Attachment VII. Stand Alone PDP Survey

Survey Instructions

This survey asks about you and your <u>former</u> prescription drug plan. Answer each question thinking about <u>yourself</u>. Please take the time to complete this survey. Your answers are very important to us. Please return the survey with your answers in the enclosed postage-paid envelope to CSS (the research organization assisting CMS in conducting this survey).

- Answer <u>all</u> the questions by putting an "X" in the box to the left of your answer, like this:

  ☒ Yes

- Be sure to read <u>all</u> the answer choices given before marking your answer.

- Some questions have instructions that tell you to skip questions that may not apply to you. When this happens you will see an arrow with a note that tells you what question to answer next, like this: **[→ If No, go to Question 3].**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1113 (Expires: TBD).** The time required to complete this information collection is estimated to average **18 minutes** per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4- 26-05, Baltimore, Maryland 21244-1850.

Please read below:

According to CMS records, the following change was made to your Medicare prescription drug coverage in [MONTH/YEAR]:

- Your **former** Medicare Prescription Drug Plan was:

  [PLAN NAME] [CONTACT #]

- Your **new** Medicare plan or coverage is:

  [PLAN NAME] [CONTRACT #]

- Please answer this survey based only on your experiences with your **former** plan:

  [PLAN MARKETING NAME/CONTRACT #]

- If you were not enrolled in [PLAN NAME/ NUMBER] recently, please answer the survey based on your experiences with the plan you had before you enrolled in your current plan.

GO TO NEXT PAGE→

ATTENTION: Some questions have instructions that tell you to skip questions that may not apply to you. Please check for a skip instruction after you answer each question.

YOUR FORMER PRESCRIPTION DRUG PLAN

We are sending you this survey because we believe you recently changed or switched to another Medicare prescription drug plan or dropped your Medicare prescription drug plan.

1. Our records show that you used to belong to [PLAN_NAME] (Contract Number [CONTRACTID]) but no longer belong to that plan. Is that right?

- ☐ Yes, I changed or switched prescription drug plans → ***Go to Question 2***
- ☐ I changed or switched prescription drug plans but my **former** plan was not [PLAN_NAME] → ***Go to Question 2***
- ☐ No, I did not change, switch, or drop prescription drug plans recently → ***Stop. Do not complete the rest of this survey. Please return the survey in the enclosed envelope.***

2. Did you have to change, switch, or drop your former prescription drug plan for any of the following reasons?

- ☐ I moved outside of the area where the plan was available
- ☐ I was dropped by the plan
- ☐ The plan was cancelled or discontinued in my area
- ☐ The plan was changed or discontinued by the organization that provides my insurance (such as a former employer or a union)

} ***Stop. Do not complete the rest of this survey. Please return the survey in the enclosed envelope.***

- ☐ None of the above → ***Continue survey, go to Question 3***

GETTING INFORMATION OR HELP FROM YOUR FORMER PRESCRIPTION DRUG PLAN

As you answer the questions in this survey, please think only of your <u>former</u> prescription drug plan.

3. Did you ever try to get information or help from your former plan's customer service?

- ☐ Yes
- ☐ No → **If No, go to Question 5**

4. How often did your former plan's customer service give you the information or help you needed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I did not try to get information or help from my former plan's customer service

5. Did you ever try to get information from your former plan about which prescription medicines were covered?

- ☐ Yes
- ☐ No → **If No, go to Question 7**

6. How often did your former plan give you all the information you needed about which prescription medicines were covered?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I did not try to get information from my former plan about which prescription medicines were covered

7. Did you ever try to get information from your former plan about how much you would have to pay for a prescription medicine?

- ☐ Yes
- ☐ No → **If No, go to Question 9**

8. How often did your former plan give you information about how much you would have to pay for a prescription medicine?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I did not try to get information from my former plan about how much I would have to pay for a prescription medicine

GETTING THE PRESCRIPTION MEDICINES YOU NEEDED FROM YOUR FORMER PRESCRIPTION DRUG PLAN

9. Did a doctor ever prescribe a medicine for you that your former plan did not cover?

- ☐ Yes
- ☐ No

10. How often was it easy to use your former plan to get the medicines your doctor prescribed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I did not use my former plan to get any prescription medicines

11. Did you ever use your former plan to fill a prescription at a pharmacy?

- ☐ Yes
- ☐ No → **If No, go to Question 13**

12. How often was it easy to use your former plan to fill a prescription at a pharmacy?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I did not use my former plan to fill a prescription at a pharmacy

13. Did you ever use your former plan to fill any prescriptions by mail?

- ☐ Yes
- ☐ No → **If No, go to Question 15**

14. How often was it easy to use your former plan to fill prescriptions by mail?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I did not use my former plan to fill a prescription by mail

15. Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your former plan?

- ☐ 0 Worst prescription drug plan possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best prescription drug plan possible

REASONS YOU LEFT YOUR FORMER PRESCRIPTION DRUG PLAN

The next questions are about reasons you may have had for changing, switching or dropping your former prescription drug plan.

16. Did you leave your former plan because you found out that someone had signed you up for the plan without your permission?

- ☐ Yes
- ☐ No

17. Did you leave your former plan because you were taken off the plan by mistake?

- ☐ Yes
- ☐ No

18. Did you leave your former plan because the dollar amount you had to pay each time you filled or refilled a prescription went up?

- ☐ Yes
- ☐ No
- ☐ I did not have to pay for my prescription medicines

19. Some people have to pay their prescription drug plan a <u>monthly</u> fee (called a premium) out of their own pocket for prescription drug coverage.

Did you leave your former plan because this <u>monthly</u> fee went up?

- ☐ Yes
- ☐ No
- ☐ I did not have to pay my former plan a monthly fee out of my own pocket

20. Prescription drug plans have a list of the prescription medicines they will cover. Did you leave your former plan because they changed the list of prescription medicines they cover?

- ☐ Yes
- ☐ No

21. Did you leave your former plan because you found a prescription drug plan that costs less?

- ☐ Yes
- ☐ No

22. Did you leave your former plan because a change in your personal finances meant you could no longer afford the plan?

- ☐ Yes
- ☐ No

23. Did you leave your former plan because the plan refused to pay for a medicine your doctor prescribed?

- ☐ Yes
- ☐ No

24. Did you leave your former plan because you had problems getting the medicines your doctor prescribed?

- ☐ Yes
- ☐ No

25. Did you leave your former plan because it was difficult to get brand name medicines?

- ☐ Yes
- ☐ No
- ☐ I did not try to get brand name medicines through my former plan

26. Did you leave your former plan because you were frustrated by the plan's approval process for medicines your doctor prescribed?

- ☐ Yes
- ☐ No

27. Did you leave your former plan because you did not know whom to contact when you had a problem filling or refilling a prescription?

- ☐ Yes
- ☐ No

28. Did you leave your former plan because it was hard to get information from the plan—like which prescription medicines were covered or how much a specific medicine would cost?

- ☐ Yes
- ☐ No

29. Did you leave your former plan because you were unhappy with how the plan handled a question or complaint?

- ☐ Yes
- ☐ No

30. Did you leave your former plan because you could not get the information or help you needed from the plan?

- ☐ Yes
- ☐ No

31. Did you leave your former plan because their customer service staff did not treat you with courtesy and respect?

- ☐ Yes
- ☐ No

32. Every year Medicare evaluates all prescription drug plans and gives them a star rating that gives information on prescription drug plan quality.

Have you ever seen the Medicare Star Rating for any health plan?

- ☐ Yes
- ☐ No→ **If No, go to Question 36**

33. Did you leave your former plan because it got a low star rating?

- ☐ Yes
- ☐ No

34. Did you leave your former plan because you found another plan with a higher star rating?

- ☐ Yes
- ☐ No

35. In the past year, did you consider the Medicare Star Ratings when trying to choose a plan?

- ☐ Yes
- ☐ No

OTHER REASONS FOR LEAVING YOUR FORMER PRESCRIPTION DRUG PLAN

36. Did you leave your former plan because a <u>family member or friend</u> told you about a better plan?

- ☐ Yes
- ☐ No

37. Did you leave your former plan because you saw a commercial or advertisement for a prescription drug plan you thought you would like better?

- ☐ Yes
- ☐ No

38. Did you leave your former plan because you found another plan that better met your prescription needs?

- ☐ Yes
- ☐ No

39. Did you leave your former plan because you take very few prescription medicines and don't need a prescription drug plan?

- ☐ Yes
- ☐ No

ABOUT YOU

40. In general, how would you rate your overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

41. In general, how would you rate your overall <u>mental or emotional</u> health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

42. In the past 12 months, how many different prescription medicines did you take?

- ☐ None
- ☐ 1 to 2 medicines
- ☐ 3 to 5 medicines
- ☐ 6 or more medicines

43. In the past 12 months, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

- ☐ Yes
- ☐ No → **If No, go to Question 45**

44. Is this a condition or problem that has lasted for at least 3 months?

- ☐ Yes
- ☐ No

45. Do you <u>now</u> need or take any medicine prescribed by a doctor for any condition?

- ☐ Yes
- ☐ No → **If No, go to Question 47**

46. Is this medicine to treat a condition that has lasted for at least 3 months?

- ☐ Yes
- ☐ No

47. Has a doctor <u>ever</u> told you that you had any of the following conditions?

	Yes	No
a. A heart attack	☐	☐
b. Angina or coronary heart disease	☐	☐
c. High blood pressure or hypertension	☐	☐
d. Cancer, other than skin cancer	☐	☐
e. Emphysema, asthma or COPD (chronic obstructive pulmonary disease)	☐	☐
f. Any kind of diabetes or high blood sugar	☐	☐

48. What is the highest grade or level of school that you have completed?

- ☐ 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 graduate
- ☐ More than 4-year college degree

49. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

50. What is your race? Please mark one or more.

- ☐ White
- ☐ Black or African-American
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ American Indian or Alaska Native

51. What language do you <u>mainly</u> speak at home?

- ☐ Chinese
- ☐ English
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Some other language (please print)

_____

52. Did someone help you complete this survey?

- ☐ Yes
- ☐ No → **If No, go to Question 54**

53. How did that person help you? Please mark one or more.

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way (please print)

_____

54. May we contact you again if we have questions about your survey responses or if we have other questions about the health care services that you received?

- ☐ Yes
- ☐ No

THANK YOU FOR COMPLETING THIS SURVEY

Please return your completed survey in the postage paid envelope to:
MEDICARE SATISFACTION SURVEY
PO BOX 1920
MANCHESTER, CT 06045-9939