Health Insurance Plans Research Study

Supporting Statement A

March 16, 2015

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- Goal of the study (e.g., determine behavioral factors that influence changes in weight over time or evaluate program delivery processes)
  The primary objective of this study is to conduct a systematic examination of prevention and wellness programs implemented by health insurance plans for their commercial population including best practices and challenges encountered.

- Intended use of the resulting data (e.g. , provide suggestions for improving community-based programs)
  Given the emphasis placed on prevention and wellness by the Patient Protection and Affordable Care Act, this study can help inform policymakers and other stakeholders about best practices in prevention and wellness, challenges and lessons learned, and topics for future research.

- Methods to be used to collect (e.g., prospective cohort design; randomized trial; etc.
  This will be a descriptive research project. A survey and telephone interviews will be used to collect data.

- The subpopulation to be studied (e.g., school-age children in North Carolina)
  The target population will be all commercial health insurance plans operating in the 50 states and the District of Columbia. The unit of sampling will be the corporate entity, not subsidiaries of a corporation.

- How data will be analyzed (e.g., logistic regression)
  Analysis methods will include frequency distributions, cross-tabulations, chi-square and statistical significance calculation.

A. Justification

1. Circumstances Making the Collection of Information Necessary

Background

The *Health Insurance Plans Research Study* is a new, one-year information collection request (ICR) that was established to examine prevention and wellness programs implemented by commercial health insurance plans.

Over the past several decades, an increasing emphasis on prevention has led to advances in the provision of clinical

preventive services. Efforts by health plans, providers, and employers have expanded beyond the realm of clinical preventive services to encompass wellness. There is a widespread recognition of the role that wellness programs can play in preventing the onset of chronic diseases through adoption of healthy lifestyles. In recent years, employers and health insurance plans have implemented numerous programs in worksites and communities to educate and promote healthy living.

The importance of prevention and wellness activities was further underscored by the recent passage of the *Patient Protection and Affordable Care Act (Affordable Care Act)*. The Affordable Care Act promotes prevention and wellness for all enrollees. The law ensures that all enrollees in non-grandfathered group plans and health insurance coverage offered in the individual or group market receive critical clinical and community preventive services and makes public health and prevention a permanent part of the health care system. A very important emphasis of the Affordable Care Act is on increasing the delivery of clinical preventive services recommended by the *United States Preventive Services Task Force (USPSTF)* and the Centers for Disease Control and Prevention (CDC) *Advisory Committee on Immunization Practices (ACIP)* as well as the recommendations of the *Institute of Medicine (IOM)* on preventive

services for women and children. The recommendations of the ACIP and the IOM are in line with USPSTF's recommendations.

The USPSTF assigns each recommendation a letter grade based on the strength of the evidence and the balance of benefits and harms of a preventive service. An "A" rating means there is high certainty that the net benefit is substantial and the service should be offered or provided. A "B" rating means there is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial. Section 2713 of the Public Health Service (PHS) Act and the final regulations related to coverage of preventive services require non-grandfathered group health plans and health insurance coverage offered in the individual or group market to provide certain preventive services:

a) Clinical preventive services that have a rating of "A" or "B" in the current recommendations of the USPSTF;

b) Immunizations for routine use in infants, children, adolescents, and adults based on recommendations of the ACIP;

c) Evidence-informed preventive care and screenings for infants, children, and adolescents supported by the *Health Resources and Services Administration (HRSA)*; and

d) Evidence-informed preventive care and screenings for women supported by HRSA.

An examination of current approaches used in the private sector to engage health plan members in prevention and wellness activities is a crucial step toward ensuring population health.

The legal justification for this study may be found in Section 301 of the Public Health Service Act (42 U.S.C. 241) (Appendix A).

2. Purpose and Use of Information Collection

The Health Insurance Plans Research Study will examine the prevalence of prevention and wellness programs offered by health insurance plans as well as the types and mix of services offered, use of incentives, program effectiveness, barriers, and lessons learned. There are no known studies that have addressed the prevalence of prevention and wellness programs across health plans or explored the granular details of these programs as this study is intended to do. Examining the experiences of health plans in designing, implementing, and evaluating prevention and wellness programs can help inform policymakers, healthcare providers, and other stakeholders in advancing the goals and priorities of the Affordable Care Act as well as the National Prevention Strategy and Healthy People 2020. The government

intends to accomplish the following as a result of this data collection: (a) identify high priority opportunities for public health and healthcare collaboration, (b) inform a public health-healthcare strategic agenda, (c) improve the use of clinical preventive services, and (d) improve capacity of healthcare systems to incorporate public health practices and principles. Not conducting this study would be one less step toward increasing healthy years of life.

Furthermore, the study will address the priorities and goals of the CDC Office of the Associate Director for Policy, Office of Health System Collaboration: (a) identify and catalyze policy opportunities such as the Affordable Care Act to enhance healthcare transformation, (b) advance CDC's public health-healthcare strategy to improve population health, (c) strengthen strategic partnerships with healthcare systems and payers, federal and non-federal, and (d) fully leverage performance measures as a tool to improve the health of individuals across health systems and payers.

3. Use of Improved Information Technology and Burden Reduction

During the development of the final survey instrument, every effort was made to limit respondent burden. The survey will be completed 100% electronically, eliminating any burden associated

with completing a paper-and-pencil survey (see Appendix D for screen shots). It is expected that the ease and convenience of completing the survey electronically will be well received and will positively impact the response rate. This data collection is in compliance with the Government Paperwork Elimination Act.

4. Efforts to Identify Duplication and Use of Similar Information

After researching the literature and consulting with experts, it was clear that while studies have previously examined prevention and wellness strategies, the majority of research exists among self-insured companies and employers. There is very little research that examines prevention and wellness programs across health plans in the United States. This data collection will uniquely address the characteristics and differences in prevention and wellness programs in this critical era of healthcare reform.

5. Impact on Small Businesses or Other Small Entities

It is not known whether small businesses will be participating in the survey. Regardless of whether small businesses are participating, the survey questions have been held to the absolute minimum required for the intended use of the data.

6. Consequences of Collecting the Information Less Frequently

This is a one-time data collection.

7. Special Circumstances Relating to the Guidelines of 1320.5

This request fully complies with the regulation 5 CFR 1320.5. There are no special circumstances applicable to this data collection. Respondents will respond once.

8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency

A. A 60-day Federal Register Notice (Appendix B) was published in the *Federal Register* on October 28, 2014, Vol. 79, No. 208, pages 64197 – 64198. There were no public comments.

B. As a trade association and membership-based organization, AHIP interacts with its health plan members on a regular basis on topics of interest to the industry including prevention and wellness. This study has benefited from the knowledge AHIP has gained through ongoing consultations with AHIP members as part of normal business operations.

9. Explanation of Any Payment or Gift to Respondents

No incentives or payments will be offered for participation.

10. Assurance of Confidentiality Provided to Respondents

No assurance of confidentiality will be provided to respondents. This submission has been reviewed by the CDC Information Collection Review Office who determined that the Privacy Act does not apply. This data collection does not require submission of personal identifiers such as name, social security number, or other identifying information. Only AHIP project team members will have access to health plan aggregate data. Names of health plans will not be linked to individual health plan data in aggregate reports. The summary report that will be provided to CDC will not include the names of health plans nor proprietary information. Although no personal identifiers will be collected, all AHIP team members have conducted numerous other surveys and are knowledgeable about the importance of protecting respondents.

IRB Approval

This study does not require IRB approval. The primary objective of this project is to examine prevention and wellness programs implemented by health insurance plans in the commercial population and as such is not research involving human subjects.

10.1 Privacy Impact Assessment Information

No information in identifiable form (IIF) will be collected.

11. Justification for Sensitive Questions

No questions of a sensitive nature will be asked. Respondents will not be required to provide any proprietary organizational information (e.g., a program developed in house). If a respondent acknowledges information as proprietary, it will not be documented or reported.

12. Estimates of Annualized Burden Hours

A. This data collection will occur once, and respondents will be surveyed once. Approximately 150 respondents at 150 select nationally representative health plans will participate in the study. The survey will take approximately 30 minutes to complete per respondent for a total estimated burden of 75 hours. Some burden associated with coordinating the time and identifying a person to take the survey will be imposed on key health plan contacts (e.g., medical directors, nurse directors, or other healthcare professional). The burden associated with this activity is estimated at 30 minutes per key health plan contact for a maximum of one key contact per health plan (1 key contact x 150 health plans = 150 key contacts), resulting in a total burden of 75 hours. In addition, administrative support staff at select health

plans may assist with coordinating communications between key health plan points of contact and AHIP; the estimated burden is 30 minutes per health plan, resulting in a total burden of 75 hours.

Following the analysis of survey data, the AHIP project team will conduct one-hour telephone interviews using an interview script (Appendix F) with no more than nine health plans (1 hour x 9 health plans) to gain a better understanding of lessons learned and best practices associated with the design and implementation of prevention and wellness programs by commercial health insurance plans. The AHIP project team will use this information to build upon the knowledge gained through the survey. For example, there may be differences in how health plans structure prevention and wellness programs for different employer accounts based on employer requests. The estimated burden is 1 hour per health plan, resulting in a total burden of 9 hours.

As shown in Table 1, the total burden calculation in hours for key health plan points of contact, and health plan respondents (e.g., physicians, nurses, other healthcare professionals) and administrative support staff for this data collection is estimated to be 234 hours.

Table A.12.1

Estimated Annualized Burden Hours

Type of Respondent	Form Name	No. Respondents	No. Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
Physician, Nurse, or Other Healthcare Professional (To Complete Survey)	Prevention and Wellness Assessment Survey	150	1	30/60	75
Key Health Plan Contact	Activity: Coordinating & Identifying	150	1	30/60	75
Administrative Support	Activity: Communication coordination	150	1	30/60	75
Physician, Nurse, or Other Healthcare Professional (To Complete 1-hour Interview Post Survey)	Telephone Interview Script	9	1	1	9
Total Estimated Burden Hours					234

B. There are no direct costs to respondents or other health plan personnel for their participation in the survey. Instead, indirect costs to key health plan contacts, healthcare personnel, and health plan administrative support were calculated as the value of time spent responding to AHIP's invitation to participate in the survey, coordinating and identifying respondents for the study, responding to the

Prevention and Wellness Assessment Survey (Appendix C), tracking respondents' completion of the survey, coordinating interviews, contacting AHIP for any questions or concerns, and providing basic administrative support were calculated.

Table A.12.2 shows the total indirect burden for key health plan contacts (e.g., medical directors) to coordinate and identify respondents; this was estimated at $6,632.00, based on 75 total hours at a rate of $88.43 per hour (http://www.bls.gov/oes/current/oes291062.htm). The total indirect burden for healthcare personnel (e.g., physicians or nurses) was estimated at $5,124.00 based on 84 total hours at a rate of $61.00 per hour (an average of physician and nurse mean hourly wages) (http://www.bls.gov/oes/2011/may/oes291111.htm). The total indirect burden for administrative support staff is $1,259.00, based on 75 total hours at a rate of $16.78 per hour (http://www.bls.gov/oes/current/oes430000.htm). The total estimated indirect cost burden of this data collection is $13,015.00.

Source: Bureau of Labor Statistics, Occupational Employment Statistics, Occupational and Employment Wages, May 2011.

Table A.12.2

Estimated Annualized Burden Cost

Type of Respondent	No. Respondents	Total Burden Hours per Response	Mean Hourly Wage Rate	Total Respondent Cost
Physician, Nurse, or Other Healthcare Professional (To Complete Survey)	1	75	$61.00	$4,575.00
Key Health Plan Contact	1	75	$88.43	$6,632.00
Administrative Support	1	75	$16.78	$1,259.00
Physician, Nurse, or Other Healthcare Professional (To Complete 1-hour Interview Post Survey	1	9	$61.00	$549.00
Total Estimated Cost				$13,015.00

13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

Data collection for this study will not result in any additional capital, start-up, maintenance, or purchase costs to respondents or record keepers.

14. Annualized Cost to the Government

This data collection is funded under Contract No. 200-2013-55917. The total cost award to America's Health Insurance Plans is $149,957.33 over a 10-month period. The annualized cost to the government is $149,957.33. Table A.14.1 provides a breakdown of contractor cost details.

Table A.14.1

Contractor Costs: Labor and Other Direct Costs

Project Task	Cost
Conduct literature review.	$15,317.42
Design survey questionnaire.	$21,814.87
Obtain feedback on draft survey instrument.	$4,118.86
Revise draft survey instrument.	$4,967.27
Conduct pilot test of survey instrument.	$887.09
Revise and finalize survey	$9,949.53

instrument.	
Construct sample and field final survey with health plans.	$3,837.21
Analyze survey data.	$14,785.96
Develop structured interview guide.	$6,747.11
Conduct follow-up interviews.	$4,928.14
Analyze findings from telephone interviews.	$17,138.57
Write preliminary report.	$27,984.49
Finalize report.	$9,618.18
Develop issue briefs on prevention and wellness.	$7,862.63
Total Cost:	$149,957.33

Additional costs in the form of CDC personnel will be incurred by the government—duties entail oversight of the project. The direct cost is approximately $10,362.00. Table A.14.2 summarizes this cost. Including the cost of the contract, the average annualized cost to the government is $160,319.33.

Table A.14.2

Other Government Costs

CDC	Tasks	Yearly	Percent of	Yearly CDC

Personnel		Salary	Effort	Direct Cost
GS-13 Public Health Analyst	Oversee and provide guidance for project-related matters.	$103,626.00	10%	$10,362.00

15.Explanation for Program Changes or Adjustments

This is a new data collection.

16.Plans for Tabulation and Publication and Project Time Schedule

This is a new study to examine characteristics of prevention and wellness programs implemented by health insurance plans in the commercial population (Appendix C). This will be a descriptive research project with descriptive data analyzed as described below.

DATA CONFIGURATION

This phase will include analysis of the basic data configuration, including missing data analysis, face

validity of responses etc. This analysis focuses on ensuring that the study data could serve as a reasonable representation of the wellness and prevention activities of the entire population of commercial health insurance plans with enrollment over ten thousand.

Analysis methods will include frequency distributions and cross-tabulations.

MEASUREMENT

This phase will include analysis of the survey and interview data aimed at answering the study research questions. This analysis focuses on describing activities of health plans in the areas of prevention and wellness and on identifying any differences in those activates based on plan size and market type (large group market, small group market etc.).

Analysis methods will include frequency distributions, cross-tabulations, chi-square and statistical significance calculation.

A time schedule for the entire project is detailed in Table A.16.1. After survey and interview data is analyzed, AHIP will prepare and submit a preliminary report to CDC. A final report will be submitted to CDC after CDC has provided

input on preliminary draft reports. The final report will include the following sections:

1. Executive Summary – An overview of the final report and its major findings and recommendations.
2. Introduction – An overview of the purpose and objectives of the study and a description of the health plans.
3. Study Design and Materials – A discussion of the design elements and sampling plan, including health plan selection criteria and procedures; data collection procedures; and analysis plan.
4. Study Findings – A presentation and discussion of the results of data collection procedures.
5. Summary and Recommendations – A statement of the implications that the study will have for further research.

Two issue briefs will be prepared by AHIP. Research findings may be presented at national, regional, and state professional meetings and training events. In addition, research findings may be submitted to select scientific journals for publication.

Table A.16.1

Activity	Time Period

Conduct pilot test of survey instrument	2 weeks after feedback received on draft survey instrument
Recruit respondents	2 weeks after OMB approval
Field final survey instrument	2–3 months after OMB approval
Analysis of final survey data	3–4 months after OMB approval
Report preparation	4–6 months after OMB approval
Issue briefs preparation	6–9 months after OMB approval
Submit manuscript for publication	10–12 months after OMB approval

17.Reason(s) Display of OMB Expiration Date is Inappropriate

The display of the OMB expiration date is not inappropriate.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.