Health Insurance Plans Research Study

Supporting Statement B

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B. Collections of Information Employing Statistical Methods

1. Respondent Universe and Sampling Methods

The sampling approach for the Health Insurance Plans Research Study is designed to meet the primary study objective, which is to examine prevention and wellness programs implemented by health insurance plans in the commercial population.

The AHIP team will conduct a nationwide census of 100 percent of eligible plans. The sample will consist of all eligible commercial non-subsidiary plans that include 10,000 enrollees or more. Records from *AIS's Directory of Health Plans 2013* indicate that there are approximately 150 plans that meet these criteria and will serve as the sample. The AHIP project team's objective is to collect nationally representative data that could describe commercial plans' general approaches to prevention and wellness, as well as the main characteristics of their programs.

The sampling procedures will take place in three steps. In the first step, a census of all listed non-subsidiary commercial health plans with enrollment of 10,000 or more will be conducted. Estimates from AIS's Directory of Health Plans 2013 indicate a sample size of approximately 150 plans. In the second step, a purposive sample of no more than nine individuals at nine health plans will be selected from the census for the purpose of pilot

testing the survey instrument. The AHIP project team will aim to include a range of plans to cover various characteristics including size, geography and product type. In the third step, to be completed after the survey has been conducted, a purposive sample of no more than nine individuals at nine plans will be selected from survey respondents for in-depth follow-up interviews based on an analysis of responses, including summary statistics for the questions, cross tabulations, and an examination of similarities and differences based on plan size and geographic region. In the case that an individual at a health plan declines to participate, another individual at another health plan with similar characteristics (i.e. size, geography, product type) will be invited to interview.

Table 6

Sample Universe of Nationwide Commercial Health Insurance Plans with Wellness and Prevention Programs and 10,000 or More Enrollees

Commercial Health Insurer	Number of Plans
Total	150
Expected Response Rate	43% - 63%

Table 7

Sub-Sample of Health Plans for Pilot Testing

Commercial Health Insurer	Number of Individuals and Plans
Total	9
Expected Response Rate	56%

Table 8

Sub-Sample of Health Plans for Follow-Up Interviews

Commercial Health Insurer	Number of Individuals and Plans
Total	9
Expected Response Rate (with replacement)	100%

2. Procedures for the Collection of Information

Data collection will be managed by *America's Health Insurance Plans,* Inc. *(AHIP)*, the Contractor selected for this project. A mixed-methods approach, including a web-based survey instrument (Appendix C) and semi-structured interviews will provide information about the state of prevention and wellness programs in commercial health insurance sectors as well as an understanding of the successes and challenges with regard to implementation, uptake, and evaluation.

A targeted literature review of studies on prevention and wellness activities of health plans, and preliminary interviews led by the AHIP project team with nine individuals at nine health plans informed development of the pilot survey instrument (see Section 4. Tests of Procedures or Methods to be Undertaken).

A national census on approximately 150 commercial health insurance plans in the United States, 50 states and the District of Columbia, will be conducted using the final web-based survey, the *Prevention and Wellness Assessment Survey* (Appendix C). The selection will be based on the latest available data published by the Atlantic Information Services, Inc. (AIS); AIS provides a national directory of commercial health insurance plans in the United States, including enrollment data and other information for all types of health plans. The following table outlines exclusion criteria that will be used to help define the sample for this study.

Exclusion Criteria	**Rationale**
Health insurance companies operating exclusively outside of 50 states and District of Columbia	The health insurance organization working in the unincorporated territories of the United States (Puerto Rico, Guam, Virgin Islands, etc.) operate in a very distinct

	regulatory and social environment. The study of their prevention practices would require designing a separate survey instrument and interview guide as well as a substantial learning process on the part of the project team.
Leased preferred provider networks, organizations that do not provide health insurance products directly to individuals or employers but instead build the provider networks and lease them to other health plans.	Leased preferred provider networks are not involved in designing or implementing prevention and wellness activities.
Health insurance companies that offer only specialty care (e.g., behavioral health services)	Specialty care companies offer healthcare services for a limited number of health conditions via contracts with health insurance plans or self-insured employers. Plans will be asked to respond on all of

	their prevention and wellness programs, whether administered in house or through vendors, including specialty care companies.
Subsidiaries of health plans	Experience has shown that prevention and wellness strategies and programs are established at the corporate level with the intent of achieving uniformity in operations. Occasionally, assimilation into such a uniform corporate structure may not have occurred for newly acquired subsidiaries. If health plans included in the study sample wish to submit separate responses for their subsidiaries, the subsidiary will be invited to participate, and for analysis purposes, the subsidiary will be counted as

	an independent responding unit.
Health plans with a commercial enrollment of less than 10,000 according to data provided by AIS's Directory of Health Plans.	Experience has shown that plans with low enrollment have unusually structured insurance products or niche markets. Small plans typically have a limited number of personnel who handle multiple responsibilities. Survey response rates to surveys are usually very low, which does not allow for robust inferences.

Once the sample has been finalized, the *Prevention and Wellness Assessment Survey* (Appendix C) will be deployed in a web-based format.

The process for fielding the *Prevention and Wellness Assessment Survey* (Appendix C) begins with notifying selected health plans. Using AHIP's internal database, contacts (e.g., chief medical officers) at the selected health plans will receive a notification email. The email notification will include information about the purpose of the survey, a web link to the *Prevention and Wellness Assessment Survey* (Appendix C), a

response deadline, a description of data use and privacy policies, and an AHIP point of contact.

The *Prevention and Wellness Assessment Survey* (Appendix C) will be administered by the AHIP project team. The survey will be available online for at least six weeks following notifications. The *Prevention and Wellness Assessment Survey* (Appendix C) will be anonymous and will not include any individually identifying information (see Section A10 Assurance of Confidentiality Provided to Respondents). Although the notification email will be sent to a specific contact at each health plan, such as the health plan's medical director, that person may or may not be the person who completes the survey.

The AHIP project team will monitor survey responses and send reminders one week before the initial deadline. Best practices in outreach will be utilized to maximize survey response rates. After the initial deadline, the AHIP project team will initiate a follow-up process aimed at maximizing response rates. Non-responding health plans will receive a 1-week extension on the deadline, and any questions or concerns will be addressed by the AHIP project team at this time. At the end of the extended deadline, AHIP will call non-responding health plans and offer one-to-one assistance if needed; the Contractor's experience has shown that such a process has resulted in response rates in the

range of 43% - 63% depending on the sample composition (e.g., AHIP health plan members versus non-members) and survey topics.

All submitted surveys will be reviewed for completeness. Contacts at health plans will be asked to verify and/or clarify responses if necessary. Health plans that submitted incomplete surveys will be given the opportunity to complete the survey; however, if unable to do so, the AHIP project team will evaluate incomplete submissions for validity and include responses to questions that were answered.

Data will be stored in a secured environment with restricted access.

The analysis will be designed to address the study's research questions:

1. What are the specific objectives of commercial health plans' prevention and wellness programs?
2. What guidelines and evidence-based comparative studies do commercial health plans use in making decisions about coverage determinations pertaining to prevention and wellness?
3. What are the key components of commercial health plans' prevention and wellness programs?
4. How do commercial health plans identify members who may benefit from a prevention and wellness program?

5. What types of incentives are offered to enrollees to advance prevention and wellness?
6. What types of patient-focused tools are offered by commercial health plans to providers to advance prevention and wellness?
7. How do plans collaborate with their providers in promoting prevention and wellness?
8. What kinds of community partnerships and programs do commercial health plan invest resources in to promote prevention and wellness?
9. What quantifiable outcomes have commercial health plans observed as a result of their prevention and wellness programs?
10. What are the barriers to implementation of prevention and wellness programs and what are the lessons learned that could be useful in accelerating change in this area? How can lessons learned be applied in the implementation of the *National Prevention Strategy (NPS)*?
11. Are there similarities and differences in prevention and wellness programs by health plan characteristics (e.g., size and geographic region)?

Summary statistics and cross tabulations, similarities and differences among health plans by size and geography, and a

description of how the data aligns with NPS and *Healthy People 2020* priorities and objectives will be examined.

Following the analysis of survey data, the AHIP project team will conduct one-hour telephone interviews with no more than nine individuals at nine 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 interviews will help the project team to better understand the drivers of these differences and what health plans have learned from these efforts and will also allow the project team to probe further regarding prevention and wellness programs. Additionally, where feasible, the AHIP project team will review specific tools that health plans provide to health plan members and providers to promote wellness.

A telephone interview script (Appendix E) will be developed and used to facilitate the interviews and will be sent to the nine individuals at the selected health plans in advance. Probing and follow-up questions will be used to help facilitate

information exchange during the interviews. Responses to interview questions will be sent to the participants for their review in order to correct any inaccuracies. Interviewees will have the latitude to shape their responses. Interview summaries will not include names of interviewees or the individual who completed the survey.

In the case that the health plan declines to participate in the telephone interviews, another health plan with similar characteristics (i.e. size, geography, product type) will be invited to participate in the interview.

3. Methods to Maximize Response Rates and Deal with Nonresponse

Best practices in outreach will be utilized to maximize survey response rates. After the initial deadline, the AHIP project team will initiate a follow-up process aimed at maximizing response rates. Non-responding health plans will receive a 1-week extension on the deadline, and any questions or concerns will be addressed by the AHIP project team at this time. At the end of the extended deadline, AHIP will call non-responding health plans and offer one-to-one assistance if needed; the Contractor's experience has shown that such a process has resulted in response rates in the range of 43% - 63% depending on the sample composition (e.g., AHIP health plan members versus non-members) and survey topics.

The AHIP team will utilize internal databases to identify the most appropriate contacts at each plan to obtain cooperation from, in most cases health plans' chief medical officers. Contractors will collect email addresses and phone numbers for each and reach out to ask for confirmation as to whether they are the best contacts for the prevention and wellness survey. This outreach will also serve as pre-notification for the survey

As previously mentioned, we anticipate a 43% - 63% percent response rate, though no payments or gifts will be provided to participants. To increase the likelihood of an affirmative decision to participate, participating plans will be offered a preliminary report of aggregated data. To maximize response rate we will: (1) indicate that they survey is being sponsored by CDC; and (2) follow-up with each participant via email reminders followed by phone calls if a response is not received by the initial deadline. Additionally, AHIP has conducted other surveys with health plans that are members of AHIP; the response rates are typically higher than those of non-members.

4. Tests of Procedures or Methods to be Undertaken

A pilot survey instrument was distributed via a web-based link to a sample of nine individuals at nine health plans to pilot test the survey instrument. The health plans selected for

the pilot test were chosen purposively to include representation by size and geography.

When the pilot survey time period ended, conference calls were conducted with six key health plan contacts at the six health plans that completed the pilot survey; the purpose of these calls was to ascertain how well the survey worked, to address concerns about specific questions or response choices, and to assess consistency in interpretation of response choices and potential challenges regarding comparability of data. This assessment was conducted by one facilitator and 1 note taker. This was not a structured interview process.

Pilot testing also helped to evaluate and estimate the amount of time required for the health plans to complete the survey (participant burden) and to discuss other relevant areas that could be revised for improving the instrument.

The Centers for Disease Control and Prevention's Office of the Associate Director for Policy, Office of Health System Collaboration contracted with AHIP to develop and establish the reliability of the survey tool. Review by programs across CDC contributed to refinements of the tool that have been incorporated into the current version.

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

The person responsible for the data collection, the statistical design of the data collection and the data analysis is –

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