through COV2x1-10]

COV2. Please tell me if anyone in your household has any of the following, healthcare coverage …
[continue to COV2x1-COV2x10]

COV2x1. … that is provided through a current or former employer or union?
1. Yes
2. No

INT Note: This type of insurance includes 'COBRA'

COV2x2. A health insurance plan that you purchase directly from an insurance company and not through an employer or union?
1. Yes
2. No

INT Note: e.g., self-employed, not employed
If plan is purchased BY someone else FOR them, answer "yes" to this question.

COV2x3. The health plan of someone who does not live in the household?
1. Yes
2. No

COV2x4. Medicare?
1. Yes
2. No

COV2x5. Medicaid?
Yes
No

COV2x6. The Utah Children's Health Insurance Program, or CHIP, is a program for children of working parents whose children are uninsured or who earn too much for Medicaid benefits. Does anyone have coverage through CHIP?
1. Yes
2. No

COV2x7: An other government plan, such as Indian Health Service, Military, Champis, Tri-care or the V.A?
1. Yes
2. No

COV2x8. Does anyone have health insurance that covers ONLY certain specific medical conditions, such as for diabetes or breast cancer?

1. Yes
2. No

INT Note: This insurance would not cover ANYTHING ELSE, just the specific condition.

COV2x9. Coverage through some other source?
[SPECIFY – OPEN ENDED RESPONSE]

COV2x10. Is there anyone in your household who has no health care coverage, that is, none of the types of plans I just mentioned?

1. Yes
2. No

CATI will be programmed to create a list of all 'YES' responses in Q80x1-10. This list will then be used as the response options in the next question.

If COV2x1-COV2x9 = Yes, then ✍
COV2Fx1-9. Are all persons in your household covered by?

SLO1 A plan available through a current or former employer or union?

1. Yes – all are covered by same plan
2. No – Only some are covered by this plan

SLO2 ……. SLO10 [10 are possible]

1. Yes – all are covered by same plan
2. No – Only some are covered by this plan

If COV2Fx1 - COV2Fx9 all = Yes, skip to cardsize;
If any of COV2Fx1 - COV2Fx9 = No, then continue to COV4b-l.

COV4a-l. I'd like to ask about coverage for each person in your household. Starting with [fill person #1], does he/she have …

SLO1 A plan available through a current or former employer or union?

3. Yes
4. No

SLO2 ……. SLO10 [10 are possible]

1. Yes
2. No

How about [fill person #2]? ……. [cycle through everyone in household]

NOTE: IF YES to COV2x-10, when going through the Short List Options, if answer = YES to any type of insurance for a given individual, then skip the "No Insurance" short list option.

If all of COV2Fx1-9 = '1', ask of respondent only
If any of COV2Fx1-9 = '2', ask for every person in household
CARDSIZE. When thinking about [fill person]'s insurance card, would you say it is credit-card-sized, or a larger piece of paper?

(1) Credit Card Size
(2) Larger piece of paper
(7) don't know
(9) refused

CARDNEW. Do you receive a new I.D. card every month or is the I.D. card valid for longer?

(1) New ID card every month
(2) ID card valid for longer than once a month
(7) don't know
(9) refused

IF YES to COV2x-10, and if SLO1-9 = NO, and SLO10 is YES for [fill person], ask

UNINS. For how many months has [fill person] been uninsured?

00..... LESS THAN 4 WEEKS
01-60 .. ENTER # OF MONTHS
61..... MORE THAN 5 YEARS
98..... (DK)
99..... (REFUSED)

Reason Uninsured

(IF YES to COV2x-10, SLO1-9 = NO, and SLO10 is YES for [fill person], continue)
(IF not, skip to BENC1)

WHY1..... The next few questions ask about those household members who are uninsured. Is anyone in your household uninsured because ….

WHY2…… Your/their employer does not offer, or stopped offering health insurance coverage to its employees?

1 Yes
2 No
3 Not employed
8 Don't know/Not sure
9 Refused

WHY2a-l ……. Which household members?
(list all household members)

WHY3…… You/they lost your job or changed employers?

1 Yes
2 No
8 Don't know/Not sure
9 Refused

WHY3a-l ……. Which household members?
(list all household members)

WHY4……You/they are a part time or temporary employee?

1 Yes
2 No
8 Don't know/Not sure
9 Refused

WHY4a-l ……. Which household members?
(list all household members)

WHY5……You/they could not afford to pay the premiums?

1 Yes
2 No
8 Don't know/Not sure
9 Refused

WHY5a-l ……. Which household members?
(list all household members)

If (answer = 1) Continue to WHY5b
Skipto WHY6

WHY5b.a-l. ....Did an existing health condition cause your/their premium to increase beyond your/their ability to pay it?

1..... YES
2..... NO
3..... (DK)
4 …….(REFUSED)

WHY6……You/they are healthy and decided it would be safe for you/them to go without coverage?

1 Yes
2 No
8 Don't know/Not sure
9 Refused

WHY6a-l …..… Which household members?
(list all household members)

WHY7……The insurance company refused to cover you/them?

1 Yes
2 No
8 Don't know/Not sure
9 Refused

WHY7a-l ……. Which household members?
(list all household members)

If (answer = 1) Continue to WHY7b
Skipto WHY8

WHY7b. a-l……Did the insurance company refuse to cover you/them because .... (READ ALL RESPONSES)

1 Of a pre-existing condition
2 They exceeded lifetime benefits limits, or
3 of some other reason (specify)
8 Don't know/Not sure (DO NOT READ)
9 Refused (DO NOT READ)

WHY8……You/they lost Medicaid or CHIP eligibility?

1 Yes
2 No
8 Don't know/Not sure
9 Refused

WHY8a-l ……. Which household members?
(list all household members)

If (answer = 1) Continue to WHY8b
Skipto WHY9a-l

WHY8b.a-l…..Did you/they lose eligibility because... (READ ALL RESPONSES)

1 Your family income increased,
2 You went off welfare,
3 You did not complete paperwork to complete eligibility,
4 Your caseworker did not return calls or requests,
5 You did not pay spenddown, or
6 For some other reason? (specify)
8 Don't know/Not sure (DO NOT READ)
9 Refused (DO NOT READ)

WHY9…… We're interested in knowing whether there are some people who COULD currently get health insurance through an employer, but decided not to enroll. Thinking about those household members who are UNinsured, could any of them currently be covered by a plan that is available through an employer?

1 Yes
2 No
8 Don't know/Not sure
9 Refused

WHY9a-l ……. Which household members?
(list all household members)

WHY10a-l…..Was there any other reason that you/they were without health insurance coverage?

INTERVIEWER: RECORD VERBATIM (EXACT RESPONSE)

Head of Household Employment Characteristics

(IF YES to COV2x-10, SLO1-9 = NO, and SLO10 is YES for [fill person], continue)
(IF not, skip to PP1)
(ONLY ASKED IF SOMEONE IN HOUSEHOLD IS UNINSURED)

EMPC1. ..... Are you/is [response in HOFH] currently employed?

1..... YES . .....**(CONTINUE)**
2..... NO..... .....**(SKIP TO PP1)**
3..... (DK)... .....**(SKIP TO PP1)**
4..... (REFUSED).....**(SKIP TO PP1)**

EMPC1a. ..... How long have/has [response in HOFH] you been working for your current employer? (Open ended **and code actual number of months)** **(1 year=12; 2 years=24; 3 years=36; 4 years=48; 5 years=60)**

00..... LESS THAN 4 WEEKS
01-60 .. ENTER # OF MONTHS
61..... MORE THAN 5 YEARS
97..... NO LONGER EMPLOYED/NOT CURRENTLY EMPLOYED **(SKIP TO PP1)**
98..... (DK)
99..... (REFUSED)

NUMEMPS.... Thinking about the company you/[response in HOFH] work[s] for, the one that pays the payroll and manages the benefits package, approximately how many employees work for this organization? **(If "DK", probe:)** What is your best guess? (Open ended and code)

01..... 1 EMPLOYEE
02..... 2-5
03..... 6-10
04..... 11-20
05..... 21-50
06..... 51-100
07..... 101-150
08..... 151-200
09..... 201-250
10..... MORE THAN 250 EMPLOYEES
11..... (DK)
12..... (REFUSED)

PRIMARY PROVIDER

(READ:) For the next question about medical visits, doctors refer to either general practitioner or specialist and osteopaths. Do NOT include dentists, chiropractors, psychotherapists or other non-medical doctors.

PP1a-l. Thinking about medical visits, is there a USUAL place that [fill person/you] (goes/go) when (he/she/you) is sick or (he/she/you) needs advise about (his/her/your) health?

1..... YES .. .. **(CONTINUE)**
2..... NO..... .....**(SKIP TO HCU1)**
3..... (DK)... .....**(SKIP TO HCU1)**
4..... (REFUSED).....**(SKIP TO HCU1)**

PP2a-l. What kind of place is it? (Open ended and code) **(read 06-10)**

01..... OTHER (LIST)
02..... (DK)
03..... (REFUSED)
06..... HOSPITAL EMERGENCY ROOM
07..... URGENT CARE FACILITY OR WALK-IN CLINIC (E.G., "INSTA-CARE")
08..... PUBLIC CLINIC, COMMUNITY HEALTH CENTER OR HEALTH DEPARTMENT CLINIC
09..... PRIVATE CLINIC/DOCTOR'S OFFICE
10..... MILITARY OR V.A. HEALTH CARE FACILITY

HEALTH CARE UTILIZATION

HCU1a-x ..... During the last 12 months, including all types of visits, how many times did [you/ fill person name] see or talk to a medical doctor? Please do not count an overnight stay in a hospital. **(NOTE: A medical doctor includes general practitioners, as well as specialists (such as dermatologist, orthopedist, etc.) and osteopaths. Do not include visits to a dentist, chiropractor, psychotherapist or other non-medical doctors.)** (Open ended **and code actual number)**

00..... DID NOT SEE A
..... MEDICAL DOCTOR IN THE LAST 12 MONTHS
01-50 .. ENTER # OF TIMES
51..... MORE THAN 50
98..... (DK)
99..... (REFUSED)

HCU5a-x ..... Did [you/he/she] receive a well visit, that is a routine medical check-up during the past 12 months?
1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

HCU7a-x ..... During the past 12 months, that is since **(DATE)**, [was fill person/were you] a patient in a hospital overnight [**(If code "2" in S8b AND code "18-54" in AAGE, read:)** for any reason other than giving birth]?
1..... YES ... . **(CONTINUE)**
2..... NO..... ..... **(SKIP TO INSDLY)**
3..... (DK) ... . **(SKIP TO INSDLY)**
4..... (REFUSED)..... **(SKIP TO INSDLY)**

HCU8a-x ..... **(If code "1" in HCU7, ask:)** During the past 12 months, on how many separate occasions did (you/he/she) stay in a hospital overnight or longer? (Open ended **and code actual number)**
31..... MORE THAN 30
98..... (DK)
99..... (REFUSED)

ACCESS TO HEALTH CARE

The next few questions ask about some reasons people might DELAY OR HAVE PROBLEMS getting MEDICAL, DENTAL, MENTAL HEALTH OR OTHER CARE.

INSDELY In the past 12 months, did you [did fill person] have problems or delay seeking care [for fill person] because the service was not covered by your/their insurance?

1 Yes **(continue to INSTYPE)**
2 No **(skip to SERVDELY)**
3 Person Uninsured **(skip to SERVDELY)**
8 Don't know/Not sure **(skip to SERVDELY)**
9 Refused **(skip to SERVDELY)**

INSTYPE For what types of services did you have this problem in the last 12 months?
With a medical doctor?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With a dentist?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With a mental health provider?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With some other type of health services?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

SERVDELY How about because you/they could not find the services in your area?

1 Yes **(continue to SERVTYPE)**
2 No **(skip to COSTDELY)**
3 Person Uninsured **(skip to COSTDELY)**
8 Don't know/Not sure **(skip to COSTDELY)**
9 Refused **(skip to COSTDELY)**

SERVTYPE For what types of services did you have this problem in the last 12 months?
With a medical doctor?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With a dentist?
1. Yes
2. No

8. Don't know/Not sure
9. Refused

With a mental health provider?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With some other type of health services?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

COSTDELY Did you [did fill person] have problems or delay getting care [for fill person] because you/they could not afford the services?

1 Yes **(continue to COSTTYPE)**
2 No **(skip to STATDELY)**
3 Person Uninsured **(skip to STATDELY)**
8 Don't know/Not sure **(skip to STATDELY)**
9 Refused **(skip to STATDELY)**

COSTTYPE For what types of services did you have this problem in the last 12 months?
With a medical doctor?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With a dentist?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With a mental health provider?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With some other type of health services?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

STATDELY How about because you/they were concerned about your/their VISA, citizenship, or residency status?

1 Yes **(continue to WHOSTAT)**
2 No **(skip to PRESCRIP)**
3 Person Uninsured **(skip to PRESCRIP)**
8 Don't know/Not sure **(skip to PRESCRIP)**
9 Refused **(skip to PRESCRIP)**

WHOSTAT For what types of services did you have this problem in the last 12 months?
With a medical doctor?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With a dentist?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With a mental health provider?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

With some other type of health services?
1. Yes
2. No
8. Don't know/Not sure
9. Refused

PRESCRIP Was there a time during the last 12 months when you [fill person] needed to use PRESCRIPTION MEDICINE, but could not because of the cost?

1 Yes
2 No
8 Don't know/Not sure
9 Refused

INJURIES

Standard Injury Questions

INJURY ..... The next few questions ask about injuries to people in your household. By injury, I mean any accidental or intentional injury to a person as a result of a fall, burn, poisoning, overdose, motor vehicle accident, sports injury, bite, gunshot, drowning, suicide attempt, or any other cause. Has anyone currently living in your household had an injury during the last 12 months, that is since **(TODAY'S MONTH)**, 2000 that LIMITED THEIR USUAL ACTIVITIES FOR A DAY OR LONGER or CAUSED THEM TO REQUIRE MEDICAL ATTENTION?

1..... YES .... **(CONTINUE)**
2..... NO..... ..... **(SKIP TO SELFREST)**
3..... (DK)... ..... **(SKIP TO SELFREST)**
4..... (REFUSED)..... **(SKIP TO SELFREST)**

INJROST..... **(If code "1" in INJURY, ask:)** I need to list all household members who have had injuries during the past 12 months starting with the oldest? **(Probe:)** Any others? Who is the next oldest household member? (Open ended and code) **(Probe for six responses)**

01 ..... **(RESPONSE IN S6-A)**	13..... **(RESPONSE IN S11-A)**
02..... **(RESPONSE IN S6-B)**	14..... **(RESPONSE IN S11-B)**
03..... **(RESPONSE IN S6-C)**	15..... **(RESPONSE IN S11-C)**
04..... **(RESPONSE IN S6-D)**	16..... **(RESPONSE IN S11-D)**
05..... **(RESPONSE IN S6-E)**	17..... **(RESPONSE IN S11-E)**
06..... **(RESPONSE IN S6-F)**	18..... **(RESPONSE IN S11-F)**
07..... **(RESPONSE IN S7-A)**	19..... **(RESPONSE IN S11-G)**
08..... **(RESPONSE IN S7-B)**	20..... **(RESPONSE IN S11-H)**
09..... **(RESPONSE IN S7-C)**	21..... **(RESPONSE IN S11-I)**
10..... **(RESPONSE IN S7-D)**	22..... **(RESPONSE IN S11-J)**
11..... **(RESPONSE IN S7-E)**	23..... **(RESPONSE IN S11-K)**
12..... **(RESPONSE IN S7-F)**	24..... **(RESPONSE IN S11-L)**

25..... NONE OF THESE..... **(SKIP TO SELFREST)**
26..... (DK) ..... **(SKIP TO SELFREST)**
27..... (REFUSED) ..... **(SKIP TO SELFREST)**

INJSELECT …. The computer will select one individual form INJROST to ask the following questions about.

INJEXAM..... The MOST RECENT TIME **(read A-F)** was injured, did he/she go to a hospital or emergency room for care?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

INJWHERE.... Where did this most recent injury happen? **(Probe:)** Where was **(read A-F, as appropriate)** when the injury happened? (Open ended and code)

01..... HOME
02..... FARM
03..... MINE/QUARRY
04..... WORK PLACE AND PREMISES (OTHER THAN FARM OR MINE)
05..... PLACE FOR RECREATION AND SPORT
06..... STREET/HIGHWAY
07..... PUBLIC BUILDING (OTHER THAN SCHOOL)
08..... SCHOOL BUILDING/GROUNDS

09..... RESIDENTIAL INSTITUTION
10..... OTHER SPECIFIED PLACE
11..... OTHER UNSPECIFIED PLACE
12..... (DK)
13..... (REFUSED)

INJCAUSE. .... What was the primary cause of the most recent injury? (Open ended and code)

01..... OTHER (LIST)
02..... (DK)
03..... (REFUSED)
06..... FALL
07..... MOTOR VEHICLE ACCIDENT
08..... PEDESTRIAN INJURY
09..... OFF-HIGHWAY MOTORIZED VEHICLE
10..... POISONING OR OVERDOSE
11..... INJURY CAUSED BY ANIMALS (DOG BITE, THROWN BY HORSE)
12..... WATERCRAFT & WATER INJURY
13..... NEAR DROWNING
14..... CHOKING/NEAR SUFFOCATION (OTHER THAN DROWNING)
15..... BICYCLE ACCIDENT
16..... ROLLERBLADE, SKATEBOARD, OR SCOOTER INJURY
17..... SKI INJURY.....
18..... OTHER SPORTS INJURY (BASKETBALL, TENNIS, HIKING, ETC.)
19..... FIREARMS/ASSAULT WITH A FIREARM
20..... PHYSICAL VIOLENCE (HIT, KICKED, PUNCHED, ETC.)
21..... FIRE/FLAMES

Car Restraints

SELFREST When you drive or ride in a car, would you say that you use a seatbelt all of the time, most of the time, some of the time, rarely or never?

1. ALL OF THE TIME
2. MOST OF THE TIME
3. SOME OF THE TIME
4. RARELY
5. NEVER
6. (DON'T KNOW)
7. (REFUSED)

CHLDREST When you are driving and children age 15 and under are riding with you, would you say that they are in a car restraint all of the time, most of the time, some of the time, rarely or never?

1. ALL OF THE TIME
2. MOST OF THE TIME
3. SOME OF THE TIME
4. RARELY
5. NEVER
6. NEVER HAVE CHILDREN RIDE IN THE CAR WITH ME **(SKIP TO ANYGUNS)**
7. (DON'T KNOW)
8. (REFUSED)

Questions to be rotated through for each child in the household who is age 8 or under.

CHLDSYS When you are driving and (AGE) rides in the vehicle with you, how often is (she/he) placed in a child specific restraint system? Child specific restraint systems include infant seats, toddler seats, and booster seats. Would you say (he/she) rides in a child restraint system... **(READ LIST)**

ALL OF THE TIME.....1

MOST OF THE TIME.....2
SOME OF THE TIME.....3
RARELY, OR.....4
NEVER.....5
NEVER DRIVE WITH CHILD.....6 **(SKIP TO ANYGUNS)**
DON'T KNOW.....7 **(SKIP TO BOOSTER)**
REFUSED.....8 **(SKIP TO BOOSTER)**

RESTTYPE What type of child restraint system does (he/she) ride in? Would you say (he/she) rides in an infant/toddler car seat, a booster seat, a lap belt, or a shoulder/lap belt?

INFANT/CHILD CAR SEAT 1
BOOSTER SEAT 2
LAP BELT 3
SHOULDER/LAP BELT 4
DON'T KNOW 8 **(SKIP TO BOOSTER)**
REFUSED 9 **(SKIP TO BOOSTER)**

LOCATED Is this in the front seat or back seat?

Front seat.....1
Back seat.....2
(VOL) Don't know.....3
(VOL) Refused.....4

[If RESTYPE=2 'Yes', skip to ANYGUNS;
If not, continue to BOOSTER]

BOOSTER Before today, had you ever seen or heard of a type of car seat called a booster seat?

Yes.....1
No.....2
(VOL) Don't know.....3

Firearms

ANYGUNS..... Are any firearms now kept in or around your home? Include those kept in the house, as well as those in a garage, storage shed, truck or car.

1..... YES ....**(CONTINUE)**
2..... NO..... .....**(SKIP TO HYPER)**
3..... (DK)... .....**(SKIP TO HYPER)**
4..... (REFUSED).....**(SKIP TO HYPER)**

HANDGUNS. **(If code "1" in ANYGUNS, ask:)** Are any of these HAND guns, such as pistols or revolvers?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

LONGUNS. .... Are any of these LONG guns, such as rifles or shotguns?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

LOCKED. ..... Including long guns and hand guns, are ALL, some, or none of these firearms currently being stored in

a drawer, closet, or any other location that is EFFECTIVELY LOCKED? **(If necessary, ask:)** Are all of the firearms currently stored in a locked location?

1..... ALL ... .**(SKIP TO HYPER)**
2..... SOME .. ..**(CONTINUE)**
3..... NONE .. ..**(CONTINUE)**
4..... (DK) ... .**(CONTINUE)**
5..... (REFUSED).....**(CONTINUE)**

LOADED..... **(If code "2" or "4-5" in LOCKED, ask:)** Thinking about those firearms that are NOT currently locked up, are ANY of these firearms currently loaded? **(If necessary, ask:)** Are any of the unlocked firearms stored in or around the house currently loaded?

(If code "3" in LOCKED, ask:) Are ANY of these firearms currently loaded? **(If necessary, ask:)** Are any of the unlocked firearms stored in or around the house currently loaded?

1..... YES ... **(SKIP TO HYPER)**
2..... NO..... **(CONTINUE)**
3..... (DK) ... **(CONTINUE)**
4..... (REFUSED) **(CONTINUE)**

AMMO. ..... **(If code "2-4" in LOADED, ask:)** Thinking about the ammunition for these guns, is the ammunition stored with the gun, or in a separate location?

1..... WITH THE GUN **(SKIP TO HYPER)**
2..... IN A SEPARATE LOCATION **(CONTINUE)**
3..... (NO AMMUNITION AT HOME) **(SKIP TO HYPER)**
4..... (DK) ... **.....(CONTINUE)**
5..... (REFUSED).....**(CONTINUE)**

AMMOLOCK. .....**(If code "2" or "4-5" in AMMO, ask:)** Is the ammunition currently locked?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

HEALTH SCREENING

BP Screening

HYPER..... Have you ever been told by a doctor or other health professional you have HYPERTENSION, sometimes called HIGH BLOOD PRESSURE?

1..... YES ... .**(CONTINUE)**
2..... NO..... .....**(SKIP TO CHOLHIGH)**
3..... (DK)... .....**(SKIP TO CHOLHIGH)**
4..... (REFUSED)..... **(SKIP TO CHOLHIGH)**

BP Management

HBPCHECK... How long has it been since you [fill person] had your [their] blood pressure checked by a doctor or other health professional? **(Open ended and code)**

1..... WITHIN LAST YEAR/LESS THAN 12 MONTHS AGO
2..... 1 TO LESS THAN 2 YEARS AGO
3..... 2 TO LESS THAN 5 YEARS AGO
4..... 5 OR MORE YEARS AGO
5..... NEVER
6 (DK)
7 (REFUSED)

HBP.... **(If code "1" in HYPER, ask:)** Are you currently under a physician's care to treat your high blood pressure?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

Cholesterol Screening

CHOLHIGH. . Have you ever been told by a doctor or other health professional that your BLOOD CHOLESTEROL level was high?

1..... YES ..... **(CONTINUE)**
2..... NO..... **(SKIP TO EXERCISE)**
3..... (DK)... **(SKIP TO EXERCISE)**
4..... (REFUSED) **(SKIP TO EXERCISE)**

Cholesterol Management

CHOLPHYS... **(If code "1" in CHOLHIGH, ask:)** Are you currently under a physician's care to treat your high cholesterol?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

CHOLMED . Are you NOW taking any medicine prescribed by a doctor for your high cholesterol?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

LIFESTYLE

Exercise (this section to be asked for all aged 12+ in household)

The next few questions ask about physical activity. .We are interested in two types of physical activity: VIGOROUS and MODERATE. Vigorous activities cause large increases in breathing or heart rate while moderate activities cause small increases in breathing or heart rate.

MOD Do you/does [fill person] do MODERATE physical activities 5 or more days per week for 30 minutes or more per occasion, such as brisk walking, bicycling, vacuuming, gardening, or anything else that causes small increases in breathing or heart rate?

1..... YES .....(CONTINUE)
2..... NO.....(SKIP TO VIG)
3..... (DK) ...(SKIP TO VIG)
4 (REFUSED)…(SKIP TO VIG)

MODDAYS How many days per week does [fill person] do these MODERATE activities for at least 30 minutes at a time?

__ __ Days per week
7 7 Don=t know/Not sure
9 9 Refused

VIG Do you/does [fill person] do VIGOROUS physical activities 3 or more days per week for 20 minutes or more per occasion, such as running, aerobics, heavy yard work, or anything else that causes large increases in breathing or heart rate?

1..... YES .....(CONTINUE)
2..... NO.....(SKIP TO SMOKED)
3..... (DK) ...(SKIP TO SMOKED)
4 (REFUSED)…(SKIP TO SMOKED)

VIGDAYS How many days per week does [fill person] do these VIGOROUS activities for at least 20 minutes at a time?

__ __ Days per week
7 7 Don=t know/Not sure
9 9 Refused

Exposure to Second Hand Smoke

SMOKED..... The next few questions ask about cigarette smoking. In the past 30 days has anyone, including yourself, smoked cigarettes, cigars, or pipes anywhere inside your home?

1..... YES ....**(CONTINUE)**
2..... NO..... .....**(SKIP TO FERTH1)**
3..... (DK)... .....**(SKIP TO FERTH1)**
4..... (REFUSED).....**(SKIP TO FERTH1)**

(Source: Florida BRFSS Module 1998)

SMOKWHRE….. On how many of the past 30 days has someone, including yourself, smoked cigarettes, cigars, or pipes anywhere inside your home?

1. __ __ Days
2. Don't know
3. Refused

(Source: Oregon 1997, Texas 1998)

The above question was cognitively tested prior to use by OR and TX.

MIGRATION

BRTHPLCE ..Were you born in the U.S., or a foreign country?

1.....U.S..... **(CONTINUE)**
2.....FOREIGN COUNTRY **(SKIP TO FOREIGN)**
3.....(DK)... ..... **(SKIP TO STEADY)**
4.....(REFUSED)..... **(SKIP TO STEADY)**

FOREIGN ..In which FOREIGN COUNTRY were you born?

001.....LIST (AS GIVEN TO PEGUS MARCH 22, 2001: SEE COUNTY LISTING.DOC)
002.....(DK)
003.....(REFUSED)

TIMEUS …….. How long have you lived in the U.S.?

..... ____ Years
..... ____ Months
.....
.....Don't Know
.....Refused

HOUSEHOLD DEMOGRAPHIC CHARACTERISTICS

The next few questions ask about your TOTAL combined HOUSEHOLD income.

INCOME. ..... The next question asks about your TOTAL combined HOUSEHOLD income during calendar year 2000. Please include income from all wage earners, and money from ALL SOURCES, not just wages and salaries, and use income BEFORE taxes and other deductions. Was your total household income during calendar year 2000 more or less than $35,000?

(If "Under", ask:)

Was it over or under $25,000?
Was it over or under $15,000?
Was it over or under $5,000?

(If "Over", ask:)

Was it over or under $45,000?
Was it over or under $55,000?
Was it over or under $65,000?

01..... LESS THAN $5,000
02..... $5,000 - $9,999
03..... $10,000 - $14,999
04..... $15,000 - $19,999
05..... $20,000 - $24,999
06..... $25,000 - $29,999
07..... $30,000 - $34,999
08..... $35,000 - $39,999
09..... $40,000 - $44,999
10..... $45,000 - $49,999
11..... $50,000 - $54,999
12..... $55,000 - $59,999
13..... $60,000 - $64,999
08..... $65,000 OR MORE
09..... (DK) ... .
10..... (REFUSED).....

STEADY Is your income steady, or does it change from month to month?

1. STEADY **(SKIP TO ZIPCODE)**
2. CHANGES EVERY MONTH **(CONTINUE …)**
3. (DK)
4. (REFUSED)

CHANGES The next question asks about your TOTAL combined HOUSEHOLD income during the past month. Please include income from all wage earners, and money from ALL SOURCES, not just wages and salaries, and use income BEFORE taxes and other deductions. Was your total household income during the past month more or less than $3,000?

(If "Under", ask:)

Was it over or under $2,000?
Was it over or under $1,000?
Was it over or under $500?

(If "Over", ask:)

Was it over or under $3,500?
Was it over or under $4,500?
Was it over or under $5,500?

01..... LESS THAN $416

02..... $417 - $833.....
03..... $834 - $1,249
04..... $1,250 - $1,666
05..... $1,667 - $2,083
06..... $2,084 - $2,416
07..... $2,417 - $2,916
08..... $2,917 - $3,333
09..... $3,334 - $3,750
10..... $3,751 - $4,166
11..... $4,167 - $4,583
12..... $4,584 - $5,000
13..... $5,001 - $5,416
08..... $5,417 OR MORE
09..... (DK) ... .
10..... (REFUSED).....

ZIPCODE. ..... What is your zip code? (Open ended **and code all five digits)**
99998.. ..... (DK)
99999.. ..... (REFUSED)

OWNRENT.... Do you own your home or are you renting? **(If necessary, read:)** Own means that you own it outright, or that you have a mortgage.

1..... OWN
2 RENTING
5..... (DK)
6..... (REFUSED)

RELIGION..... Do you consider yourself **(read 1-6)**?
1..... PROTESTANT
2..... CATHOLIC
3..... JEWISH
4..... LDS (LATTER DAY SAINTS/MORMON)
5..... SOME OTHER RELIGION I HAVE NOT MENTIONED … **(OPEN-ENDED. PLEASE TYPE ANSWER EXACTLY AS IT IS GIVEN BY THE RESPONDENT)**
.... OR .....
6..... NO RELIGION ... **(SKIP TO PHNSTS)**
7..... (DK) ... . **(SKIP TO PHNSTS)**
8..... (REFUSED)..... **(SKIP TO PHNSTS)**

ACTIVE..... **(If code "1-5" in RELIGION, ask:)** How frequently do you attend services? (READ all)
1..... ONCE A WEEK OR MORE
2..... ONCE A MONTH OR MORE
2..... LESS OFTEN THAN ONCE A MONTH
3..... (DK)
4..... (REFUSED)

PHNSTS..... Is this phone number listed, unlisted, or unpublished?
1..... LISTED
2..... UNLISTED (AVAILABLE THROUGH
..... DIRECTORY ASSISTANCE BUT NOT PRINTED IN THE PHONE BOOK)
3..... UNPUBLISHED (NOT AVAILABLE
..... THROUGH DIRECTORY ASSISTANCE)
4..... (DK)
5..... (REFUSED)

PHLINES..... How many different phone LINES do you have in your household? We need the number of different PHONE NUMBERS, NOT the number of PHONES. (Open ended and code)

1..... ONE .... **(SKIP TO LLCR)**
2..... TWO.... ..... **(CONTINUE)**
3..... THREE. ..... **(CONTINUE)**
4..... FOUR... ..... **(CONTINUE)**
5 ..... FIVE OR MORE. **(CONTINUE)**
6..... (DK)... ..... **(SKIP TO LLCR)**
7..... (REFUSED)..... **(SKIP TO LLCR)**

PHCALLS..... **(If code "2-5" in D12, ask:)** How many of these different numbers allow incoming VOICE phone calls? Do not include telephone numbers that are for data transmission or fax transmission only. (Open ended **and code actual number)**

98..... (DK)
99..... (REFUSED)

LLCR . How long have you lived at your current residence? (Open ended **and code actual number** in D14A or D14B, depending on whether the answer was given in months or years.)

14A ..... 0-96..... ENTER # OF MONTHS
14B ..... 0-96..... ENTER # OF YEARS
97..... RESPONSE NOT IN MONTHS/YEARS
98..... (DK)
99..... (REFUSED)

WOPHONE.... **(If code "01-12" in LLCR-a or code "01" in LLCR-b, ask:)** Aside from periods of a few days while you were moving, was there ever a time, during the last 12 months, that this household was WITHOUT telephone service for more than 24 hours?

(Otherwise, ask:) Was there ever a time, during the last 12 months, that this household was WITHOUT telephone service for more than 24 hours?

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

✍ ✍ **SEE IF HOUSEHOLD IS ELEGIBLE FOR CHIP**

All three conditions must be met:
1. If COV1=No, and YES to COV2x-10, and SLO1-9 = NO, and SLO10 is YES for [fill person], and
2. If Household is eligible for CHIP based on INCOME, and
3. If there is one or more children in the household, then skip to CHIP Section.

ASK 'CHIP FOLLOWUP' SECTIONS, THEN RETURN FOR 'FOLLOWUP' AND CLOSEING.

IF NOT ELIGIBLE, CONTINUE TO FOLLOWUP

FOLLOWUP. Occasionally programs at the Department of Health or researchers at Utah universities would like to conduct follow-up surveys. Would you be willing to be contacted at sometime in the future to participate in a follow-up survey?

IF NECESSARY, READ: You are not agreeing to participate. You may decline if you like once they ask you to participate.

1..... YES
2..... NO
3..... (DK)
4..... (REFUSED)

(READ:) ..... Those are all the questions I have. Thank you for your participation, and for contributing to public health in Utah.

PART TWO: SPECIFIC FOLLOW-UP QUESTIONS

CHIP Follow-up

Q:THRE3
It looks like you may be eligible for insurance coverage through a state-sponsored program for children. Have you ever heard of an insurance plan called Children's Health Insurance Program, or CHIP?
1 YES
2 NO
8 don't know
9 refused
IF (ans > 1) skp thre10

Q:THRE4
Has [fill child] ever had insurance coverage with CHIP?
1 YES
2 NO
8 don't know
9 refused
IF (ans = 2) skp thre6
If (ans > 2)skp thre10

Q:THRE5
Why does [fill child] no longer have coverage through the CHIP program?
PROBE: Is there some reason that his/her CHIP coverage was discontinued?
PROBE: Any other reason? (PROBE UNTIL YOU GET A SIGN-OFF)
1. Make too much money
2. Have other insurance
3. On Medicaid
7 Enter Response
8 don't know
9 refused
skp end2

Q:THRE6
Have you ever applied to see whether [fill child] was eligible for insurance coverage with CHIP?
1 YES
2 NO
8 don't know
9 refused
IF (ANS > 1) skp thre9

Q:THRE7
When you applied, was [fill child] eligible?
1 YES
2 NO
8 don't know
9 refused
IF (ANS > 1)skp end

Q:THRE8
What are the reasons that [fill child] did not sign up with CHIP at that time?
PROBE: Is there some reason that he/she did not get CHIP coverage?
PROBE: What else? (PROBE UNTIL YOU GET A SIGN-OFF)
7 Enter Response
8 don't know
9 refused
if (ans > 1) skp end

Q:THRE9
What are the reasons you decided not to apply for CHIP coverage for [fill child]?
PROBE: What else? (PROBE UNTIL YOU GET A SIGN-OFF)
7 Enter Response
8 don't know
9 refused
if (ans > 1)skp end

Q:THRE10
CHIP is an affordable health insurance program for working families whose children are uninsured or for families who earn too much for Medicaid benefits. It covers children 18 years old and younger. There is no monthly premium, yet there are co-payments. Eligibility is determined by family income and number of people in the family.
Would you like the phone number of the CHIP hotline so you can contact them?
1. yes (1-888-222-2542)
2. No
8. Don't know
9. Refused
IF (ans > 0)skp end2

Q:Refusal
Try to talk them into it.
1 yes
2 no

Q:END
Would you like the phone number of the CHIP hotline so you can contact them?
1 Yes (1-888-222-2542)
2 No
8 Don't know/Not sure
9 Refused

[CONTINUE TO FOLLOWUP]

Utah Department of Health

State of Utah

Michael O. Leavitt
Governor

Rod L. Betit
Executive Director

Chad J. Westover
Project Director

OFFICE OF THE EXECUTIVE DIRECTOR

COVERING THE UNINSURED IN 2002 PROJECT

Martha Hughes Cannon Building
288 North 1460 West

Mailing Address:
Box 144102
Salt Lake City, Utah 84114-4102
(801)538-6689
Fax: (801)538-6860

Dear <insert name>

The Utah Department of Health is involved in a year long project designed to address the difficult question of how best to assist employers who wish to offer affordable health care coverage to their employees. Your business has been randomly selected to represent the views of businesses like yours in Utah. Your participation is essential in helping us understand the needs of all Utah businesses.

This survey should be completed by the person most responsible for making decisions about health care benefits for your company.

The answers you provide will have no effect on any health coverage options you may currently have. All of your answers will remain completely confidential. Your name and address will never be associated with the answers you provide. The code numbers that appear on your survey are to assist with data entry only.

While this survey may appear long, there are actually only a few questions. Our experience suggests that it will take most people between 10 and 20 minutes to complete.

If you require any assistance in completing the survey, please call us **toll-free** at the following number:

<ADVANIS INSERT NUMBER HERE>, Ask for Sue Day

When you are done, place the survey in the enclosed self-addressed postage-paid envelope and put it in the mail. If you prefer, you can call us on the phone number listed above and give us your answers over the phone.

We would appreciate your returning the survey in the enclosed envelope within one week.

Your help will make a difference.

Thank you in advance for your time and effort.

Shane Carlson
Project Manager
Covering the Uninsured 2002
Utah Department of Health

Utah Department of Health

State of Utah

Michael O. Leavitt
Governor

Rod L. Betit
Executive Director

Chad J. Westover
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OFFICE OF THE EXECUTIVE DIRECTOR

COVERING THE UNINSURED IN 2002 PROJECT

Martha Hughes Cannon Building
288 North 1460 West

Mailing Address:
Box 144102
Salt Lake City, Utah 84114-4102
(801)538-6689
Fax: (801)538-6860

Dear <insert name>

Earlier this year you, or someone in your household, participated in the Utah Health Status Survey. Thank you for your contribution to this important project. The information provided is essential in helping us understand the healthcare needs of all Utahn's, as well as the need for improvements in health care coverage.

This follow up survey will help us develop alternative health coverage options for many Utahns who presently have difficulty affording adequate medical care.

During the Utah Health Status Survey, we discussed the health care needs of <insert recruit>. *This follow up survey should be completed by that person*. We need these answers to help us design the *best* and most affordable alternatives for similar people in Utah. Without this help we risk creating options that would fail to meet these needs, and no one would benefit from that outcome.

The enclosed gift is a small token of our appreciation for your help with this project.

Participation is completely voluntary. The answers will have no effect on current health care coverage or the options currently available. All of the answers will remain completely confidential. Names and addresses will never be associated with the answers. The code numbers that appear on the survey are to assist with data entry only.

While this survey may appear long, there are actually only a few questions. Our experience suggests that it will take most people between 10 and 20 minutes to complete.

If any assistance is required, please call us **toll-free** at **<ADVANIS INSERT NUMBER HERE>. Ask for Sue Day.**

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We would appreciate your returning in the survey in the enclosed envelope within one week.

Your help will make a difference.

Thank you in advance for taking the time and effort to help.

Shane Carlson
Project Manager
Covering the Uninsured 2002
Utah Department of Health

GLOSSARY – Page 1

Standard Insurance Plans:

Fee-for-Service (Traditional Insurance): The employee can choose any doctor they wish and submit claims to the insurance company for medical expenses. The insurance company will reimburse them or their doctor for a percentage of approved medical expenses. These plans charge a monthly premium but not a co-payment for each doctor visit.

HMO (Health Maintenance Organization): Prepaid health plans in which the employee pays a monthly premium and a co-payment for each doctor or hospital visit. The HMO covers the remainder of any medical expenses. The plan will not usually pay for medical services received from doctors or facilities outside the HMO network. A primary care physician coordinates all care services and makes referrals to any specialists.

PPO (Preferred Provider Organization): A network of doctors, clinics & hospitals that provide medical services at discounted costs to PPO members. Members can use non-network doctors and facilities, but these will be more expensive. Employees make their own decisions about health care rather than going through a primary care physician.

POS (Point-of-Service): A plan that combines features of HMOs and PPOs. Employees can pay a flat co-payment to you use the services of a network provider (like an HMO) or pay a deductible and/or a co-insurance charge for the services of non-network providers (like a PPO).

Coverage

The medical procedures and expenses that the health care plan covers. Different policies will provide different amounts of coverage for different procedures. For example, some health plans do not cover maternity, dental care, or mental health care. Other plans are more comprehensive and will cover all these procedures.

For the purposes of this survey, coverage is broken down into four categories:

Primary Care	Catastrophic Coverage
✍ Diagnostic services (x-rays, etc) ✍ Preventative care and Immunizations ✍ Emergency, Ambulance & Urgent care	✍ Hospital & related surgical services
Specialist Services	**Extra Benefits**
✍ Surgeon & Anesthesia ✍ Orthopedic Care ✍ Cardiologist ✍ Endocrinology ✍ And Etc.	✍ Pharmacy & Prescriptions ✍ Dental care (cleaning, fillings, etc.) ✍ Vision care (exams & lenses) ✍ Mental health & Substance abuse ✍ Maternity & Prenatal ✍ Medical equipment & Home care ✍ Physical therapy ✍ Alternative Medicine

(Continued on the Other Side)

GLOSSARY – Page 2

Where care is accessed

Community Health Center: Some plans require a visit to a local health clinic to receive basic health care services. These facilities are located in communities throughout the state, many times attached to a local hospital.

Approved Providers: These plans require a visit doctors and facilities that are either owned by the health care provider or are members of the health care network. Network members agree to provide services at reduced costs.

Provider of Your Choice: These plans allow a visit any doctor or facility to receive care.

Fees & Premiums

Monthly Premiums: A fee paid each month to maintain coverage.

Co-Pay: A flat fee, for example $10, paid each visit to a doctor's office or other facility to receive care. The health plan pays the rest of the cost for medical services. Co-pays can apply to a variety of different types of care including outpatient office visits, medicines, dental care, and etc.

Co-Insurance: The percentage of medical services the health care plan will pay, usually for inpatient hospitalization or to visit a doctor not on an approved provider list. For example, if the plans pay 80% of expenses, the employee must pay 20%.

Deductibles & Exclusions

Deductible: The amount the employee must pay each year for medical expenses before the health plan starts paying. *In Section B, please assume that any new plans have no deductible.*

Preexisting Condition: A health problem that existed before the date coverage became effective. *In Section B, please assume that there are no pre-existing condition restrictions.*

Exclusions: Specific conditions or circumstances for which the policy will not provide benefits. *In section B, please assume that any exclusion policies are the same for all plans.*

Waiting periods: Periods of time the employee must wait before they can access coverage benefits. *In section B, please assume that there are no waiting periods for any of these plans.*

(Continued on the Other Side)

Standard Health Plans:

Fee-for-Service (Traditional Insurance): You can choose any doctor you wish and submit claims to your insurance company for medical expenses. The insurance company will reimburse you or your doctor for a percentage of approved medical expenses. These plans charge a monthly premium but not a co-payment for each doctor visit.

HMO (Health Maintenance Organization): Prepaid health plans in which you pay a monthly premium and a co-payment for each doctor or hospital visit. The HMO covers the rest of your medical expenses. The plan will not usually pay for medical services you receive from doctors or facilities outside the HMO network. Your primary care physician coordinates your care and makes referrals to any specialists.

PPO (Preferred Provider Organization): A network of doctors, clinics & hospitals that provide medical services at discounted costs to PPO members. You can also use non-network doctors and facilities, but these will be more expensive. You make you own decisions about their health care rather than going through a primary care physician.

POS (Point-of-Service): A plan that combines features of health maintenance organizations (HMOs) and preferred provider organizations (PPOs). You pay a co-payment when using network facilities (like an HMO) or pay a co-insurance charge for the services of non-network providers (like a PPO).

Where Health Plans are purchased

Through an employer: Health care plans are selected by the employer and premiums are deducted from the employee's paycheck. In many cases the employer pays part of your monthly premium.

Direct from an insurance company: The health care plan is purchased from and premiums are paid directly to an insurance company.

State or Federal Government: Health care plans or programs offered by or through federal or state government.

Coverage

These are the medical procedures and expenses that your plan agrees to pay. Different policies provide different amounts of coverage. For the purposes of this survey, coverage is broken down into four categories:

Primary Care	Catastrophic Coverage
✍ Diagnostic services (x-rays, etc) ✍ Preventative care and Immunizations ✍ Emergency, Ambulance & Urgent care	✍ Hospital & related surgical services
Specialist Services	**Extra Benefits**
✍ Surgeon & Anesthesia ✍ Orthopedic Care ✍ Cardiologist ✍ Endocrinology ✍ And Etc.	✍ Pharmacy & Prescriptions ✍ Dental care (cleaning, fillings, etc.) ✍ Vision care (exams & lenses) ✍ Mental health & Substance abuse ✍ Maternity & Prenatal ✍ Medical equipment & Home care ✍ Physical therapy ✍ Alternative Medicine

(Continued on the Other Side)

Where care is accessed

Community Health Center: Some plans would require you to visit a local health clinic to receive basic health care services. These facilities are located in communities throughout the state, many times attached to a local hospital.

Approved Providers: These plans require you to visit doctors and facilities that are either owned by the health care provider or are members of the health care network. Network members agree to provide services at reduced costs.

Provider of Your Choice: You can visit any doctor or facility to receive care.

Fees & Premiums

Monthly Premiums: A fee you pay each month to maintain your coverage

Annual Enrollment fees: A fee you pay each year to enroll in the health plan. Plans that have an annual fee do not have monthly premiums.

Co-Pay: A flat fee, for example $10, you pay every time you receive care. The health plan pays the rest of the cost for medical services. Co-pays can apply to a variety of different types of care including outpatient office visits, pharmaceuticals, dental care, and etc.

Co-Insurance: The percentage of your medical services your health care plan will pay, usually for inpatient hospitalization or to visit a doctor not on an approved provider list. For example, if your plans pay 80% of expenses, you must pay 20%.

Deductibles & Exclusions

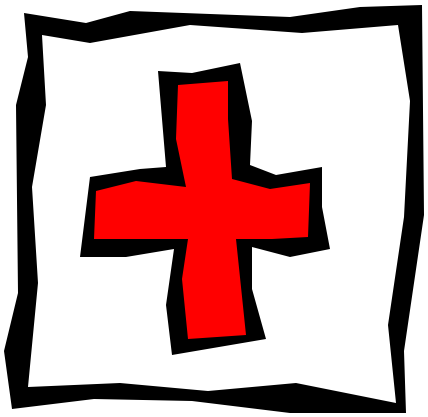
Deductible: The amount you must pay each year for your medical care expenses before your plan starts paying. In Section B, *please assume that any new plans have no deductibles.*

Preexisting Condition: A health problem that existed before the date your insurance became effective. In section B, *please assume that there are no pre-existing condition restrictions on any of the plans.*

Exclusions: Specific conditions or circumstances for which the policy will not provide benefits. In section B, *please assume that any exclusion policies are the same for all plans.*

Waiting periods: Periods of time you must wait before you can access coverage benefits. In section B, *please assume that there are no waiting periods for you to qualify for any of these plans.*

(Continued on the Other Side)



Utah Employers' Health Benefit Survey

Sponsored by

Utah Department of Health

ABOUT THIS SURVEY

Many small and medium sized employers struggle to provide basic health care benefits to their employees. Utah is studying a variety of new health coverage alternatives for the uninsured.

The State of Utah has not yet determined the specific features of these new health coverage alternatives or even whether to move forward with them. Your responses to this survey will be help Utah determine whether businesses like yours would be interested in offering these health plans to your employees and what combination of health care benefits, services, and premiums are most attractive and important to you.

The survey begins with some basic questions about health care coverage. This is followed by a section showing a series of health plan scenarios. Each scenario contains a variety of hypothetical health coverage plans from which you could choose. The scenarios will differ from one another in terms of the types of plans available and the specific features of each plan. You will be asked to imagine what you would do if these were the plans available to you.

Mark your answers directly on the survey. Return the survey to us in the enclosed self-addressed and postage-paid envelope OR call us back at the number below and give us your answers directly over the phone.

The codes on the bottom of the survey are only required to track your version of the survey. Your responses are strictly confidential and your input is greatly appreciated.

Feel free to call the number below if you have any questions about the survey or how to complete and return your responses.

Thank you,

Sue Day
<ADVANIS INSERT TOLL FREE NUMBER HERE>

Section A: Health Plan Experiences

This section asks a few questions about your experiences with currently available Health Coverage plans.

Q1: Do you currently offer health care benefits? (✍ ***ONE***)

✍1 Yes ✍2 No

The rest of the questions

If you answered YES to Question 1 ✍

If you answered NO to Question 1 ✍

in this section ask you to describe a health plan you currently offer or could offer your employees.

Please select the answers that will best describe the plan that…

you currently offer your employees.

If you have more than one plan, describe the plan most popular among your staff

Please select the answers that will describe, as best as you can, the health plan that…

you would buy,

if you were to purchase one.

Please read the attached glossary for definitions of the terms used below.
If you are unsure of any answer, please make your best guess.

Q2: What type of health plan is this: (✍ ***ONE***)

✍1 Traditional Insurance - Fee-for-service plan
✍2 Preferred Provider Organization (PPO)
✍3 Health Maintenance Organization (HMO)
✍4 Point of Service (POS)
✍5 Self-funded

Q3: Where do employees go to get health care service? (✍ ***ONE***)

✍1 Community health clinic
✍2 Doctors or hospitals approved by the plan
✍3 Any doctor or hospital your employee chooses

Q4: How much is an employee's typical monthly premium (for an Individual plan)?
(*write in the approximate amount, if no fee, write 0*) $_____ per month

Q5: How much is your monthly contribution to coverage (for an individual plan)?
(*write in the approximate amount, if no fee, write 0*) $_____ per month per employee

Q6: How much does an employee typically pay for an outpatient doctor visit?
(*write in the approximate amount, if no fee, write 0*) $_____ per visit

Q7: How much is an employee's typical annual deductible (for an individual plan)?
(*write in the approximate amount, if none, write 0*) $_____ per year

Q8: What percent of an employee's inpatient hospital expenses does the insurance plan typically pay?
(✍ ***ONE*** *for the percent of allowable expenses the insurance* ***plan pays*** *for inpatient hospital services*)

✍1 50% ✍2 60% ✍3 70% ✍4 80% ✍5 90% ✍6 100%

Q9: What services are covered under your plan? (✍ ***ANY*** *benefits that are covered*)

✍a Primary Care (for example)
Diagnostic services (x-rays, etc.)
Preventative care & Immunizations
Emergency, Ambulance, Urgent care

✍b Catastrophic Coverage (for example)
Hospital & related surgical services

✍c Specialist Services (for example)
Other Surgeon & Anesthesia
Orthopedic Care
Cardiologist
Endocrinologist

Extra Benefits
✍d Pharmacy & Prescriptions

✍e Dental care (cleaning, fillings, etc.)

✍f Hearing & Vision care

✍g Mental health & Substance abuse

✍h Maternity & Prenatal

✍i Medical equipment & Home care

✍j Physical therapy

✍k Alternative Medicine

Q10: How many full-time employees do you have (30 hours or more per week)?
(*write in the approximate amount, if none, write 0*) _____ full-time employees

Q11: What is the approximate average wage of your full-time employees?
(*write in the approximate amount per hour to the nearest $1.00*) $_____ per hour on average

Q12: How many part-time employees do you have (less than 30 hours per week)?
(*write in the approximate amount, if none, write 0*) _____ part-time employees

Q13: What is the approximate average wage of your part-time employees?
(*write in the approximate amount per hour to the nearest $1.00*) $_____ per hour on average

Q14: About what percent of your employees are <u>parents</u> with children under 18 AND earn about <u>$10 per hour or less</u>?
(✍ ***ONE*** *for the approximate percent of your employees who match this description*)

✍01 None ✍02 10% ✍03 20% ✍04 30% ✍05 40% ✍06 50% ✍07 60% ✍08 70% ✍09 80% ✍10 90% ✍11 100%

Section B: Future Health Plan Choices

This section presents eight different hypothetical health coverage scenarios. Each scenario describes a different combination of health plans and plan features. Please review the glossary for definitions of the terms that will be used to describe the plans.

Each scenario gives you the option to choose from at least one new health coverage option and a standard health plan like one of those already on the market. The specific features of the plans vary from one scenario to another.

CHIP Buy-in: The CHIP program (Children's Health Insurance Program) already provides health insurance to low-income children. The CHIP *Buy-in* would extend this coverage to your employees who are parents and who earn less than about $10.00 per hour. To qualify for the CHIP Buy-in plan you would agree to pay a low monthly premium on your employee's behalf. Your employee would not be charged a monthly premium. You would not need to provide this coverage to all employees. If you take up this plan you would be agreeing to provide coverage only to those employees who qualify *and* who ask to participate in the CHIP Buy-In program.

Cost-Sharing: Under this plan the cost of health insurance coverage would be shared three-ways - between you, your employee and the State of Utah. Employer's who qualify for the Cost-Sharing plan would offer the plan to all their employees, similar to standard group insurance coverage. Because the premiums are split three-ways, the overall cost to you and your employees are lower than they would be otherwise.

Standard Insurance Plan: This is the plan you described in Section A: Either the most popular plan you currently offer or another plan you could purchase from among those currently on the market.

Primary Care Network:

In addition to these plans, your employees who earn approximately $10 per hour or less may also qualify for another new health care plan available directly to them from the State of Utah. This is not a plan you would offer to your employees. However, you should image that it is another alternative available to your qualifying employees.

This is a plan offered direct to low-income residents (those who earn about $10 per hour or less). It does not require your participation. Qualifying individuals sign-up for the plan with a low annual membership fee. This membership gives them access to the Primary Care Network providing basic preventative and primary care.

Examine the plans in each scenario. Imagine what you would do if these were the plans available to you. You should assume that your company would qualify for any plans offered.

You can choose to offer as many of these plans as you like. If you do not want or feel you cannot afford to offer any of these plans, you can choose "None". If you choose to offer more than one plan, indicate which one plan you would most likely choose if you could only choose one by ticking the box on the second row.

Your choices between these various plans will help the Department of Health understand what types of health plans and health plan features are most important to you.

An example scenario is shown on the next page.

1. Notice that there are three different plans from which to choose as well as the option to offer no health plans. In some situations only two plans will be available.

2. Assume your company would qualify for any plan offered. *But note, only those employees who are parents and earn less than about $10 per hour can qualify for the Chip-Buy In plan.*

3. Compare the different health plans. They provide different levels of coverage.

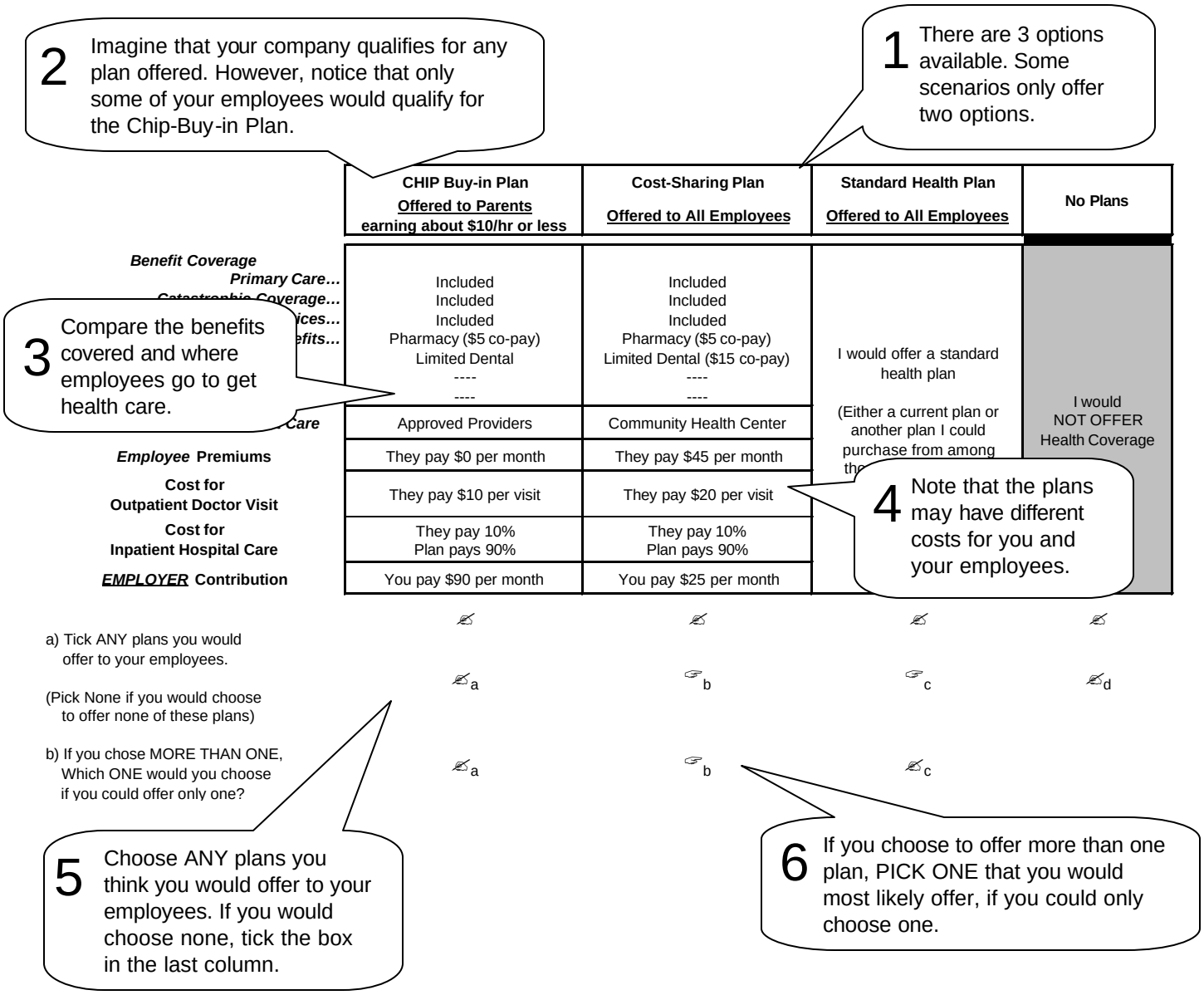
4. Notice that the plans entail different costs to your employees and to you.

5. Tick the box under ANY insurance plan you think you would offer your employees. You may choose more than one plan.

6. *If you selected more than one* plan, please indicate which ONE plan you would most likely choose if you could only offer one.

7. Remember, if you don't believe you would offer any of these plans to your employees, you should choose None.

Future Health Insurance Choice – Example



In the example, the person who answered this question chose to offer two plans: the Cost-Sharing plan and a Standard Insurance plan. They did not choose to participate in the Chip-Buy-in plan. You may prefer a different combination of plan or to offer no plans at all.

Because this person chose more than one plan, they also indicated that the plan they most preferred to offer was the Cost-Sharing plan.

Future Health Plan Choice 1

	CHIP Buy-in Plan ***Offered to Parents*** **earning about $10/hr or less**	**Cost-Sharing Plan** ***Offered to All Employees***	**Standard Health Plan** ***Offered to All Employees***	**No Plans**
Benefit Coverage				
Primary Care…	**Included**	**Included**		
Catastrophic Coverage…	**Included**	**Included**		
Specialist Services…	**Included**	**Included**		
Extra Benefits…	**Pharmacy ($5 co-pay)** **Limited Dental** **Hearing & Vision** **----**	**Pharmacy ($5 co-pay)** **Limited Dental ($15 co-pay)** **----** **----**	I would offer a standard health plan (Either a current plan or another plan I could purchase from among those currently on the market)	I would NOT OFFER Health Coverage
Where Employee Goes to Get Care	**Approved Providers**	**Approved Providers**		
***Employee* Premiums**	**They pay $0 per month**	**They pay $25 per month**		
Cost for Outpatient Doctor Visit	**They pay $20 per visit**	**They pay $20 per visit**		
Cost for Inpatient Hospital Care	**They pay 20%** **Plan pays 80%**	**They pay 10%** **Plan pays 90%**		
***EMPLOYER* Contribution**	**You pay $60 per month**	**You pay $35 per month**		
	✍✍	✍✍	✍✍	✍✍
a) Tick ANY plans you would offer to your employees. (Pick None if you would choose to offer none of these plans)	✍a✍	✍b✍	✍c✍	✍d✍
b) If you chose MORE THAN ONE, Which ONE would you choose if you could offer only one?	✍a✍	✍b✍	✍c✍	✍

Future Health Plan Choice 2

	CHIP Buy-in Plan ***Offered to Parents*** **earning about $10/hr or less**	**Cost-Sharing Plan** ***Offered to All Employees***	**Standard Health Plan** ***Offered to All Employees***	**No Plans**
Benefit Coverage				
Primary Care…	**Included**			
Catastrophic Coverage…	**Included**			
Specialist Services…	**Included**			
Extra Benefits…	**Pharmacy ($5 co-pay)** **Limited Dental** **Hearing & Vision** **----**		I would offer a standard health plan (Either a current plan or another plan I could purchase from among those currently on the market)	I would NOT OFFER Health Coverage
Where Employee Goes to Get Care	**Approved Providers**	**Not Available**		
***Employee* Premiums**	**They pay $0 per month**			
Cost for Outpatient Doctor Visit	**They pay $15 per visit**			
Cost for Inpatient Hospital Care	**They pay 0%** **Plan pays 100%**			
***EMPLOYER* Contribution**	**You pay $45 per month**			
	✍✍	✍	✍✍	✍✍
a) Tick ANY plans you would offer to your employees. (Pick None if you would choose to offer none of these plans)	✍a✍	✍	✍c✍	✍d✍
b) If you chose MORE THAN ONE, Which ONE would you choose if you could offer only one?	✍a✍	✍	✍c✍	✍

Future Health Plan Choice 3

	CHIP Buy-in Plan ***Offered to Parents*** **earning about $10/hr or less**	**Cost-Sharing Plan** ***Offered to All Employees***	**Standard Health Plan** ***Offered to All Employees***	**No Plans**
Benefit Coverage				
Primary Care…		**Included**		
Catastrophic Coverage…		**Included**		
Specialist Services…		**Included**		
Extra Benefits…		**Pharmacy ($5 co-pay)** **Limited Dental ($15 co-pay)** **----** **Mental Health ($20 co-pay)**	I would offer a standard health plan (Either a current plan or another plan I could purchase from among those currently on the market)	I would NOT OFFER Health Coverage
Where Employee Goes to Get Care	**Not Available**	**Approved Providers**		
***Employee* Premiums**		**They pay $35 per month**		
Cost for Outpatient Doctor Visit		**They pay $15 per visit**		
Cost for Inpatient Hospital Care		**They pay $50**		
***EMPLOYER* Contribution**		**You pay $35 per month**		
	✍	✍✍	✍✍	✍✍
a) Tick ANY plans you would offer to your employees. (Pick None if you would choose to offer none of these plans)	✍	✍b✍	✍c✍	✍d✍
b) If you chose MORE THAN ONE, Which ONE would you choose if you could offer only one?	✍	✍b✍	✍c✍	✍

Future Health Plan Choice 4

	CHIP Buy-in Plan ***Offered to Parents*** **earning about $10/hr or less**	**Cost-Sharing Plan** ***Offered to All Employees***	**Standard Health Plan** ***Offered to All Employees***	**No Plans**
Benefit Coverage				
Primary Care…	**Included**			
Catastrophic Coverage…	**Included**			
Specialist Services…	**Included**			
Extra Benefits…	**Pharmacy ($5 co-pay)** **Limited Dental** **----** **Mental Health Care**		I would offer a standard health plan (Either a current plan or another plan I could purchase from among those currently on the market)	I would NOT OFFER Health Coverage
Where Employee Goes to Get Care	**Approved Providers**	**Not Available**		
***Employee* Premiums**	**They pay $0 per month**			
Cost for Outpatient Doctor Visit	**They pay $20 per visit**			
Cost for Inpatient Hospital Care	**They pay 20%** **Plan pays 80%**			
***EMPLOYER* Contribution**	**You pay $45 per month**			
	✍✍	✍	✍✍	✍✍
a) Tick ANY plans you would offer to your employees. (Pick None if you would choose to offer none of these plans)	✍a✍	✍	✍c✍	✍d✍
b) If you chose MORE THAN ONE, Which ONE would you choose if you could offer only one?	✍a✍	✍	✍c✍	✍

Future Health Plan Choice 5

	CHIP Buy-in Plan ***Offered to Parents*** **earning about $10/hr or less**	**Cost-Sharing Plan** ***Offered to All Employees***	**Standard Health Plan** ***Offered to All Employees***	**No Plans**
Benefit Coverage				
Primary Care…	**Included**	**Included**	I would offer a standard health plan (Either a current plan or another plan I could purchase from among those currently on the market)	I would NOT OFFER Health Coverage
Catastrophic Coverage…	**Included**	**Included**		
Specialist Services…	**Included**	**Included**		
Extra Benefits…	**Pharmacy ($5 co-pay)** **Limited Dental** **----** **----**	**Pharmacy ($5 co-pay)** **Limited Dental ($15 co-pay)** **----** **----**		
Where Employee Goes to Get Care	**Approved Providers**	**Community Health Center**		
***Employee* Premiums**	**They pay $0 per month**	**They pay $25 per month**		
Cost for Outpatient Doctor Visit	**They pay $5 per visit**	**They pay $5 per visit**		
Cost for Inpatient Hospital Care	**They pay 10%** **Plan pays 90%**	**They pay 20%** **Plan pays 80%**		
***EMPLOYER* Contribution**	**You pay $90 per month**	**You pay $45 per month**		
	✍✍	✍✍	✍✍	✍✍
a) Tick ANY plans you would offer to your employees. (Pick None if you would choose to offer none of these plans)	✍a✍	✍b✍	✍c✍	✍d✍
b) If you chose MORE THAN ONE, Which ONE would you choose if you could offer only one?	✍a✍	✍b✍	✍c✍	✍

Future Health Plan Choice 6

	CHIP Buy-in Plan ***Offered to Parents*** **earning about $10/hr or less**	**Cost-Sharing Plan** ***Offered to All Employees***	**Standard Health Plan** ***Offered to All Employees***	**No Plans**
Benefit Coverage				
Primary Care…	**Included**	**Included**	I would offer a standard health plan (Either a current plan or another plan I could purchase from among those currently on the market)	I would NOT OFFER Health Coverage
Catastrophic Coverage…	**Included**	**Included**		
Specialist Services…	**Included**	**Included**		
Extra Benefits…	**Pharmacy ($5 co-pay)** **Limited Dental** **Hearing & Vision** **----**	**Pharmacy ($5 co-pay)** **----** **----** **----**		
Where Employee Goes to Get Care	**Approved Providers**	**Community Health Center**		
***Employee* Premiums**	**They pay $0 per month**	**They pay $55 per month**		
Cost for Outpatient Doctor Visit	**They pay $10 per visit**	**They pay $15 per visit**		
Cost for Inpatient Hospital Care	**They pay 0%** **Plan pays 100%**	**They pay 10%** **Plan pays 90%**		
***EMPLOYER* Contribution**	**You pay $75 per month**	**You pay $25 per month**		
	✍✍	✍✍	✍✍	✍✍
a) Tick ANY plans you would offer to your employees. (Pick None if you would choose to offer none of these plans)	✍a✍	✍b✍	✍c✍	✍d✍
b) If you chose MORE THAN ONE, Which ONE would you choose if you could offer only one?	✍a✍	✍b✍	✍c✍	✍

Future Health Plan Choice 7

	CHIP Buy-in Plan ***Offered to Parents*** **earning about $10/hr or less**	**Cost-Sharing Plan** ***Offered to All Employees***	**Standard Health Plan** ***Offered to All Employees***	**No Plans**
Benefit Coverage				
Primary Care…	**Included**	**Included**	I would offer a standard health plan (Either a current plan or another plan I could purchase from among those currently on the market)	I would NOT OFFER Health Coverage
Catastrophic Coverage…	**Included**	**Included**		
Specialist Services…	**Included**	**Included**		
Extra Benefits…	**Pharmacy ($5 co-pay)** **Limited Dental** **Hearing & Vision** **Mental Health Care**	**Pharmacy ($5 co-pay)** **----** **----** **Mental Health ($20 co-pay)**		
Where Employee Goes to Get Care	**Approved Providers**	**Community Health Center**		
***Employee* Premiums**	**They pay $0 per month**	**They pay $45 per month**		
Cost for Outpatient Doctor Visit	**They pay $20 per visit**	**They pay $10 per visit**		
Cost for Inpatient Hospital Care	**They pay 20%** **Plan pays 80%**	**They pay $300**		
***EMPLOYER* Contribution**	**You pay $45 per month**	**You pay $55 per month**		
	✍✍	✍✍	✍✍	✍✍
a) Tick ANY plans you would offer to your employees. (Pick None if you would choose to offer none of these plans)	✍a✍	✍b✍	✍c✍	✍d✍
b) If you chose MORE THAN ONE, Which ONE would you choose if you could offer only one?	✍a✍	✍b✍	✍c✍	✍

Future Health Plan Choice 8

	CHIP Buy-in Plan ***Offered to Parents*** **earning about $10/hr or less**	**Cost-Sharing Plan** ***Offered to All Employees***	**Standard Health Plan** ***Offered to All Employees***	**No Plans**
Benefit Coverage				
Primary Care…	**Included**	**Included**	I would offer a standard health plan (Either a current plan or another plan I could purchase from among those currently on the market)	I would NOT OFFER Health Coverage
Catastrophic Coverage…	**Included**	**Included**		
Specialist Services…	**Included**	**Included**		
Extra Benefits…	**Pharmacy ($5 co-pay)** **Limited Dental** **Hearing & Vision** **Mental Health Care**	**Pharmacy ($5 co-pay)** **Limited Dental ($15 co-pay)** **----** **----**		
Where Employee Goes to Get Care	**Approved Providers**	**Community Health Center**		
***Employee* Premiums**	**They pay $0 per month**	**They pay $25 per month**		
Cost for Outpatient Doctor Visit	**They pay $15 per visit**	**They pay $15 per visit**		
Cost for Inpatient Hospital Care	**They pay 30%** **Plan pays 70%**	**They pay $300**		
***EMPLOYER* Contribution**	**You pay $75 per month**	**You pay $25 per month**		
	✍✍	✍✍	✍✍	✍✍
a) Tick ANY plans you would offer to your employees. (Pick None if you would choose to offer none of these plans)	✍a✍	✍b✍	✍c✍	✍d✍
b) If you chose MORE THAN ONE, Which ONE would you choose if you could offer only one?	✍a✍	✍b✍	✍c✍	✍

Section C: About your company

This section asks a few questions about your company. This information will only be used to compare your responses with other companies and will be kept confidential.

Q1: In which County is your state business headquarters? (✍ *one*)

✍01	Beaver	✍11	Iron	✍21	Sevier
✍02	Box Elder	✍12	Juab	✍22	Summit
✍03	Cache	✍13	Kane	✍23	Tooele
✍04	Carbon	✍14	Millard	✍24	Uintah
✍05	Daggett	✍15	Morgan	✍25	Utah
✍06	Davis	✍16	Piute	✍26	Wasatch
✍07	Duchesne	✍17	Rich	✍27	Washington
✍08	Emery	✍18	Salt Lake	✍28	Wayne
✍09	Garfield	✍19	San Juan	✍29	Weber
✍10	Grand	✍20	Sanpete		

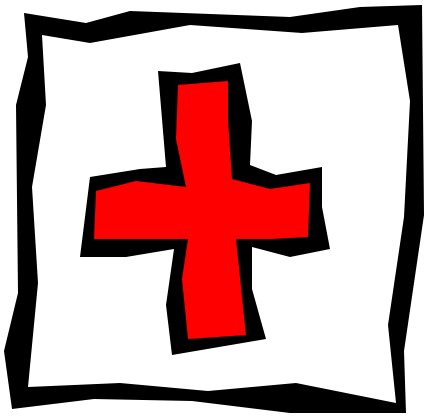
Q2: What industry would best describe your primary business? (✍ *one*)

✍01	Service	✍05	Construction	✍10	Utilities
✍02	Retail Trade	✍06	Manufacturing	✍11	Agriculture
✍03	Wholesale Trade	✍07	Mineral Industry	✍12	Other
✍04	Financial/insurance /real estate	✍08	Transportation		
		✍09	Communications		

Thank you very much for your assistance with this survey.

Please return the survey to us in the enclosed self-addressed postage-paid envelope. Alternatively, you can call us at the listed on the front of the survey.

Utah Health Coverage Survey



Sponsored by

Utah Department of Health

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ABOUT THIS SURVEY

The state of Utah is studying a variety of new health coverage alternatives for qualified residents. The Utah Department of Health wants your help in determining the combination of health care benefits, services, and prices that are most attractive and important to you.

This survey will help the Department of Health understand your preferences for health care coverage. Your answers will also help us estimate the number of Utahns like yourself who would participate in one of these plans.

Your participation is voluntary and completely confidential. Your answers will not affect any health care coverage you currently have or the options currently available to you.

The survey begins with some basic questions about health care coverage. These questions are followed by a section showing a series of health plan scenarios. Each scenario contains a variety of hypothetical health coverage plans from which you could choose. The scenarios will differ from one another in the types of plans available and the specific features of each plan. You will be asked to decide whether or not you would purchase one of these plans if they were offered to you. Finally, the survey ends with a few questions about you and your household.

Mark your answers directly on the survey. Return the survey to us in the enclosed self-addressed and postage-paid envelope OR call us back at the number below and give us your answers directly over the phone.

The codes on the bottom of the survey are only required to track your version of the survey. Your responses are strictly confidential and your input is greatly appreciated.

Feel free to call the number below if you have any questions about the survey or how to complete and return your responses.

Thank you,

Sue Day
<ADVANIS TO INSERT TOLL FREE NUMBER HERE>

Section A: Health Coverage Experiences

This section asks a few questions about your experiences with currently available Health Insurance plans.

Q1: Do you currently have health insurance? (✍ ***ONE***)

✍1 Yes ✍2 No

The rest of the questions on this page ask you to describe a health coverage plan.

If you answered YES

✍

Please select the answers that will best describe the plan that…

<u>you current health plan</u>.

If you have more than one plan, describe your primary plan.

If you answered NO

✍

Please select the options that will describe the health plan that

<u>you would buy</u>,

if you were to purchase one.

Please read the attached glossary for definitions of the terms used below.
If you are unsure of any answer, please make your best guess.

Q2: What type of insurance plan is this: (✍ ***ONE***)

- ✍1 Traditional Insurance - Fee-for-service
- ✍2 Preferred Provider Organization (PPO)
- ✍3 Health Maintenance Organization (HMO)
- ✍4 Point-of-Service plan (POS)
- ✍5 Medicaid or Medicare

Q3: From whom do you get this health care coverage? (✍ ***ONE***)

- ✍1 Through your or a family members' employer
- ✍2 Purchased directly from a health insurance company
- ✍3 A state or federal government program

Q4: Where do you go to get health care service? (✍ ***ONE***)

- ✍1 Community health clinic
- ✍2 Doctors or hospitals approved by the plan
- ✍3 Any doctor or hospital you choose

Q5: How much is the annual enrollment fee (if any)?
(*write in the approximate amount, if no fee, write 0*) $_____ per year

Q6: How much is the monthly premium?
(*write in the approximate amount, if no fee, write 0*) $_____ per month

Q7: How much is the typical co-payment for an outpatient doctor visit?
(*write in the approximate amount, if no fee, write 0*) $_____ per doctor visit

Q8: How much is the deductible – for a single person?
(*write in the approximate amount, if none, write 0*) $_____ per year

Q9: What percent of your inpatient hospital expenses does your health plan cover?
(✍ ***ONE*** *for the percent of expenses your health care* ***<u>plan pays</u>*** *for inpatient hospital services*)

✍1 50% ✍2 60% ✍3 70% ✍4 80% ✍5 90% ✍6 100%

Q10: What services are covered under this plan? (✍ ***ANY*** *benefits that are covered*)

✍a Primary Care (for example)
Diagnostic services (x-rays, etc.)
Preventative care & Immunizations
Emergency, Ambulance, Urgent care

✍b Catastrophic Coverage (for example)
Hospital & related surgical services

✍c Specialist Services (for example)
Other Surgeon & Anesthesia
Orthopedic Care
Cardiologist
Endocrinologist

Extra Benefits

✍d Pharmacy & Prescriptions

✍e Dental care (cleaning, fillings, etc.)

✍f Hearing & Vision care

✍g Mental health & Substance abuse

✍h Maternity & Prenatal

✍i Medical equipment & Home care

✍j Physical therapy

✍k Alternative Medicine

Section B: Future Health Plan Choices

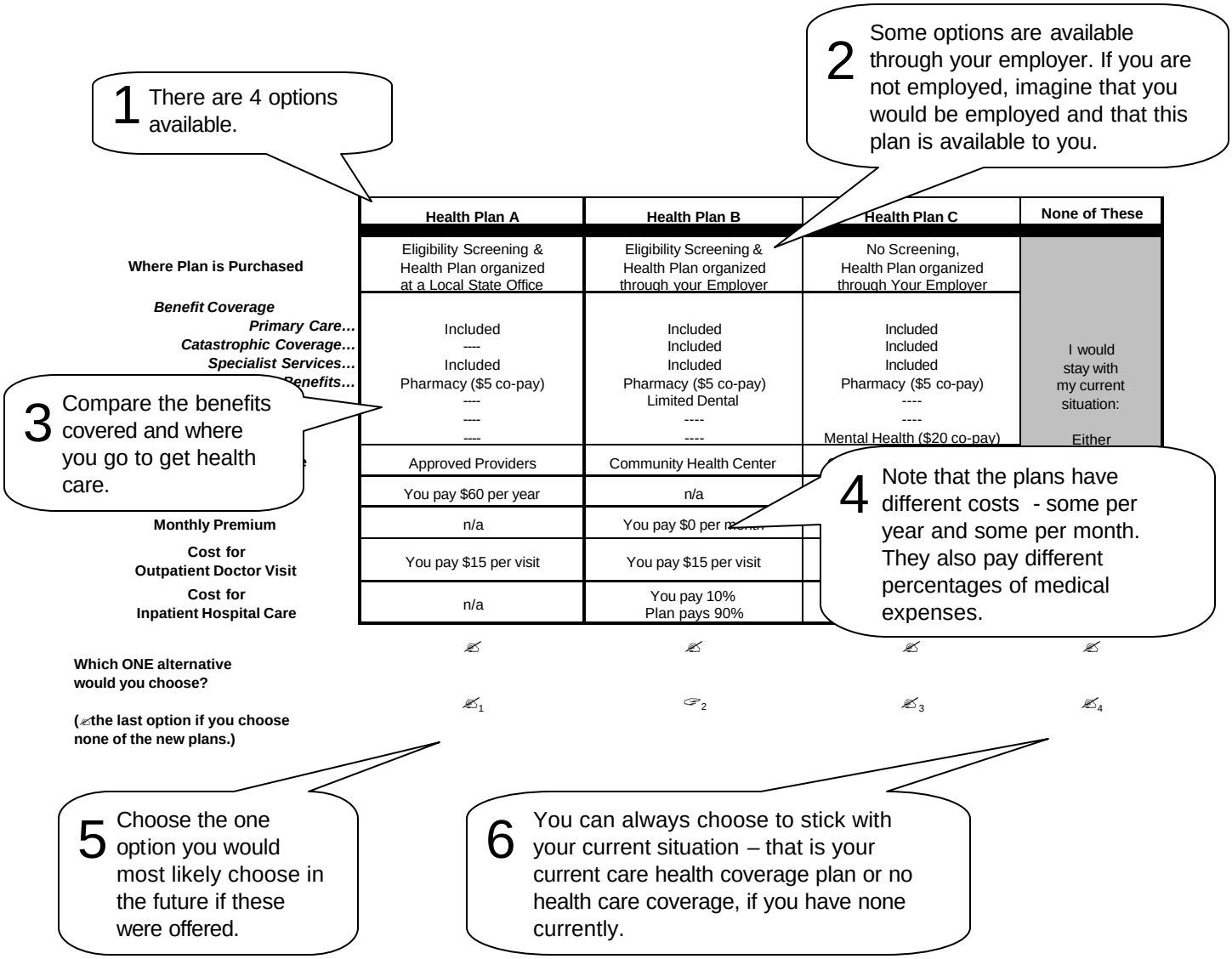
The next set of 8 questions asks you to make choices about your health coverage at some point in the future. For each question you should imagine that these are your health coverage options next year.

In each scenario, you will be asked to choose to purchase one of the new health care coverage plans or to stick with your current situation – whether that is to maintain your current health coverage if you have it or to go without if you don't currently have health coverage.

An example is shown on the next page.

1. Notice there are four different options from which to choose. Three of these, Plan A, B and C are new options. The last option is to stay with your current situation. In some situations, not all of these will be available.
2. Some health plan options may only be available through an employer. If you are not employed, please choose as if you were employed.
3. Compare the different health plans. They provide different levels of benefit coverage and provide you with different choices for where you can go to get health care.
4. Notice that these options also differ in their costs. Some have annual fees others have monthly premiums. Also note any co-payments and what percent of other insurance costs will be paid by the health plan.
5. Tick the box under the plan you think you would purchase if these were offered to you.
6. If you don't believe you would purchase any of these new plans you should choose to stick with your current situation.

Future Health Care Coverage Choice – Example



In the example, the person who answered this question chose Health Plan B.

You may prefer a different plan or to stay with your current situation.

Future Health Plan Choice A

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased	**Eligibility Screening & Health Plan organized at a Local State Office**	**Eligibility Screening & Referral to Insurance Co. by State of Utah**	**No Screening, Health Plan organized through Your Employer**	**I would stay with my current situation: Either no plan or my current health plan**
Benefit Coverage				
Primary Care…	**Included**	**Included**	**Included**	
Catastrophic Coverage…	**----**	**Included**	**Included**	
Specialist Services…	**Included**	**Included**	**Included**	
Extra Benefits…	**Pharmacy ($5 co-pay) ---- ---- ----**	**Pharmacy ($5 co-pay) Limited Dental ---- Mental Health Care**	**Pharmacy ($5 co-pay) ---- ---- Mental Health ($20 co-pay)**	
Where You Go to Get Care	**Community Health Center**	**Approved Providers**	**Community Health Center**	
Annual Fee	**You pay $60 per year**	**n/a**	**n/a**	
Monthly Premium	**n/a**	**You pay $90 per month**	**You pay $35 per month**	
Cost for Outpatient Doctor Visit	**You pay $5 per visit**	**You pay $10 per visit**	**You pay $20 per visit**	
Cost for Inpatient Hospital Care	**n/a**	**You pay 0% Plan pays 100%**	**You pay 10% Plan pays 90%**	
	✍✍	✍✍	✍✍	✍✍
Which ONE alternative would you choose?				
(✍the last option if you choose none of the new plans.)	✍1✍	✍2✍	✍3✍	✍4✍

Future Health Plan Choice B

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased		**Eligibility Screening & Health Plan organized through your Employer**	**No Screening, Health Plan organized through Your Employer**	
Benefit Coverage				
Primary Care…		**Included**	**Included**	
Catastrophic Coverage…		**Included**	**Included**	
Specialist Services…		**Included**	**Included**	
Extra Benefits…		**Pharmacy ($5 co-pay)** **Limited Dental** **----** **----**	**Pharmacy ($5 co-pay)** **----** **----** **----**	
Where You Go to Get Care	**Not Available**	**Approved Providers**	**Approved Providers**	**I would stay with my current situation:** **Either no plan or my current health plan**
Annual Fee		**n/a**	**n/a**	
Monthly Premium		**You pay $0 per month**	**You pay $45 per month**	
Cost for Outpatient Doctor Visit		**You pay $20 per visit**	**You pay $15 per visit**	
Cost for Inpatient Hospital Care		**You pay 0%** **Plan pays 100%**	**You pay 10%** **Plan pays 90%**	
	✍	✍✍	✍✍	✍✍
Which ONE alternative would you choose?				
(✍the last option if you choose none of the new plans.)	✍	✍2✍	✍3✍	✍4✍

Future Health Plan Choice 1

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased	**Eligibility Screening & Health Plan organized at a Local State Office**	**Eligibility Screening & Health Plan organized through your Employer**	**Not Available**	**I would stay with my current situation: Either no plan or my current health plan**
Benefit Coverage				
Primary Care…	**Included**	**Included**		
Catastrophic Coverage…	**----**	**Included**		
Specialist Services…	**Included**	**Included**		
Extra Benefits…	**Pharmacy ($5 co-pay) ---- ---- ----**	**Pharmacy ($5 co-pay) Limited Dental ---- ----**		
Where You Go to Get Care	**Community Health Center**	**Approved Providers**		
Annual Fee	**You pay $40 per year**	**n/a**		
Monthly Premium	**n/a**	**You pay $0 per month**		
Cost for Outpatient Doctor Visit	**You pay $15 per visit**	**You pay $20 per visit**		
Cost for Inpatient Hospital Care	**n/a**	**You pay 20% Plan pays 80%**		
	✍✍	✍✍	✍	✍✍
Which ONE alternative would you choose?				
(✍the last option if you choose none of the new plans.)	✍1✍	✍2✍	✍	✍4✍

Future Health Plan Choice 2

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased	**Eligibility Screening & Health Plan organized at a Local State Office**		**No Screening, Health Plan organized through Your Employer**	
Benefit Coverage				
Primary Care…	**Primary Care**		**Included**	
Catastrophic Coverage…	**Catastrophic Coverage**		**Included**	
Specialist Services…	**Specialist Services**		**Included**	
Extra Benefits…	**Pharmacy ($5 co-pay)**		**Pharmacy ($5 co-pay)**	
	----		**Limited Dental ($15 co-pay)**	
	----	**Not Available**	**----**	**I would stay with my current situation:**
	----		**Mental Health ($20 co-pay)**	
Where You Go to Get Care	**Approved Providers**		**Approved Providers**	**Either no plan or my current health plan**
Annual Fee	**You pay $20 per year**		**n/a**	
Monthly Premium	**n/a**		**You pay $55 per month**	
Cost for Outpatient Doctor Visit	**You pay $15 per visit**		**You pay $15 per visit**	
Cost for Inpatient Hospital Care	**n/a**		**You pay 20% Plan pays 80%**	
	✍✍	✍	✍✍	✍✍
Which ONE alternative would you choose?				
(✍the last option if you choose none of the new plans.)	✍1✍	✍	✍3✍	✍4✍

Future Health Plan Choice 3

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased		**Eligibility Screening & Health Plan organized through your Employer**	**No Screening, Health Plan organized through Your Employer**	
Benefit Coverage				
Primary Care…		**Included**	**Included**	
Catastrophic Coverage…		**Included**	**Included**	
Specialist Services…		**Included**	**Included**	
Extra Benefits…		**Pharmacy ($5 co-pay)** **Limited Dental** **----** **Mental Health Care**	**Pharmacy ($5 co-pay)** **----** **----** **----**	
Where You Go to Get Care	**Not Available**	**Approved Providers**	**Community Health Center**	**I would stay with my current situation:** **Either no plan or my current health plan**
Annual Fee		**n/a**	**n/a**	
Monthly Premium		**You pay $0 per month**	**You pay $35 per month**	
Cost for Outpatient Doctor Visit		**You pay $15 per visit**	**You pay $5 per visit**	
Cost for Inpatient Hospital Care		**You pay 30%** **Plan pays 70%**	**You pay $50**	
	✍	✍✍	✍✍	✍✍
Which ONE alternative would you choose?				
(✍the last option if you choose none of the new plans.)	✍	✍2✍	✍3✍	✍4✍

Future Health Plan Choice 4

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased		**Eligibility Screening & Referral to Insurance Co. by State of Utah**	**No Screening, Health Plan organized through Your Employer**	
Benefit Coverage				
Primary Care…		**Included**	**Included**	
Catastrophic Coverage…		**Included**	**Included**	
Specialist Services…		**Included**	**Included**	
Extra Benefits…		**Pharmacy ($5 co-pay)** **Limited Dental** **----** **Mental Health Care**	**Pharmacy ($5 co-pay)** **Limited Dental ($15 co-pay)** **----** **----**	**I would stay with my current situation:** **Either no plan or my current health plan**
Where You Go to Get Care	**Not Available**	**Approved Providers**	**Community Health Center**	
Annual Fee		**n/a**	**n/a**	
Monthly Premium		**You pay $90 per month**	**You pay $45 per month**	
Cost for Outpatient Doctor Visit		**You pay $5 per visit**	**You pay $10 per visit**	
Cost for Inpatient Hospital Care		**You pay 10%** **Plan pays 90%**	**You pay 10%** **Plan pays 90%**	
Which ONE alternative would you choose? (✍the last option if you choose none of the new plans.)	✍	✍2✍	✍3✍	✍4✍

Future Health Plan Choice 5

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased	Not Available	Eligibility Screening & Health Plan organized through your Employer	No Screening, Health Plan organized through Your Employer	I would stay with my current situation: Either no plan or my current health plan
Benefit Coverage				
Primary Care…		Included	Included	
Catastrophic Coverage…		Included	Included	
Specialist Services…		Included	Included	
Extra Benefits…		Pharmacy ($5 co-pay) Limited Dental Hearing & Vision ----	Pharmacy ($5 co-pay) ---- ---- ----	
Where You Go to Get Care		Approved Providers	Community Health Center	
Annual Fee		n/a	n/a	
Monthly Premium		You pay $0 per month	You pay $55 per month	
Cost for Outpatient Doctor Visit		You pay $5 per visit	You pay $10 per visit	
Cost for Inpatient Hospital Care		You pay 0% Plan pays 100%	You pay $50	
	✍	✍ ✍	✍ ✍	✍ ✍
Which ONE alternative would you choose?				
(✍ the last option if you choose none of the new plans.)	✍	✍ 2 ✍	✍ 3 ✍	✍ 4 ✍

Future Health Plan Choice 6

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased	**Eligibility Screening & Health Plan organized at a Local State Office**	**Eligibility Screening & Health Plan organized through your Employer**	**No Screening, Health Plan organized through Your Employer**	**I would stay with my current situation: Either no plan or my current health plan**
Benefit Coverage				
Primary Care…	**Included**	**Included**	**Included**	
Catastrophic Coverage…	**----**	**Included**	**Included**	
Specialist Services…	**----**	**Included**	**Included**	
Extra Benefits…	**Pharmacy ($5 co-pay) ---- ---- ----**	**Pharmacy ($5 co-pay) Limited Dental Hearing & Vision Mental Health Care**	**Pharmacy ($5 co-pay) Limited Dental ($15 co-pay) ---- Mental Health ($20 co-pay)**	
Where You Go to Get Care	**Community Health Center**	**Approved Providers**	**Approved Providers**	
Annual Fee	**You pay $60 per year**	**n/a**	**n/a**	
Monthly Premium	**n/a**	**You pay $0 per month**	**You pay $25 per month**	
Cost for Outpatient Doctor Visit	**You pay $5 per visit**	**You pay $10 per visit**	**You pay $20 per visit**	
Cost for Inpatient Hospital Care	**n/a**	**You pay 10% Plan pays 90%**	**You pay $300**	
	✍✍	✍✍	✍✍	✍✍
Which ONE alternative would you choose?				
(✍the last option if you choose none of the new plans.)	✍1✍	✍2✍	✍3✍	✍4✍

Future Health Plan Choice 7

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased	**Eligibility Screening & Health Plan organized at a Local State Office**	**Eligibility Screening & Health Plan organized through your Employer**	**No Screening, Health Plan organized through Your Employer**	**I would stay with my current situation: Either no plan or my current health plan**
Benefit Coverage				
Primary Care…	**Included**	**Included**	**Included**	
Catastrophic Coverage…	**----**	**Included**	**Included**	
Specialist Services…	**Included**	**Included**	**Included**	
Extra Benefits…	**Pharmacy ($5 co-pay) ---- ---- ----**	**Pharmacy ($5 co-pay) Limited Dental Hearing & Vision ----**	**Pharmacy ($5 co-pay) ---- ---- Mental Health ($20 co-pay)**	
Where You Go to Get Care	**Community Health Center**	**Approved Providers**	**Approved Providers**	
Annual Fee	**You pay $60 per year**	**n/a**	**n/a**	
Monthly Premium	**n/a**	**You pay $0 per month**	**You pay $55 per month**	
Cost for Outpatient Doctor Visit	**You pay $1 per visit**	**You pay $5 per visit**	**You pay $5 per visit**	
Cost for Inpatient Hospital Care	**n/a**	**You pay 10% Plan pays 90%**	**You pay $300**	
	✍✍	✍✍	✍✍	✍✍
Which ONE alternative would you choose?				
(✍the last option if you choose none of the new plans.)	✍1✍	✍2✍	✍3✍	✍4✍

Future Health Plan Choice 8

	Health Plan A	Health Plan B	Health Plan C	None of these
Where Plan is Purchased	**Eligibility Screening & Health Plan organized at a Local State Office**	**Eligibility Screening & Health Plan organized through your Employer**	**No Screening, Health Plan organized through Your Employer**	**I would stay with my current situation: Either no plan or my current health plan**
Benefit Coverage				
Primary Care…	**Included**	**Included**	**Included**	
Catastrophic Coverage…	**Included**	**Included**	**Included**	
Specialist Services…	**----**	**Included**	**Included**	
Extra Benefits…	**Pharmacy ($5 co-pay) ---- ---- ----**	**Pharmacy ($5 co-pay) Limited Dental Hearing & Vision Mental Health Care**	**Pharmacy ($5 co-pay) Limited Dental ($15 co-pay) ---- Mental Health ($20 co-pay)**	
Where You Go to Get Care	**Approved Providers**	**Approved Providers**	**Community Health Center**	
Annual Fee	**You pay $0 per year**	**n/a**	**n/a**	
Monthly Premium	**n/a**	**You pay $0 per month**	**You pay $45 per month**	
Cost for Outpatient Doctor Visit	**You pay $10 per visit**	**You pay $10 per visit**	**You pay $10 per visit**	
Cost for Inpatient Hospital Care	**n/a**	**You pay 0% Plan pays 100%**	**You pay $50**	
	✍✍	✍✍	✍✍	✍✍
Which ONE alternative would you choose?				
(✍the last option if you choose none of the new plans.)	✍1✍	✍2✍	✍3✍	✍4✍

Section C: About yourself

This section asks a few questions about you. This information will only be used to compare your responses with other individuals and will be kept confidential.

Q1: What is your gender? (✍ ***ONE***)

✍1 Male ✍2 Female

Q2: What is your age? (✍ ***ONE***)

✍1 18 to 24
✍2 25 to 34
✍3 35 to 54
✍4 55 to 64
✍5 65 or over

Q3: In which County do you normally live? (✍ ***ONE***)

✍01	Beaver	✍11	Iron	✍21	Sevier
✍02	Box Elder	✍12	Juab	✍22	Summit
✍03	Cache	✍13	Kane	✍23	Tooele
✍04	Carbon	✍14	Millard	✍24	Uintah
✍05	Daggett	✍15	Morgan	✍25	Utah
✍06	Davis	✍16	Piute	✍26	Wasatch
✍07	Duchesne	✍17	Rich	✍27	Washington
✍08	Emery	✍18	Salt Lake	✍28	Wayne
✍09	Garfield	✍19	San Juan	✍29	Weber
✍10	Grand	✍20	Sanpete		

Q4: How many children under 18 years of age are living at home with you?
(*write in the amount, if no children, write 0*) _____ children at home

Q5: How many adults (18 years or older) live at home, including yourself?
(*write in the amount, if only yourself, write 1*) _____ adults

Q6: How would you describe your general health status? (✍ ***ONE***)

✍1 Excellent
✍2 Very Good
✍3 Good
✍4 Fair
✍5 Poor

Q7: Over the past 12 months, were you employed, that is working for pay, most of the time? (✍ ***ONE***)

✍1 Yes ✍2 No

Q8: What was your TOTAL combined HOUSEHOLD income during the year 2000. Include income from all wage earners, and money from ALL SOURCES, not just wages and salaries, and use income BEFORE taxes and other deductions. (✍ ***ONE***)

✍01 Less than $5,000	✍06 $25,000 - $29,999	✍11 $50,000 - $54,999
✍02 $5,000 - $9,999	✍07 $30,000 - $34,999	✍12 $55,000 - $59,999
✍03 $10,000 - $14,999	✍08 $35,000 - $39,999	✍13 $60,000 - $64,999
✍04 $15,000 - $19,999	✍09 $40,000 - $44,999	✍14 $65,000 or more
✍05 $20,000 - $24,999	✍10 $45,000 - $49,999	

Thank you very much for your assistance with this survey.
Please return the survey to us in the enclosed self-addressed postage-paid envelope.
Alternatively, you can call us at the listed on the front of the survey.

Thank you for participating in this important survey. It is our hope that businesses will welcome this opportunity to voice their concerns and expectations regarding the future of healthcare coverage in Utah.

A primary purpose of the survey is to establish a descriptive profile for employment-based health coverage in Utah. Some of the information you provide will be used to identify obstacles associated with employee health benefits programs. Other information will be used to develop more efficient ways to support employers who sponsor health care coverage or identify more efficient options for individual workers.

This worksheet provides an outline of the survey so that you can locate and prepare the requested information in advance. Within the next week or two an interviewer from the private firm of Dan Jones and Associates will call. The interviewer will ask for you by name and then go through your answers to the questions on this worksheet with you. At that time, your information will be entered directly into a computer database for aggregate analysis. Your name and business identity will remain separate from all of the information you provide. Thus anonymity and confidentiality of your participation are guaranteed.

If you have any questions regarding information requested on this worksheet, please contact Rita Hanover at 801-538-6614 or Shane Carlson at 801-538-6821.

Utah Employer Survey

Thank you for participating in this important survey. Within the next week an interviewer from Dan Jones and Associates will call. The interviewer will ask for you by name and then go through your answers to the questions on this worksheet with you. If you have any questions regarding information requested on this worksheet, please contact Rita Hanover at 538-6614 or Shane Carlson at 538-6821.

Please note the following:

- **All** businesses are asked to complete Sections **A and B**. (Pages 1-4)

In addition,

- Complete **Section C** if your business **offers healthcare coverage** to employees. (Pages 5-11)
- Complete **Section D** if **you are the owner or a partner** of this business. (Regardless of whether your company sponsors employee healthcare coverage.) (Pages 12-13)
- Complete Section E **if you are the owner or a partner of this business and your business does not offer healthcare coverage** to employees. (Page 14)
- Complete **Section F** if **you are self-employed with no employees**. (Pages 15-18)

Please take some time to complete the appropriate worksheet(s) in the next few days so that you will have the information available when the interviewer calls.

Sections A and B:
For All Businesses in the Survey

Section A: Business Contact Person Identification

A1. What is your relationship to this business?

- ✍ Owner **(Go to B1)**
- ✍ Partner **(Go to B1)**
- ✍ Manager or Employee **(Continue)**

A2. What is your position in this company? _____

A3. How long have you been an employee with this business?

- ✍ _____ years or
- ✍ _____ months

Section B: Description of the Business

B1. How long has your company been in business?

- ✍ _____ years or
- ✍ _____ months

B2. Which term below best describes the industry or principal activity of your business?

- ✍ Service
- ✍ Retail trade
- ✍ Wholesale trade
- ✍ Financial, insurance or real estate
- ✍ Construction
- ✍ Manufacturing
- ✍ Mineral industry
- ✍ Transportation, communications, utilities
- ✍ Agriculture
- ✍ Other (specify) _____

B3. How many active full-time, non-seasonal employees does your company have during a typical pay period?

- ✍ None (**If you are self-employed with no employees, Stop here and complete Sections E and F only)**
- ✍ 10-24
- ✍ 25-49
- ✍ 50-99
- ✍ >100

B4. For the same typical pay period, how many part-time employees do you have in each of the following categories? ***Please provide the number (or your best estimate) for each category:***

25-34 hours per week	_____	5-14 hours per week	_____
15-24 hours per week	_____	< 5 hours per week	_____

B5. For the same typical pay period, how many employees are temporary or seasonal workers?

_____ employees

B6. Including regular, full-time, part-time, and seasonal or temporary workers, (all paid employees) what is the gross amount of your payroll for a typical pay period?

✍	< $50,000		✍✍week
✍	$50,000-$99,999		✍✍every 2 weeks
✍	$100,000-$249,999		✍✍twice a month
✍	$250,000-$499,999	per	✍✍each month
✍	$500,000-$999,999		✍✍six months
✍	$1,000,000-$5,000,000		✍✍year
✍	>$5,000,000		

B7. How many of your regular, full-time employees earn: ***Please provide the number (or your best estimate) for <u>each</u> category:***

Less than $5 per hour ($10,000 or less per year)	_____
More than $5 but less than $7 per hour (more than $10,000 but less than $14,000 per year)	_____
More than $7 but less than $10 per hour (more than 14,000 but less than $20,000 per year)	_____
More than $10 but less than $15 per hour (more than $20,000 but less than $30,000 per year)	_____
More than $15 but less than $20 per hour (more than $30,000 but less than $40,000 per year)	_____
More than $20 but less than $25 per hour (more than $40,000 but less than $50,000 per year)	_____
More than $25 but less than $30 per hour (more than $50,000 but less than $60,000 per year)	_____
More than $30 per hour (more than $60,000 per year)	_____

B8. How many of your part-time, temporary or seasonal workers earn: ***Please provide the number (or your best estimate) for <u>each</u> category:***

Less than $5 per hour	_____
More than $5 but less than $7 per hour	_____
More than $7 but less than $10 per hour	_____
More than $10 but less than $15 per hour	_____
More than $15 but less than $20 per hour	_____
More than $20 but less than $25 per hour	_____
More than $25 but less than $30 per hour	_____
More than $30 per	_____

B9. How many of the regular full-time employees have worked for this business for: ***Please provide the number (or your best estimate) for <u>each</u> category:***

< 1 year	_____ employees
1-5 years	_____ employees
6-10 years	_____ employees
>10 years	_____ employees ✍

✍

B10. How many of your regular, full-time employees are: ***Please provide the number (or your best estimate) for <u>each</u> category:***

Under 30 years old	_____ employees
30-39 years old	_____ employees
40-49 years old	_____ employees
50-59 years old	_____ employees
60-64 years old	_____ employees
65 or older	_____ employees

B11. Does your business offer employees any of the following benefits? ***(answer all)***

	Yes	No	Don't know
Disability coverage	✍	✍✍ ✍	✍✍✍
Any type of pension or retirement plan, such as a 401(k)or profit sharing plan	✍	✍✍ ✍	✍✍✍
Long term care coverage	✍	✍✍ ✍	✍✍✍
Flexible spending account for health care	✍	✍✍ ✍	✍✍✍
Paid sick leave	✍	✍✍ ✍	✍✍✍
Paid vacations	✍	✍✍ ✍	✍✍✍✍
Wellness program or exercise facilities	✍	✍✍ ✍	✍✍✍
Term life insurance	✍	✍✍ ✍	✍✍✍
Medicare supplement coverage	✍	✍✍ ✍	✍✍✍

B12. Does your company make available and/or contribute to the cost of any healthcare coverage for employees? ***(Include coverage obtained through union or trade or professional associations if the company contributes.)***

✍ Yes **All respondents answering yes to this question should continue to section C.**

✍ No **If you answered no to this question and you are the owner or a partner of this company please go to Section D.**

If you answered no to this question and you are an employee or manager, but not an owner or partner of this business, Question B12 concludes your worksheet preparation. Please have this completed worksheet available when our interviewer calls. Thank you!

Section C: Businesses with Employer-Sponsored Healthcare Coverage

Please use the following descriptions to identify the health plans currently offered by your company.

HMO: Health Maintenance Organization: Pays for care only when received from a specified list or network of physicians and hospitals. Includes IPA, network, staff, and group models.
POS: Point of Service Plans: Uses a primary care physician, called a gatekeeper, to control access to a specified network
PPO: Preferred Provided Organizations: Patients are given a list of "preferred" providers and they pay less when they use providers on their list. Members can use physicians or hospitals not on the list at a higher cost.
IND: Traditional Indemnity Plan: No list of physicians or hospitals and no restrictions on choice of physician or hospital.

Please provide the following information for each general medical plan (a healthcare coverage plan providing hospital or physician coverage) currently offered to employees. If you have more than three general medical plans, please answer for the three plans with the largest enrollment. **You may want to make a separate copy of this section for each of these plans:**

C1. What is the name of this plan? _____

C2. If applicable,what is the name of the Insurance company, carrier or HMO that offers this plan? _____

C3. What type of plan is it? (**Please see descriptions above and check one)**

- ✍✍ HMO
- ✍ POS
- ✍ PPO
- ✍ IND

C4. Did your company purchase this plan through any of the following pooling arrangements? **Check all that apply.**

- ✍ Alliance or cooperative
- ✍ Business coalition
- ✍ MET or MEWA
- ✍ Union
- ✍ Professional or trade association
- ✍ Other (specify) _____

- ✍ Did not purchase through pooling arrangement

C5. What services are covered under this plan? Indicate **yes** if the service is ever covered (even if it is not covered under some conditions) and **no** if the service is NOT covered under each plan.

	Yes	No	Don't know
Physician services	✍	✍	✍
Inpatient hospital stays	✍	✍	✍
Outpatient prescription drugs	✍	✍	✍
Inpatient mental health	✍	✍	✍
Outpatient mental health	✍	✍	✍
Dental care	✍	✍	✍
Maternity care	✍	✍	✍
Prenatal care	✍	✍	✍
Preventive health care	✍	✍	✍
Ambulance services	✍	✍	✍
Diagnostic Lab and X-ray	✍	✍	✍
Home heath care	✍	✍	✍
Hospice care	✍	✍	✍
Pre-existing conditions	✍	✍	✍
Health Education	✍	✍	✍
Adult Physical Examination	✍	✍	✍
Well-baby care	✍	✍	✍
Well-child care	✍	✍	✍
Childhood immunizations	✍	✍	✍
Mammography screening	✍	✍	✍
Screening pap test	✍	✍	✍
Outpatient drug treatment	✍	✍	✍
Outpatient alcohol treatment	✍	✍	✍
Occupational therapy	✍	✍	✍
Chiropractic	✍	✍	✍
Emergency Room Services	✍	✍	✍
Outpatient surgery	✍	✍	✍

C6. Can this plan refuse to cover employees who have certain health problems or conditions?

✍Yes ✍No

C7. Does this plan have a waiting period for pre-existing conditions that employees may have at the time of enrollment?

✍Yes ✍No **(Skip to C9)**

C8. How long is the waiting period for coverage of pre-existing conditions? _____

C9. What is the minimum number of hours per week an employee has to work in order to be eligible for health coverage under this plan?

_____ hours

C10. How many employees are currently **eligible** for this plan?

Full-time employees	_____
Part-time employees	_____
Temporary or seasonal employees	_____
COBRAs	_____
Retirees age 65 and over	_____
Retirees under age 65	_____

How many eligible Employees are

Under 30 years old	_____
30-39 years old	_____
40-49 years old	_____
50-64 years old	_____

C11. How many employees are currently **enrolled** in this plan?

Full-time employees	_____
Part-time employees	_____
Temporary or seasonal employees	_____
COBRAs	_____
Retirees age 65 and over	_____
Retirees under age 65	_____

How many enrolled employees are

Under 30 years old	_____
30-39 years old	_____
40-49 years old	_____
50-64 years old	_____

C12. What is the **total** premium for an employee with employee-only coverage **(Total of employer and employee contributions**)

$ _____ each

✍✍week
✍✍2 weeks
✍✍2 times a month
✍✍month
✍✍year

C13. How much of the total premium for employee-only coverage is paid for by the employee? Use same period as for C12.

$_____
or
_____%

C14. Does this plan offer an employee the option of covering a spouse or dependent children?

✍✍Yes
✍✍No (skip to C17)

C15. What is the **total** premium for an employee with family (spouse and **dependent children) coverage? (Total of employer and employee contributions**)

$ _____ each

✍✍week
✍✍2 weeks
✍✍2 times a month
✍✍month
✍✍year

C16. How much of the total premium for family coverage is paid for by the employee? (Use same time period as for C15.)

$_____
or
_____%

C17. Does this plan have an annual individual deductible for covered services (a dollar amount that members must pay before benefits are paid)?
✍✍Yes
✍✍No **(go to C19)**

C18. How much is the annual individual deductible for covered services?
$_____
or
_____% per year

C19. Do employees have to pay anything (a co-payment or coinsurance) when they visit a physician?
✍✍Yes
✍✍No **(go to C21)**

C20. What is the copayment or coinsurance amount that employees pay for physician visits?
$_____
or
_____% per visit

C21. What is the annual individual out-of pocket maximum?
$_____ per year

C22. What is the annual family out-of-pocket maximum?
$_____ per year

C23. How long has your company offered this plan?
_____ months
or
_____ years

If C23 = 2 or more years, continue. If less than 2 years, go to C26

C24. Is the current **per employee** premium higher, lower, or about the same compared to last year?
✍✍higher (by _____%)
✍✍lower (by _____%)
✍✍about the same

C25. Is the current **per family** premium higher, lower, or about the same compared to last year?
✍✍higher (by _____%)
✍✍lower (by _____%)
✍✍about the same ___

C26. Is this plan fully insured or Self-funded? (Check one)
✍✍Fully insured ✍✍Self- Funded

If fully insured, go to C30

Note: A fully insured plan is one in which the underwriting risk for losses is borne by a commercial insurer. These plans are regulated by the State. A self-funded plan is one in which the underwriting risk for losses is borne by the business or employer. Self-funded plans are not regulated by the State, but by the Federal Government under ERISA.

C27. Does your company purchase a stop-loss or reinsurance policy for this plan?
✍✍Yes
✍ No **(go to C30)**

C28. At what dollar amount does the reinsurance plan begin to pay benefits?
$_____

C29. Is this dollar amount for aggregate claims or for an individual's claims?
✍✍Aggregate
✍✍Individual

C30. Have there been any interruptions in health benefits since your company began sponsoring employee health care coverage?

☐☐ Yes **(continue)**
☐☐ No **(go to C40)**
☐☐ Don't know **(go to C40)**

C31. In what year did the most recent gap begin?

_____

C32. How long was the company without healthcare coverage?

_____ ☐☐ Months
or
☐☐ Years

If you are the owner or a partner of this business, please answer C33 and C34. If not, skip to C40.

C33. Regarding the interruption in healthcare benefits in **C31** please indicate if each of the following was a major, minor, or not a contributing reason for the change in healthcare coverage.

	Major Reason	Minor Reason	Not a Reason
A. Change in state insurance laws	☐☐	☐☐ ☐	☐☐☐
B. Change in federal insurance laws	☐☐	☐☐ ☐	☐☐☐
C. Increase in price	☐☐	☐☐ ☐	☐☐☐
D. Reduction in benefits	☐☐	☐☐ ☐	☐☐☐
E. Employee illness	☐☐	☐☐ ☐	☐☐☐
F. Disagreement with insurance agent or company.	☐☐	☐☐ ☐	☐☐☐
G. Lack of enrollment	☐☐	☐☐ ☐	☐☐☐
H. Business decision based on economy or business profitability	☐☐	☐☐ ☐	☐☐☐
I. Other	☐☐	☐☐ ☐	☐☐☐

C34. Following the interruption of benefits in **C31**, please indicate if each of the following was a major reason, a minor reason or not a contributing reason for beginning to offer employee health benefits again.

	Major Reason	Minor Reason	Not a Reason
A. More favorable state insurance laws	☐☐	☐☐ ☐	☐☐☐
B. More favorable federal insurance laws	☐☐	☐☐ ☐	☐☐☐
C. Decrease in price	☐☐	☐☐ ☐	☐☐☐
D. Change in benefits package	☐☐	☐☐ ☐	☐☐☐
E. Change in employee health status or employee roster	☐	☐☐ ☐	☐☐☐
F. Change in number of employees	☐☐	☐☐ ☐	☐☐☐
G. Competition for employees	☐☐	☐☐ ☐	☐☐☐
H. Business decision based on economy or business profitability	☐☐	☐☐ ☐	☐☐☐
I. Other _____	☐	☐☐ ☐	☐☐☐

C35. Have there been any <u>other</u> interruptions in health benefits since your company began sponsoring employee health coverage?

☐☐ Yes **(continue)**
☐☐ No **(go to C40)**
☐ ☐ ☐☐ Don't know **(go to C40)**

C36. Prior to the gap you just described, in what year did the next most recent time there was an interruption in overage begin?

Year _____

C37. For how long was the company without employee healthcare coverage that time?

_____ ✍✍ Months
or
✍✍ Years

If you are the owner or a partner of this business, please answer C38 and C39. If not, skip to C40.

C38. Regarding the interruption in healthcare benefits in **C36** please indicate if each of the following was a major reason, a minor reason, or not a contributing reason for the change in healthcare coverage.

	Major Reason	Minor Reason	Not a Reason
A. Change in state insurance laws	✍✍	✍✍ ✍	✍✍✍
B. Change in federal insurance laws	✍✍	✍✍ ✍	✍✍✍
C. Increase in price	✍✍	✍✍ ✍	✍✍✍
D. Reduction in benefits	✍✍	✍✍ ✍	✍✍✍
E. Employee illness	✍✍	✍✍ ✍	✍✍✍
F. Disagreement with insurance agent or company.	✍✍	✍✍ ✍	✍✍✍
G. Lack of enrollment	✍✍	✍✍ ✍	✍✍✍
H. Business decision based on economy or business profitability	✍✍✍	✍✍ ✍	✍✍✍
I. Other	✍✍	✍✍ ✍	✍✍✍

C39. Following the interruption of benefits in **C36** please indicate if each of the following was a major, minor or not a contributing reason for beginning to offer employee health benefits again.

	Major Reason	Minor Reason	Not a Reason
A. More favorable state insurance laws	✍✍	✍✍ ✍	✍✍✍
B. More favorable federal insurance laws	✍✍	✍✍ ✍	✍✍✍
C. Decrease in price	✍✍	✍✍ ✍	✍✍✍
D. Change in benefits package	✍✍	✍✍ ✍	✍✍✍
E. Change in employee health status or employee roster	✍	✍✍ ✍	✍✍✍
F. Change in number of employees	✍✍	✍✍ ✍	✍✍✍
G. Competition for employees	✍✍	✍✍ ✍	✍✍✍
H. Business decision based on economy or business profitability	✍✍	✍✍ ✍	✍✍✍
I. Other _____	✍	✍✍ ✍	✍✍✍

C40. Does your company offer employees any of the following single-service plans? **(Report on single-service plans only—do not include services covered under the basic medical plans.)**

	Yes	No
Dental	✍✍	✍
Vision	✍✍	✍
Prescription Drugs	✍✍	✍✍
Long-term Care (nursing home)	✍✍	✍

C41. If the answer to any of the options in C40 is yes, what percentage of these single-services premiums does your company contribute?

Dental	_____%
Vision	_____%
Prescription Drugs	_____%
Long-term Care (nursing home)	_____%

C42. Did your company make any changes with regard to its employee health care benefits program in the last year?

☐☐ Yes
☐☐ No
☐☐ Don't Know

C43. If you answered yes to C42, which of the following changes were made? For each of the following options, please indicate **yes**, if this is a change that occurred in the last year, or **no**, if this change did not occur in the last year or **don't know** if you are unsure whether this is a change that has been made in employee health benefits in the last year.

	Yes	No	Don't Know
A. One or more plans were dropped	☐☐	☐☐ ☐	☐☐☐
B. A new health plan was added	☐☐	☐☐ ☐	☐☐☐
C. An old health plan was replaced	☐☐	☐☐ ☐	☐☐☐
D. Benefits were decreased	☐☐ ☐☐	☐☐ ☐	☐☐☐
E. Benefits were increased	☐☐ ☐☐	☐☐ ☐	☐☐☐
F. Employee costs were increased	☐☐ ☐☐	☐☐ ☐	☐☐☐
G. Employee costs were decreased	☐☐ ☐☐	☐☐ ☐	☐☐☐
H. The cost to the company was increased	☐☐☐☐	☐☐ ☐	☐☐☐
I. The cost to the company was decreased	☐☐☐☐	☐☐ ☐	☐☐☐
J. Single service plans were added	☐ ☐☐	☐☐ ☐	☐☐☐
K. Single service plans were dropped	☐☐ ☐☐	☐☐ ☐	☐☐☐
L. Single service plans were replaced	☐	☐☐ ☐	☐☐☐

Section D: All Owners or Partners of Businesses (including Self Employed with no employees)

D1. What percentage of your total household income was derived from this business last year?

_____%

D2. Approximately how many of your competitors offer healthcare coverage for their workers?

- ✍ None
- ✍✍ <25%
- ✍✍ 25-50%
- ✍✍ >50% but <75%
- ✍✍ >75%
- ✍✍ Almost 100%
- ✍✍ Don't know

For the following questions, assume that a working Utahn includes any resident with at least a part-time job for which they are compensated in any way by an employer such as yourself. In each question, healthcare coverage might be any form of premium-based third-party assistance in paying a health professional or company for an individual's basic and/or catastrophic health care.

D3. On a scale of 1 to 7 where 1 is not important and 7 is extremely important, how important do you think is it for <u>all</u> working Utahns and their families to have healthcare coverage?

1	2	3	4	5	6	7
✍✍	✍✍	✍✍	✍✍	✍✍	✍✍	✍

Not Important Extremely Important

D4. In your opinion, what percentage of a worker's health insurance premiums should be paid by the employer?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍

D5. In your opinion, what percentage of a worker's health insurance premiums should be paid by the individual worker?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍	✍✍✍

✍
✍
✍
✍
✍
✍
✍
✍

D6. For each of the following statements, indicate whether you strongly agree, somewhat agree, are unsure, somewhat disagree, or strongly disagree.

		Strongly Agree	Somewhat Agree	Unsure	Somewhat Disagree	Strongly Disagree
A.	Providing health insurance to more Utahns would make financial sense overall.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
B	Businesses pay in other ways if they don't provide healthcare coverage for their employees.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
C.	Employees see healthcare coverage as part of their compensation.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
D.	Uninsured get the same quality of healthcare as those with healthcare coverage.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
E.	The benefits of early intervention and better management of chronic and acute health problems outweigh the costs of health insurance.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
F.	In general, health insurance is not a good value for what it costs.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
G.	Workers without healthcare coverage have more absenteeism and are less productive than those who do.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
H.	Hospital bills are inflated to pay for uninsured healthcare.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
I.	Uninsured use the ER twice as much as those with insurance.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
J.	Money spent on health coverage for employees reduces other costs.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
K.	Basic only healthcare coverage (without preventive care, mental health, dental, etc) is no better than being uninsured.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			
L.	Employers would be more likely to offer employee health benefits if they had some control over costs.	✍✍	✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍✍			

Section E: Owners/Partners who do not sponsor healthcare coverage for employees.

E1. A list of reasons for not offering healthcare coverage by employers to their employees is presented. Please answer for each of them if they are a major reason, a minor reason, or not a reason why your business does not offer a health plan? ***(answer all)***

	Major Reason	Minor Reason	Not a Reason
A. Setting up a plan is too complicated and time consuming	✍✍ ✍	✍✍✍✍ ✍	✍✍✍✍
B. Revenue is too uncertain to commit to a plan.	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
C. Employees cannot afford it.			
D. Employees are healthy and do not need it	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
E. Employees have coverage elsewhere.	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
F. Employees prefer wages and/or other benefits.	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
G. My/our business does not need to offer health insurance in order ✍ to recruit and retain good workers.	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
H. A large portion of my/our workers are seasonal, part – time, or high turnover.	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
I. The company has had an adverse experience with employee healthcare coverage administration	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
J. The company was denied coverage.	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
K. Don't have enough information to make a decision about benefits.	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
L. Costs of employee health benefits are too difficult to control.	✍✍ ✍	✍✍✍✍ ✍	✍✍✍
M. Other reason why your business does not offer a health plan? _____			

E2. Under current economic conditions, how likely is it that your business will start a health plan for employees in the next two years? It is?
(check one)

✍Extremely likely
✍Somewhat likely
✍Don't know
✍Somewhat unlikely
✍Not at all likely

Section F: Self Employed with no Employees

F1. Did you have any kind of health insurance (including any form of government-sponsored healthcare coverage) in the last year?

✍Yes **(continue)**
✍No **(End of Survey)**

F2. Were you covered by Medicare at any time in the last year? (Medicare is a Social Security health program for disabled persons and for persons over 65 years of age.)

✍Yes **(continue)**
✍No **(go to F4)**

F3. For approximately how long were you covered by Medicare in the last year?
_____Months

F4. Were you covered by Medicaid or any other state funded health plans (such as UMAP or TANF) In the last year?

✍Yes **(continue)**
✍No **(go to F6)**

F5. For approximately how long were you covered by Medicaid or other state plans in the last year?

_____Months

F6. Are you currently covered by an individual or group health insurance policy?

✍Yes **(continue)**
✍No **(go to F25)**

F7. For approximately how long have you been covered by an individual or group health plan?

_____Months

F8. Which of the following describes that plan?

✍✍Insurance through parent's policy
✍✍Insurance through working spouse's policy
✍✍By purchase of individual or family healthplan
✍✍Other _____

F9. What is the name of your plan? _____

F10. If applicable,what is the name of the Insurance company, carrier or HMO that offers this plan?

_____

Please use the following descriptions to identify the health plan in F11.

HMO: Health Maintenance Organization: Pays for care only when received from a specified list or network of physicians and hospitals. Includes IPA, network, staff, and group models.

POS: Point of Service Plans: Uses a primary care physician, called a gatekeeper, to control access to a specified network

PPO: Preferred Provided Organizations: Patients are given a list of "preferred" providers and they pay less when they use providers on their list. Members can use physicians or hospitals not on the list at a higher cost.

IND: Traditional Indemnity Plan: No list of physicians or hospitals and no restrictions on choice of physician or hospital.

F11. What type of plan is it? (Please see descriptions above)

- ✍✍HMO
- ✍✍POS
- ✍✍PPO
- ✍✍IND
- ✍✍Other _____

F12. Did you purchase this plan through any of the following pooling arrangements? Check all that apply.

- ✍✍Alliance or cooperative
- ✍✍Business coalition
- ✍✍MET or MEWA
- ✍✍Union
- ✍ Professional or trade association
- ✍ Other **(specify)** _____
- ✍ Did not purchase through pooling arrangement

F13. What services are covered under this plan? Indicate **yes** if the service is ever covered (even if it is not covered under some conditions) and **no** if the service is NOT covered your plan.

	Yes		No	Don't know
✍				
Physician services	✍✍	✍	✍✍	✍✍✍✍
Inpatient hospital stays	✍✍	✍	✍✍	✍✍✍✍
Outpatient prescription drugs	✍✍	✍	✍✍	✍✍✍✍
Inpatient mental health	✍✍	✍	✍✍	✍✍✍✍
Outpatient mental health	✍✍	✍	✍✍	✍✍✍✍
Dental care	✍✍	✍	✍✍	✍✍✍✍
Maternity care	✍✍	✍	✍✍	✍✍✍✍
Prenatal care	✍✍	✍	✍✍	✍✍✍✍
Preventive health care	✍✍	✍	✍✍	✍✍✍✍
Ambulance services	✍✍	✍	✍✍	✍✍✍✍
Diagnostic Lab and X-ray	✍✍	✍	✍✍	✍✍✍✍
Home heath care	✍✍	✍	✍✍	✍✍✍✍
Hospice care	✍✍	✍	✍✍	✍✍✍✍
Pre-existing conditions	✍✍	✍	✍✍	✍✍✍✍
Health Education	✍✍	✍	✍✍	✍✍✍✍
Adult Physical Examination	✍✍	✍	✍✍	✍✍✍✍
Well-baby care	✍✍	✍	✍✍	✍✍✍✍
Well-child care	✍✍	✍	✍✍	✍✍✍✍
Childhood immunizations	✍✍	✍	✍✍	✍✍✍✍
Mammography screening	✍✍	✍	✍✍	✍✍✍✍
Screening pap test	✍✍	✍	✍✍	✍✍✍✍
Outpatient drug treatment	✍✍	✍	✍✍	✍✍✍✍
Outpatient alcohol treatment	✍✍	✍	✍✍	✍✍✍✍
Occupational therapy	✍✍	✍	✍✍	✍✍✍✍
Chiropractic	✍✍	✍	✍✍	✍✍✍✍
Emergency Room Services	✍✍	✍	✍✍	✍✍✍✍
Outpatient surgery	✍✍	✍	✍✍	✍✍✍✍

F14. Does this plan have a waiting period for pre-existing conditions that individuals may have at the time of enrollment

✍✍Yes **(continue)**
✍✍No **(go to F16)**

F15. How long is the waiting period for coverage of pre-existing conditions?

____ months
or
____ years

F16. Who else in your family is covered under this plan?

✍✍No one
✍✍Spouse only
✍✍Dependent children only
✍✍Spouse and children (family)

F17. What is the total annual premium for this plan? $ _____

F18. Does this plan have an annual individual deductible for covered services a dollar amount that members must pay before benefits are paid)?

✍✍Yes **(continue)**
✍✍No **(go to F20)**

F19. How much is the annual individual deductible for covered services?

$_____
or
_____%

F20. Do you pay anything (a co-payment or coinsurance) when you visit a physician?

✍✍Yes **(continue)**
✍✍No **(go to F22)**

F21. What is the copayment or coinsurance amount that you pay for physician visits?

$_____
or
_____%

F22. If applicable, what is the annual individual out-of pocket maximum?

$_____

✍✍NA

F23. How long have you been covered Under this healthcare plan?

_____ ✍✍months
✍✍years

If more than 2 years, continue. If less, go to F25.

F24. Was your healthcare premium for last year higher, lower, or about the same compared to this year?

✍✍higher___%
✍✍lower ___%
✍✍about the same

F25. Do you purchase any of the following single-service plans?
(Report on single-service plans only—do not include services covered under your basic medical plan.)

✍✍Dental
✍✍Vision
✍✍Prescription Drugs
✍✍Long-term Care (nursing home)

F26. How many dependents do you have ?

✍✍None	**End of Survey for Self-employed**
✍✍Spouse only	**(Go to F27)**
✍✍Children only	**(Go to F28)**
✍✍Spouse and children	**continue**

F27. In the last year, please indicate the number of months your spouse had healthcare coverage through each of the following:

Individual or family plan	_____ Months
Group plan at work	_____ Months
Medicaid or other government sponsored plan	_____ Months
or	
No healthcare coverage	_____ Months

F28. During the year 2000, please indicate the number of months your dependent children had healthcare coverage through each of the following:

Individual or family plan	_____ Months
Group plan at work	_____ Months
CHIP or other government sponsored plan	_____ Months
or	
No healthcare coverage	_____ Months

End of Survey. Thank you for preparing this worksheet in advance. An interviewer will be calling you in the next few days to collect this information.