Reviewer's report

Title: Patient-provider communication in Medicare Part D beneficiaries with diabetes: a cross-sectional survey

Version: 1 Date: 4 March 2010

Reviewer: Brian Bruen

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General Comment

1) The purpose of the study as stated in the abstract is “to assess Medicare Part D beneficiaries with diabetes’ levels of communication with physicians regarding prescription drug costs; the perceived importance of these communications; levels of prescription drug switching due to cost; and self-reported cost-related medication non-adherence.” The definition is clear, but the focus is narrow. As the citations in the background section show, lack of communication about drug costs is not a new phenomenon and a number of studies prove this point. This study primarily confirms those findings for a relatively narrow (albeit large) population—that is, Medicare Part D beneficiaries with diabetes. As such, it is not groundbreaking but it does provide some useful insights for those concerned about diabetes care.

Major Compulsory Revisions:
None

Minor Essential Revisions:

2) The methods section provides very little information about the characteristics of the plans represented in the survey. The authors note the survey included participants from MA-PD plans and PDP plans in eight states, and an integrated model MA-PD plan in California. Following conventions often used in Part D about what defines a “plan” it could be that all of the for-profit MA-PD plans and PDPs were offered by the same plan sponsor, in which case there could be little difference in the structure of the drug benefits. My own research on Part D plan offerings (not publicly available) found that sponsors do not vary cost sharing (coinsurance or copayments) or gap coverage between their MA-PD plans and PDPs, and they report the same negotiated prices for drugs in their MA-PD plans and PDPs. This makes sense from an administrative standpoint, and suggests that surveying people with different plan sponsors may be more important than different plan types.

3) Do any of these plans offer any form of coverage in the gap? Do the authors know from the claims that the respondents actually ended up in the gap (i.e., paying 100% out of pocket) or did they just have total drug costs that would put them in the gap assuming no gap coverage? This distinction could make a
difference in the price sensitivity of consumers.

4) Given that the survey took place several months after the close of 2006 (April-October 2007) yet asked about events that happened in 2006, the time lag might affect respondents’ ability to recall conversations, switches, etc. that may have happened a year or so in the past. Responses may reflect more recent activity. The authors should note the time delay as a potential limitation.

5) Citation #5 on page 3 does not exactly support the statement that precedes it. The cited article does not fully address the “up to 50%” for prescription drugs. More importantly, the cited paper is not the original source of those statistics. It is more appropriate to cite the original source (a MEPS brief in this case) rather than a secondary source. Perhaps even more importantly, that MEPS brief uses data from a 1996 survey, which is quite old and likely not reflective of current prescription drug spending patterns. For example, National Health Expenditures estimates from CMS estimate out-of-pocket spending for drugs is closer to 20% to 25% of total drug spending in 2006-2008. Part D had a major impact on out of pocket drug spending, and current levels of drug coverage in private insurance are higher now than in the mid-1990s.

6) There is an odd discrepancy in the findings, in that the results for “MD switched any drug to a less expensive version because of cost” routinely exceed the percentages for “talked with MD about amount paid for drugs.” The authors should address whether some switching may have involved brand-to-generic switches initiated either by the pharmacist (where the physician simply wrote the brand name but did not prohibit dispensing of a generic equivalent, as allowed by law) or where new generics came to market (with several high use, high cost brands losing patent protection in this time period).

7) There are a couple of minor text edits I would suggest to improve readability and to clarify important points:

- Page 3 (background, 1st paragraph): You should be more clear about the fact that a patient has spent about $750 out of pocket under the standard benefit when they enter the gap at $2,250 in total drug costs, and that the gap represents about $2,850 in OOP spending for beneficiaries. As written, it can be misconstrued to suggest the gap is only $1,350 ($3,600 OOP - $2,250 total).

- Page 4 (methods, 1st paragraph): Please divide this paragraph into at least two paragraphs. One should provide as much info about the plans as possible to address concerns raised in comments #5 and #6 (above). I would add this info after the sentence that lists the three types of plans studied. The second paragraph would then start with the sentence “To be eligible for the survey,…” and contain the rest of the existing paragraph up to the “The survey response rate was…” sentence. Note that there should be a comma in the $2250 in that section and that low-income subsidy abbreviates to LIS, not LICS. Finally, consider starting a third paragraph with the survey response rate sentence and address how your sample compares to the general Part D population (notably, it severely under-represents PDP enrollment relative to MA-PD enrollment), since this limits how much one can generalize the findings. If you don’t do this here, it
should definitely be in the limitations in your discussion at the end of the paper.

- Page 6 (results, paragraph 3): There is an extra space after the 80% in the comparisons based on income. I take it the difference between the 80% for <25K and the 78% for 25-40K is not significant?

- Table 1: please put findings in rows under the group headings (e.g., white, <high school, <25K, integrated delivery system MAPD, excellent/very good should not be on the same lines as their group headings); also, add a $ to the 359 for out of pocket costs

Discretionary Revisions

8) In the background section, the authors broaden the purpose statement to include “and to assess how these vary by patient and health plan characteristics.” Unfortunately, since it was the most interesting part of the question to me, the analysis of differences based on health plan characteristics is a weak part of the analysis. The authors call attention to this weakness (intentionally or not) by leaving it out of the abstract and by not providing more detail about the plans themselves (see comments #2 and #3, above).

9) The methodology section could be clearer about the structure of the multivariate regressions used in the analysis. A sample showing one of the regression model formulas would be valuable.

10) More technical/statistics-oriented readers would probably like to see standard errors reported in the tables. It would not hurt to repeat the n’s shown in table 1 on table 2.

11) The paper generally seems balanced, but the discussion dedicates a fair bit of space to the differences between the IDS MA-PD plan and the other plans. Because the lead author works for an IDS provider, readers may perceive a conflict between the length of this part of the discussion and the relative strength of findings. The lack of a citation for the “further evidence” mentioned on page 8-9 leaves additional questions unanswered (e.g., did the other study control for population differences in measuring the 31% gap entry for the MA-PD plans vs. 19% for the IDS MA-PD plan). Consider broadening the discussion of other points or noting the limits of the survey in comparing the plan types.

12) The title of the paper suggests a broader focus (i.e., all patient-provider communications) than the rather narrow subject (i.e., just those communications about drugs).

13) Journal citations in references #2, #5, and #7 are missing issue numbers. Please add them to make it easier for readers to find your sources. Also, check the citations for #11 and #12 to make sure you are using a consistent format for your journal citations.

**Level of interest:** An article whose findings are important to those with closely related research interests
Quality of written English: Needs some language corrections before being published

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Declaration of competing interests:

I declare that I have no competing interests.