MEPS HC-043:
1998 Supplemental Public Use File

December 2002

Agency for Healthcare Research and Quality
Center for Cost and Financing Studies

TABLE OF CONTENTS

A. Data Use Agreement

Individual identifiers have been removed from the micro-data contained in the files that are part of this Public Use Release. Nevertheless, under sections 308 (d) and 903 (c) of the Public Health Service Act (42 U.S.C. 242m and 42 U.S.C. 299 a-1), data collected by the Agency for Healthcare Research and Quality (AHRQ) and /or the National Center for Health Statistics (NCHS) may not be used for any purpose other than for the purpose for which they were supplied; any effort to determine the identity of any reported cases, is prohibited by law.

Therefore in accordance with the above referenced Federal Statute, it is understood that:

No one is to use the data in this data set in any way except for statistical reporting and analysis; and

If the identity of any person or establishment should be discovered inadvertently, then (a) no use will be made of this knowledge, (b) The Director Office of Management AHRQ will be advised of this incident, (c) the information that would identify any individual or establishment will be safeguarded or destroyed, as requested by AHRQ, and (d) no one else will be informed of the discovered identity.

No one will attempt to link this data set with individually identifiable records from any data sets other than the Medical Expenditure Panel Survey or the National Health Interview Survey.

By using this data you signify your agreement to comply with the above stated statutorily based requirements with the knowledge that deliberately making a false statement in any matter within the jurisdiction of any department or agency of the Federal Government violates 18 U.S.C. 1001 and is punishable by a fine of up to $10,000 or up to 5 years in prison.

The Agency for Healthcare Research and Quality requests that users cite AHRQ and the Medical Expenditure Panel Survey as the data source in any publications or research based upon these data.

B. Background

This documentation describes one in a series of public use files from the Medical Expenditure Panel Survey (MEPS). The survey provides a new and extensive data set on the use of health services and health care in the United States.

MEPS is conducted to provide nationally representative estimates of health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian non-institutionalized population. MEPS is cosponsored by the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research (AHCPR)) and the National Center for Health Statistics (NCHS).

MEPS comprises three component surveys: the Household Component (HC), the Medical Provider Component (MPC), and the Insurance Component (IC). The HC is the core survey, and it forms the basis for the MPC sample and part of the IC sample. Together these surveys yield comprehensive data that provide national estimates of the level and distribution of health care use and expenditures, support health services research, and can be used to assess health care policy implications.

MEPS is the third in a series of national probability surveys conducted by AHRQ on the financing and use of medical care in the United States. The National Medical Care Expenditure Survey (NMCES, also known as NMES-1) was conducted in 1977, the National Medical Expenditure Survey (NMES-2) in 1987. Beginning in 1996, MEPS continues this series with design enhancements and efficiencies that provide a more current data resource to capture the changing dynamics of the health care delivery and insurance system.

The design efficiencies incorporated into MEPS are in accordance with the Department of Health and Human Services (DHHS) Survey Integration Plan of June 1995, which focused on consolidating DHHS surveys, achieving cost efficiencies, reducing respondent burden, and enhancing analytical capacities. To accommodate these goals, new MEPS design features include linkage with the National Health Interview Survey (NHIS), from which the sampled households for the MEPS HC are drawn, and continuous longitudinal data collection for core survey components. The MEPS HC augments NHIS by selecting a sample of NHIS respondents, collecting additional data on their health care expenditures, and linking these data with additional information collected from the respondents' medical providers, employers, and insurance providers.

1.0 Household Component

The MEPS HC, a nationally representative survey of the U.S. civilian non-institutionalized population, collects medical expenditure data at both the person and household levels. The HC collects detailed data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment.

The HC uses an overlapping panel design in which data are collected through a preliminary contact

followed by a series of five rounds of interviews over a 2½ - year period. Using computer-assisted personal interviewing (CAPI) technology, data on medical expenditures and use for two calendar years are collected from each household. This series of data collection rounds is launched each year on a new sample of households to provide overlapping panels of survey data and, when combined with other ongoing panels, will provide continuous and current estimates of health care expenditures.

The sample of households selected for the MEPS HC is drawn from among respondents to the NHIS, conducted by NCHS. The NHIS provides a nationally representative sample of the U.S. civilian non-institutionalized population, with oversampling of Hispanics and blacks.

2.0 Medical Provider Component

The MEPS MPC supplements and/or replaces information on medical care events reported in the MEPS HC by contacting medical providers and pharmacies identified by household respondents. The MPC sample includes all home health agencies and pharmacies reported by HC respondents. Office-based physicians, hospitals, and hospital physicians are also included in the MPC but may be sub-sampled at various rates, depending on burden and resources, in certain years.

Data are collected on medical and financial characteristics of medical and pharmacy events reported by HC respondents. The MPC is conducted through telephone interviews and record abstraction.

3.0 Insurance Component

The MEPS IC collects data on health insurance plans obtained through employers, unions, and other sources of private health insurance. Data obtained in the IC include the number and types of private insurance plans offered, benefits associated with these plans, premiums, contributions by employers and employees, eligibility requirements, and employer characteristics.

Establishments participating in the MEPS IC are selected through four sampling frames:

- A list of employers or other insurance providers identified by MEPS HC respondents who report having private health insurance at the Round 1 interview.
- A Bureau of the Census list frame of private sector business establishments.
- The Census of Governments from Bureau of the Census.
- An Internal Revenue Service list of the self-employed.

To provide an integrated picture of health insurance, data collected from the first sampling frame (employers and insurance providers) are linked back to data provided by the MEPS HC respondents. Data from the other three sampling frames are collected to provide annual national and

State estimates of the supply of private health insurance available to American workers and to evaluate policy issues pertaining to health insurance.

The MEPS IC is an annual panel survey. Data are collected from the selected organizations through a prescreening telephone interview, a mailed questionnaire, and a telephone followup for nonrespondents.

4.0 Survey Management

MEPS data are collected under the authority of the Public Health Service Act. They are edited and published in accordance with the confidentiality provisions of this act and the Privacy Act. NCHS provides consultation and technical assistance.

As soon as data collection and editing are completed, the MEPS survey data are released to the public in staged releases of summary reports and microdata files. Summary reports are released as printed documents and/or electronic files on the MEPS web site (www.meps.ahrq.gov). All microdata files are available for download from the MEPS web site in compressed formats (zip and self-extracting executable files.) Selected data files are available on CD-ROM from the MEPS Clearinghouse.

For printed documents and CD-ROMs that are available through the AHRQ Publications Clearinghouse, write or call:

AHRQ Publications Clearinghouse
Attn: (publication number)
P.O. Box 8547
Silver Spring, MD 20907
800/358-9295
410/381-3150 (callers outside the United States only)
888/586-6340 (toll-free TDD service; hearing impaired only)

Be sure to specify the AHRQ number of the document or CD-ROM you are requesting.

Additional information on MEPS is available from the MEPS project manager or the MEPS public use data manager at the Center for Cost and Financing Studies, Agency for Healthcare Research and Quality.

C. Technical and Programming Information

1.0 General Information

This documentation describes a series of MEPS variables that were obtained for calendar year 1998. This data release is intended to supplement the MEPS variables previously released for 1998. In order to use these variables, researchers will need to link them to the 1998 Consolidated Full-Year Use and Expenditure File (HC-028) which contains all previously released 1998 person level data including demographic and socio-economic information. Please refer to the HC-028 documentation for further information.

The following documentation offers a brief overview of the types and levels of data provided the content and structure of the files, and programming information. It contains the following sections:

- Data File Information
- Variable-Source Crosswalk (Section D)

Codebooks of all the variables included in these 1998 Supplemental Files are provided in separate files (H43F1CB.PDF, H43F2CB.PDF). The person-level and event level variables will be in separate files.

A database of all MEPS products released to date and a variable locator indicating the major MEPS HC data items on public use files (including weights) that have been released to date can be found at the following link on the MEPS website: www.meps.ahrq.gov/.

2.0 Data File Information

This 1998 supplemental variable public use data set consists of one person-level file (File 1) and one event-level file (File 2). Unweighted frequencies are provided for each variable on the files. In conjunction with the weight variable (WTDPER98) provided on MEPS HC-028: 1998 Full Year Consolidated Data File, data for these persons can be used to make estimates for the civilian non-institutionalized U. S. population for 1998. The records on this data release can be linked to all other 1998 MEPS-HC public use data files by using the sample person identifier (DUPERSID). Panel 2 cases (Panel 98=2) can be linked back to the 1997 MEPS-HC public use data files. A longitudinal weight to facilitate Panel 2, 1997-98 analysis can be found on HC-035.

File 2 contains a variable (SEETLKPV) which was inadvertently omitted from the 1998 Outpatient Department Visits File (HC-026 F).

2.1 Codebook Structure

The codebook and data file sequence lists variables in the following order:

- Unique person identifiers
- Survey administration variables
- Health insurance variables
- Disability variables
- Access to care variables

2.2 Reserved Codes

The following reserved code values are used:

VALUE		DEFINITION
-1	INAPPLICABLE	Question was not asked due to skip pattern
-7	REFUSED	Question was asked and respondent refused to answer question
-8	DK	Question was asked and respondent did not know answer
-9	NOT ASCERTAINED	Interviewer did not record the data

2.3 Codebook Format

This codebook describes an ASCII data set and provides the following programming identifiers for each variable:

IDENTIFIER	DESCRIPTION
Name	Variable name (maximum of 8 characters)
Description	Variable descriptor (maximum 40 characters)
Format	Number of bytes
Type	Type of data: numeric (indicated by NUM) or character (indicated by CHAR)
Start	Beginning column position of variable in record

End Ending column position of variable in record

2.4 Variable Naming

In general, variable names reflect the content of the variable, with an eight-character limitation. Edited variables end in an X, and are so noted in the variable label. The last two characters in round-specific variables denote the rounds of data collection, Round 3, 4, or 5 of Panel 2 and Round 1, 2, or 3 of Panel 3. Unless otherwise noted, variables that end in 98 represent status as of December 31, 1998.

Variables contained in this delivery were derived either from the questionnaire itself or from the CAPI. The source of each variable is identified in the section of the documentation entitled "Section D. Variable-Source Crosswalk." Sources for each variable are indicated in one of four ways: (1) variables derived from CAPI or assigned in sampling are so indicated; (2) variables derived from complex algorithms associated with re-enumeration are labeled "RE Section"; (3) variables that are collected by one or more specific questions in the instrument have those question numbers listed in the Source column; (4) variables constructed from multiple questions using complex algorithms are labeled "Constructed."

2.5 File 1 Contents

2.5.1 Survey Administration Variables

Dwelling Units and Health Insurance Eligibility Units

The definitions of Dwelling Units (DUs) in the MEPS Household Survey are generally consistent with the definitions employed for the National Health Interview Survey. The dwelling unit ID (DUID) is a five-digit random ID number assigned after the case was sampled for MEPS. A person number (PID) uniquely identifies each person within the dwelling unit. The variable DUPERSID is the combination of the variables DUID and PID.

Health Insurance Eligibility Units (HIEUs) are sub-family relationship units constructed to include adults plus those family members who would typically be eligible for coverage under the adults' private health insurance family plans. To construct the HIEUIDX variable which links persons into a common HIEU, we begin with the family identification variable CPSFAMID. Working with this family ID, we define HIEUIDX using family relationships as of the end of 1999. Persons missing end of year relationship information are assigned to an HIEUIDX using relationship information from the last round in which they provided such information. HIEUs comprise adults, their spouses, and their unmarried natural/adoptive children age 18 and under. We also include children under age 24 who are full-time students who are living with their parents in their parents' homes. Children who do not live with their natural/adoptive adult parents are placed in an HIEUIDX as follows:

- Foster children always comprise a separate HIEUIDX.

- Other unmarried children are placed in stepparent HIEUIDX, grandparent HIEUIDX, great-grandparent HIEUIDX, or aunt/uncle HIEUIDX.

- Children of unmarried minors are placed (along with their minor parents) in the HIEUIDX of their adult grandparents (if possible). Married minors are placed into separate HIEUs along with any spouses and children they might have.

- Some HIEUs are headed by unmarried minors, when there is no adult family member present in the CPSFAMID.

HIEUs do not, in general, comprise adult (nonmarital) partnerships, because unmarried adult partners are rarely eligible for dependent coverage under each other's insurance. The exception to this rule is that we include adult partners in the same HIEU if there is at least one (out-of-wedlock) child in the family that links to both adult partners. In cases of missing or contradictory relationship codes, HIEUs are edited by hand, with the presumption being that the adults and children form a nuclear family.

Language of Interview

The language of interview (INTVLANG) was recorded in the closing section of the interview, and has the following possible values:

1	ENGLISH
2	SPANISH
3	ENGLISH & SPANISH
91	OTHER LANGUAGE
-1	INAPPLICABLE

Although this question is round-specific, the responses were summarized to the person-level variable, INTVLANG. The hierarchy used in determining the value is as follows: 1) assign the value from the first round with a reported value recorded for each person; 2) if one is not recorded at the person level, then assign the first recorded value within the reporting unit (RU); 3) if one is not available at that level, then assign the first recorded value of the dwelling unit (DU); 4) if no value is available, then a value of –1 is assigned.

2.5.2 Health Insurance Variables

2.5.2.1 Managed Care Variables (MCDHMO31, MCDHMO42, MCDHMO98, MCDMC31, MCDMC42, MCDMC98, PRVHMO31, PRVHMO42, PRVHMO98, PRVMC31, PRVMC42, PRVMC98)

HMO and gatekeeper plan variables have been constructed from information on health insurance coverage at any time in a reference period and the characteristics of the plan. A separate set of managed care variables has been constructed for private insurance and Medicaid coverage. The purpose of these variables is to provide information on managed care participation during the portion of the three rounds (i.e., reference periods) that fall within the same calendar year.

Managed care variables for calendar year 1998 are based on responses to health insurance questions asked during the round 3, 4, and 5 interviews of panel 2, and the round 1, 2, and 3 interviews of panel 3. Each variable ends in "xy" where x and y denote the interview round for panels 2 and 3, respectively. The variables ending in "31" and "42" correspond to the first two interviews of each panel in the calendar year. Because round 3 interviews typically overlap the final months of one year and the beginning months of the next year, the "31" variables for panel 2 have been restricted to the 1998 portion of the reference period. Similarly, the panel2/round 5 and panel 3/round 3 interviews have been restricted to the 1998 portion of these reference periods, and the corresponding managed care variables have been given the suffix "98" (as opposed to "53") to emphasize the restricted time frame.

Construction of the managed care variables is straightforward, but four caveats are appropriate. First, MEPS estimates of the number of persons in HMOs are higher than figures reported by other sources, particularly those based on HMO industry data. The differences stem from the use of household-reported information, which may include respondent error, to determine HMO coverage in MEPS.

Second, the managed care questions are asked about the last plan held by a respondent through his or her establishment even though the person could have had a different plan through the establishment at an earlier point in the reference period. As a result, in instances where a respondent changed his or her establishment-related insurance, the managed care variables describe the characteristics of the last plan held in the round.

Third, the "98" versions of the HMO and gatekeeper variables for panel 3 are developed from round 3 variables that cover different time frames. The health insurance variable for round 3 is restricted to the same calendar year as the round 1 and 2 data. The round 3 variables describing plan type, on the other hand, overlap the next calendar year. As a consequence, the round 3 managed care variables may not describe the characteristics of the last plan held in the calendar year if the person changed plans after the first of the year.

Fourth, the 1998 Full Year Population Characteristics file contains a small number of

persons who had their round 2 interview in 1999 rather than 1998. These individuals are called "crossover" persons, and they can be differentiated from persons who had a round 2 interview in 1998 by using the R2FLAG in the full year file. The panel 3/round 2 crossover persons in this file have 3 managed care variables, but only two are distinct values—one showing their status during round 1 and another for the 1998 portion of the round 2 interview—while other panel 3 respondents have 3 distinct managed care variables for 1998.

Medicaid Managed Care Plans

Persons were assigned Medicaid coverage based on their responses to the health insurance questions or through logical editing of the survey data. The number of persons who were edited to have Medicaid coverage is small, but they are comprised of two distinct groups of individuals. The first group includes persons in Other Government programs that were identified as being in a Medicaid HMO or gatekeeper plan that did not require premium payment from the insured party. By definition, this group was asked about the managed care characteristics of their insurance coverage. The second group includes a small number of persons who did not report public insurance, but were classified as Medicaid recipients because they reported receiving AFDC, SSI, or WIC. The health insurance plan type questions were not asked of this group. As a consequence, the plan type could be determined for some, but not all, respondents who were assigned Medicaid coverage through logical editing of the data.

Medicaid HMOs

If Medicaid or Other Government programs were identified as the source of hospital/physician insurance coverage, the respondent was asked about the characteristics of the coverage. The variable MCDHMO has been set to "yes" if the plan was identified from a list of state names or programs for Medicaid HMOs in the area, or if an affirmative response was provided to the following question:

1 Under {{Medicaid/{STATE NAME FOR MEDICAID}/the program sponsored by a state or local government agency which provides hospital and physician benefits} (are/is) (READ NAME(S) FROM BELOW) signed up with an HMO, that is a Health Maintenance Organization?

[With an HMO, you must generally receive care from HMO physicians. If another doctor is seen, the expense is not covered unless you were referred by the HMO, or there was a medical emergency.]

In subsequent rounds, respondents who had been previously identified as covered by Medicaid were asked whether the name of their insurance plan had changed since the previous interview. An affirmative response triggered the previous set of questions about managed care (name on list of Medicaid HMOs or signed up with an HMO as well as the question described below).

In each round, the variable MCDHMO has five possible values:

1 The person was covered by a Medicaid HMO.
2 The person was covered by Medicaid but the plan was not an HMO.
3 The person was not covered by Medicaid.
-9 The person was covered by Medicaid but the plan type was not ascertained.
-1 The person was out-of-scope.

Medicaid Gatekeeper Plans

If the respondent did not belong to a Medicaid HMO, a third question was used to determine whether the person was in a gatekeeper plan. The variable MCDMCxy was set to "yes" if the person provided an affirmative response to the following question:

1. Does {{Medicaid /{STATE NAME FOR MEDICAID}} require (READ NAME(S) BELOW) to sign up with a certain primary care doctor, group of doctors, or with a certain clinic which they must go to for all of their routine care?

Probe: Do not include emergency care or care from a specialist to which they were referred to.

In each round, the variable MCDMC has five possible values:

1 The person was covered by a Medicaid gatekeeper plan.
2 The person was covered by Medicaid, but it was not a gatekeeper plan.
3 The person was not covered by Medicaid.
-9 The person was covered by Medicaid but the plan type was not ascertained.
-1 The person was out-of-scope.

Private Managed Care Plans

Persons with private insurance were identified from their responses to questions in the health insurance section of the MEPS questionnaire. In some cases, persons were assigned private insurance as a result of comments collected during the interview, but data editing was minimal. As a consequence, most persons with private insurance were asked about the characteristics of their plan, and their responses were used to identify HMO and gatekeeper plans.

Private HMOs

Persons with private insurance were classified as being covered by an HMO if they met any of the three following conditions:

1. The person reported that his or her insurance was purchased directly through an HMO,

2. The person reporting private insurance coverage obtained from other sources (such as an employer) identified the type of insurance company providing the coverage as an HMO, or

3. The person answered "yes" to the following question:

   Now I will ask you a few questions about how (POLICYHOLDER)'s insurance through (ESTABLISHMENT) works for non-emergency care.

   We are interested in knowing if (POLICYHOLDER)'s (ESTABLISHMENT) plan is an HMO, that is, a health maintenance organization. With an HMO, you must generally receive care from HMO physicians. For other doctors, the expense is not covered unless you were referred by the HMO or there was a medical emergency. Is (POLICYHOLDER)'s (INSURER NAME) an HMO?

In subsequent rounds, policyholders were asked whether the name of their insurance plan had changed since the previous interview. An affirmative response triggered the detailed question about managed care (i.e., was the insurer an HMO as well as other managed care questions).

Some insured persons have more than one private plan. In these cases, if the policyholder identified any plan as an HMO, the variable PRVHMOxy was set to "yes." If a person had multiple plans and one or more were identified as not being an HMO and the other(s) had missing plan type information, the person level variable was set to missing. In each round, the variable PRVHMO has five possible values:

1 The person was covered by a private HMO.
2 The person was covered by private insurance, but not an HMO.
3 The person was not covered by private insurance.
-9 The person was covered by private insurance, but the plan type was not ascertained.
-1 The person was out-of-scope.

Private Gatekeeper Plans

If the respondent did not report belonging to a private HMO, a follow up question was used to determine whether the person was in a gatekeeper plan. The variable PRVMCxy was set to "yes" if the person provided an affirmative response to the following question:

1. (Do/Does) (POLICYHOLDER)'S insurance plan require (POLICYHOLDER) to sign up with a certain primary care doctor, group of doctors, or a certain clinic which (POLICYHOLDER) must go to for all of (POLICYHOLDER)'s routine care?

   Probe: Do not include emergency care or care from a specialist you were referred to.

Some insured persons have more than one private plan. In these cases, if the policyholder

identified any plan as a gatekeeper plan, the variable PRVMCxy was set to "yes." If a person had multiple plans and one or more were identified as not being a gatekeeper plan and the other(s) had missing plan type information, the person level variable was set to missing. In each round, the variable PRVMCxy has five possible values:

1 The person was covered by a private gatekeeper plan.
2 The person was covered by private insurance, but not a gatekeeper plan.
3 The person was not covered by private insurance.
-9 The person was covered by private insurance, but the plan type was not ascertained.
-1 The person was out-of-scope.

2.5.2.2 Unedited Health Insurance Variables (PREVCOVR-LIMITOT)

Duration of Uninsurance

If a person was identified as being without insurance as of January 1st in the MEPS Round 1 interview, a series of follow-up questions were asked to determine the duration of uninsurance prior to the start of the MEPS survey. If the person said he/she was covered by insurance in the 2 years prior to the MEPS Round 1 interview (PREVCOVR), the month, year (COVRMM, COVRYY), and type of coverage (Employer-sponsored (WASESTB), Medicare (WASMCARE), Medicaid (WASMCAID), CHAMPUS/CHAMPVA (WASCHAMP), VA/Military Care (WASVA), Other public (WASOTGOV, WASAFDC,WASSSI, WASSTAT1-3, WASOTHER) or Private coverage purchased through a group, association or insurance company (WASPRIV) was ascertained. For persons who were covered by health insurance on January 1st, it was ascertained if they were ever without health insurance in the previous year (NOINSBEF). The number of weeks/months without health insurance was also ascertained (NOINSTM, NOINUNIT). For persons who reported only non-comprehensive coverage as of January 1st, a question was asked to determine if they had been covered by more comprehensive coverage that paid for medical and doctors bills in the previous 2 years (MORCOVR). If they were, the most recent month and year of coverage was ascertained (INSENDMM, INSENDYY) as was the type of coverage (see the variable names above). Note that these variables are unedited and have been taken directly as they were recorded from the raw data. There may be inconsistencies with the health insurance variables released on public use files that indicate that an individual is uninsured in January.

Pre-Existing Condition Exclusions/ Denial of Insurance

All individuals, regardless of their insurance status, were also asked in Round 1 if they had ever been denied insurance (DENYINSR) and if so, due to what conditions (DNYCANC, DNYHYPER, DNYDIAB, DNYCORON, DENYOTH). Individuals insured in January were asked whether there were any limitations or restrictions on their plans due to any physical or mental health condition (INSLIMIT) and if so, which conditions caused these limitations or restrictions (LMTASTHM, LMTBACK, LMTMIGRN, LMTCATAR, LIMITOT). Individuals under age 65 without any coverage in January were also asked if

they had ever tried to purchase health insurance (INSLOOK). It should be noted that conditions collected in these questions were not recorded on the condition roster.

Note that the duration of uninsurance, limitation, denial and ever looked for insurance questions were only asked in Round 1. These variables are included on the file only for individuals in Panel 3 since Panel 3's Round 1 occurred in 1998 but Panel 2's Round 1 occurred in 1997. Round 1 data for Panel 2 members is contained on a different public use file for calendar year 1997. Users who wish to construct a time line for respondents' health insurance status for Panel 2 members need to obtain health insurance variables for calendar year 1997 as well as the Round 1 variables discussed above from other public use tapes. The unedited health insurance variables are included on this supplemental file to facilitate longitudinal analysis. However, since they are not available for Panel 2, Round 3, they can not be used to generate national estimates for the estimation year.

2.5.2.3 Health Insurance Coverage Variables (CHAMP31X-STPRAT98)

Constructed and edited variables are provided that indicate health insurance coverage at any time in the 1998 portion of Rounds 3/1, at any time in Rounds 4/2, at any time in Rounds 5/3, at any time in Rounds 5/3 (or Round 2 for crossover cases described below) through December 31st, 1998, on the MEPS interview dates and on December 31st, 1998. Note that for respondents who left the RU before the MEPS interview date or before December 31st, the variables measuring coverage at the interview date or on December 31st represent coverage at the date the person left the RU. For individuals who are Round 2 crossover cases (identified with the variable R2FLAG on the full-year 1998 public use file) the variables ending in "98" or "98X" were constructed from the 1998 portion of Round 2. For all other Panel 3 respondents, the December 31st variables were constructed from Round 3 information. In addition, since Round 5 only covers the time period from the Round 4 interview date up to December 31st, values for the December 31st variables are equivalent to those for Round 5 variables for Panel 2 members.

The health insurance variables are constructed for the sources of health insurance coverage collected during the MEPS interviews (Panel 2, Rounds 3 through 5 and Panel 3, Rounds 1 through 3). Note that the Medicare variables on this file as well as the private insurance variables that indicate the particular source of private coverage (rather than "any" private coverage) only measure coverage at the interview date and on December 31st. Users should also note that while the same general editing rules were followed for the month-by-month health insurance variables released on other MEPS public use files and those on this file, in a small number of cases the month-by-month variables experienced further edits performed after the variables on this file were completed. Since editing programs checking for consistencies between these sets of variables developed over time, there should be fewer discrepancies in data for calendar year 1998 and beyond than in data for the years 1996 and 1997.

In Rounds 2, 3, 4 and 5, insurance that was in effect at the previous round's interview date was reviewed with the respondent. Most of the insurance variables have been logically edited to address issues that arose during such reviews in Rounds 2, 3, 4, and 5. One edit

to the private insurance variables corrects for a problem concerning covered benefits that occurred when respondents reported a change in any of their private health insurance plan names. Additional edits address issues of missing data on the time period of coverage for both public and private coverage that was either reviewed or initially reported in a given round. For TRICARE (formerly CHAMPUS/CHAMPVA) coverage (CHAMP31X, CHAMP42X, CHAMP53X, CHAMP98X, CHMAT31X, CHMAT42X, CHMAT53X, CHMAT98X), respondents who were age 65 and over had their reported TRICARE coverage overturned. Additional edits, described below, were performed on the Medicare and Medicaid variables to assign persons to coverage from these sources. Observations that contain edits assigning person to Medicare or Medicaid coverage can be identified by comparing the edited and unedited versions of the Medicare and Medicaid variables.

Public sources include Medicare, TRICARE, Medicaid and other public hospital/physician coverage. State-specific program participation (STAPR31, STAPR42, STAPR53, STAPR98, STPRAT31, STPRAT42, STPRAT53, STPRAT98) in non-comprehensive coverage was also identified but is not considered health insurance for the purpose of this survey.

Medicare

Medicare (MCARE31, MCARE42, MCARE53 and MCARE98) coverage was edited (MCARE31X, MCARE42X, MCARE53X and MCARE98X) for persons age 65 or over. Within this age group, individuals were assigned Medicare coverage if:

They answered yes to a follow-up question on whether or not they received Social Security benefits; or

They were covered by Medicaid, other public hospital/physician coverage or Medigap coverage: or

Their spouse was covered by Medicare.

They reported TRICARE coverage.

Medicaid and Other Public Hospital/Physician Coverage

Questions about other public hospital/physician coverage were asked in an attempt to identify Medicaid recipients who may not have recognized their coverage as Medicaid. These questions were asked only if a respondent did not report Medicaid directly. Respondents reporting other public hospital/physician coverage were asked follow-up questions to determine if their coverage was through a specific Medicaid HMO or if it included some other managed care characteristics. Respondents who identified managed care from either path were asked if they paid anything for the coverage and/or if a government source paid for the coverage.

The Medicaid variables (MCAID31, MCAID42, MCAID53, MCAID98) have been edited

to include persons who paid nothing for their other public hospital/physician insurance when such coverage was through a Medicaid HMO or reported to include some other managed care characteristics (MCAID31X, MCAID42X, MCAID53X, MCAID98X, MCDAT31X, MCDAT42X, MCDAT53X, MCDAT98X).

To assist users in further editing sources of insurance, this file contains variables constructed from the other public hospital/physician series that measure whether:

> The respondent reported some type of managed care and paid something for the coverage, Other Public A Insurance (OTPUBA31, OTPUBA42, OPUBA53, OTPUBA98, OTPAAT31, OTPAAT42, OTPAAT53, OTPAAT98); and
>
> The respondent did not report any managed care, Other Public B insurance (OTPUBB31, OTPUBB42, OTPUBB53, OTPUBB98, OTPBAT31, OPTBAT42, OPTBAT53, OTPBAT98).

The variables for Other Public A and B Insurance are provided only to assist in editing and should not be used to make separate insurance estimates for these types of insurance categories.

Any Public Insurance

The file includes summary measures that indicate whether or not a sample person has public coverage at any time in the 1998 portion of Rounds 3/1, at any time in Rounds 4/2, at any time in Rounds 5/3, at any time in Rounds 5/3 (or Round 2 for crossover cases) through December 31st, 1998, on the MEPS interview dates and on December 31st, 1998. (PUB31X, PUB42X, PUB53X, PUB98X, PUBAT31X, PUBAT42X PUBAT53X and PUBAT98X). Persons identified as covered by public insurance are those reporting coverage under TRICARE, Medicare, Medicaid, or other public hospital/physician programs. Persons covered only by state-specific programs that did not provide comprehensive coverage (STAPR31, STAPR42, STAPR53, STAPR98, STPRAT31, STPRAT42, STPRAT53, STPRAT98), for example, the Maryland Kidney Disease Program, were not considered to have public coverage when constructing the variables PUB31X.....PUBAT98X.

Private Insurance

Variables identifying private insurance in general (PRIV31, PRIV42, PRIV53, PRIV98, PRIVAT31, PRIVAT42, PRIVAT53, PRIVAT98) and specific private insurance sources [such as employer/union group insurance (PRIEU31, PRIEU42, PRIEU53, PRIEU98); non-group (PRING31, PRING42, PRING53, PRING98); and other group (PRIOG31, PRIOG42, PRIOG53, PRIOG98)] were constructed. Variables indicating any private insurance coverage are available for the following time periods: any time in the 1998 portion of Rounds 3/1, at any time in Rounds 4/2, at any time in Rounds 5/3, at any time in Rounds 5/3 (or Round 2 for crossover cases) through December 31st, 1998, on the MEPS interview dates and on December 31st, 1998. The variables for the specific sources

of private coverage are only available for coverage on the interview dates and on December 31st. Note that these variables indicate coverage within a source and do not distinguish between persons who are covered on one or more than one policy within a given source. In some cases, the policyholder was unable to characterize the source of insurance (PRIDK31, PRIDK42, PRIDK53, PRIDK98). Covered persons are also identified when the policyholder is living outside the RU (PROUT31, PROUT42, PROUT53, PROUT98). An individual was considered to have private health insurance coverage if, at a minimum, that coverage provided benefits for hospital and physician services (including Medigap coverage). Sources of insurance with missing information regarding the type of coverage were assumed to contain hospital/physician coverage. Persons without private hospital/physician insurance were not counted as privately insured.

Health insurance through a job or union (PRIEU31, PRIEU42, PRIEU53, PRIEU98) was initially asked about in the Employment Section of the interview and later confirmed in the Health Insurance Section. Respondents also had an opportunity to report employer and union group insurance for the first time in the Health Insurance Section, but this insurance was not linked to a specific job.

All insurance reported to be through a job classified as self-employed with firm size of 1 (PRIS31, PRIS42, PRIS53, PRIS98) was initially reported in the Employment Section and verified in the Health Insurance Section. Unlike the other employment-related variables, self-employed-firm size 1 health insurance could not be reported in the Health Insurance section for the first time. The variables PRIS31, PRIS42, PRIS53, and PRIS98 have been constructed to allow users to determine if the insurance should be considered employment-related. Private insurance that was not employment-related was reported in the Health Insurance section only.

Any Insurance in Month

Summary measures that indicate whether or not a person has any insurance any time in the 1998 portion of Rounds 3/1, at any time in Rounds 4/2, at any time in Rounds 5/3, at any time in Rounds 5/3 (or Round 2 for crossover cases) through December 31st, 1998, on the MEPS interview dates and on December 31st, 1998 (INS31X, INS42X, INS53X, INS98X, INSAT31X, INSAT42X, INSAT53X, INSAT98X) were constructed. Persons identified as insured are those reporting coverage under TRICARE, Medicare, Medicaid or other public hospital/physician or private hospital/physician insurance (including Medigap plans). A person is considered uninsured if not covered by one of these insurance sources.

Persons covered only by state-specific programs that provide non-comprehensive coverage (STAPR31, STAPR42, STAPR53, STAPR98, STPRAT31, STPRAT42, STPRAT53, STPRAT98), for example, the Maryland Kidney Disease Program, and those without hospital/physician benefits (for example, private insurance for dental or vision care, accidents or specific diseases only) were not considered to be insured when constructing the variables INS31X, INS42X, INS53X, INS98X, INSAT31X, INSAT42X,

INSAT53X and INSAT98X.

2.5.2.4 Dental Private Insurance Variables

Round specific variables (DENTIN31/42/53) are provided that indicate the respondent was covered by a private health insurance plan that included at least some dental coverage for each round of 1998. It should be noted that the information was elicited from a pick-list, code all that apply, question that asked what type of health insurance person obtained through an establishment. The list included: hospital and physician benefits including coverage through an HMO, Medigap coverage, vision coverage, dental, and prescription drugs. It is possible that some dental coverage provided by hospital and physician plans was not independently enumerated in this question. Respondents who reported dental coverage from at least one reported private plan were coded as having private dental coverage. Users should note that persons with missing information on dental benefits for all reported private plans and those who reported that they did not have dental coverage for one or more plans but had missing information on other plans are coded as not having private dental coverage.

Users should be aware that the 1998 variables differ from those released on public use files for 1996 and 1997. For example, persons in the military were coded as -1 in 1997, while in the current year they are not. In 1996, persons with dental insurance were set to 1 if there was any indication that they had dental coverage. All others (including those out-of-scope, without health insurance as well as those with health insurance but no dental coverage, and those with missing information on dental coverage) were set to 2. Also, records were checked more carefully for coverage dates in 1998 to insure consistency with the health insurance variables.

2.5.2.5 Prescription Drug Private Insurance Variables

Round specific variables (PMEDIN31/42/53) are provided that indicate the respondent was covered by a private health insurance plan that included at least some prescription drug insurance coverage for each round of 1998. It should be noted that the information was elicited from a pick-list, code all that apply, question that asked what type of health insurance a person obtained through an establishment. The list included: hospital and physician benefits including coverage through an HMO, Medigap coverage, vision coverage, dental, and prescription drugs. It is possible some prescription drug coverage provided by hospital and physician plans was not independently enumerated in this question. Respondents who reported prescription drug coverage from at least one reported private plan were coded as having private prescription drug coverage. Users should note that persons with missing information on prescription drug benefits for all reported private plans and those who reported that they did not have prescription drug coverage for one or more plans but had missing information on other plans are coded as not having private prescription drug coverage. This differs from variables released for previous years (1996 and 1997) when missing information (not ascertained) was coded as -9. In addition, persons with no health insurance were coded as -1 in 1996 and 1997, while in 1998 such persons were coded as not having prescription drug insurance. Also, persons

in the military were coded as -1 in 1996 and 1997, while in the current year they are not. Finally, records were checked more carefully for coverage dates in 1998 to insure consistency with the health insurance variables.

2.5.3 Disability Days Indicator Variables (DDNWRK31-OTHNDD53)

The disability days section of the core interview contains questions about time lost from work or school and days spent in bed because of a physical illness, injury, or mental or emotional problem. Data were collected on each individual in the household. These questions were repeated in each round of interviews; these files contains data from Rounds 3, 4, and 5 of the MEPS panel initiated in 1997 and Rounds 1, 2, and 3 of the MEPS panel initiated in 1998 respectively. The number at the end of the variable name (31, 42 or 53) identifies the Rounds in which the information was collected.

The reference period for these questions is the time period between the beginning of the panel or the previous interview date and the current interview date. In order to establish the length of a round, analysts are referred to the variables that indicate the beginning date and ending date of each Round (BEGREFD, BEGREFM, BEGREFY, ENDREFD, ENDREFM, ENDREFY). Analysts should be aware that Round 3 was conducted across years. Some data from Round 3 thus pertains to the following year. The number of disability days in Round 3 that occurred in each calendar year was not ascertained. If analysts want to create an indicator of disability days for a given calendar year, some adjustment must be made to the Round 3 data. Analysts who want to estimate disability days for a given calendar year will need to develop an algorithm for deciding what portion of reported disability days occurred in the year of interest and what portion occurred in the following year.

The variables DDNWRK31, DDNWRK42 and DDNWRK53 represent the number of times the respondent lost a half-day or more from work because of illness, injury or mental or emotional problems during Rounds 31, 42, and 53, respectively. A response of "no work days lost" was coded zero; if the respondent did not work, these variables were coded -1 (inapplicable), and for some analyses these values may have to be recoded to zero. Respondents who were less than 16 years old were not asked about lost workdays, and these variables are coded -1 (inapplicable) for them.

WKINBD31, WKINBD42 and WKINBD53 represent the number of work-loss days during each round in which the respondent spent at least half of the day in bed. These questions were asked only of persons aged 16 and over. Persons aged 15 or younger received a code of -1 (inapplicable). If a respondent answered the preceding work-loss question with "zero days" or "does not work", then the corresponding WKINBD question was coded as -1 (inapplicable).

DDNSCL31, DDNSCL42 and DDNSCL53 indicate the number of times that a respondent missed a half-day or more of school during Rounds 31, 42, or 53, respectively. These questions were asked of persons aged 3 to 22; respondents aged less than 3 or older than 22 did not receive these questions and are coded as -1 on these variables (in a small

number of cases this was not done for the 1996 data, the analyst will need to make this edit when doing longitudinal analyses). A code of -1 also indicates that the person does not attend school. The analyst should be aware that there was no attempt to reconcile school loss days with the time of year (e.g., summer vacation). In order to establish time of year, analysts are referred to the variables that indicate the beginning date and ending date of each Round (BEGREFD, BEGREFM, BEGREFY, ENDREFD, ENDREFM, ENDREFY).

SCLNBD31, SCLNBD42 and SCLNBD53 represent the number of school-loss days during each round in which the individual spent at least a half-day in bed. Respondents aged less than 3 or older than 22 did not receive these questions and are coded as -1 on these variables (in a small number of cases this was not done for the 1996 data, the analyst will need to make this edit when doing longitudinal analyses). If a respondent answered the preceding school-loss question with "zero days" or "does not attend school", then the corresponding SCLNBD question is coded as -1 (inapplicable).

DDBDYS31, DDBDYS42 and DDBDYS53 represent additional days, other than school or work days, in which the respondent spent at least half a day in bed, because of a physical illness or injury or a mental or emotional problem. These are the only indicators of disability days for persons who do not work or go to school. This question was not asked of children less than one year of age (coded -1).

A final set of variables indicate if an individual took a half-day or more off from work to care for the health problems of another individual in the family. OTHDYS31, OTHDYS42, and OTHDYS53 indicate if a person missed work because of someone else's illness, injury or health care needs, for example to take care of a sick child or relative. These variables each have three possible answers: yes -- missed work to care for another (coded 1); no - did not miss work to care for another (coded 2); or the person does not work (coded 2), based on responses to the DDNWRK variable for the same Round. Respondents younger than 16 were not asked these questions and are coded as -1 (in a small number of cases this was not done for the 1996 data, the analyst will need to make this edit when doing longitudinal analyses).

OTHNDD31, OTHNDD42 and OTHNDD53 indicate the number of days during each round in which work was lost because of another's health problem. Respondents younger than 16, those who do not work, and those who answer "no" to OTHDYS are skipped out of OTHNDD and receive codes of -1.

For respondents with positive weights, a minimal amount of editing was done on these variables to preserve the skip patterns. No imputation was done for those with missing data.

2.5.4 Access to Care Variables (ACCELI42-OTHRPR42)

The variables ACCELI42 through OTHRPR42 describe data from the Access to Care section of the HC questionnaire, which was administered in Panel 2 Round 4 and Panel 3

Round 2 of the MEPS HC. This supplement serves a number of purposes in the MEPS HC by gathering information on three main topic areas: whether each family member has a usual source of health care, the characteristics of usual source of health care providers for the family, and barriers the family has faced in obtaining needed health care. The variable ACCELI42 indicates whether persons were eligible to receive the Access to Care questions.

Family members' usual source of health care. For each individual family member, MEPS HC ascertains whether there is a particular doctor's office, clinic, health center, or other place that the individual usually goes to if he/she is sick or needs advice about his/her health (HAVEUS42). For those family members who do not have a usual source of health care, MEPS HC ascertains the reason(s) why (YNOUSC42 through OTHREA42). If any family members changed their usual source of health care during the 12 months prior to the interview, MEPS HC gathers information on the reason why this change was made (CHNGUS42 through YNOMOR42).

Characteristics of usual source of health care providers for the family. For each unique usual source of care provider for a given family, MEPS HC asks for information on the following characteristics of the usual source of care provider:

- is the provider a medical doctor or some other type of medical provider (followed by questions which ask either the provider's medical specialty or the type of non-physician provider) (TYPEPE42), and is the provider hospital-based (TYPEPL42 and LOCATI42);

- is the provider the person or place family members would go to for new health problems, preventive health care, and referrals to other health professionals (MINORP42 through REFFRL42);

- does the provider have office hours nights and weekends, characteristics of the provider related to appointments and waiting time, ease of contacting a medical person at the provider's office by telephone (OFFHOU42 through PHONED42);

- a number of quality-related characteristics of the provider, including whether the provider generally listens to family members, asks about prescription medications other doctors may give them, and family members' confidence in and satisfaction with the care received from the provider (PRLIST42 through USCQUA42).

Family barriers. Finally, the Access to Care supplement gathers information on barriers to health care for the family. This includes one question that asks if any family members have recently gone without needed health care because the family needed money to buy food, clothing, or pay for housing (NOCARE42). In addition, the respondent is asked to rate his/her satisfaction with the ability of family members to obtain health care if needed (HCNEED42). A series of two questions is asked to directly assess whether any family members experienced difficulty in obtaining any type of health care, delayed obtaining care, or did not receive health care they thought

they needed due to any of the following reasons (OBTAIN42 through OTHRPR42):

- Financial/Insurance Problems, including couldn't afford care; insurance company wouldn't approve, cover, or pay for care; pre-existing condition; insurance required a referral, but couldn't get one; doctor refused to accept family's insurance plan;

- Transportation Problems, including medical care was too far away; can't drive or don't have car/no public transportation available; too expensive to get there;

- Communication Problems, including hearing impairment or loss; different language;

- Physical Problems, including hard to get into building; hard to get around inside building; no appropriate equipment in office;

- Other Problems, including couldn't get time off work; didn't know where to go to get care; was refused services; couldn't get child care; didn't have time or took too long.

Editing of the Access to Care Variables

Editing consisted primarily of logical editing for consistency with skip patterns. Other editing included the construction of new variables describing the USC provider, and recoding several "other specify" text items into existing or new categorical values, which are described below.

Not all variables or categories that appear in the Access to Care section are included on the file, as some small cell sizes have been suppressed to maintain respondent confidentiality. This affects the following questions:

AC03: Category 5 was combined with 91 OTHER REASON (YNOUSC42)

AC11: Category 7 was combined with 10 OTHER NON-MD PROVIDER (TYPEPE42).

AC23: Categories 2 and 4 were combined with 91 OTHER REASON (YNOMOR42)

AC25A: Categories 9, 11, 12, 13 and 17 were combined with 91 OTHER (MAINPR42)

Constructed Variables Describing the Usual Source of Care Provider

The variables PROVTY42, TYPEPL42, TYPEPE42 and LOCATI42 provide information on the type and location of the usual source of care provider. These variables were

constructed as follows, using one or more questionnaire items which are not included on the file:

PROVTY42 was constructed from items in the Provider Roster Section (available as a downloadable file on the MEPS Home Page), and has the following possible values:

1 FACILITY
2 PERSON
3 PERSON IN FACILITY PROVIDER

Question PV01 asks whether the provider is a person or a facility. For providers designated as a person, the responses to item PV05 (which indicates if the provider is part of a group practice or HMO) and items PV03/ PV10 (which indicate the provider's address), were used to determine if the provider is a "person in facility" provider (i.e., a person for whom both person and facility characteristics are known, such as "Dr. X at Y Medical Associates").

TYPEPE42 was constructed from responses to items AC10, AC11, AC11OV, AC12 and AC12OV in the Access to Care Section and describes the type of medical provider for providers indicated as person or person in facility providers (records with PROVTY42 = 1 have a value of -1 for TYPEPE42). TYPEPE42 has the following possible values:

1 MD - GENERAL/FAMILY PRACTICE
2 MD - INTERNAL MEDICINE
3 MD - PEDIATRICS
4 MD - OB/GYN
5 MD - SURGERY
6 MD - OTHER
7 CHIROPRACTOR
8 NURSE/NURSE PRACTITIONER
9 PHYSICIAN'S ASSISTANT
10 OTHER NON-MD PROVIDER
11 UNKNOWN

Note that the value 6 MD-OTHER includes doctors of osteopathy, as well as a small number of medical doctors whose specialty is unknown.

TYPEPL42 was constructed from responses to Access to Care items AC06 and AC07 and describes the type of place corresponding to the usual source of care provider with the following values:

1 HOSPITAL CLINIC OR OUTPATIENT DEPARTMENT
2 PRIVATE OFFICE IN HOSPITAL
3 HOSPITAL EMERGENCY ROOM

4 NON-HOSPITAL PLACE

TYPEPL42 was only constructed for cases with provider type indicated as facility or person in facility provider (records with PROVTY42=2 have a value of -1 for TYPEPL42).

LOCATI42 was constructed from the variables PROVTY42 and TYPEPL42, and describes the location of the provider as either office based or hospital based, and if hospital based, as either emergency room or non-emergency room. LOCATI42 has the following values:

1 OFFICE
2 HOSPITAL, NOT EMERGENCY ROOM
3 HOSPITAL EMERGENCY ROOM

Note that all cases with PROVTY42=2 PERSON have LOCATI42 = 1 OFFICE.

These 4 variables in combination describe the usual source of care provider. For example, a group practice or clinic with no particular person named is coded as: PROVTY42 = 1 FACILITY, LOCATI42 = 1 OFFICE and TYPEPE42 = -1 INAPPLICABLE.

Re-coding of Additional Other Specify Text Items

For Access to Care items AC03, AC04, AC08, AC09, AC21 and AC23, the other specify text responses were reviewed and coded as an existing or new value for the related categorical variable (for AC03, AC08, AC21 and AC23), or coded as an existing or new "yes/no" variable (for items AC04 and AC09). The following are the new codes or variables which were created from these other specify text responses.

for item AC03 - this new value was constructed for the variable YNOUS42:

10 OTHER INSURANCE RELATED REASON

for item AC04 - the new variable OTHINS42 was constructed for insurance-related reasons

for item AC08 - these new values were constructed for the variable YGOTOU42:

8 MILITARY/VA
10 INSURANCE RELATED REASON

for item AC09 - the new variable INSREA42 was constructed for insurance-related reasons

for item AC21 - these new values were constructed for the variable YCHNGU42:

8 COST-RELATED REASON
9 OTHER INSURANCE-RELATED REASON
10 JOB RELATED REASON
11 NEW DOCTOR WAS REFERRED OR RECOMMENDED
12 OTHER COMPLAINTS ABOUT OLD DOCTOR
13 TRANSPORTATION REASON

for item AC23 - these new values were constructed for the variable YNOMOR42:

8 COST-RELATED REASON
9 SELDOM OR NEVER SICK/NO NEED FOR DOCTOR
10 OTHER INSURANCE-RELATED REASON

2.6 File 2 Contents: Outpatient Department Visit Variable

2.6.1 Characteristics of Outpatient Visits

This file contains a variable describing an outpatient event reported by respondents in the Outpatient Department section of the MEPS Household questionnaire. The following variable, which was inadvertently omitted from the original 1998 Outpatient Department Visit file, is provided as unedited: see (HC-026F) for complete documentation.

2.6.1.2 Visit Details (SEETLKPV)

When a person reported having had a visit to a hospital outpatient department or special clinic, it was reported whether the person actually saw the provider or talked to the provider on the telephone (SEETLKPV).

D. Variable-Source Crosswalk

File 1:

SURVEY ADMINISTRATION VARIABLES

VARIABLE	DESCRIPTION	SOURCE
DUID	DWELLING UNIT ID	Assigned in Sampling
PID	PERSON NUMBER	Assigned in Sampling or by CAPI
DUPERSID	PERSON ID (DUID+PID)	Assigned in Sampling
HIEUIDX	HIEU IDENTIFIER – END OF 98	Constructed
INTVLANG	LANGUAGE INTERVIEW WAS CONDUCTED IN	Constructed

HEALTH INSURANCE VARIABLES

Managed Care/HMO Indicators

VARIABLE	DESCRIPTION	SOURCE
MCDHMO31	PID COV BY MEDICAID HMO AT ANY TIME IN RD 31 (ED)	Constructed
MCDHMO42	PID COV BY MEDICAID HMO AT ANY TIME IN RD 42 (ED)	Constructed
MCDHMO98	PID COV BY MEDICAID HMO ANY TIME – 12/31/98 (ED)	Constructed
MCDMC31	PID COV BY MEDICAID GATEKEEPER PLAN AT ANY TIME IN RD 31 (ED)	Constructed
MCDMC42	PID COV BY MEDICAID GATEKEEPER PLAN AT ANY TIME IN RD 42 (ED)	Constructed
MCDMC98	PID COV BY MEDICAID GATEKEEPER PLAN – ANY TIME 12/31/98 (ED)	Constructed
PRVHMO31	PID COV BY PRIVATE HMO AT ANY TIME IN RD 31 (ED)	Constructed
PRVHMO42	PID COV BY PRIVATE HMO AT ANY TIME IN RD 42 (ED)	Constructed
PRVHMO98	PID COV BY PRIVATE HMO ANY TIME –12/31/98 (ED)	Constructed
PRVMC31	PID COV BY PRIVATE GATEKEEPER PLAN AT ANY TIME IN RD 31 (ED)	Constructed
PRVMC42	PID COV BY PRIVATE GATEKEEPER PLAN AT ANY TIME IN RD 42 (ED)	Constructed
PRVMC98	PID COV BY PRIVATE GATEKEEPER PLAN ANY TIME – 12/31/98 (ED)	Constructed

Duration of being without insurance (non-insurance)

VARIABLE	DESCRIPTION	SOURCE
PREVCOVR	WAS PERSON COVERED BY INS IN PREVIOUS TWO YEARS – PANEL 3 ONLY	HX64
COVRMM	MONTH MOST RECENTLY COVERED – PANEL 3 ONLY	HX65
COVRYY	YEAR MOST RECENTLY COVERED – PANEL 3 ONLY	HX65
WASESTB	WAS PREV INS BY EMPLOYER OR UNION – PANEL 3 ONLY	HX66, HX78
WASMCARE	WAS PREV INS BY MEDICARE – PANEL 3 ONLY	HX66, HX78
WASMCAID	WAS PREV INS BY MEDICAID – PANEL 3 ONLY	HX66, HX78
WASCHAMP	WAS PREV INS BY CHAMPUS/CHAMPVA – PANEL 3 ONLY	HX66, HX78
WASVA	WAS PREV INS BY VA/MILITARY CARE – PANEL 3 ONLY	HX66, HX78
WASPRIV	WAS PREV INS BY GROUP/ASSOC/INS CO – PANEL 3 ONLY	HX66, HX78
WASOTGOV	WAS PREV INS BY OTHER GOVT PROG – PANEL 3 ONLY	HX66, HX78
WASAFDC	WAS PREV INS BY PUBLIC AFDC – PANEL 3 ONLY	HX66, HX78
WASSSI	WAS PREV INS BY SSI PROGRAM – PANEL 3 ONLY	HX66, HX78
WASSTAT1	WAS PREV INS BY STATE PROGRAM 1 – PANEL 3 ONLY	HX66, HX78
WASSTAT2	WAS PREV INS BY STATE PROGRAM 2 – PANEL 3 ONLY	HX66, HX78
WASSTAT3	WAS PREV INS BY STATE PROGRAM 3 – PANEL 3 ONLY	HX66, HX78
WASOTHER	WAS PREV INS BY SOME OTHER SOURCE – PANEL 3 ONLY	HX66, HX78
NOINSBEF	EVER WITHOUT HEALTH INSURANCE IN PREVIOUS YEAR – PANEL 3 ONLY	HX70
NOINSTM	NUM WEEKS/MONTHS WITHOUT HI IN PREVIOUS YEAR – PANEL 3 ONLY	HX71
NOINUNIT	UNIT FOR TIME WITHOUT HEALTH INSURANCE – PANEL 3 ONLY	HX71OV
MORECOVR	COVERED BY MORE COMPREHENSIVE PLAN IN PREVIOUS TWO YEARS – PANEL 3 ONLY	HX76
INSENDMM	MONTH MOST RECENTLY COVERED – PANEL 3 ONLY	HX77
INSENDYY	YEAR MOST RECENTLY COVERED – PANEL 3 ONLY	HX77

Pre-existing conditions exclusions

VARIABLE	DESCRIPTION	SOURCE
DENYINSR	PERSON EVER DENIED INSURANCE – PANEL 3 ONLY	HX67,HX74, HX79
DNYCANC	CANCER CAUSED INSURANCE DENIAL – PANEL 3 ONLY	HX68,HX75, HX80
DNYHYPER	HYPERTENSION CAUSED INSURANCE DENIAL – PANEL 3 ONLY	HX68,HX75, HX80
DNYDIAB	DIABETES CAUSED INSURANCE DENIAL – PANEL 3 ONLY	HX68,HX75, HX80
DNYCORON	CORONARY ARTERY DISEASE CAUSED INSURANCE DENIAL – PANEL 3 ONLY	HX68,HX75, HX80
DENYOTH	OTHER REASON CAUSED INSURANCE DENIAL – PANEL 3 ONLY	HX68,HX75, HX80
INSLOOK	PERSON EVER LOOKED FOR INSURANCE – PANEL 3 ONLY	HX69
INSLIMIT	ANY LIMIT/RESTRICTIONS ON INSURANCE – PANEL 3 ONLY	HX72
LMTASTHM	CONDITION CAUSED LIMIT: ASTHMA – PANEL 3 ONLY	HX73
LMTBACK	CONDITION CAUSED LIMIT: BACK PROBLEMS – PANEL 3 ONLY	HX73
LMTMIGRN	CONDITION CAUSED LIMIT: MIGRAINE – PANEL 3 ONLY	HX73
LMTCATAR	CONDITION CAUSED LIMIT: CATARACT – PANEL 3 ONLY	HX73
LIMITOT	CONDITION CAUSED LIMIT: OTHER – PANEL 3 ONLY	HX73

Health Insurance Coverage

VARIABLE	DESCRIPTION	SOURCE
CHAMP31X	PID COV BY CHAMPUS/CHAMPVA - RD 31 INT (ED)	Constructed
CHAMP42X	PID COV BY CHAMPUS/ CHAMPVA - RD 42 INT (ED)	Constructed
CHAMP53X	PID COV BY CHAMPUS/ CHAMPVA - RD 53 INT (ED)	Constructed
CHAMP98X	PID COV BY CHAMPUS/ CHAMPVA - 12/31/98 (ED)	Constructed
CHMAT31X	AT ANY TIME COVERAGE BY CHAMPUS - RD 31	Constructed
CHMAT42X	AT ANY TIME COVERAGE BY CHAMPUS - RD 42	Constructed
CHMAT53X	AT ANY TIME COVERAGE BY CHAMPUS - RD 53	Constructed
CHMAT98X	AT ANY TIME COV BY CHAMPUS - 12/31/98	Constructed
INS31X	PID IS INSURED - RD 31 INT (ED)	Constructed

VARIABLE	DESCRIPTION	SOURCE
INS42X	PID IS INSURED - RD 42 INT (ED)	Constructed
INS53X	PID IS INSURED - RD 53 INT (ED)	Constructed
INS98X	PID IS INSURED - 12/31/98 (ED)	Constructed
INSAT31X	INSURED ANY TIME IN RD31	Constructed
INSAT42X	INSURED ANY TIME IN RD42	Constructed
INSAT53X	INSURED ANY TIME IN RD53	Constructed
INSAT98X	INSURED ANY TIME 12/31/98	Constructed
MCAID31	COV BY MEDICAID - RD 31 INT	Constructed
MCAID42	COV BY MEDICAID - RD 42 INT	Constructed
MCAID53	COV BY MEDICAID - RD 53 INT	Constructed
MCAID98	PID COV BY MEDICAID - 12/31/98	Constructed
MCAID31X	PID COV BY MEDICAID - RD 31 INT (ED)	Constructed
MCAID42X	PID COV BY MEDICAID - RD 42 INT (ED)	Constructed
MCAID53X	PID COV BY MEDICAID - RD 53 INT (ED)	Constructed
MCAID98X	PID COV BY MEDICAID - 12/31/98 (ED)	Constructed
MCARE31	PID COV BY MEDICARE - RD 31 INT	Constructed
MCARE42	PID COV BY MEDICARE - RD 42 INT	Constructed
MCARE53	PID COV BY MEDICARE - RD 53 INT	Constructed
MCARE98	PID COV BY MEDICARE - 12/31/98	Constructed
MCARE31X	PID COV BY MEDICARE - RD 31 INT (ED)	Constructed
MCARE42X	PID COV BY MEDICARE - RD 42 INT (ED)	Constructed
MCARE53X	PID COV BY MEDICARE - RD 53 INT (ED)	Constructed
MCARE98X	PID COV BY MEDICARE - 12/31/98 (ED)	Constructed
MCDAT31X	AT ANY TIME COVERAGE BY MEDICAID - RD 31	Constructed
MCDAT42X	AT ANY TIME COVERAGE BY MEDICAID - RD 42	Constructed
MCDAT53X	AT ANY TIME COVERAGE BY MEDICAID - RD 53	Constructed
MCDAT98X	AT ANY TIME COV BY MEDICAID - 12/31/98	Constructed
OTPAAT31	ANY TIME COV BY/PAYS OTH GOV MCAID HMO - RD 31	Constructed
OTPAAT42	ANY TIME COV BY/PAYS OTH GOV MCAID HMO - RD 42	Constructed
OTPAAT53	ANY TIME COV BY/PAYS OTH GOV MCAID HMO - RD 53	Constructed
OTPAAT98	ANY TIME COV BY/PAYS OTH GOV MCAID HMO - 12/31/98	Constructed
OTPBAT31	ANY TIME COV BY OTH GOV NOT MCAID HMO -RD 31	Constructed
OTPBAT42	ANY TIME COV BY OTH GOV NOT MCAID HMO -RD 42	Constructed
OTPBAT53	ANY TIME COV BY OTH GOV NOT MCAID HMO -RD 53	Constructed

VARIABLE	DESCRIPTION	SOURCE
OTPBAT98	ANY TIME COV BY OTH GOV NOT MCAID HMO -12/31/98	Constructed
OTPUBA31	COV BY/PAYS OTH GOV MCAID - RD 31 INT	Constructed
OTPUBA42	COV BY/PAYS OTH GOV MCAID - RD 42 INT	Constructed
OTPUBA53	COV BY/PAYS OTH GOV MCAID - RD 53 INT	Constructed
OTPUBA98	COV BY/PAYS OTH GOV MCAID - 12/31/98	Constructed
OTPUBB31	COV BY OTH GOV NOT MCAID HMO - RD 31 INT	Constructed
OTPUBB42	COV BY OTH GOV NOT MCAID HMO - RD 42 INT	Constructed
OTPUBB53	COV BY OTH GOV NOT MCAID HMO - RD 53 INT	Constructed
OTPUBB98	COV BY OTH GOV NOT MCAID HMO - 12/31/98	Constructed
PRIDK31	PID COV BY PRIV INS (DK PLAN)- RD 31 INT	Constructed
PRIDK42	PID COV BY PRIV INS (DK PLAN) -RD 42 INT	Constructed
PRIDK53	PID COV BY PRIV INS (DK PLAN) -RD 53 INT	Constructed
PRIDK98	PID COV BY PRIV INS (DK PLAN) - 12/31/98	Constructed
PRIEU31	PID COV BY EMPL/UNION GRP INS- RD 31 INT	Constructed
PRIEU42	PID COV BY EMPL/UNION GRP INS- RD 42 INT	Constructed
PRIEU53	PID COV BY EMPL/UNION GRP INS- RD 53 INT	Constructed
PRIEU98	PID COV BY EMPL/UNION GRP INS - 12/31/98	Constructed
PRING31	PID COV BY NON-GROUP INS - RD 31 INT	Constructed
PRING42	PID COV BY NON-GROUP INS - RD 42 INT	Constructed
PRING53	PID COV BY NON-GROUP INS - RD 53 INT	Constructed
PRING98	PID COV BY NON-GROUP INS - 12/31/98	Constructed
PRIOG31	PID COV BY OTHER GROUP INS - RD 31 INT	Constructed
PRIOG42	PID COV BY OTHER GROUP INS- RD 42 INT	Constructed
PRIOG53	PID COV BY OTHER GROUP INS - RD 53 INT	Constructed
PRIOG98	PID COV BY OTHER GROUP INS - 12/31/98	Constructed
PRIS31	PID COV BY SELF-EMP-1 INS - RD 31 INT	Constructed
PRIS42	PID COV BY SELF-EMP-1 INS - RD 42 INT	Constructed
PRIS53	PID COV BY SELF-EMP-1 INS - RD 53 INT	Constructed
PRIS98	PID COV BY SELF-EMP-1 INS - 12/31/98	Constructed
PRIV31	PID HAS PRIVATE HLTH INS - RD 31 INT	Constructed
PRIV42	PID HAS PRIVATE HLTH INS- RD 42 INT	Constructed
PRIV53	PID HAS PRIVATE HLTH INS - RD 53 INT	Constructed
PRIV98	PID HAS PRIVATE HLTH INS - 12/31/98	Constructed
PRIVAT31	ANY TIME COV BY PRIVATE - RD 31	Constructed
PRIVAT42	ANY TIME COV BY PRIVATE - RD 42	Constructed
PRIVAT53	ANY TIME COV BY PRIVATE - RD 53	Constructed
PRIVAT98	ANY TIME COV BY PRIVATE - 12/31/98	Constructed

VARIABLE	DESCRIPTION	SOURCE
PROUT31	PID COV BY SOMEONE OUT OF RU - RD 31 INT	Constructed
PROUT42	PID COV BY SOMEONE OUT OF RU - RD 42 INT	Constructed
PROUT53	PID COV BY SOMEONE OUT OF RU - RD 53 INT	Constructed
PROUT98	PID COV BY SOMEONE OUT OF RU - 12/31/98	Constructed
PUB31X	PID COV BY PUBLIC INS-RD 31 INT (ED)	Constructed
PUB42X	PID COV BY PUBLIC INS-RD 42 INT (ED)	Constructed
PUB53X	PID COV BY PUBLIC INS-RD 53 INT (ED)	Constructed
PUB98X	PID COV BY PUBLIC INS - 12/31/98 (ED)	Constructed
PUBAT31X	AT ANY TIME COV BY PUBLIC - RD 31	Constructed
PUBAT42X	AT ANY TIME COV BY PUBLIC - RD 42	Constructed
PUBAT53X	AT ANY TIME COV BY PUBLIC - RD 53	Constructed
PUBAT98X	AT ANY TIME COV BY PUBLIC - 12/31/98	Constructed
STAPR31	PID COV BY STATE-SPECIFIC PROG-RD 31 INT	Constructed
STAPR42	PID COV BY STATE-SPECIFIC PROG-RD 42 INT	Constructed
STAPR53	PID COV BY STATE-SPECIFIC PROG-RD 53 INT	Constructed
STAPR98	PID COV BY STATE-SPECIFIC PROG-12/31/98	Constructed
STPRAT31	AT ANY TIME COVERAGE BY STATE INS - RD 31	Constructed
STPRAT42	AT ANY TIME COVERAGE BY STATE INS - RD 42	Constructed
STPRAT53	AT ANY TIME COVERAGE BY STATE INS - RD 53	Constructed
STPRAT98	AT ANY TIME COV BY STATE INS - 12/31/98	Constructed

DENTAL PRIVATE INSURANCE VARIABLES

VARIABLE	DESCRIPTION	SOURCE
DENTIN31	DENTAL PRIVATE INSURANCE - RD 31	HX 48, OE 10, OE 24, OE 37
DENTIN42	DENTAL PRIVATE INSURANCE - RD 42	HX 48, OE 10, OE 24, OE 37
DENTIN53	DENTAL PRIVATE INSURANCE - RD 53	HX 48, OE 10, OE 24, OE 37

PMED PRIVATE INSURANCE VARIABLES

VARIABLE	DESCRIPTION	SOURCE
PMEDIN31	PRESCRIPTION DRUG PRIVATE INSURANCE - RD 31	HX 48, OE 10, OE 24, OE 37
PMEDIN42	PRESCRIPTION DRUG PRIVATE INSURANCE - RD 42	HX 48, OE 10, OE 24, OE 37
PMEDIN53	PRESCRIPTION DRUG PRIVATE INSURANCE - RD 53	HX 48, OE 10, OE 24, OE 37

DISABILITY DAYS INDICATOR VARIABLES

VARIABLE	DESCRIPTION	SOURCE
DDNWRK31	# OF DAYS MISSED WORK DUE TO ILL/INJURY (RD 31)	DD 02
DDNWRK42	# OF DAYS MISSED WORK DUE TO ILL/INJURY (RD 42)	DD 02
DDNWRK53	# OF DAYS MISSED WORK DUE TO ILL/INJURY (RD 53)	DD 02
WKINBD31	# OF DAYS MISSED WORK STAYED IN BED (RD 31)	DD 04
WKINBD42	# OF DAYS MISSED WORK STAYED IN BED (RD 42)	DD 04
WKINBD53	# OF DAYS MISSED WORK STAYED IN BED(RD 53)	DD 04
DDNSCL31	# OF DAYS MISSED SCHOOL DUE TO ILL/INJURY (RD 31)	DD 05
DDNSCL42	# OF DAYS MISSED WORK DUE TO ILL/INJURY (RD 42)	DD 05
DDNSCL53	# OF DAYS MISSED WORK DUE TO ILL/INJURY (RD 53)	DD 05
SCLNBD31	# OF DAYS MISSED SCHOOL STAYED IN BED (RD 31)	DD 07
SCLNBD42	# OF DAYS MISSED SCHOOL STAYED IN BED (RD 42)	DD 07
SCLNBD53	# OF DAYS MISSED SCHOOL STAYED IN BED (RD 53)	DD 07
DDBDYS31	# OF OTHER DAYS SPENT IN BED SINCE START (RD 31)	DD 08
DDBDYS42	# OF OTHER DAYS SPENT IN BED SINCE START (RD 42)	DD 08
DDBDYS53	# OF OTHER DAYS SPENT IN BED SINCE START (RD 53)	DD 08
OTHDYS31	MISS ANY WORK/SCH DAY TO CARE FOR OTHER (RD 31)	DD 10
OTHDYS42	MISS ANY WORK/SCH DAY TO CARE FOR OTHER (RD 42)	DD 10
OTHDYS53	MISS ANY WORK/SCH DAY TO CARE FOR OTHER (RD 53)	DD 10
OTHNDD31	# OF DAYS MISSED WORK/SCH CARE FOR OTHER (RD 31)	DD 11
OTHNDD42	# OF DAYS MISSED WORK/SCH CARE FOR OTHER (RD 42)	DD 11
OTHNDD53	# OF DAYS MISSED WORK/SCH CARE FOR OTHER (RD 53)	DD 11

ACCESS TO CARE VARIABLES

VARIABLE	DESCRIPTION	SOURCE
ACCELI42	PERS ELIGIBLE FOR ACCESS SUPPLEMENT	Constructed
HAVEUS42	AC01 DOES PERSON HAVE A USC PROVIDER?	AC01
YNOUSC42	AC03 MAIN REASON PERS DOESN'T HAVE A USC	AC03
NOREAS42	AC04 OTH REAS NO USC: NO OTHER REASONS	AC04
SELDSI42	AC04 OTH REAS NO USC: SELDOM OR NEV SICK	AC04
NEWARE42	AC04 OTH REAS NO USC: RECENTLY MOVED	AC04
DKWHRU42	AC04 OTH REAS NO USC: DK WHERE TO GO	AC04
USCNOT42	AC04 OTH REAS NO USC: USC NOT AVAILABLE	AC04
PERSLA42	AC04 OTH REAS NO USC: LANGUAGE	AC04
DIFFPL42	AC04 OTH REAS NO USC: DIFFERENT PLACES	AC04
INSRPL42	AC04 OTH REAS NO USC: JUST CHANGED INSUR.	AC04
MYSELF42	AC04 OTH REAS NO USC: NO DOCS / TREAT SELF	AC04
CARECO42	AC04 OTH REAS NO USC: COST OF MED. CARE	AC04
OTHINS42	AC04 OTH REAS NO USC: INS. RELATED REASON	AC04
OTHREA42	AC04 OTH REAS NO USC: OTHER REASON	AC04
TYPEPL42	USC TYPE OF PLACE	AC06, Ac07
PROVTY42	PROVIDER TYPE	PV01,PV03,PV 05,Pv10
YGOTOU42	AC08 MAIN REASON PERS GOES TO HOSP USC	AC08
NOREA942	AC09 OTH REAS GO TO USC: NO OTHER REASONS	AC09
LIKESU42	AC09 OTH REAS TO GO TO USC: PREFERS/LIKES	AC09
DKELSE42	AC09 OTH REAS TO GO TO USC: DK WH ELSE TO GO	AC09
AFFORD42	AC09 OTH REAS TO GO TO USC: CAN'T AFFORD OTH	AC09
OFFICE42	AC09 OTH REAS TO GO TO USC: DR. OFFICE AT OPD	AC09
AVAILT42	AC09 OTH REAS TO GO TO USC: AVAIL WHEN TIME	AC09
CONVEN42	AC09 OTH REAS TO GO TO USC: CONVENIENCE	AC09
BSTPLA42	AC09 OTH REAS TO GO TO USC: BEST FOR COND	AC09
INSREA42	AC09 OTH REAS TO GO TO USC: INSURANCE-RELATED	AC09
OTHRE942	AC09 OTH REAS TO GO TO USC: OTHER REASON	AC09
GETTOU42	AC09A HOW DOES PERSN GET TO USC PROVIDER	AC09A
TYPEPE42	USC TYPE OF PROVIDER	AC10,AC11,AC 11OV,AC12,A C12OV
LOCATI42	USC LOCATION	Constructed
MINORP42	AC14 GO TO USC FOR NEW HEALTH PROBLEM	AC14

VARIABLE	DESCRIPTION	SOURCE
PREVEN42	AC14 GO TO USC FOR PREVENTVE HEALTH CARE	AC14
REFFRL42	AC14 GO TO USC FOR REFERRALS	AC14
OFFHOU42	AC15 USC HAS OFFICE HRS NIGHTS/WEEKENDS	AC15
APPTWL42	AC16 WHEN SEE USC, HAVE APPT OR WALK IN	AC16
APPDIF42	AC17 HOW DIFFICULT TO GET APPT WITH USC	AC17
WAITTI42	AC18 WITH APPT, HOW LONG TIL SEEN BY USC	AC18
PHONED42	AC19 HOW DIFFICULT CONTACT USC BY PHONE	AC19
PRLIST42	AC19A DOES USC PROV LISTEN?	AC19A
TREATM42	AC19B PROV ASK ABOUT OTHER TREATMENTS	AC19B
CONFID42	AC19C CONFIDENT IN USC PROV'S ABILITY?	AC19C
PROVST42	AC19D HOW SATISFIED WITH USC STAFF	AC19D
USCQUA42	AC19E SATISFIED WITH QUALITY OF CARE	AC19E
CHNGUS42	AC20 HAS ANYONE CHANGED USC IN LAST YEAR	AC20
YCHNGU42	AC21 WHY DID PERSON(S) CHANGE USC	AC21
ANYUSC42	AC22 HAS ANYONE HAD A USC IN LAST YEAR	AC22
YNOMOR42	AC23 WHY DON'T THEY HAVE A USC ANYMORE?	AC23
NOCARE42	AC24 DID ANYONE GO W/OUT HEALTH CARE?	AC24
HCNEED42	AC24A SATISFIED FAMILY CAN GET CARE	AC24A
OBTAIN42	AC25 ANYONE HAVE DIFFICULTY OBTAIN CARE	AC25
MAINPR42	AC25A MAIN REASON EXPERIENCED DIFFICULTY	AC25A
NOOTHP42	AC26 DIFFICULTY: NO OTHER PROBLEMS	AC26
NOAFFO42	AC26 DIFFICULTY: COULDN'T AFFORD CARE	AC26
INSNOP42	AC26 DIFFICULTY: INS COMPANY WON'T PAY	AC26
PREEXC42	AC26 DIFFICULTY: PRE-EXISTING CONDITION	AC26
INSRQR42	AC26 DIFFICULTY: INS REQUIRED REFERRAL	AC26
REFUSI42	AC26 DIFFICULTY: DR. REFUSED INS PLAN	AC26
DISTAN42	AC26 DIFFICULTY: DISTANCE	AC26
PUBTRA42	AC26 DIFFICULTY: PUBLIC TRANSPORTATION	AC26
EXPENS42	AC26 DIFFICULTY: TOO EXPENSIVE TO GET THERE	AC26
HEARPR42	AC26 DIFFICULTY: HEARING IMPAIR/LOSS	AC26
LANGBA42	AC26 DIFFICULTY: LANGUAGE BARRIER	AC26
INTOBL42	AC26 DIFFICULTY: HARD TO GET INTO BLDG	AC26
INSIDE42	AC26 DIFFICULTY: HARD TO GET AROUND	AC26
EQUIPM42	AC26 DIFFICULTY: NO APPROPRIATE EQUIP	AC26
OFFWOR42	AC26 DIFFICULTY: COULDN'T GET TIME OFF	AC26
DKWHER42	AC26 DIFFICULTY: DK WHERE TO GO	AC26
REFUSE42	AC26 DIFFICULTY: WAS REFUSED SERVICES	AC26

VARIABLE	DESCRIPTION	SOURCE
CHLDCA42	AC26 DIFFICULTY: COULDN'T GET CHILD CARE	AC26
NOTIME42	AC26 DIFFICULTY: NO TIME/TOOK TOO LONG	AC26
OTHRPR42	AC26 DIFFICULTY: OTHER	AC26

File 2:

SURVEY ADMINISTRATION AND ID VARIABLES

VARIABLE	DESCRIPTION	SOURCE
DUID	DWELLING UNIT ID	Assigned in sampling
PID	PERSON NUMBER	Assigned in sampling
DUPERSID	PERSON ID (DUID + PID)	Assigned in sampling
EVNTIDX	EVNT ID:DUPERSID + EVENT NUMBER	CAPI Derived

OUTPATIENT DEPARTMENT VISIT VARIABLE

VARIABLE	DESCRIPTION	SOURCE
SEETLKPV	DID PATIENT VISIT PROVIDER IN PERSON OR TELEPHONE	OP02