



PRIVACY OFFICE

OMB 0938-1113

<<name>>

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<<city>>, <<state>> <<zip>>

Dear Medicare Beneficiary,

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program, and it is our responsibility to ensure that you get that high-quality care at a reasonable price. One of the ways we can fulfill that responsibility is to find out directly from you about the care you received from your **prescription drug plan** (also known as Medicare Part D).

CMS is conducting a survey of people who have changed or switched their Medicare prescription drug plan. The purpose of this survey is to learn more about the reasons **why people change or switch prescription drug plans**. Your name was selected at random by CMS because according to our records, you recently left **[PLAN_NAME] (Contract Number [CONTRACTID])** and enrolled in or changed to **[NEW_PLAN] (Contract Number [NEW_ID])**. We would greatly appreciate it if you would take the time, about 18 minutes, to fill out this questionnaire. As you answer the questions in the survey, please think about your experiences with **[PLAN_NAME] (Contract Number [CONTRACTID])**.

All information you provide will be held in confidence and is protected by the Privacy Act. This means that the information you provide will not be shared with anyone other than authorized persons at CMS and CSS, the survey research organization assisting us in this survey. **You do not have to participate in this survey. Your help is voluntary, and your decision to participate or not to participate will not affect your Medicare benefits in any way.** The information you provide will help us improve the quality of services you receive. This is your opportunity to help us serve you better.

If you have any questions about the survey please call the CSS direct toll-free number 1-855-400-3657 anytime from 9:00 a.m. to midnight Eastern time, Monday through Friday.

Thank you for your help with this important survey.

Sincerely,

Walter Stone
CMS Privacy Officer

Si quiere una encuesta en español
por favor llame al 1-855-400-3657.

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**. 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.

Survey Instructions

This survey asks about you and your former health plan. Answer each question thinking about yourself. 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.

- ◆ Answer all the questions by putting an “X” in the box to the left of your answer, like this:
☒ Yes
- ◆ Be sure to read all the answer choices given before marking your answer.
- ◆ You are sometimes told not to answer some questions in this survey. 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**]. See the examples below:

Example

1. Do you wear a hearing aid now?

- ☐ Yes
☒ No → **If No, Go to Question 3**

2. How long have you been wearing a hearing aid?

- ☐ Less than one year
☐ 1 to 3 years
☐ More than 3 years
☐ I don't wear a hearing aid

3. In the last 6 months, did you have any headaches?

- ☒ Yes
☐ No

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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.

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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.

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 a plan but it was not [PLAN_NAME] → **Go to Question 2**

☐ No, I did not change or switch health 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 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 an 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

These questions ask about your experience with your former prescription drug plan. As you answer the rest of the questions in this survey, please think only of your former plan.

3. Customer service is information you get from staff about what is covered and how to use the plan. Did you ever try to get information or help from [PLAN_NAME]'s customer service?

☐ Yes
☐ No → If No, go to Question 5

4. How often did the 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 the plan's customer service

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

☐ Yes
☐ No → If No, go to Question 7

6. How often did the 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 about which prescription medicines were covered

7. Did you ever try to get information from the 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 the plan give you all the information you needed about how much you would have to pay for a prescription medicine?

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

9. Did you ever need written information from the plan in a language other than English?

☐ Yes

☐ No → If No, go to Question 11

10. How often did the plan give you written information in a language other than English?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

☐ I did not need written information in a language other than English

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

11. Did a doctor ever prescribe a medicine for you that the plan did not cover?

☐ Yes

☐ No

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

☐ Never

☐ Sometimes

☐ Usually

☐ Always

☐ I did not use the plan to get any prescription medicines

13. Did you ever use the plan to fill a prescription at a local pharmacy?

☐ Yes

☐ No → If No, go to Question 15

14. How often was it easy to use the plan to fill a prescription at a local pharmacy?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

☐ I did not use the plan to fill a prescription at a local pharmacy

15. Did you ever use the plan to fill any prescriptions by mail?

☐ Yes

☐ No → If No, go to Question 17

16. How often was it easy to use the plan to fill prescriptions by mail?

☐ Never

☐ Sometimes

☐ Usually

☐ Always

☐ I did not use the plan to fill a prescription by mail

17. 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 the 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

People leave, drop, or switch prescription drug plans for different reasons. These questions are about reasons you may have had for switching, leaving, or dropping [PLAN_NAME].

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

- ☐ Yes
- ☐ No

19. Did you leave the plan because you were accidentally taken off the plan (or because of some other paperwork or clerical error)?

- ☐ Yes
- ☐ No

20. Some Medicare beneficiaries have to pay their prescription drug plan a monthly fee out of their own pocket for coverage for prescription medicines.

Did you leave the plan because the monthly fee that the plan charges to provide coverage for prescription medicines went up?

- ☐ Yes
- ☐ No

21. Did you leave the plan because you stopped paying the monthly fee for coverage for prescription medicines?

- ☐ Yes
- ☐ No → If No, go to Question 23

22. Why did you stop paying the plan's monthly fee?

- ☐ I stopped paying the monthly fee because I could not afford it
- ☐ I stopped paying the monthly fee because I was unhappy with the plan
- ☐ I stopped paying the monthly fee for some other reason

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

- ☐ Yes
- ☐ No

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

- ☐ Yes
- ☐ No

25. Did you leave the plan because you found a prescription drug plan that costs less?

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No

29. Did you leave the plan because it was difficult to get brand name medicines?

- ☐ Yes
☐ No

30. Did you leave the plan because you were frustrated by the plan's approval process for medicines your doctor prescribed that were not on the plan's list of medicines that the plan covers?

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No

32. Did you leave the 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

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

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No

35. Did you leave the plan because their customer service staff did not treat you with courtesy and respect?

- ☐ Yes
☐ No

36. Every year Medicare evaluates all Medicare prescription drug plans and gives each plan a quality rating. The ratings are referred to as the Medicare Star or Plan Ratings. The ratings provide Medicare beneficiaries information on the quality of services a plan provides.

Did you leave the plan because it got a low Medicare Star Rating?

- ☐ Yes
☐ No

37. Did you leave the plan because you found another plan with a higher Medicare Star Rating?

- ☐ Yes
☐ No

38. In the past year, did you think about the Medicare Star or Plan Ratings when making a decision about enrolling in a prescription drug plan?

- ☐ Yes
☐ No

**OTHER REASONS FOR LEAVING
YOUR FORMER PRESCRIPTION
DRUG PLAN**

39. Did you leave the plan because a family member or friend told you that another prescription drug plan was a better plan?

- ☐ Yes
☐ No

40. Did you leave the plan because you saw a commercial or advertisement for a prescription drug plan you thought you would like better?

- ☐ Yes
☐ No

41. Did you leave the plan because you found another plan that better met your prescription needs?

- ☐ Yes
☐ No

42. Did you leave the plan because you take very few prescription medicines and don't need a prescription drug plan?

- ☐ Yes
☐ No

43. What was the one most important reason you left [PLAN_NAME]? (Check one.)

- ☐ Financial or cost reasons
☐ Problems getting prescription drugs through the plan
☐ Problems getting information from the plan about prescription drugs
☐ Switched to another plan that offers better benefits or coverage
☐ Another reason. Please specify:

**YOUR EXPERIENCE WITH
INSURANCE AGENTS, BROKERS, OR
PLAN REPRESENTATIVES**

44. Different kinds of people sell health insurance. Insurance may be sold by independent insurance agents or brokers who don't work for the health plan OR by plan representatives who work directly for the plan.

Did an insurance agent, broker, or plan representative ever call you without your asking them to, to tell you about insurance for prescription medicines?

- ☐ Yes
☐ No

45. Did an insurance agent, broker, or plan representative ever visit your home without your asking them to, to tell you about insurance for prescription medicines?

- ☐ Yes
☐ No

46. Did you decide to leave [PLAN_NAME] because of information you got from an insurance agent, broker, or plan representative?

- ☐ Yes
☐ No

47. Did an insurance agent, broker, or plan representative give you any information that was not correct?

- ☐ Yes
☐ No → If No, go to Question 49

48. What kind of information was not correct? Please check all that apply.

- ☐ What the plan covered
☐ What the plan would cost you
☐ Which pharmacies are covered by the plan
☐ Some other information (please print)

ABOUT YOU

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

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

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

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

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51. In the last 12 months, how many different prescription medicines did you fill? (Don't count the same prescriptions twice.)

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

52. 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 54

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

- ☐ Yes
☐ No

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

- ☐ Yes
☐ No → If No, go to Question 56

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

- ☐ Yes
☐ No

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56. 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. Hypertension or high blood pressure? | <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"/> |

57. What is your age?

- ☐ 18 to 24
☐ 25 to 34
☐ 35 to 44
☐ 45 to 54
☐ 55 to 64
☐ 65 to 74
☐ 75 to 79
☐ 80 to 84
☐ 85 or older

58. Are you male or female?

- ☐ Male
☐ Female

59. 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

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

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

61. 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

62. What language do you mainly speak at home?

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

63. Did someone help you complete this survey?

- ☐ Yes
- ☐ No → If No, Go to Question 65

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

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

65. The Medicare Program is trying to learn more about the health care or services provided to people with Medicare. May we contact you again 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

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