

Center for Studying Health System Change

Community Tracking Study Followback Survey Instrument

(Round One, Release 1)

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This is one in a series of technical documents that have been done as part of the Community Tracking Study being conducted by the Center for Studying Health System Change (HSC). The study will examine changes in the local health system and the effects of those changes on the people living in the area.

HSC welcomes your comments on this document. Write to us at 600 Maryland Avenue, SW, Suite 550, Washington, DC 20024-2512 or visit our web site at www.hschange.org.

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COMMUNITY TRACKING STUDY 1996-97 FOLLOWBACK SURVEY

The Community Tracking Study (CTS) is designed to track changes in the health system and their effects on people. The CTS 1996-97 Followback Survey is a component of the CTS in which the privately financed health insurance policies covering CTS 1996-97 Household Survey respondents are "followed back" to the organizations that administer the policies. The purpose of the Followback Survey is to obtain more detailed and accurate information about those policies than could be provided by the Household Survey respondents. Interviews for the Followback Survey were conducted between October 1997 and August 1998, typically with health plan marketing staff. The information obtained from Followback Survey respondents includes product type, in-network and out-of-network coverage, provider payment methods, and consumer cost sharing. Data collected by the Followback Survey are linked to over 28,000 respondents to the 1996-97 Household Survey who had private comprehensive health insurance policies.

The Followback Survey data were collected by telephone interview and a faxed self-administered follow-up form. The organizations that responded to the Followback Survey are also referred to as "entities." The Main Questionnaire for Large Entities provided here is representative of the telephone interview instruments used in the Followback Survey. Separate instruments were used to obtain information from small and large entities. The instruments had some cosmetic differences but were not substantively different with respect to the "core" survey questions that ask about the characteristics of a product or of the insurance entity. The differences involved wording for general/background comments and different instructions about where and how to fill in information for the different products that an entity may offer. The faxed self-administered follow-up form provided here was used only for matching an entity's health insurance products with specific policies covering the Household Survey respondents.

Under the direction of the Center for Studying Health System Change, Mathematica Policy Research, Inc., was the primary contractor involved with the 1996-97 Followback Survey design, instrument development, and interviewing. Additional information about the design of the survey and the Community Tracking Study is available in two technical documents: Site Definition and Sample Design for the Community Tracking Study. C. Metcalf, P. Kemper, L. Kohn, J. Pickreign. Center for Studying Health System Change, Technical Publication No. 1, Washington, DC, October 1996; and "The Design of the Community Tracking Study." P. Kemper et al. *Inquiry* 33:195-206 (Summer 1996).

OVERVIEW OF TOPICS COVERED IN THE FOLLOWBACK SURVEY

MODULE A: Site and Entity Screener

MODULE B: Product Attributes

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

MODULE C: Network Size, Physician Payment Arrangements

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

MODULE D: Organizational Information

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

HSC FOLLOWBACK SURVEY

MAIN QUESTIONNAIRE FOR LARGE ENTITIES

8418-202

Main Site Name: _____	Main Site Number: _____
Entity Name: _____	Entity ID Number: _____
Supplemental Site Name: _____	Supplemental Site Number: _____
Supplemental Site Name: _____	Supplemental Site Number: _____
Supplemental Site Name: _____	Supplemental Site Number: _____
Supplemental Site Name: _____	Supplemental Site Number: _____
Supplemental Site Name: _____	Supplemental Site Number: _____

INTRODUCTIONS

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

Would you be able to help me with this? → **GO TO MODULE A**

IF NEEDED

HOW WAS MY ORGANIZATION SELECTED?

- Your organization was selected for the survey because earlier this year, we spoke with residents across the country and asked them about their source of health coverage. Several people told us they are covered by a product offered through your organization. Now I'd like to verify that your organization offers these products and ask some basic questions about the coverage.

WHY ARE YOU DOING THIS STUDY?

- In the residential survey we gathered basic information on the general characteristics about the plan, such as the type of plan (HMO, PPO, etc.), and whether a primary care physician is required. Because individual policyholders frequently do not know about or understand the details of their coverage, we'd like to validate the health plan information obtained from these community residents and gather supplemental information about those plans.
- The U.S. health care system is undergoing change at an unprecedented pace. However, little systematic information is available to understand the nature and extent of health system change and its impact on the local marketplace. In response to this information gap, the Robert Wood Johnson Foundation is sponsoring the "Community Tracking Study"-- a major multi-year study to track changes in the health care system at the community level.

WHO IS SPONSORING THE SURVEY?

- The survey is sponsored by the Robert Wood Johnson Foundation, a non-profit organization based in Princeton, New Jersey, whose sole mission is to improve health care. Some of the other projects sponsored by the foundation include:
 - *Medicaid Managed Care Program*: Aimed at helping states, managed care organizations, providers, and consumers take advantage of the unique opportunities presented by managed care to meet the needs of Medicaid recipients.
 - *Service Credit Banking in Managed Care*: Intended to help HMOs and other prepaid delivery systems respond to growing numbers of enrollees in need of informal care by developing and implementing volunteer caregiver programs for their elderly members.
 - *Addressing Tobacco in Managed Care*: Designed to help managed care providers help people avoid harm caused by tobacco and promote exemplary tobacco intervention practices.

WHO IS CONDUCTING THE SURVEY?

- This survey is being conducted by Mathematica Policy Research, an independent survey research organization.

WHO CAN I CALL TO GET MORE INFORMATION ABOUT THE SURVEY?

- For more information about the study, or to schedule an interview appointment, you can call Joel Brosse of Mathematica Policy Research at 800-263-3909.

HOW LONG WILL THE SURVEY TAKE?

- The interview will take only about 20-30 minutes. We can schedule an appointment for anytime that's convenient for you, and we can break up the interview into several shorter sessions.

WILL THE DATA BE CONFIDENTIAL?

- All the information you provide will be kept strictly confidential. Our reports and analyses will group individual enrollees by type of health plan (e.g., HMO, POS, PPO, indemnity); at no time will individual health plans or insurers be identified by name.

MODULE A: Site and Entity Screener

During the course of this interview, I will be asking you questions about your organization's products and services in the following areas: [SITE 1], [SITE 2]... At the end of this interview, I'll fax you a list with information we gathered from residents in these areas and ask you to indicate the product in which they are enrolled. In most cases, the fax will include the employer through which the resident obtained the coverage, and in some cases a group number will also be included.

INTERVIEWER: SEE ENTITY COVER SHEET FOR LIST OF SITES AND NUMBER OF FIU PLANS PER SITE. IF NECESSARY, READ COUNTIES INCLUDED IN SITE (SEE GREEN COUNTY LISTS)

PROBE: Of course, we'd like to compensate you for the time this takes by sending a check to you personally, or to your organization. The payment will be based on the number of residents' plans contained in the fax.

A1. To begin, does your organization offer or administer basic medical health care plans?

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

- 1 YES → GO TO A2
 - 2 NO
 - 8 DK
 - 9 REF
- } GO TO A1a

A1a. I see. Is your organization affiliated with another organization that does provide or administer basic medical health care plans?

- 1 YES → RECORD ALL AVAILABLE CONTACT INFORMATION IN GRID (NEXT PAGE)
 - 2 NO
 - 8 DK
 - 9 REF
- } END; SEE SUPERVISOR

A2. Are you able to answer questions about your organization's products, contracts and services in these sites?

PROBE: If there's a different office that handles accounts in [SITE], could you tell me the city, state and name of a contact person in that office?

PROBE: If you don't have time now to answer questions for all sites, we can proceed with only one high-priority site, and I'll call you back at a later time for the others.

PROBE: If your organization does not offer or administer basic medical health care plans in [SITE], but you do offer plans in a neighboring site, may I have the name of that city, town or region?

COMPLETE GRID (NEXT PAGE)

A3. Please tell me which of the following categories *best* describes your organization . . .

PROBE: Overall, which category comes *closest* to describing your organization.

INTERVIEWER: IF AFTER USING ABOVE PROBE, THE RESPONDENT STILL CANNOT CHOOSE A *SINGLE* BEST CATEGORY, CIRCLE THE RESPONDENT'S ANSWER WITH THE LOWEST NUMBER

- 1 A Blue Cross/Blue Shield Plan
- 2 A licensed insurer or HMO
- 3 A PPO or other managed care organization
- 4 A TPA (Third Party Administrator)
- 5 A provider organization
- 6 An employer, union or trust plan
- 7 An employer
- 8 Or something else (SPECIFY) _____
- 88 DK
- 98 REF

SITE (RECORD ONE PER ROW)	STATUS (CIRCLE ONE PER ROW)	CONTACT AND NEIGHBORING SITE INFORMATION
_____	1 Site covered during THIS interview 2 Site deferred until later 3 Site referred to another office for interview 4 Entity does not offer basic medical health care plans in this site or any neighboring site 9 Respondent refused to participate for this site	ENTITY: _____ CITY/STATE: _____ CONTACT: _____ TITLE: _____ PHONE: _____ NEIGHBORING SITE: _____
_____	1 Site covered during THIS interview 2 Site deferred until later 3 Site referred to another office for interview 4 Entity does not offer basic medical health care plans in this site or any neighboring site 9 Respondent refused to participate for this site	ENTITY: _____ CITY/STATE: _____ CONTACT: _____ TITLE: _____ PHONE: _____ NEIGHBORING SITE: _____
_____	1 Site covered during THIS interview 2 Site deferred until later 3 Site referred to another office for interview 4 Entity does not offer basic medical health care plans in this site or any neighboring site 9 Respondent refused to participate for this site	ENTITY: _____ CITY/STATE: _____ CONTACT: _____ TITLE: _____ PHONE: _____ NEIGHBORING SITE: _____
_____	1 Site covered during THIS interview 2 Site deferred until later 3 Site referred to another office for interview 4 Entity does not offer basic medical health care plans in this site or any neighboring site 9 Respondent refused to participate for this site	ENTITY: _____ CITY/STATE: _____ CONTACT: _____ TITLE: _____ PHONE: _____ NEIGHBORING SITE: _____
_____	1 Site covered during THIS interview 2 Site deferred until later 3 Site referred to another office for interview 4 Entity does not offer basic medical health care plans in this site or any neighboring site 9 Respondent refused to participate for this site	ENTITY: _____ CITY/STATE: _____ CONTACT: _____ TITLE: _____ PHONE: _____ NEIGHBORING SITE: _____
_____	1 Site covered during THIS interview 2 Site deferred until later 3 Site referred to another office for interview 4 Entity does not offer basic medical health care plans in this site or any neighboring site 9 Respondent refused to participate for this site	ENTITY: _____ CITY/STATE: _____ CONTACT: _____ TITLE: _____ PHONE: _____ NEIGHBORING SITE: _____

MODULE B: Product Attributes

SITE _____

In this interview I'll be asking about your organization's "products" in (SITE). By "product" I mean groups of plans or contracts that are similar regarding out-of-network coverage, referrals and primary care physicians. If products are similar in these ways but differ on copays, deductibles, coinsurance rates, or supplemental benefits such as prescription drugs or dental care, consider them the same product. Examples are open-ended HMOs, PPOs without a primary care physician, and traditional indemnity plans.

B1. First, what are the complete names of the health care products your organization offers or administers in (SITE)?

ENTER PRODUCT NAME(S) IN GRID COLUMNS

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

B2. **VERIFY IF KNOWN OR ASK:**

First/Next, [PRODUCT NAME]. Do you think of that type of product as an . . .

INTERVIEWER: IF HMO, POS or PPO, CIRCLE "NET" IN HEADER

PROBE: SEE PRODUCT DEFINITIONS BELOW

INTERVIEWER: CODE "PPO/INDEMNITY HYBRID" PLANS AS PPOs; CODE "HMO/INDEMNITY HYBRID" PLANS AS HMOs

- 1 HMO (Health Maintenance Organization)
- 2 Point of Service Plan
- 3 PPO (Preferred Provider Organization)
- 4 FFS (Traditional Fee For Service)
- 5 Or something else? (SPECIFY)
- 8 DK
- 9 REF

→ **GO TO B2a**

→ **GO TO NEXT**

B2a. **IF HMO OR POS:** Which of the following best characterizes the network model? Is it a . . .

- 1 Staff or group model
- 2 Network or IPA model
- 3 Mixed model
- 4 Or something else (SPECIFY)
- 8 DK
- 9 REF

→ **GO TO NEXT**

B3. Does your organization offer or administer any other products in (SITE)?

PROBE: If products have the same basic features and only vary by copays, deductibles, or supplementary benefits such as dental or pharmaceutical coverage, consider them the same product.

YES → RECORD PRODUCT NAME IN NEXT AVAILABLE COLUMN IN HEADER

B4. **INTERVIEWER: USE PRODUCT NAMES FROM PREVIEW REPORT BELOW AS PROBES IF THEY WERE NOT MENTIONED BY THE RESPONDENT DURING PRODUCT ENUMERATION IN B1.**

- 1: _____ 5: _____
- 2: _____ 6: _____
- 3: _____ 7: _____
- 4: _____ 8: _____

PRODUCT DEFINITIONS:

HMO: A product in which enrolled individuals are provided health care services by a network of affiliated providers. Services provided to enrollees outside the network are generally not covered, other than for some specialized services or in emergencies.

POS: A product in which enrollees may select in-network or out-of-network physicians at the "point-of-service" usually with significant differences in coinsurance or deductibles. Some POS products are also referred to as an "open-ended" HMOs or "triple option" plans.

PPO: A product in which enrollees are given a financial incentive to use a "preferred" network of providers, usually through differences in coinsurance or deductibles.

FFS: A traditional indemnity product in which enrollees may select any provider and referrals are not necessary for most procedures.

MODEL DEFINITIONS:

Staff/Group Model HMO: Delivers health services either through a salaried physician group that is employed by the HMO unit, or through one independent group practice that is contracted to provide health care services.

Network/IPA Model HMO: Delivers health services either by contracting with two or more independent group practices, or by contracting directly with physicians in independent practices to provide health services.

Mixed Model HMO: Delivers health services through both of the arrangements described above.

1 HMO } GO TO B2a 2 POS } 3 PPO } 4 FFS } 5 Other } GO TO NEXT 8 DK } 9 REF }	1 HMO } GO TO B2a 2 POS } 3 PPO } 4 FFS } 5 Other } GO TO NEXT 8 DK } 9 REF }	1 HMO } GO TO B2a 2 POS } 3 PPO } 4 FFS } 5 Other } GO TO NEXT 8 DK } 9 REF }	1 HMO } GO TO B2a 2 POS } 3 PPO } 4 FFS } 5 Other } GO TO NEXT 8 DK } 9 REF }	1 HMO } GO TO B2a 2 POS } 3 PPO } 4 FFS } 5 Other } GO TO NEXT 8 DK } 9 REF }	1 HMO } GO TO B2a 2 POS } 3 PPO } 4 FFS } 5 Other } GO TO NEXT 8 DK } 9 REF }	1 HMO } GO TO B2a 2 POS } 3 PPO } 4 FFS } 5 Other } GO TO NEXT 8 DK } 9 REF }	1 HMO } GO TO B2a 2 POS } 3 PPO } 4 FFS } 5 Other } GO TO NEXT 8 DK } 9 REF }
1 2 GO TO NEXT 3 4 } 8 9 }	1 2 GO TO NEXT 3 4 } 8 9 }	1 2 GO TO NEXT 3 4 } 8 9 }	1 2 GO TO NEXT 3 4 } 8 9 }	1 2 GO TO NEXT 3 4 } 8 9 }	1 2 GO TO NEXT 3 4 } 8 9 }	1 2 GO TO NEXT 3 4 } 8 9 }	1 2 GO TO NEXT 3 4 } 8 9 }

Next I have some questions about the basic features of these products.

INTERVIEWER: IF FFS OR OTHER IN B2 ASK:

B5. Is there a book, directory or list of doctors associated with [PRODUCT] in [SITE]?

PROBE: Is there a network composed of salaried or contracted primary care physicians, specialists and other professionals.

- 1 YES → **CIRCLE "NET" IN HEADER**
- 2 NO
- 8 DK
- 9 REF

GO TO B13

NETWORK PRODUCTS ONLY:

B6. Under the [PRODUCT] in [SITE] if enrollees do not have a referral and go to *out-of-network* doctors, does the plan cover *any* of the costs for these visits?

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

- 1 YES
- 2 NO
- 8 DK
- 9 REF

B7. Does that answer apply to all contracts and enrollees in this product?

- 1 YES → **GO TO B8**
- 2 NO }
- 8 DK } **GO TO B7a**
- 9 REF }

B7a. For our purposes, we'd like to separate this product into two groups: contracts and enrollees that have some out-of-network coverage and those that don't. Is there a name, or can you suggest a label, for the this other group of contracts and enrollees?

- 1 YES → **RECORD SPLIT PRODUCT IN NEXT AVAILABLE COLUMN; COMPLETE B2-B2a FOR THIS NEW PRODUCT NOW, THEN RESUME QUESTIONS FOR THE CURRENT PRODUCT**
- 2 **NO/CAN'T DIFFERENTIATE PRODUCTS BASED ON THIS ATTRIBUTE**
- 8 DK
- 9 REF

B8. Under the [PRODUCT] in [SITE] if enrollees do not have a referral and go to *in-network* specialists, does the plan cover *any* of the costs for these visits?

PROBE: Specialists include such doctors as surgeons, allergists, orthopedists, cardiologists and dermatologists. Exclude mental health providers and OB/GYNs.

PROBE: If enrollees go to specialists who then get referrals from primary care providers "on-the-spot" or after the visit, consider this a requirement to get a referral.

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

- 1 YES
- 2 NO
- 8 DK
- 9 REF

B9. Does that answer apply to all contracts and enrollees in this product?

- 1 YES → **GO TO B10**
- 2 NO }
- 8 DK } **GO TO B9a**
- 9 REF }

B9a. For our purposes, we'd like to separate these products into two groups: contracts and enrollees that have some coverage for self-referrals and those that don't. Is there a name, or can you suggest a label, for this other group of contracts and enrollees?

- 1 YES → **RECORD SPLIT PRODUCT IN NEXT AVAILABLE COLUMN; COMPLETE B2-B2a FOR THIS NEW PRODUCT NOW, THEN RESUME QUESTIONS FOR THE CURRENT PRODUCT**
- 2 **NO/CAN'T DIFFERENTIATE PRODUCTS BASED ON THIS ATTRIBUTE**
- 8 DK
- 9 REF

1 2 8 9 } GO TO B13	1 2 8 9 } GO TO B13	1 2 8 9 } GO TO B13	1 2 8 9 } GO TO B13	1 2 8 9 } GO TO B13	1 2 8 9 } GO TO B13	1 2 8 9 } GO TO B13	1 2 8 9 } GO TO B13
1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9
1 → GO TO B8 2 8 9 } GO TO B7a	1 → GO TO B8 2 8 9 } GO TO B7a	1 → GO TO B8 2 8 9 } GO TO B7a	1 → GO TO B8 2 8 9 } GO TO B7a	1 → GO TO B8 2 8 9 } GO TO B7a	1 → GO TO B8 2 8 9 } GO TO B7a	1 → GO TO B8 2 8 9 } GO TO B7a	1 → GO TO B8 2 8 9 } GO TO B7a
1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9
1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9
1 → GO TO B10 2 8 9 } GO TO B9a	1 → GO TO B10 2 8 9 } GO TO B9a	1 → GO TO B10 2 8 9 } GO TO B9a	1 → GO TO B10 2 8 9 } GO TO B9a	1 → GO TO B10 2 8 9 } GO TO B9a	1 → GO TO B10 2 8 9 } GO TO B9a	1 → GO TO B10 2 8 9 } GO TO B9a	1 → GO TO B10 2 8 9 } GO TO B9a
1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9

NETWORK PRODUCTS ONLY:

B10. Does [PRODUCT] in [SITE] require members to have a primary care doctor, group of doctors, or clinic for all routine care?

PROBE: By "require" I mean that enrollees must sign up with a primary care doctor, group of doctors, or clinic in order to receive maximum coverage.

- 1 YES
- 2 NO
- 8 DK
- 9 REF

B11. Does that answer apply to all contracts and enrollees in this product?

- 1 YES → GO TO B12 (IF B10=YES) OR B13 (IF B10=NO, DK, REF)
- 2 NO
- 8 DK } GO TO B11a
- 9 REF }

B11a. For our purposes, we'd like to separate these products into two groups: contracts and enrollees that have *do* require enrollees to have a primary care physician, group or clinic, and those that don't. Is there a name, or can you suggest a label, for this other group of contracts and enrollees?

- 1 YES → RECORD SPLIT PRODUCT IN NEXT AVAILABLE COLUMN; COMPLETE B2-B2a FOR THIS NEW PRODUCT NOW, THEN RESUME QUESTIONS FOR THE CURRENT PRODUCT
- 2 NO/CAN'T DIFFERENTIATE PRODUCTS BASED ON THIS ATTRIBUTE
- 8 DK
- 9 REF

B12. **IF B10=YES:** Which types of providers can serve as primary care physicians for enrollees in this product? **CHECK ALL THAT APPLY**

PROBE: Exclude non-major medical services such as dental, vision and mental health care.

- 1 Generalists, such as an internists, pediatricians or family practitioners
- 2 OB/GYNs or
- 3 Other specialists
- 8 DK
- 9 REF

ALL PRODUCTS

B13. Under [PRODUCT] in [SITE], what is the copayment or coinsurance rate [NETWORK PRODUCTS: for in-network office visits]?

PROBE: The coinsurance rate is the percentage for which the enrollee is responsible.
PROBE: If there are different copays for sick versus well visits, please tell me the copay for sick visits.
PROBE: Your best estimate is fine. Please tell me what is *typical* for this product in [SITE].

- 1 COPAYMENT (ENTER DOLLAR AMOUNT)
- 2 COINSURANCE RATE (ENTER PERCENTAGE)
- 8 DK
- 9 REF

B14. Under [PRODUCT] in [SITE], what is the dollar amount of the *individual deductible* [NETWORK PRODUCTS: that applies to in-network office visits]?

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

- 1 ENTER NUMBER
- 8 DK
- 9 REF

NETWORK PRODUCTS

1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9
1 → GO TO B12 or B13 2 } GO TO B11a 8 } 9 }	1 → GO TO B12 or B13 2 } GO TO B11a 8 } 9 }	1 → GO TO B12 or B13 2 } GO TO B11a 8 } 9 }	1 → GO TO B12 or B13 2 } GO TO B11a 8 } 9 }	1 → GO TO B12 or B13 2 } GO TO B11a 8 } 9 }	1 → GO TO B12 or B13 2 } GO TO B11a 8 } 9 }	1 → GO TO B12 or B13 2 } GO TO B11a 8 } 9 }	1 → GO TO B12 or B13 2 } GO TO B11a 8 } 9 }
1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9
IF B10=YES	IF B10=YES	IF B10=YES	IF B10=YES	IF B10=YES	IF B10=YES	IF B10=YES	IF B10=YES
1 2 3 8 9	1 2 3 8 9	1 2 3 8 9	1 2 3 8 9	1 2 3 8 9	1 2 3 8 9	1 2 3 8 9	1 2 3 8 9

ALL PRODUCTS

1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9
1 8 9	1 8 9	1 8 9	1 8 9	1 8 9	1 8 9	1 8 9	1 8 9

MODULE C: Network Size, Physician Payment Arrangements

NETWORK PRODUCTS:

Next I have a few questions about the network associated with (this/these) product(s).

IF NEEDED, REPEAT COUNTY INFORMATION

C1. Approximately what percentage of all physicians in [SITE] are associated with the [PRODUCT]?

- PROBE:** If you can't provide a percentage, a number is fine.
- PROBE:** Include both primary care physicians and specialists.
- PROBE:** Your best estimate is fine.

- 1 ENTER PERCENT
- 2 ENTER NUMBER
- 8 DK
- 9 REF

C2. Approximately how many hospitals in [SITE] are associated with the [PRODUCT]?

- PROBE:** If you can't provide a number, a percentage is fine.
- PROBE:** Your best estimate is fine.

- 1 ENTER NUMBER
- 2 ENTER PERCENT
- 8 DK
- 9 REF

ALL PRODUCTS:

C3. Approximately what proportion of your organization's enrollees in [SITE] are enrolled in each product?

- PROBE:** Your best estimate is fine.

- 1 ENTER PERCENT
- 8 DK
- 9 REF

NETWORK PRODUCTS

1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9
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1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9	1 2 8 9
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ALL PRODUCTS:

1 8 9	1 8 9	1 8 9	1 8 9	1 8 9	1 8 9	1 8 9	1 8 9
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Next, I have some questions about payment arrangements for primary care physicians, specialists and hospitals in [SITE]. Since this may vary somewhat depending on the provider, I just want to know what is *typical* for the providers who serve a majority of enrollees in each product.

C4. In the [PRODUCT] in [SITE], what is the typical method of payment that your organization uses for primary care providers? Is it . . .

PROBE: By that I mean the method *your* organization uses to pay individuals or other entities for primary care services in [SITE].
PROBE: Capitation is a fixed payment per enrollee per year for a class of services.

- 1 Fee For Service (for example, Usual and Customary Rates)
- 2 Discounted Fee For Service (for example, a Fixed Fee Schedule or Relative Value Units)
- 3 Salaried by your organization, or
- 4 Capitation or a combined "professional" or "global" capitation → **GO TO C4a**
- 5 OTHER (SPECIFY)
- 8 DK
- 9 REF

C4a. What *other* services are included in this capitated payment? **CHECK ALL THAT APPLY**

- 1 Referrals to specialists → **SKIP C5**
- 2 Hospitalizations → **SKIP C6**
- 3 Other services, or
- 4 None of these
- 8 DK
- 9 REF

C5. In the [PRODUCT] in [SITE], what is the typical method of payment that your organization uses for specialists? Is it . . .

PROBE: By that I mean the method *your* organization uses to pay individuals or other entities for specialist services in [SITE].
PROBE: Exclude mental health providers and specialists acting as primary care physicians.

- 1 Fee For Service (for example, Usual and Customary Rates)
- 2 Discounted Fee-for-Service (for example, a Fixed Fee Schedule or Relative Value Units)
- 3 Salaried by your organization, or
- 4 Capitation
- 5 OTHER (SPECIFY)
- 8 DK
- 9 REF

C6. In the [PRODUCT] in [SITE], what is the typical method of payment for hospital services?

- 1 Per diem
- 2 According to DRG or per stay
- 3 Capitation
- 4 Billed charges or discounted billed charges, or
- 5 Something else (SPECIFY)
- 7 NOT APPLICABLE; HOSPITALS OWNED BY ORGANIZATION
- 8 DK
- 9 REF

1 2 3 4→GO TO C4a 5 _____ 8 9	1 2 3 4→GO TO C4a 5 _____ 8 9	1 2 3 4→GO TO C4a 5 _____ 8 9	1 2 3 4→GO TO C4a 5 _____ 8 9	1 2 3 4→GO TO C4a 5 _____ 8 9	1 2 3 4→GO TO C4a 5 _____ 8 9	1 2 3 4→GO TO C4a 5 _____ 8 9	1 2 3 4→GO TO C4a 5 _____ 8 9
1 → SKIP C5 2 → SKIP C6 3 4 8 9	1 → SKIP C5 2 → SKIP C6 3 4 8 9	1 → SKIP C5 2 → SKIP C6 3 4 8 9	1 → SKIP C5 2 → SKIP C6 3 4 8 9	1 → SKIP C5 2 → SKIP C6 3 4 8 9	1 → SKIP C5 2 → SKIP C6 3 4 8 9	1 → SKIP C5 2 → SKIP C6 3 4 8 9	1 → SKIP C5 2 → SKIP C6 3 4 8 9
If C4a not 1 1 2 3 4 5 _____ 8 9	If C4a not 1 1 2 3 4 5 _____ 8 9	If C4a not 1 1 2 3 4 5 _____ 8 9	If C4a not 1 1 2 3 4 5 _____ 8 9	If C4a not 1 1 2 3 4 5 _____ 8 9	If C4a not 1 1 2 3 4 5 _____ 8 9	If C4a not 1 1 2 3 4 5 _____ 8 9	If C4a not 1 1 2 3 4 5 _____ 8 9
If C4a not 2 1 2 3 4 5 _____ 7 8 9	If C4a not 2 1 2 3 4 5 _____ 7 8 9	If C4a not 2 1 2 3 4 5 _____ 7 8 9	If C4a not 2 1 2 3 4 5 _____ 7 8 9	If C4a not 2 1 2 3 4 5 _____ 7 8 9	If C4a not 2 1 2 3 4 5 _____ 7 8 9	If C4a not 2 1 2 3 4 5 _____ 7 8 9	If C4a not 2 1 2 3 4 5 _____ 7 8 9

C7. Does the [PRODUCT] in [SITE] ever include any mental health and/or substance abuse services?

PROBE: Include chemical dependency services.

PROBE: I'm interested in whether the employer contracts directly with your organization for mental health and/or substance abuse services. If the employer provides these services but does not go through your organization, consider the answer "no."

- 1 YES → GO TO C7a
- 2 NO
- 8 DK } GO TO NEXT
- 9 REF }

C7a. Are mental health and/or substance abuse services ever provided or managed separately by a specialty managed behavioral health organization?

- 1 YES → GO TO C7b
- 2 NO
- 8 DK } GO TO NEXT
- 9 REF }

C7b. What is the name and location of this specialty managed behavioral health organization? **REFER TO LIST A**

NAME OR CODE (IF AVAILABLE FROM LIST) _____

CITY AND STATE (IF NOT LISTED) _____

} → GO TO NEXT

INTERVIEWER: FOR SUPPLEMENTAL SITES TO BE COVERED DURING THIS INTERVIEW WITH THIS RESPONDENT, GO TO A SUPPLEMENTAL BOOKLET (WHITE COVER). IF THERE ARE NO SUPPLEMENTAL SITES, OR IF ALL SUPPLEMENTAL SITES ARE DEFERRED UNTIL LATER, GO TO MODULE D.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8
1→GO TO C7a 2 8 } GO TO 9 } NEXT	1→GO TO C7a 2 8 } GO TO 9 } NEXT	1→GO TO C7a 2 8 } GO TO 9 } NEXT	1→GO TO C7a 2 8 } GO TO 9 } NEXT	1→GO TO C7a 2 8 } GO TO 9 } NEXT	1→GO TO C7a 2 8 } GO TO 9 } NEXT	1→GO TO C7a 2 8 } GO TO 9 } NEXT	1→GO TO C7a 2 8 } GO TO 9 } NEXT
1→GO TO C7b 2 8 } GO TO 9 } NEXT	1→GO TO C7b 2 8 } GO TO 9 } NEXT	1→GO TO C7b 2 8 } GO TO 9 } NEXT	1→GO TO C7b 2 8 } GO TO 9 } NEXT	1→GO TO C7b 2 8 } GO TO 9 } NEXT	1→GO TO C7b 2 8 } GO TO 9 } NEXT	1→GO TO C7b 2 8 } GO TO 9 } NEXT	1→GO TO C7b 2 8 } GO TO 9 } NEXT
Use Column 1 line below to record code/name and location	Use Column 2 line below to record code/name and location	Use Column 3 line below to record code/name and location	Use Column 4 line below to record code/name and location	Use Column 5 line below to record code/name and location	Use Column 6 line below to record code/name and location	Use Column 7 line below to record code/name and location	Use Column 8 line below to record code/name and location

Column 1: _____

Column 2: _____

Column 3: _____

Column 4: _____

Column 5: _____

Column 6: _____

Column 7: _____

Column 8: _____

MODULE D: Organizational Information

Finally, I have some basic questions to ask about your organization.

D1. What is your organization's tax status? Is it . . . **CHECK ONE**

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

- 1 For-profit, privately held
- 2 For-profit, publicly held, or
- 3 Nonprofit
- 4 OTHER (SPECIFY) _____
- 8 DK
- 9 REF

D2. Is your organization a division or subsidiary of another health plan organization?

- 1 YES → **GO TO D2A**
- 2 NO → **GO TO D3**
- 8 DK
- 9 REF

D2a. Is this parent company a national or multi-state organization?

- 1 YES
- 2 NO
- 8 DK
- 9 REF

D2b. What is the name of that parent company? **REFER TO LIST B**

CODE (IF AVAILABLE FROM LIST) OR NAME: _____

D2c. In what city and state is this parent company located?

CITY: _____

STATE: _____

 **GO TO D4**

D3. Is your organization a national or multi-state organization?

- 1 YES
- 2 NO
- 8 DK
- 9 REF

D4. **IF ANY PRODUCT COVERS MENTAL HEALTH SERVICES:** Finally, may I have the name and phone number of the person within your organization who could answer questions about mental health and/or substance abuse benefits?

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

NAME: _____

PHONE NUMBER: _____

ORGANIZATION: _____

D5. Finally, in order to send you our report on this study, may I have your name, title and mailing address?

NAME: _____

TITLE AND ORGANIZATION: _____

STREET ADDRESS OR POB: _____

CITY, STATE, ZIP: _____

D6. Thank you very much. This concludes the telephone part of this interview, and I'd like to ask you to do one more related task. As I mentioned earlier, in a previous study we spoke with _____ residents [FILL FROM COVER PAGE] in the geographic sites we discussed who identified your organization as their source of health coverage. We'd like to fax you a form with the plan name each one reported and their location and employer, and ask you to indicate in which of the products you've identified they are actually enrolled. We know that this may take some time to reference files, and to compensate you for the time that would take, we'll send a check to you personally, or to your organization, for \$_____ for completing that task. Would that be acceptable to you?

Size:	Payment amount:
6-10	\$25
11-25	\$50
26-more	<i>cite amount which is \$2 times number of FIUs</i>

[REFER ANY NEGOTIATION TO JOEL OR JOANNE]

Okay, we'll fax this form as soon as possible. It will have instructions, a return fax number, and a form to tell us how to make out the check. In the meantime, you can call our research group and ask for me at 800-263-3909 if you have any questions. Thanks.

INTERVIEWER: RECORD FINAL AMOUNT OFFERED HERE: \$_____

1 NET

1 NET

1 NET

1 NET

1 NET

1 NET

1 NET

1 NET

MATHEMATICA
Policy Research, Inc.

Princeton Office
Tel #: 800-263-3909
Fax #: 609-275-6858

FROM Mathematica

TO Mathematica

DATE:
TO:
COMPANY:
FAX #:
FROM:
OF PAGES (incl. cover sheet):
ENTITY ID NUMBER:

DATE:
TO: Joel Brosse
COMPANY: Mathematica Policy Research
FAX #: 609-275-6858
FROM:
OF PAGES (incl. cover sheet):

Thanks so much for your time on the phone. This fax is the final phase of the survey--matching employer contracts and direct purchase contracts to the products we identified in our interview. Please:

- * Complete the attached form titled "Module X Fax Sheet," or send it along to another department for completion.
- * As compensation for completing the Module X Fax Sheet, we'd like to send you or your organization a check for \$_____. Please complete the bottom of this page, indicating the person or organization to whom the check for should be made, and the address to which it should be sent.
- * Complete the top right of this page under "*TO* Mathematica" and fax all forms back to:

MATHEMATICA FAX: 609-275-6858

Thanks again for all your help on behalf of Mathematica Policy Research and the Robert Wood Johnson Foundation.

Please indicate the name and address to which a check should be mailed:

Check in name of: _____

Social Security Number: _____

Care Of (Optional): _____

Street Address or POB: _____

Street Address (addl.): _____

City, State and Zip Code: _____

Instructions for Completing “Module X Fax Form”

Thanks for agreeing to complete this important task. As we mentioned during the telephone interview, we have identified a number of families from a previous survey who we believe receive health care coverage through your organization. During the interview we asked you about your products in one or more geographic areas. Now we’d like you to indicate which product each family is enrolled in.

Here is a sample of the form. We’ve provided all the information in the white portions. Each row on the form corresponds to one family insurance unit. Please note that we are not asking you about individual families, but only products as available through employers or direct purchase. The columns on the right list the health plan products you told us about during the telephone interview. Please note that we may have combined some products in the same column for convenience, or noted where some products are different in different areas.

Identifiers			Data from Family Interviews			Indicate Product(s)													
<i>Ignore all but the <u>site</u>.</i>			<i>This is exactly what the families told us:</i>			<i>We’ve listed the products you told us about in the interview. We may have combined some in the same column for convenience.</i>										No Match			
																	Plan name	Employer	Plan/Group #
<i>sample</i>			<i>PPO plus</i>	<i>state gov’t</i>		<i>You ✓ here in appropriate column(s) ...</i>													

Please consult your account records or with your staff to do two things:

- * First, verify that the employer listed for each family had a contract with your organization during the period of the initial survey, from July 1996 through July 1997. If the family indicated that the plan was purchased directly, please verify that the product they cite is actually available for individual purchase in that area. If you cannot verify either of these facts, please check the “No Match” column, at the very right, for that family listing.
- * Second, based on the employer contract and the plan name provided by the family, please indicate with a check mark **which product the family is enrolled in**. If the employer offers multiple plans and the name reported by the family is not specific enough to decide which, **check all products that the family might be enrolled in** given what you see.

That’s all we need for each individual family. You can help us out greatly with two types of problem:

- * If you find that we have mistakenly identified some plans as related to your organization and you can tell us the correct organization, please attach a separate sheet to let us know.
- * Also, in the cases of families you could **not** verify as covered by your organization, if you happen to know who does cover that employer, please let us know that.

Thanks very much for your effort. We’ll begin processing your payment when you return the form to us. If you have any questions or problems, please feel free to call Joel Brosse of Mathematica Policy Research at 800-263-3909.