Please return your completed questionnaire in the pre-addressed postage paid envelope. If you have any questions about the questionnaire, please feel free to call us at 1-800-759-7947.

THANK YOU!

Conducted by:

The Survey Research Center The University of Michigan

Sponsored by:

The National Institute on Aging Centers for Medicare and Medicaid Services





Place barcode label here

Name and ID#

Health and Retirement Study: 2007 Prescription Drug Study

HOW TO FILL IN THIS QUESTIONNAIRE

Please answer the questions by:

Marking a box like this: X

Writing a number in a box like this: 16

Sometimes you will find an instruction telling you which questions to answer next like this:

☐ Yes

 \blacksquare No \longrightarrow Go to Question \blacksquare 3.

33.

Please use a #2 pencil.

Erase unwanted marks completely.

PLEASE START THE QUESTIONNAIRE AT QUESTION



ON PAGE 1



ABOUT THIS QUESTIONNAIRE

This questionnaire is a part of the Health and Retirement Study. We greatly value your past participation in the HRS, and we hope that you will find this questionnaire interesting to complete. As always, your answers are extremely important to us. Please remember that your participation is *voluntary* and that you may skip over any questions that you would prefer not to answer.

A Department of Health and Human Services Certificate of Confidentiality covers this research in order to help ensure your privacy. This certificate can help protect the investigators from being forced to release any research information that identifies you. Please note that we must report credible evidence of serious harm or abuse to any person to the authorities, but this questionnaire does not ask any questions about such topics.

It is very important that the questions be answered by the person whose name is printed on the front cover of this questionnaire (or by someone who knows this person well enough to answer the questions for them, if the addressee is unable to complete the questionnaire alone).

Many questions can be answered by placing an (X) in the box (\square) in front of your response. Some questions may not apply to you, and you will be instructed to skip them. When this occurs, you will find an arrow (\longrightarrow) from your answer to the next appropriate question number. When no special instruction is given for your response choice, please continue with the next question.

If you have any questions about the questionnaire, please feel free to call us at 1-800-759-7947.

THANK YOU!

Section H: Comments

H1.	Were the questions in this questionnaire answered by the person to whom this questionnaire was addressed, or did someone else answer for that person? (Mark (X) ONE.) AGED
	Yes, the questions were answered by the person to whom the questionnaire was addressed.
	 □ The questions were answered by that person's spouse or partner. □ The questions were answered by that person's son or daughter. □ The questions were answered by someone else: Please say if you are a relative, a friend, a care provider, or what: Q G@F[c@D
H2.	Approximately, how long did it take you to complete this questionnaire?ÁQ G@D # of minutes
Н3.	Please add any comments that you wish in the space below: ÁG G@+D
	(All comments should be written inside of the box.)
	Thank you for your participation in this important survey!

G1.	wi ab	tho	out it b	a d efo	loc re	tor's	s pi	rese tior	crip ı E)	tio). E	n (d Exa	do r mp	not les	inc	lud uld	e a		me	dic	atio	ons	yo	u to	old		
a.	П															Π										
b.				<u> </u>	<u> </u>	<u> </u>									<u> </u>	I	<u> </u>		<u> </u>							1
۱.																										
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. [<u>'</u>																									<u> </u>
h.																										
i. [
, [T																									
j.																										

End of Section G.

Section A: Access to Prescription Medicines

A1a.	Have you used prescription drugs in the past year? ÁQ CæFæDÁ
	☐ Yes → Go to question A2.
	□ No → A1b. Do you have any insurance that would cover some of the cost of prescription drugs if you did use them? ♀ Get
	□ Yes → Go to Section B on Page 3
	□ No → Go to Section D on Page 11
A2.	Who does most of the shopping for the prescription drugs that you take? (Mark (X) ONE.) AG GOOD
	□ I do most of the shopping myself.
	☐ My spouse does most of the shopping.
	☐ My child or other family member does most of the shopping.
	☐ A nurse or other paid helper does most of the shopping.
	☐ Other (please specify
A3.	Other (please specify
A3.	How many different prescription drugs did you use in the last month? AQ Cat-D
A3. A4.	How many different prescription drugs did you use in the last month? AG Cat-D # of prescription drugs Of those prescription drugs, how many are ones you take on a regular basis (for example, every day or every week)? AG Cat D

	If you take ten or fewer medication
In a typical month, how many different pharmacies do you get prescription drugs from (including mail order)? A G Can D # of pharmacies	Please list any other prescription medications you told us about be
Where do you typically get your prescription medicines? (Mark (X) all that apply.) A Gai D Big drugstore chain pharmacy such as Walgreens or Osco Pharmacy inside a grocery store or supermarket Pharmacy inside a chain department store such as Target, Kmart or Wal-Mart Independent pharmacy (pharmacy that is locally owned) Veterans Administration pharmacy Pharmacy inside a medical clinic or hospital By mail order Over the internet Free samples from physician Other (please specify: ************************************	a.
How often do you purchase prescription drugs from a supplier in another country such as Canada or Mexico? (Mark (X) ONE.)ÄQ Gaè D Never Rarely Often	9. h. i.
In addition to your prescription medications, which of the following types of medicines do you regularly use that you buy without a doctor's prescription? (Mark (X) all that apply.) (Cod D) Pain relievers Antacids or other stomach medicines Allergy or cold medicine Sleep aids	End
☐ Herbal medications☐ I do not regularly use any of these medications	

Section F: Other Prescription Medications

If you take ten or fewer medications, please go to Section G on page 28.

F1.	Plea	ase dica	list tior	an ns y	y oʻ /ou	the tol	r pr d u	res s a	crip bou	otio ut b	n m efo	ned re	ica in S	tior Sec	is t tior	hat n E)	yoı).ÁX	u ta] G	ake FD	(do	o no	ot ii	nclu	ude	an	ıy	
a.[
b.																											
c.[
d.[
e.[
f. [
g.[
h.[
i. [
j. [

End of Section F.

Medication #10. **Section B: Coverage and Cost of Prescriptions** If you take only nine or fewer medications, please Go to Section G on page 28. Please write down some information from the label on the prescription bottle:Á Which of the following best describes how your insurance works when you buy prescription drugs? (Mark (X) ONE.)ÁC GàFD Name of the medication: (Please PRINT clearly) ☐ I pay some of the price and insurance pays the rest. ☐ Capsule ☐ Tablet ☐ Inhalant ☐ mgs or Medication Format/Unit: ☐ Liquid ☐ Drop ☐ Other Strength other units ☐ I get a small discount off of full price with a discount card and pay the rest myself. (# of times) per ☐ Day ☐ Week ☐ Month Dosage Instructions (# of units) ☐ I pay full price for all medications out of my own pocket, About how long have you been taking this medication? (Mark (X) ONE.)Á with no insurance. Go to Section C on Page 10 ☐ Just started ☐ 1-5 months ☐ 6-12 months ☐ 1-2 years 3-5 years more than 5 years ☐ I don't pay anything. How much did you pay the last time you filled this prescription? ☐ OtherÁ GàFI c @D Please indicate how strongly you agree or disagree with the following statements What is the source of your most important prescription drug insurance? about the medication you listed above. (Mark (X) one answer for each line.)Á (Mark (X) ONE.)ÁCC GàCD Strongly Don't Strongly Agree Neutral Disagree Disagree Know ☐ A plan provided by my employer, a family member's employer, a. This medication is very important for my health. or a former employer or union b. It often gives me unpleasant side effects. ☐ A Medicare Part D plan c. It is too expensive. ☐ A Medicare HMO or Medicare Advantage Plan d. It is the best one available for what it does. Medicaid In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE.)Á □ Veterans Administration □ Yes □ No **Go to Question** F1. ☐ State Pharmacy Assistance Program □ Don't Know → Go to Question F1. ☐ Other (please specify: Q GàQ c@ FÊ GàQ c@ GD How important were the following reasons for missing a dose or not filling a □ Don't Know prescription when that happened? (Mark (X) one answer for each line.) Not at all Somewhat Verv **Important** Important **Important** What is the name of your most important prescription drug insurance plan? AG CàHD a. Cost b. Unpleasant side effects c. Away from home □ Don't Know d. Forgot 0071066448 3. 26.

	If you take only eight or fewer medications, please Go to Section G on page 28.
Does your prescription drug coverage have an annual deductible, that is, an amount you have to pay yourself each year before the insurance will start to help pay? (Mark (X) ONE.)ÂQ GàI D ☐ Yes ☐ No → Go to Question B6.	Please write down some information from the label on the prescription bottle:Á Name of the medication: (Please PRINT clearly) Strength
□ Don't Know → Go to Question B6. If yes, how much is your deductible? ÁQ GàÍ D	About how long have you been taking this medication? (Mark (X) ONE.)ÁÁ ☐ Just started ☐ 1-5 months ☐ 6-12 months ☐ 1-2 years ☐ 3-5 years ☐ more than 5 ye
\$ Deductible per year	How much did you pay the last time you filled this prescription?
What kind of monthly premium is there for your prescription drug insurance? (Mark (X) ONE.) A GàÎ D	Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.) Agree Agree Neutral Disagree Disagree Known
□ I pay it myself.	a. This medication is very important for my health.
☐ It's included in the premium for my HMO, Medicare Advantage, Medigap coverage, or other health insurance	b. It often gives me unpleasant side effects.
 □ It's deducted from my Social Security check. □ It's deducted from my or my spouse's paycheck. □ Other (please specify:	In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE.)Á ☐ Yes ☐ No → Go to Question E55. ☐ Don't Know → Go to Question E55.
B7. How much is your monthly premium? Á Q Cà D \$, per month	How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)Á Not at all Somewhat Very Important Important a. Cost

9651066441

☐ Capsule ☐ Tablet ☐ Inhalant ☐ Liquid ☐ Drop ☐ Other

more than 5 years

Don't Know

Medication #9.

Medication #8. If you take only seven or fewer medications, please Go to Section G on page 28.	
Please write down some information from the label on the prescription bottle:Á Name of the medication: (Please PRINT clearly) Strength	Some prescription drug insurance plans restrict the number, type or dollar amount of prescriptions they will pay for. Check any of the following types of restrictions that your plan has. (Mark (X) all that apply.) A Gài D My plan won't pay at all for some types of drugs. My plan makes me pay more for some types of drugs. My plan only pays for a certain number of prescriptions per month. My plan only pays up to a certain amount of money each month. My plan only pays up to a certain amount of money each year.
Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)Á Strongly Agree Agree Neutral Disagree Disagree a. This medication is very important for my health. b. It often gives me unpleasant side effects. c. It is too expensive. d. It is the best one available for what it does.	□ Other restriction. □ My plan has no restrictions. □ Don't Know Some prescription drug insurance plans have what's called a coverage gap, or a doughnut hole, where you have to pay all or nearly all of the costs of your drugs for part of the year after the insurance has paid up to a certain amount. Have you reached the coverage gap in your prescription drug plan this year?
In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE.)ÁÁ ☐ Yes ☐ No → Go to Question ☐ Don't Know → Go to Question ☐ E49.	 (Mark (X) ONE.)ÄQ GàJD □ Yes □ No → Go to Question B11. □ My plan does not have a coverage gap → Go to Question B12.
How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)Á\(\) Not at all Somewhat Very Important Important a. Cost	□ Don't know → Go to Question B12.

24.

If you have reached the coverage gap in your plan this year, have you done any of the following to save money after you reached it? (Mark (X) all that apply.) AÇ GàF€D ☐ I stopped taking one or more of my drugs. ☐ I delayed refilling one or more of my drugs. ☐ I took smaller doses to make my medicine last longer. ☐ I skipped doses to make my medicine last longer. ☐ I got free drug samples. ☐ I did not fill a prescription for a new drug. ☐ I bought drugs outside of the U.S. ☐ I cut back on purchases of other things to be able to pay for my drugs. __C}CàF€[c@;FDÉÀ,GàF€[c@;GD_ ☐ Other (please specify:_____ Did you cut your spending on drugs early in the year to try to avoid reaching the gap? (Mark (X) ONE.) Á GàFFD □ Yes □ Don't Know Overall, how satisfied are you with your current prescription drug coverage? (Mark (X) ONE.) Á GGAFGD □ Very satisfied □ Somewhat satisfied □ Somewhat dissatisfied □ Very dissatisfied

ı	If you take only six or fewer	Medicat medications		to Section	G on page	28.
E37.	Please write down some ir		·			
Nam	ne of the medication: (Please PF	RINT clearly)				
	mgs or				<u> </u>	l et □ Inhalant
Stre	ength other u	I\/I	ledication Forr	mat/Unit: 🗀	iquid Drop	_
Dos	age Instructions (# of un	its)	(# of times) per	□ Day □	Week	nth
E38.	About how long have you l	peen taking	this medicat	tion? (Mark	(X) ONE.)Á	
	☐ Just started ☐ 1-5 months	6-12 months	1-2 years	3-5 ye	ears 🗌 mor	e than 5 years
E39.	How much did you pay the this prescription?			, ,		
E40.	Please indicate how strong about the medication you l	isted above. Stro		one answer		e.) gly Don't
a. This	medication is very important for	ŭ	_			_
	en gives me unpleasant side eff			П		_
	too expensive.					
	the best one available for what i					
u. It is i	the best one available for what h	. uoes. L		Ш		
E41.	In the last year, have you delayed or not filled a presidence of the last year, have you delayed or not filled a presidence of Yes □ No → Go to □ Don't Know →	cription for i	t? (Mark (X)	ONE.)Á	is medicatio	on or
E42.	How important were the fo prescription when that hap	pened? (Ma Not at all		•	,-	a
	a. Cost					
	b. Unpleasant side effects					
	c. Away from home					
	d. Forgot					

23.

Medication #6.	-
If you take only five or fewer medications, please Go to Section G on page 28.	
Please write down some information from the label on the prescription bottle:ÁD Name of the medication: (Please PRINT clearly)	Over the last year, would you say your prescription drug coverage has: (Mark (X) ONE.) A GAFHD
	☐ Gotten better
Strength	☐ Stayed the same
Dosage Instructions (# of units) (# of times) per	☐ Gotten worse
About how long have you been taking this medication? (Mark (X) ONE.)Á ☐ Just started ☐ 1-5 months ☐ 6-12 months ☐ 1-2 years ☐ 3-5 years ☐ more than 5 years	In the last year (twelve months), have you done any of the following? (Mark (X) all that apply.) AG CàFI D
How much did you pay the last time you filled this prescription?////////////////////////////////////	☐ Switched to a different prescription drug plan
tins prescription: //www.www.www.	☐ Changed the brand of a drug you use or switched to generic drugs to save money
Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)Á Strongly Strongly Don't	☐ Talked to your doctor about changing drugs to save money
Agree Agree Neutral Disagree Disagree Know a. This medication is very important for my health. b. It often gives me unpleasant side effects. c. It is too expensive.	In the last year, have you thought about switching to a different provider or a different plan of the same provider? (Mark (X) ONE.) Á G CàFÍ D No, I have not thought about switching. I am happy with my plan.
	, rear a maragine and a mining in a mining promise may promise
d. It is the best one available for what it does.	No, I have not thought about switching. I wanted to avoid the trouble of going through the whole plan comparison and choice process again.
delayed or not filled a prescription for it? (Mark (X) ONE.)Á	☐ Yes, I have briefly considered switching to a different plan or provider.
□ Yes □ No → Go to Question E37.	☐ Yes, I have thoroughly considered switching to a different plan or
□ Don't Know → Go to Question E37.	provider and compared plan details.
How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)Á	How would you rate your current prescription drug plan (i.e. the plan in which you are enrolled for 2007) overall? (Mark (X) ONE.) ÁG GàFÎ D
Not at all Somewhat Very Important Important Important	Very
a. Cost	Excellent good Good Fair Poor
b. Unpleasant side effects □ □ □	Overall rating
c. Away from home	
d. Forgot	

How would you rate these features of your current prescription drug plan? (Mark (X) one answer for each line.) Á GàFÏ D Very Excellent good Fair Good Poor a. Cost of monthly premium b. Deductible c. Amount you pay for each prescription (co-pay) d. Keeping your costs the same from month to month e. The drugs it covers and doesn't cover (formulary) f. Choice of pharmacies or mail order options g. Customer service How important are the following features of a prescription drug insurance plan for you? (Mark (X) one answer for each line.) ÁQ CàFÌ D Not at all Very Less important important important Critical a. Cost of monthly premium b. Deductible c. Amount you pay for each prescription (co-pay) d. Keeping your costs the same from month to month e. The drugs it covers and doesn't cover (formulary) f. Choice of pharmacies or mail order options g. Customer service

Medication #5.

If you take only four or fewer		ons, pleas	e Go to Se	ction G on	page 28.	
E25. Please write down some inf	ormation	from the la	abel on the	e prescript	ion bottle:	Á
Name of the medication: (Please PRI						
Otacath				☐ Capsule	 ☐ Tablet ☐	I Inhalant
Strength	its	Medication	Format/Unit	•		Other
Dosage Instructions (# of units	s)	(# of times)	per Day	□Week	☐ Month	
About how long have you be	een takin	a this med	ication? (N	/lark (X) O	NE.)Á	
E20.	☐ 6-12 mont		`	3-5 years	more tha	n 5 vears
	0-12 1110110	113 🔲 1-2)	rears	5-5 years	more tha	ii o years
How much did you pay the this prescription?	ast time y	you filled	\$			
Please indicate how strongl	v vou agr	ee or disa	aree with t	he followir	na statem	ents
about the medication you list			•			•
		rongly .gree Ag	ree Neutra	al Disagree	Strongly Disagree	Don't Know
a. This medication is very important for r		5		<u>2.04.9</u> .00		
b. It often gives me unpleasant side effe	•					
c. It is too expensive.	0.0.		, o	П		П
d. It is the best one available for what it	does.					
				_	_	
E29. In the last year, have you ex				//	dication o	r
delayed or not filled a preso	ription toi	r It? (IVIark	(X) ONE.)	///		
□ No → Go to	Ouestion	E31.				
□ Don't Know —			F31			
□ DOITE KNOW —	Golo	Question				
How important were the foll	_		_		, -	
prescription when that happ	ened? (M Not at all	lark (X) or Somewha		tor each li	ne.)A	
	mportant	Important	- ,	nt		
a. Cost						
b. Unpleasant side effects						
c. Away from home						
d. Forgot						

Medication #4. If you take only three or fewer medications, please Go to Section G on page 28. Please write down some information from the label on the prescription bottle:Á Name of the medication: (Please PRINT clearly) ☐ Capsule ☐ Tablet ☐ Inhalant mgs or Medication Format/Unit: Strength other units ☐ Liquid ☐ Drop ☐ Other Dosage Instructions (# of times) per ☐ Day ☐ Week ☐ Month (# of units) About how long have you been taking this medication? (Mark (X) ONE.)Á ☐ Just started ☐ 1-5 months ☐ 6-12 months ☐ 1-2 years ☐ 3-5 years more than 5 years How much did you pay the last time you filled this prescription? Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)Á Strongly Strongly Don't Agree Neutral Disagree Disagree Know

		O	•	O	
a. This medication is very important for my health.	. 🗆				
b. It often gives me unpleasant side effects.					
c. It is too expensive.					
d. It is the best one available for what it does.					
In the last year, have you ever miss delayed or not filled a prescription for ☐ Yes ☐ No → Go to Questic ☐ Don't Know → Go to	or it? (Ma on E25.	rk (X) Ol	 is medica	ation or	
How important were the following represcription when that happened? (_		,-	

319. P	lease tell us anything else about your prescription drug insurance that you think is nportant that we have not asked about. AG CàFJD
	(All comments should be written inside of the box.)

End of Section B.

7569066447

Not at all

Important

a. Cost

d. Forgot

b. Unpleasant side effects

c. Away from home

Somewhat

Important

Very

Important

Section C: Use of Prescription Medications

C1.	The next set of questions is about problems you may the cost of prescription medications. (Mark (X) ONE				(C) G&FD More
	N	lever	1-2 times	3-4 times	than 4 times
	a. In the past year, how often did you not fill a new prescription because of the cost?Á				
	b. In the past year, how often did you stop taking a prescription medication because of the cost?				
	c. In the past year, how often did you skip doses of a prescription medication in order to save money?				
C2.	In the past year, have you had any side effects, unw problems from medications you were taking? (Mark				er health
	□ Yes				
	□ No → Go to Section D on Page 11				
	☐ Not sure → Go to Section D on Page 11				
C3.	Thinking about the MOST SEVERE of the reactions past year, what did you do in response? (Mark (X) O	•	•		e.)ÁÇG&H
	a. Did you cut down or stop taking the drug on your ow	/n?	Υe)
	b. Did you talk to a doctor about this reaction?				
	c. Did you visit a doctor's office or emergency room mostly because of this reaction?				
	d. Did your doctor ask you to cut down or stop taking the medication because of this reaction?	he			
	e. Did you take another medication or treatment to treat this reaction?	at			
	f. Were you admitted to a hospital overnight mostly because of this reaction?			l 🗆	

Medication #3.

If you take only two or fewer medications, please Go to Section G on page 28.													
Please write down some information from the label on the prescription bottle: Name of the medication: (Please PRINT clearly)													
Traine of the medica	T	THE CICALLY,	, 			<u> </u>							
							<u> </u>						
Strength	☐ mgs or ☐ other un	its	Medicati	on Forma	t/Unit: —	Capsule Liquid	_	Other					
					_	· <u> </u>	Бтор 🔲	Otrici					
Dosage Instructions	S (# of units	s) <u> </u>	(# of tin	nes) per E] Day 🔲	Week [] Month						
E14. About how lo	ong have you be	een takin	g this m	edicatio	n? (Mark	(X) ONE	Ξ.) Á Á						
☐ Just started	1-5 months	☐ 6-12 mont	hs 🗌 1	-2 years	☐ 3-5 y	ears 🗆] more thar	n 5 years					
E15. How much d this prescript	lid you pay the l tion? <i>/</i> ///////////////////////////////////	ast time y	you fille XXXXX	d \$ [
Please indic	ate how strongl	v voli adr	ee or d	sagree v	with the	following	statem	ante					
	edication you lis			•		•	,						
			rongly			S	Strongly	Don't					
		А	gree	Agree N	Neutral D	sagree D	isagree	Know					
a. This medication is v	ery important for r	ny health.											
b. It often gives me un	pleasant side effe	cts.											
c. It is too expensive.													
d. It is the best one av	ailable for what it o	does.											
In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE.) ☐ Yes ☐ No → Go to Question ☐ Don't Know → Go to Question ☐ E19.													
		ened? (M Not at all	lark (X) Somew	one ans	swer for overy		, ,						
a. Cost	II	mportant	Import	anı m	nportant								
	nt side effects												
c. Away fron													
d. Forgot													

End of Section C.

Medication #2. If you take only one or fewer medications, please Go to Section G on page 28. Please write down some information from the label on the prescription bottle: Á Name of the medication: (Please PRINT clearly) ☐ Capsule ☐ Tablet ☐ Inhalant mgs or Medication Format/Unit: Strength other units □ Drop □ Other Liquid **Dosage Instructions** (# of units) (# of times) per ☐ Day ☐ Week ☐ Month About how long have you been taking this medication? (Mark (X) ONE.)Á ☐ Just started ☐ 1-5 months ☐ 6-12 months ☐ 1-2 years 3-5 years more than 5 years How much did you pay the last time you filled Please indicate how strongly you agree or disagree with the following statements about the medication you listed above. (Mark (X) one answer for each line.)Á Strongly Don't Strongly Agree Neutral Disagree Disagree Know Agree a. This medication is very important for my health. b. It often gives me unpleasant side effects. c. It is too expensive. d. It is the best one available for what it does. In the last year, have you ever missed a scheduled dose of this medication or delayed or not filled a prescription for it? (Mark (X) ONE.)Á ☐ Yes □ No → Go to Question ☐ Don't Know → Go to Question E13. How important were the following reasons for missing a dose or not filling a prescription when that happened? (Mark (X) one answer for each line.)Á Not at all Somewhat Verv

Section D: Medicare

The following questions have to do with the Medicare program and Medicare prescription drug coverage. Whether you participate in a Medicare prescription drug plan or not, please try to answer the following questions as best you can.

D'	1.	Do you agree or disagree with the following Part D and the enrollment process? (Mar	_	•		,,	G åFD
			Strongly agree	Agree	Disagree	Strongly disagree	Does not apply
	a.	I had sufficient information to determine whether I would benefit.					
	b.	It was difficult to determine whether specific medications are covered by the plans that are offered.					
	C.	There were too many alternative plans to choose from.					
	d.	It was useful to have more choices of alternative insurers.					
	e.	The enrollment process was very complicated.					
	f.	I had difficulty getting my questions answered.					
	g.	Not all of the medications that Medicare Part D plans promise to cover are actually covered.					
	h.	I have had difficulty getting the prescription drugs that I need covered.					
	i.	I had difficulty understanding how					

Important

Important

a. Cost

d. Forgot

b. Unpleasant side effects

c. Away from home

Important

Medicare Part D works and what savings

it would provide.

Do you agree or disagree with the following statements about the Medicare Part D program? (Mark (X) one answer for each line.) AG CaGD Strongly Strongly Don't Agree Disagree disagree know agree a. Having insurance companies compete for my business improves my options. b. Having coverage provided through private companies rather than through a single government-managed program complicates my choices. c. Information on this program provided by Medicare has been useful. d. Information on this program provided by insurance companies has been useful. e. It was easy to get my questions answered. f. The enrollment process was clear and straightforward. g. The Medicare Part D program is well designed. □ h. The Medicare Part D program is a major benefit to seniors. i. It would have been better to provide drug insurance automatically as part of Medicare, rather than an optional program with multiple providers. j. Once one gets past the enrollment process, the Part D program works well. k. The exclusion of some drugs from the lists of what's covered by Medicare Part D plans is a major drawback. I. The \$250 deductible in the Medicare standard plan is a significant drawback.

Medication #1.

E1. Please write down some information from the label on the prescription bottle: A G FD															
Name of the medication: (Please PRINT clearly)															
				Π	Т	Т	T								
Ш				Ш											
Str	Strength														
Do	Dosage Instructions (# of units) (# of times) per Day Week Month														
About how long have you been taking this medication? (Mark (X) ONE.)ÄG G^G															
LZ.	☐ Just started ☐ 1-5 months ☐ 6-12 months ☐ 1-2 years ☐ 3-5 years ☐ more than 5 years														
	How much did you now!	ha laat t	ima v	ou f	illad	ı		, _							
E3.	How much did you pay the last time you filled this prescription? #Q G`HD \$,														
	Please indicate how stro	naly you	Lagra	20.0	r die	saara	20 V	vith	the follow	ina statem	onte				
E4.	about the medication yo		_			_				•					
	,			ongly		()				Strongly	Don't				
			Αį	gree	A	Agree	: N	eutr	al Disagre	e Disagree	Know				
a. This	a. This medication is very important for my health.														
b. It of	ften gives me unpleasant side	effects.													
	too expensive.			П					П	П					
	the best one available for what	at it does													
u. 11 15	THE BEST ONE AVAILABLE TO WITE	at it 4000.		_				Ь	Ь						
E.E.	In the last year, have yo	u ever m	nissed	das	sche	edule	ed d	ose	of this me	edication o	r				
E5.	delayed or not filled a pr														
	□ Yes														
	□ No → Go	to Que	stion	E	7.										
	□ Don't Know	→ G	o to C)ues	stio	n E	7. 								
	_ Done Halow		. , , ,		- 										
E6.	How important were the		_							,,	↑ _				
	prescription when that h	• •	•							line.)##G\	ΙD				
		Not at Import			newl oorta			Very port							
	a. Cost		J. 14	٠											
	b. Unpleasant side effec	ts 🗆													
	c. Away from home														
	d. Forgot														

Section E. Medicines

To really understand the impact of prescription medications on the health and economic security of Americans like you, it is important to know something about the specific medications that people actually take. This section asks you to provide some information about each of the different medications you take. Please list all the medications prescribed, including those you only take occasionally, for the person whose first name is printed on the front cover of this questionnaire. Do not include any medications prescribed for someone else. There are ten pages provided for up to ten medications. If you take fewer than ten, fill out pages for the ones you take and then go on to Section G on page 28. If you take more than ten, fill out all the pages for the ten medications you consider most important and then please give just the names of the other medications in Section F on page 27.

The first part of the page for each medication asks for some information that should be printed right on the label of the pill bottle or other container. An example of a medication label and how to fill out the top part of the medication page is shown below.

Prescription Label Example

VAMC Ann Arbor, MI 48104-2300
506 (DD/) Ph: 866-316-9350

RX#4599773 Sept. 6, 2005 Fill 1 of 1
John Doe 60-4596

Take one capsule by mouth as directed in morning and at bedtime
Discard after Sept. 6,2006 Mfr_____
Qty: 60 CAP Kroll, Phil MD

Phenytoin NA (Dilantin) 100MG SA CAP

Medication Form Example:

Medication #1.

E	Please write down some information from the label on the prescription bottle:Á																												
	Name of the medication: (Please PRINT clearly)																												
																													\Box
	Strength mgs or other units											Medication Format/Unit: ☐ Capsule ☐ Tablet [☐ Liquid ☐ Drop [Inha Oth	ilant er							
	Do	sag	je Ir	str	uctic	ons			(#	of u	nits)				(#	of tir	nes)	per	X] Da	y	□ \	<i>N</i> ee	k	<u> </u>	Mont	h		

16.

D2.	Do you agree or disagree with the following statements about the Medicare Part D program? (Mark (X) one answer for each line.) AG CåGD												
(cont.)		Th		Strongly agree	Agree	Disagree	Strongly disagree	Don't know					
	m.	standard	in coverage in the Medicare I plan between pharmacy bil D and \$5,100 is a significant k.	lls									
	n.	protectio	e Part D plans offer significa n against catastrophic ion drug costs.	ant									
	0.	under Me difficult to	g formularies of drugs included edicare Part D plans makes to know if drugs one might no cure will be covered.	it									
D3.			rrently enrolled in a Medical					HMO or					
	Advantage plan that helps pay for prescription drugs?AQ CåHD												
			No										
			Don't Know										
D4.			peneficiaries with limited income for their prescription drug of Yes	cove	erage. Di	d you k	now abou	ut this pro	gram?				
			No										
			Don't Know										
D5.	Н	ave you	ever applied for extra help?	ÁÁÇIG	åĺ D								
			Yes										
			No										
			Don't Know										

D6.	How helpful do you think the ne for the following people? (Mark		answer	for each li	ne.)ÁKÇIG	àÎ D		D7.	agree or disagree with the follo	changes in your Medicare coverage, how much do you following statements? (Mark (X) one answer for each							
			Very helpful	Somewhat I helpful	helpful	Not at all helpful	Don't know	(cont.) line.)Á ÇGå ÏD			Neither					
	a. People with low incomes			Ġ	Ġ	Ġ				Agree strongly	Agree somewhat			Disagree strongly	Don't know		
	 b. People with very high prescrip drug costs 	ption						e.	Choosing a Medicare plan is a task I would rather avoid.								
	c. People with low prescription costs	drug						f.	I often feel overwhelmed becaus there is too much information	e 🗆							
	d. People with no other insurance drugs	ce for						_	about each plan to take in.								
	e. People with good other insura	ance						g.	I have difficulty understanding th information about Medicare coverage options.	e □							
	f. A typical person with Medicar	re						h.	Whenever I make a choice abou Medicare, I worry it will be the	t 🗆							
D7.	When it comes to making chan							_	wrong one.								
	you agree or disagree with the fo each line.)ÁG GåÏ D		g statem	ents? (Ma Neither	rk (X) on	e answer t	for	I.	I am confused about the change in Medicare.	s							
	a. I am more likely to make a	Agree strongly	Agree somewha	Agree nor at Disagree		Disagree t strongly	Don't know	j.	I am upset about the changes to Medicare.								
	wrong choice if I have lots of different options to choose from.							D8.	Who do you trust or count on to (Mark (X) all that apply.)ÁÇ GåÌ		ou make c	hoices ab	out healt	h insurand	ce?		
	 b. When it comes to making decisions about my health insurance coverage, I prefer to have someone knowledgeable decide for me 								□ Spouse□ Children□ Other family members□ Friends								
	c. I prefer to have lots of information about each option.								 □ Doctor □ Nurse or other health care □ Financial advisor 	·			2°) (7 0			
	d. I prefer to choose a plan without help from anyone.								☐ Other (please specify :☐ No one		[c@(FDÉÁ)(±aı[o@(C	<u>طل</u>			
96	79066441	14.							End	of Sect	ion D		15.				