E. Sample TSSD Mail Survey Instrument

This appendix reproduces the actual survey sent to TSSD enrollees and eligible nonenrolled beneficiaries as part of our evaluation of the TRICARE Senior Supplement Demonstration. The survey was prepared by RAND’s Center for Military Health Policy Research.

Note: The following survey instrument was sent to individuals in the Santa Clara County, California, TSSD demonstration site. The survey used for the Cherokee County, Texas, demonstration site was the same as the California survey except that it omitted questions regarding Medicare+Choice HMO plans.
INSTRUCTIONS

About This Questionnaire

The information being collected in this questionnaire will help the Department of Defense better serve the healthcare needs of military retirees and their families. The responses you provide in this questionnaire are confidential. RAND will not release any of the information you report in such a way that it could be linked to you. Please do not write your name on the questionnaire.

Completing This Questionnaire

Please answer all of the questions as best you can. Some questions ask you about past events and others refer to your spouse. Your best guess in answering these questions is fine. At the beginning of each section, you will find a written introduction with additional instructions of how to complete that particular section. Please read these instructions carefully.

❖ You will also find instructions on how to complete a particular question immediately following that question. These instructions appear in italics.

❖ Most of the questions are followed by a list of responses from which you are asked to choose your answer by placing an X or ✓ in the square corresponding to your choice.

❖ If your response is other than those specifically listed, you are asked to include more information in the line provided as follows:

☐ Other (please specify): ________________________________

❖ For a few other questions, you are asked to write your answer in a blank.

❖ For some questions, responses are immediately followed by specific instructions in italics on whether to go to the next question or to skip to another question or page.

Questions or Comments

If you have any questions or comments regarding this questionnaire, please call Ana Suarez at RAND toll free at 800-255-6935. You can also provide written comments next to a specific question or on the last page of the questionnaire.

Returning the Questionnaire

Please return your completed questionnaire to RAND in the self-addressed and stamped envelope included with this questionnaire. If you do not have this envelope, please call us toll free at 800-255-6935 and we will send you another one.

PLEASE TURN TO PAGE 1
**Section A: Your Use of Health Care Services**

This first set of questions is about your use of medical care. Please tell us about your use of health care services, not that of your spouse or any other family member.

A1. In the past YEAR, about how many times, if any, did you stay overnight for one or more nights in a hospital?  
*(Check One)*

- [ ] None  
- [ ] 1 time  
- [ ] 2 to 4 times  
- [ ] 5 or more times  
- [ ] Don’t know

A2. In the past YEAR, about how many times did you visit an emergency room for medical care?  
*(Check One)*

- [ ] None  
- [ ] 1 time  
- [ ] 2 to 4 times  
- [ ] 5 or more times  
- [ ] Don’t know

A3. In the past YEAR, about how many times did you visit a doctor or other medical professional in an office or clinic? Please do not include visits to the emergency room, hospital or dentist, or visits for eyeglasses or contact lenses.  
*(Check One)*

- [ ] None  
- [ ] 1 time  
- [ ] 2 to 4 times  
- [ ] 5 to 9 times  
- [ ] 10 or more times  
- [ ] Don’t know
A4. How many prescription drugs are you currently taking?  
(Check One)  
☐ None  
☐ 1 to 2 prescriptions  
☐ 3 to 4 prescriptions  
☐ 5 or more prescriptions  
☐ Don’t know

A5. In the past YEAR, where did you fill or refill most of your prescriptions?  
(Check All That Apply)  
☐ Military pharmacy  
☐ Military mail-order program  
☐ Civilian pharmacy or mail-order program  
☐ VA pharmacy or mail-order program  
☐ Other (please specify): ________________________________  
☐ Don’t know

A6. Over the past 5 YEARS, about how much of your own health care was at military health care facilities (excluding visits to the pharmacy)?  Please do NOT include care at VA facilities.  
(Check One)  
☐ None  
☐ Some  
☐ Most  
☐ All  
☐ Don’t know
Section B:
Health Plan Features and Benefits You Prefer

B1. Choosing a health care insurance plan can be difficult. Desirable plans are often very expensive. How important are the following features to you in choosing a health plan? You may find it helpful to read through the entire list of features before answering.

(Check One Box For Each Statement)

<table>
<thead>
<tr>
<th>Feature</th>
<th>Don’t Need</th>
<th>Desirable But Not Necessary</th>
<th>Must Have</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Low monthly premiums</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>b. Coverage for care outside of the U.S.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>c. Low out-of-pocket costs for doctor office visits</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>d. Low out-of-pocket costs for hospital stays</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>e. Coverage of preventive services</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>f. Being able to choose my physician</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>g. Being able to choose my hospital</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>h. Coverage for mental health services</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>i. Spending little or no time on paperwork</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>j. Low out-of-pocket costs for prescription drugs</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>k. Being able to keep my current physician(s)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

B2. Please refer back to your responses to Question B1 above. Of the features that you “must have”, which two are the most important to you? Please enter the letters that correspond to the two most important ones. Please enter only one letter in each box.

Your response ➔ The two most important to me are and .

B3. Again, please refer back to your responses to Question B1 above. Of the features that you find “desirable but not necessary” or that you “don’t need”, which two are the least important to you? Please enter only one letter in each box.

Your response ➔ The two least important to me are and .
B4. How strongly do you agree or disagree with the following statements?  
(Check One Box For Each Statement)

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neither</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Can't Say</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Military retirees and their dependents can count on getting care at military treatment facilities when they need it.</td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
</tr>
<tr>
<td>b. Military retirees and their dependents age 65 and over should have the option of enrolling in TRICARE.</td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
</tr>
<tr>
<td>c. Military retirees and their dependents should contribute to the cost of their health care.</td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
</tr>
<tr>
<td>d. Compared to other employers, the Military provides its retirees age 65 and over with generous health benefits.</td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
</tr>
<tr>
<td>e. Assuming that cost is not an issue, I prefer to have military-sponsored health care.</td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
<td><img src="1" alt="Box" /></td>
</tr>
</tbody>
</table>
Section C:  
Your Health Insurance Coverage

This section is about Medicare as well as any other health insurance coverage that you may have at this time, other than TRICARE sponsored plans.

C1. Are you currently covered by Medicare?  
   (Check One)  
   ☐ Yes ➔ GO TO QUESTION C2  
   ☐ No ➔ SKIP TO PAGE 7, QUESTION D1  
   ☐ Don’t know ➔ SKIP TO PAGE 7, QUESTION D1

C2. Medicare Part B helps pay for doctors’ services and outpatient hospital services for an additional monthly premium. Are you currently enrolled in Medicare Part B?  
   (Check One)  
   ☐ Yes  
   ☐ No  
   ☐ Don’t know

C3. Several Medicare HMOs are available in your area as alternatives to traditional Medicare. Are you currently enrolled in a Medicare HMO (e.g., Senior Secure, Health Net Seniority Plus, Secure Horizons Standard, Secure Horizons Basic, Kaiser Permanente Senior Advantage, or another Medicare HMO)?  
   (Check One)  
   ☐ Yes  
   ☐ No  
   ☐ Don’t know
C4. Aside from Medicare and a TRICARE sponsored plan, do you currently have any of the following types of health insurance plan(s)?
(Check All That Apply)

☐ Medigap or Medicare supplement insurance purchased from an insurance company or agent.

☐ A plan sponsored by former civilian employer or union

☐ Medicaid

☐ Other (please specify): _______________________

☐ None → SKIP TO NEXT PAGE, QUESTION D1

☐ Don’t know → SKIP TO NEXT PAGE, QUESTION D1

C5. Do any of the plans that you selected in Question C4 above cover prescription drugs?
(Check One)

☐ Yes

☐ No

☐ Don’t know
Section D:
TRICARE Senior Supplement Demonstration Program

TRICARE Senior Supplement is a demonstration program that allows retired Uniformed Services personnel and their family members who are age 65 and over to enroll, for a limited period of time, in TRICARE Standard or TRICARE Extra as a supplement to their Medicare coverage.

D1. Before receiving this questionnaire, did you (or your spouse) know about the TRICARE Senior Supplement Demonstration Program?

(Check One)

☐ Yes ➔ GO TO QUESTION D2
☐ No ➔ SKIP TO PAGE 12, QUESTION E1
☐ Not sure ➔ SKIP TO PAGE 12, QUESTION E1

D2. How did you (or your spouse) learn about the TRICARE Senior Supplement Demonstration Program?

(Check All That Apply)

☐ Read information that the military mailed
☐ Got information from an organization that represents military retirees or their families
☐ Heard about it from my Congressman’s office
☐ Attended a health fair or town meeting
☐ Heard about the demonstration on radio or television
☐ Read an article about the demonstration in the local newspaper
☐ Heard about the demonstration from family or friends
☐ Other (please specify): ________________________________
☐ Not sure

D3. Did you (or your spouse) have trouble deciding whether or not to join the TRICARE Senior Supplement Demonstration Program?

(Check One)

☐ Yes ➔ GO TO QUESTION D4, NEXT PAGE
☐ No ➔ SKIP TO QUESTION D5, NEXT PAGE
☐ Not sure ➔ SKIP TO QUESTION D5, NEXT PAGE
D4. Why did you (or your spouse) have trouble deciding whether or not to join the TRICARE Senior Supplement Demonstration Program?
   (Check All That Apply)
   □ wasn’t sure how much the plan would really cost
   □ Couldn’t tell how the plan would work with Medicare benefits
   □ It was hard to understand what services the plan covered
   □ It was hard to understand which physicians and hospitals were covered
   □ It was hard to tell how much paperwork is required
   □ It was hard to compare TRICARE Senior Supplement to other plans
   □ Concerned about dropping my [our] other insurance
   □ Other (please specify): ___________________________
   □ Can’t say

D5. Are you currently enrolled in the TRICARE Senior Supplement Demonstration Program?
   Please answer this question about yourself, not your spouse.
   (Check One)
   □ Yes  ➔ SKIP TO PAGE 10, QUESTION D8
   □ No  ➔ GO TO QUESTION D6, NEXT PAGE
   □ Don’t know  ➔ SKIP TO PAGE 12, QUESTION E1
For non-participants in the TRICARE Senior Supplement Demonstration Program

Answer the following questions if you are not currently enrolled in the TRICARE Senior Supplement Demonstration Program. If you are currently enrolled in the TRICARE Senior Supplement Demonstration Program, please skip to page 10, Question D8.

D6. Why didn’t you join the TRICARE Senior Supplement Demonstration Program? (Check All That Apply)

1. □ I’m not eligible
2. □ I’m satisfied with my current coverage
3. □ I plan to enroll but have not done so yet
4. □ I dislike military health care
5. □ I wanted/needed benefits that are not covered by TRICARE Senior Supplement
6. □ I don’t like any of the doctors in the TRICARE Extra network
7. □ I don’t like having to file claims for reimbursement
8. □ I have not received enough information about TRICARE Senior Supplement
9. □ I live in another part of the country during the year
10. □ The coverage is only available for a limited period of time
11. □ Other (please explain): ____________________________
12. □ Not sure ➔ SKIP TO PAGE 12, QUESTION E1

D7. Of the reasons you gave in question D6 above, what are the two main reasons you didn’t join the TRICARE Senior Supplement Demonstration Program? Please refer back to your responses to the question above and enter the numbers that correspond with the two main reasons why you didn’t join TRICARE Senior Supplement. Please enter only one number in each box.

Your response ➔ The two main reasons I didn’t join are □ and □
For participants in the TRICARE Senior Supplement Demonstration Program

Answer the following questions if you are currently enrolled in the TRICARE Senior Supplement Demonstration Program. If you are not currently enrolled in the TRICARE Senior Supplement Demonstration Program, please skip to page 12, Section E.

D8. Why did you join the TRICARE Senior Supplement Demonstration Program? (Check All That Apply)

1. It costs less than my previous coverage (insurance or health plan)
2. It costs less than other coverage that I could buy
3. The plan’s benefits package meets my needs
4. The plan’s benefits package is better than other coverage I could get
5. It offers a wide choice of physicians and hospitals
6. It offers better drug coverage
7. The plan has a good reputation for quality of care
8. I don’t want to use military health care facilities
9. My friends or relatives recommended that I join the plan
10. It is more convenient if my spouse and I are in the same plan
11. I prefer to have military sponsored health care
12. Other (please specify): ____________________________
13. Not sure ➔ SKIP TO PAGE 11, QUESTION D10

D9. Of the reasons you gave in question D8 above, what are the two main reason you joined the TRICARE Senior Supplement Demonstration Program? Please refer back to your responses to the question above and enter the numbers that correspond with the two main reasons why you joined TRICARE Senior Supplement. Please enter only one number in each box.

Your response ➔ The two main reasons I joined are __ and __
D10. Overall, how satisfied are you with the TRICARE Senior Supplement Demonstration Program?

(Check One)

☐ Very satisfied
☐ Satisfied
☐ Not satisfied
☐ Can’t say

D11. Aside from traditional Medicare, what type of health insurance plan(s) did you have before you enrolled in TRICARE Senior Supplement Demonstration Program?

(Check All That Apply)

☐ Medigap or Medicare supplement insurance purchased from an insurance company or agent.

Please specify plan letter: 

☐ A Medicare HMO
☐ A plan sponsored by former civilian employer or union
☐ Medicaid
☐ Other (please specify): 

☐ None ➔ SKIP TO NEXT PAGE, QUESTION E1
☐ Don’t know ➔ SKIP TO NEXT PAGE, QUESTION E1

D12. Did any of the plans that you selected in Question D11 above cover prescription drugs?

(Check One)

☐ Yes
☐ No
☐ Don’t know
The following questions are about your overall health.

**E1. In general, compared to other people your age, would you say your health is:**

*(Check One)*
- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Can’t say

**E2. Compared to 6 MONTHS ago, how would you rate your health in general now?**

*(Check One)*
- ☐ Much better now than 6 months ago
- ☐ Somewhat better now than 6 months ago
- ☐ About the same
- ☐ Somewhat worse now than 6 months ago
- ☐ Much worse now than 6 months ago
- ☐ Can’t say

**E3. Do you expect your health to be better or worse 6 MONTHS from now?**

*(Check One)*
- ☐ Better than today
- ☐ About the same as today
- ☐ Worse than today
- ☐ Can’t say
E4. During the past YEAR, did you have a serious illness, chronic condition, injury or disability that required a lot of medical care? (Check One)

☐ Yes
☐ No
☐ Don’t know

E5. During the past MONTH, how much of the time has your health limited social activities like visiting with friends or relatives? (Check One)

☐ None of the time
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Can’t say
E6. Has a doctor or other medical professional ever told you that you had any of the following medical conditions?  
(Check All That Apply)

☐ Hardening of the arteries or arteriosclerosis
☐ High blood pressure or hypertension
☐ Heart attack or myocardial infarction
☐ Coronary heart disease
☐ Congestive heart failure
☐ Stroke, brain hemorrhage or cerebrovascular accident
☐ Skin cancer
☐ Cancer, malignancy, or tumor other than skin cancer
☐ Diabetes, high blood sugar or sugar in your urine
☐ Rheumatoid arthritis
☐ Fragile bones or osteoporosis
☐ Parkinson’s disease
☐ Emphysema, asthma, or chronic obstructive pulmonary disease
☐ Complete or partial paralysis
☐ None of the above
☐ Don’t know

E7. Because of impairment or health problems, how often do you need the help of other people with your personal care needs, such as eating, bathing/dressing, or getting around the house?  
(Check One)

☐ None of the time
☐ Some of the time
☐ Most of the time
☐ All of the time
☐ Can’t say

California
Section F:
Facts About You and Your Family

The information you provide in this section will be used to study how different groups of people use health care services and military health benefits. This information will NOT be used to identify you personally.

F1. Are you male or female?
   (Check One)
   ☐ Male
   ☐ Female

F2. How old were you on your last birthday? Age: [Blank]

F3. How many people live in your household? Number of people: [Blank]

F4. Do you (or your spouse) belong to an organization that represents military retirees and their families?
   (Check One)
   ☐ Yes
   ☐ No
   ☐ Don’t know

F5. What was your rank at the time of retirement from the military? If you are eligible for military health care because of your own as well as your spouse’s military services, please give your own rank.
   (Check One)
   ☐ Officer
   ☐ Warrant officer
   ☐ Non-commissioned officer
   ☐ Enlisted
   ☐ Other (please specify): __________________________
   ☐ Don’t know
F6. What is your race?
(Check One)
☐ White
☐ Black or African-American
☐ American Indian or Alaska Native
☐ Asian
☐ Native Hawaiian or other Pacific Islander
☐ Other (please specify): ________________________

F7. Are you Hispanic, Latino or of Spanish origin?
(Check One)
☐ Yes
☐ No

F8. What is the highest grade or level of school that you have completed?
(Check One)
☐ 8th grade or less
☐ Some high school, but did not graduate
☐ High school graduate or GED
☐ Some college or 2-year degree
☐ 4-year college degree
☐ More than 4-year college degree
F9. In 2000, what was your family’s TOTAL income BEFORE taxes? Please include income from ALL sources such as work; pensions; dividend; annuities; interest; Social Security benefits; SSI; alimony; rental income and any other money income received by you or members of your family who are 15 years or older and living with you. Your best guess is fine.

(Check One)

☐ Less than $20,000
☐ $20,000 to $39,999
☐ $40,000 to $59,999
☐ $60,000 to $79,999
☐ $80,000 and over
☐ Don’t know

F10. Other than health insurance premiums, approximately how much do you spend out of your own pocket on health care services for you (and your spouse) each YEAR? Your best guess is fine. Think about the money you (and your spouse) spend on co-pays, deductibles, prescription drugs and services not covered by your insurance plan. Please do not include health insurance premiums.

(Check One)

☐ $0 to $99 per year
☐ $100 to $499 per year
☐ $500 to $999 per year
☐ $1000 to $4999 per year
☐ $5000 or more per year
☐ Don’t know

F11. Which of the following best describes your current marital status?

(Check One)

☐ Married → GO TO SECTION G, NEXT PAGE
☐ Never married
☐ Separated
☐ Divorced
☐ Widowed

SKIP TO END, PAGE 24
Section G: 
Your Spouse

The following questions are about your spouse. Please answer them to the best of your knowledge.

G1. Is your spouse currently covered by Medicare?
   (Check One)
   ☑ Yes ➔ GO TO QUESTION G2
   ☑ No ➔ SKIP TO END, PAGE 24
   ☑ Don’t know ➔ SKIP TO PAGE 19, QUESTION G5

G2. Is your spouse currently enrolled in Medicare Part B?
   (Check One)
   ☑ Yes
   ☑ No
   ☑ Don’t know

G3. Several Medicare HMOs are available in your area as alternatives to traditional Medicare. Is your spouse currently enrolled in a Medicare HMO (e.g., Senior Secure, Health Net Seniority Plus, Secure Horizons Standard, Secure Horizons Basic, Kaiser Permanente Senior Advantage, or another Medicare HMO)?
   (Check One)
   ☑ Yes
   ☑ No
   ☑ Don’t know

G4. Aside from Medicare and a TRICARE sponsored plan, does your spouse currently have any of the following types of health insurance plan(s)?
   (Check All That Apply)
   ☑ Medigap or Medicare supplement insurance purchased from an insurance company or agent.
   ☑ A plan sponsored by former civilian employer or union
   ☑ Medicaid
   ☑ Other (please specify): ________________________________
   ☑ None
   ☑ Don’t know
G5. In the past YEAR, how many times, if any, did your spouse stay overnight for one or more nights in a hospital?
   (Check One)
   □ None
   □ 1 time
   □ 2 to 4 times
   □ 5 or more times
   □ Don’t know

G6. In the past YEAR, about how many times did your spouse visit an emergency room for medical care?
   (Check One)
   □ None
   □ 1 time
   □ 2 to 4 times
   □ 5 or more times
   □ Don’t know

G7. In the past YEAR, about how many times did your spouse visit a doctor or other medical professional in an office or clinic? Please do not include visits to the emergency room, hospital or dentist, or visits for eyeglasses or contact lenses.
   (Check One)
   □ None
   □ 1 time
   □ 2 to 4 times
   □ 5 to 9 times
   □ 10 or more times
   □ Don’t know
G8. How many prescription drugs is your spouse currently taking?

(Check One)
- None
- 1 to 2 prescriptions
- 3 to 4 prescriptions
- 5 or more prescriptions
- Don’t know

G9. Over the past 5 YEARS, about how much of your spouse’s health care was at military health care facilities (excluding visits to the pharmacy)? Please do NOT include care at VA facilities.

(Check One)
- None
- Some
- Most
- All
- Don’t know

G10. In general, compared to other people his/her age, would you say that your spouse’s health is:

(Check One)
- Excellent
- Very good
- Good
- Fair
- Poor
- Can’t say
G11. Compared to 6 MONTHS ago, how would you rate your spouse’s health in general now?  
(Check One)  
☐ Much better now than 6 months ago  
☐ Somewhat better now than 6 months ago  
☐ About the same  
☐ Somewhat worse now than 6 months ago  
☐ Much worse now than 6 months ago  
☐ Can’t say  

G12. During the past YEAR, did your spouse have a serious illness, chronic condition, injury or disability that required a lot of medical care?  
(Check One)  
☐ Yes  
☐ No  
☐ Don’t know  

G13. Because of impairment or health problems, how often does your spouse need the help of other people with his/her personal care needs, such as eating, bathing/dressing, or getting around the house?  
(Check One)  
☐ None of the time  
☐ Some of the time  
☐ Most of the time  
☐ All of the time  
☐ Can’t say  

G14. Is your spouse currently enrolled in the TRICARE Senior Supplement Demonstration Program?  
(Check One)  
☐ Yes ➔ GO TO QUESTION G15, NEXT PAGE  
☐ No ➔ SKIP TO PAGE 23, QUESTION G17  
☐ Don’t know ➔ SKIP TO END, PAGE 24
G15. Why did your spouse join the TRICARE Senior Supplement Demonstration Program?  
(Check All That Apply)  
☐ It cost less than my spouse’s previous coverage (insurance or health plan)  
☐ It costs less than other coverage my spouse could buy  
☐ The plan’s benefits package meets the needs of my spouse  
☐ The plan’s benefits package is better than other coverage my spouse could get  
☐ My spouse needed better coverage for prescriptions  
☐ My spouse did not want to use military health care facilities  
☐ Friends or relatives recommended it to my spouse  
☐ It is more convenient if my spouse and I are in the same plan  
☐ My spouse prefers to have military sponsored health care  
☐ Other (please explain): __________________________  
☐ Don’t know  

G16. Overall, how satisfied is your spouse with the TRICARE Senior Supplement Demonstration Program?  
(Check One)  
☐ Very satisfied  
☐ Satisfied  
☐ Not satisfied  
☐ Don’t know  

NOW SKIP TO END, PAGE 24
G17. Why didn’t your spouse join the TRICARE Senior Supplement Demonstration Program? (Check All That Apply)

☐ My spouse is not eligible
☐ My spouse is satisfied with his/her current coverage
☐ My spouse plan’s to enroll but have not done so yet
☐ My spouse dislikes military health care
☐ My spouse wanted/needed benefits that are not covered by TRICARE Senior Supplement
☐ My spouse doesn’t like any of the doctors in the TRICARE Extra network
☐ My spouse doesn’t like having to file claims for reimbursement
☐ Other (please explain): ________________________________
☐ Don’t know
Is there anything else you would like to share with us? Your comments are greatly appreciated.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please return your completed survey to RAND in the self-addressed and stamped envelope provided. If you do not have this envelope, please call us toll-free at 800-255-6935 and we will send you another one.

It is not necessary for you to write your name and address on the envelope.

Please remember not to write your name anywhere on the questionnaire.

THANK YOU FOR YOUR PARTICIPATION IN THIS IMPORTANT STUDY!