



Medicare Prescription Drug Plan Disenrollment Survey

The questions in this survey are about **your former prescription drug plan**.
The name and contract number of your former plan are --

< PREV_BENEFIT>

Provided by <PREV_PLAN_CODE>

Survey Instructions

Thank you for taking time to complete this survey! Your answers are very important to us and will help other people with Medicare choose a health or drug plan.

You received this survey because records show you recently switched or dropped your Medicare prescription drug plan.

How to complete this survey:

- ◆ Answer each question based only on your experiences with your former plan (the plan name is printed on the cover of this survey).
- ◆ Answer each question thinking about yourself.
- ◆ Answer each question by putting an “X” in the box to the left of your answer, like this:

☒ Yes
- ◆ Read all the answer choices 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**].
- ◆ Return your completed survey in the enclosed postage-paid envelope.

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, with an expiration date of 11/30/2027. The time required to complete this information collection is estimated to average **10 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.

YOUR FORMER PRESCRIPTION DRUG PLAN

1. Our records show that you used to belong to this prescription drug plan:

< PREV_BENEFIT>

Provided by <PREV_PLAN_CODE>

but that you no longer belong to that plan. Is that correct?

☐ Yes, I left the prescription drug plan printed above → **Go to Question 2**

☐ No, I left a different prescription drug plan → **Go to Question 2**

☐ No, I did not switch plans or leave ANY prescription drug plan recently → **Stop.**

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

2. Did you have to switch plans or drop your former Medicare 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**

As you answer the questions in this survey, please think only of your former prescription drug plan (whose name is printed on the cover of this survey).

3. 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

4. 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
☐ Best prescription drug plan possible

REASONS YOU LEFT YOUR FORMER PRESCRIPTION DRUG PLAN

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

5. Did you leave your former plan because someone else signed you up for the plan without your permission?
- ☐ Yes
☐ No
6. Did you leave your former plan because the dollar amount you had to pay each time you filled or refilled a prescription (copayment) went up?
- ☐ Yes
☐ No
☐ I did not have to pay for my prescription medicines
7. Did you leave your former plan because you found a plan with a lower copayment for prescription drugs?
- ☐ Yes
☐ No

8. Some people have to pay their prescription drug plan a monthly premium (fee) out of their own pocket for prescription drug coverage.

Did you leave your former plan because the monthly premium went up?

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

9. Did you leave your former plan because you found a plan with a lower monthly premium?

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

10. 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

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

- ☐ Yes
☐ No

12. Did you leave your former plan because it turned out to be more expensive than you expected?

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No

15. 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

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

- ☐ Yes
☐ No

17. 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

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

22. Every year Medicare evaluates all prescription drug plans and gives them a star rating.

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

☐ Yes

☐ No

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

☐ Yes

☐ No

OTHER REASONS FOR LEAVING YOUR FORMER PRESCRIPTION DRUG PLAN

24. Did you leave your former plan because a family member or friend told you about a better plan?

☐ Yes

☐ No

25. Did you leave your former plan because an insurance agent or broker told you about a better plan?

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

28. 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

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

☐ Excellent

☐ Very good

☐ Good

☐ Fair

☐ Poor

30. In general, how would you rate your overall mental or emotional health?

☐ Excellent

☐ Very good

☐ Good

☐ Fair

☐ Poor

31. 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

32. 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 34

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

☐ Yes

☐ No

34. Do you now need or take medicine prescribed by a doctor?

☐ Yes

☐ No → If No, go to Question 36

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

☐ Yes

☐ No

36. Has a doctor ever told you that you had any of the following conditions?

- | | <u>Yes</u> | <u>No</u> |
|--|--------------------------|--------------------------|
| a. A heart attack | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Angina or coronary heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| c. High blood pressure or hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cancer, other than skin cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Emphysema, asthma or COPD (chronic obstructive pulmonary disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Any kind of diabetes or high blood sugar | <input type="checkbox"/> | <input type="checkbox"/> |

37. 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

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

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

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

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

40. What language do you mainly speak at home?

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

41. Did someone help you complete this survey?

- ☐ Yes
- ☐ No → If No, go to Question 43

42. 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):

■

43. May we contact you again if we have questions about your survey responses or the health care services 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 3416
HOPKINS, MN 55343-9740**

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