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<https://doi.org/10.1016/j.jclinepi.2018.11.026>

Improving representation in telephone-based health care access surveys requires purposeful efforts to include prepaid cell phone users



To the Editor

Access to health care and its impact on health status had been at the forefront of American health policy well before the passage of the Affordable Care Act (ACA). Four years after ACA implementation, the American public still rates

health care as a top priority [1]. To better understand the impact ACA has upon access to health care (e.g., insurance, primary care, preventive care, unmet medical needs) and health status, states such as California, Colorado, and Ohio, all of which expanded Medicaid to include persons up to 138% of the federal poverty level (FPL) (\$28,767 in 2018), conduct surveys of residents to estimate uninsured rates, health status, and access and utilization of care [2–4].

To reach populations of interest, most of these surveys implement telephone surveys, for which respondents are selected through the random selection of their telephone number. Research indicates that in the first half of 2017, 52% of all adults, including 75% of young adults (25–34 years) and 70% of adults who rent their home, were cell phone only users [5]. Although adjusting sample frames to increased cell phone use results in an improved demographic distribution of completed interviews, difficulties remain for capturing oversamples of low socioeconomic (SES) and minority populations.

One new aspect for surveying low SES persons and minorities is the large growth in prepaid cell phone plans—estimated at 33% of cell phone users [6]. Prepaid plans fix the number of minutes a cell phone owner can use in a month, resulting in a respondent burden in terms of cell phone minutes used for the survey and cell phone costs—interviewees are often reluctant to use 20 to 30 of their limited plan minutes to take a health survey. Persons on prepaid plans are significantly more likely to be a minority, less than 138% FPL, and to experience household budget stress (Fig. 1)—the type of persons who experience difficulties obtaining health care coverage and who are typically under-represented in telephone surveys. This indicates that contact difficulties with prepaid cell phone users increases the chances of biased survey estimates.

To address the increase of overall cell phone and prepaid phone use, in particular, the 2015 Ohio Medicaid Assessment Survey, a general population survey of Ohio residents, conducted an experiment to test whether using a \$10 respondent incentive would increase the number of prepaid cell phone users in the respondent sample [4]. The study had two critical findings worth noting for future health survey designs. First, persons on prepaid plans are significantly associated with lower access to health care, lower health care utilization, health statuses, and higher rates of health risk behaviors, unmet health care needs, and chronic conditions—this held for working-aged adults and children with or without Medicaid (Fig. 1). Second, the \$10 incentive, because it covers part of the prepaid cell phone user's costs, does increase the proportion of completed interviews for those with a prepaid plan. Therefore, based on our experiment, we determined that increasing the proportion of prepaid cell phone users in the respondent sample will decrease bias in key survey outcomes by increasing the representation of difficult to include populations.

This work was sponsored by The Ohio State University Government Resource Center as a part of the Ohio Medicaid Assessment Survey through contract number RF01379286.

Conflict of interest: No authors have any conflict of interests.

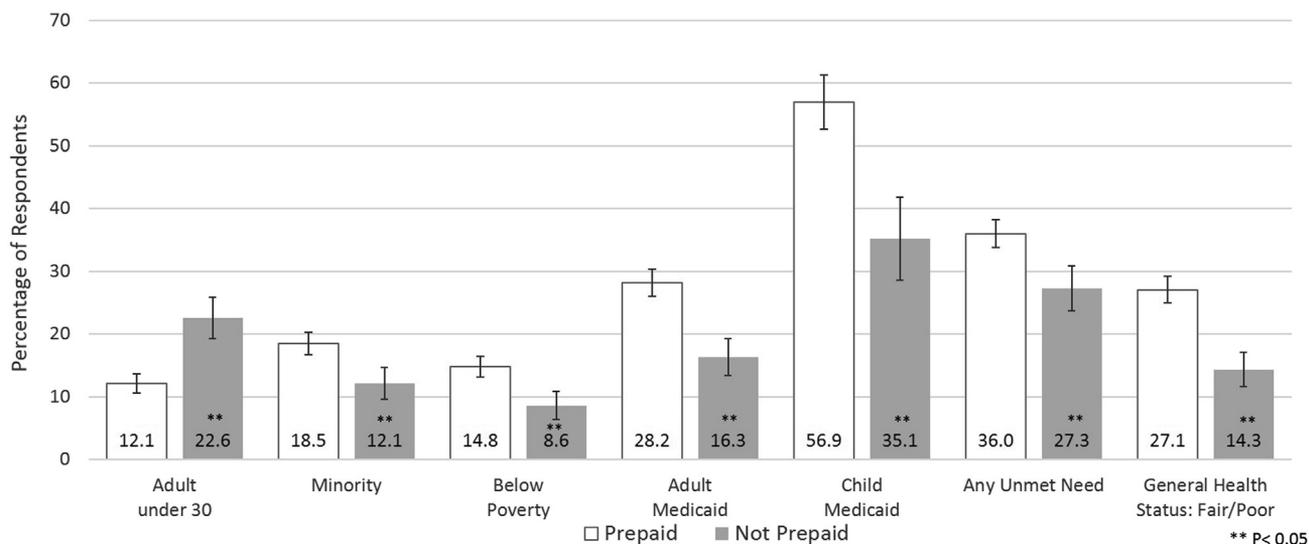


Fig. 1. Percentage of respondents by demographic and health care status and prepaid phone use.

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<https://doi.org/10.1016/j.jclinepi.2018.11.029>

Noninferiority drug trials fail to report adequate methodological detail: an assessment of noninferiority trials from 2010 to 2015



1. Introduction

Noninferiority (NI) trials are prevalent in many therapeutic areas and are used to evaluate new drugs [1–4]. When reading NI trials, one must pay special attention to the justification for the NI margin [5,6]. With the NI margin being a key part of NI trial design, any questionable justification for the choice of the NI margin can lead to

Conflict of interest: The authors have no conflict of interest to report.

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