Supporting Statement A

Revision Request for Clearance

NATIONAL HEALTH INTERVIEW SURVEY

OMB No. 0920-0214, Expiration Date 01/31/2019

Contact Information:

Marcie Cynamon

Division of Health Interview Statistics
National Center for Health Statistics/CDC
3311 Toledo Road
Hyattsville, MD 20782
301.458.4174 (voice)
301.458.4035 (fax)
mlc6@cdc.gov

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Supporting Statement

NCHS National Health Interview Survey

- Goal: To collect data to measure and monitor the amount, distribution, and effects of illness and disability in the population and the utilization of health care services for such conditions.
- Intended use: For use by the Department of Health and Human Services (DHHS) to monitor trends in illness and disability and to track progress toward achieving many of the Healthy People objectives for the nation, and for the public health research community to conduct epidemiologic and policy analysis of such timely issues as characterizing those with various health problems, determining barriers to accessing and using health care, and evaluating the impact of changes in federal health programs.
- Data collection methods: In-person household interviews via Computer Assisted Personal Interview.
- Subpopulation to be studied: Civilian noninstitutionalized population residing in the United States.
- Data analysis methods: Descriptive, bivariate, and multivariate statistics, including frequencies; chi-square and t-tests; and linear, logistic, and multilevel regression.

The National Health Interview Survey (NHIS) is a critical ongoing information source of information on the health of the civilian, noninstitutionalized population of the United States. This revision request is to modify selected sections of the NHIS (OMB# 0920-0214, expires 01/31/2019) in order to add annual and periodic questions; to delete annual and periodic questions; to conduct methodological and cognitive testing; and to survey subsamples of former or current NHIS respondents or members of commercial survey panels. A three year clearance is requested.

On January 7, 2016, OMB approved the NHIS through the 2016 data collection, including the estimated sample size and estimated annual burden. In this application, we seek OMB approval to:

- Conduct the National Health Interview Survey in 2017, 2018, and 2019.
- Carry out methodological and cognitive testing that will inform the 2018 questionnaire redesign, using web and/or mail survey tools (as noted in Line 5 of the burden table).
- Modify selected sections of the questionnaire, for example to include new supplementary questions on alternative and integrative medicine, cognitive disability, receipt of culturally and linguistically appropriate health care services, epilepsy, and heart disease and stroke, as well as continue from 2016 questions about the Affordable Care Act, chronic pain, diabetes, disability and functioning, family food security, ABCS of heart disease and stroke prevention,

hepatitis B/C screening, immunizations, smokeless tobacco and e-cigarettes, vision, and children's mental health. Most of these modules appeared on the NHIS in previous years and will be used to track progress toward achieving the objectives set forth in Healthy People 2020.

A. Justification

1. Circumstance Making the Collection of Information Necessary

Background

The NHIS is conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC), to comply with the NCHS mandate under 42 USC 242k (Attachment 1) to collect, on an annual basis, statistically valid data on the amount, distribution, and effects of illness and disability in the population and on the utilization of health care services for such conditions. NHIS data are used widely throughout the Department of Health and Human Services (DHHS) to monitor trends in illness and disability and to track progress toward achieving many of the Healthy People objectives for the nation. The data are also used by the public health research community for epidemiologic and policy analysis of such issues as characterizing those with various health problems, determining barriers to accessing and using health care, and evaluating the impact of changes in federal health programs.

In accordance with the 1995 initiative to increase the integration of surveys within DHHS, respondents to the NHIS serve as the sampling frame for the Medical Expenditure Panel Survey (MEPS; OMB# 0935-0118, expires 12/31/2018). This survey is conducted by the Agency for Healthcare Research and Quality. MEPS uses completed interviews from the NHIS to identify and select the desired sample, contact that sample to collect additional data, and combine their survey data with the original NHIS data. These procedures reduce survey costs, reduce overall burden on the public, and increase the amount of data available for critical health-related analysis.

The NHIS has been conducted every year since 1957. The current design of the NHIS questionnaire was implemented in 1997, and consists of a standard basic or Core Module, covering general health topics and demographic characteristics that is repeated every year. In addition to the Core Module, each year supplementary questions or modules are included. Topics are rotated in and out of the annual NHIS depending on funding availability and data requirements of federal programs such as Healthy People 2020. For example, the 2017 NHIS will include new supplementary questions on alternative and integrative medicine, cognitive disability, receipt of culturally and linguistically appropriate health care services, epilepsy, and heart disease and stroke, as well as continue from 2016 questions about the Affordable Care Act, chronic pain, diabetes, disability and functioning, family food security, ABCS of heart disease and stroke prevention, hepatitis B/C screening, immunizations, smokeless tobacco and e-cigarettes, vision, and children's mental health.

The NHIS serves a critical role in providing information for monitoring and evaluating the performance of public health programs. The NHIS meets this need in several ways. First, the NHIS provides information on the overall health status of the U.S. population and its health care needs, which serves as a background of "contextual" data against which program goals and performance measures are formulated and evaluated. Secondly, data from the NHIS serve as the national benchmark against which individual state monitoring efforts and other national surveys are compared.

2. Purpose and Use of Information Collection

The purposes of the NHIS are (1) to provide national data on an annual basis on the incidence of acute illness and accidental injuries, the prevalence of chronic conditions and impairments, the extent of disability, the utilization of health care services, and other health-related topics; (2) to provide more detailed information on selected topics periodically and on a one time basis; and (3) to provide a sampling frame for the Medical Expenditure Panel Survey and other follow-back surveys. It is also a main provider of data for the Congressionally-mandated *Health*, *United States* report and provides data for many indicators used in monitoring progress toward the Healthy People goals and for detailing health disparities.

A major strength of the NHIS is its ability to display health characteristics by selected demographic and socio-economic characteristics of the U.S. civilian, noninstitutionalized population. The uses of NHIS data are generally in the areas of program planning and evaluation, public health education and health promotion and epidemiological research.

Data collection procedures remain unchanged for 2017. Under an interagency agreement, the U.S. Census Bureau is the data collection agent for the National Health Interview Survey. NHIS data are collected by Census interviewers, primarily through personal visits to households using laptop computers. Personal household visits may be supplemented with telephone data collection under certain circumstances: telephone interviews may be attempted when efforts to make personal contact have not been successful, when the respondent requests a telephone interview, when part of the interview needs to be completed and it is not possible to schedule another personal visit, or when road conditions or travel distances would make it difficult to schedule a personal visit. Nationally, the NHIS uses about 800 trained interviewers, directed by survey supervisors in the 6 U.S. Census Bureau Regional Offices. Interviewers (also referred to as Field Representatives or FRs) receive initial and/or annual refresher training in common interviewing procedures, the concepts and procedures unique to the NHIS, and survey content changes.

To conduct the computer-assisted personal interviewing (CAPI), interviewers use official Census Bureau-furnished laptop computers equipped with Blaise software that presents the questionnaire on the computer screen. The CAPI program guides the interviewer through the questionnaire, automatically routing the interviewer to appropriate questions based on answers to previous questions. Interviewers enter survey responses directly into the computer, and the CAPI program determines if the selected response is within an allowable range, checks it for consistency against other data collected during the interview, and saves the responses into a survey data file. This data collection technology reduces the time required for collecting, transferring, processing, and releasing data, and it ensures the accurate flow of the questionnaire. Publicly released data sets are available indefinitely on the NCHS website.

Responsibility for developing questions and monitoring field work in each of these areas is assigned to NCHS staff. Input to the design of questions is solicited from experts in a variety of organizations within the federal government, and from outside researchers and public health professionals.

Questionnaire Structure: The Core Module is repeated every year with little change; this allows for trend analyses and for data from more than one year to be pooled to increase sample size for analytic purposes. The Core Module contains three major parts: the Family Core (Attachment 2a), the Adult Core (Attachment 2b), and the Child Core (Attachment 2c). The Family Core component collects information on everyone in the family. This allows the NHIS to serve as a sampling frame for additional integrated surveys, specifically MEPS and NHIS follow-back surveys and other special projects. A summary of the need for each of the topic areas of the NHIS Core Module previously approved by OMB is noted in Attachment 2d.

The OMB statement (Attachment 2e) is located at the beginning of the computerized instrument, ahead of the household composition section that marks the beginning of the Family Core component, which is administered to any available adult respondent to obtain information about all household and family members. The Adult Core component is administered to a randomly selected adult family member who must respond for himself or herself unless physically or mentally incapable. If there are children under 18 in the family, one is randomly selected and the Child Core component is administered to an adult family member who is knowledgeable about that child’s health. Finally, recontact information is collected from an adult family member to obtain names, addresses, and telephone numbers of persons who might know the family’s whereabouts if they move.

Items of Information to be Collected

This clearance request is for continuing the previously approved Core and Supplemental Modules of the NHIS as well as new content. To put this request in context, a brief description of the overall questionnaire design is given here.

Five broad content domains and associated subdomains are covered by the Core Module: health status, health care services, health behavior, health care coverage, and socio-demographic characteristics. The subdomains are listed as follows:

Health status
- Conditions
- Injuries/Poisoning
- Activity limitations

Health care services
- Access to care
- Service utilization
- Barriers to care

Health Behaviors
- Tobacco product use
- Physical activity
- Alcohol consumption
- Obesity
- Sleep

Health Care Coverage
- Type(s) of coverage
- Cost and who pays
- Periods of noncoverage

Socio-demographics
- Household composition
- Race/national origin
- Education
- Income and assets
- Sex
- Sexual orientation

The previously-approved questions for the Core Module are included in Attachments 2a, 2b, and 2c, with additions to the core listed in Attachment 2f.

Supplementary questions may be embedded within or attached to one of the principal sections (Family, Sample Adult, and Sample Child). The supplementary questions that will be administered in 2017 are shown in Attachment 3a; a description of each set of supplementary questions is provided in Attachment 3b, and changes in supplemental content from 2016 to 2017 are summarized in Attachment 3c.

For 2017, supplemental questions will be cycled in pertaining to alternative and integrative medicine, cognitive disability, receipt of culturally and linguistically appropriate health care services, epilepsy, and heart disease and stroke. Supplemental topics that continue largely unchanged from previous years (many most recently from 2016) will be related to the Affordable Care Act, chronic pain, diabetes, disability and functioning, family food security, ABCS of heart disease and stroke prevention, hepatitis B/C screening, immunizations, smokeless tobacco and e-cigarettes, vision, and children's mental health. Flashcards used in the administration of the questionnaire are included in Attachment 4.

In addition to the principal questionnaires, a small sample of respondents is reinterviewed as a quality control measure; the reinterview questionnaire is provided in Attachment 5.

Past follow-back surveys and special projects served as methodological tests to expand the depth and breadth of information related to the Affordable Care Act, test the impact of respondent incentives, and assess the feasibility of using adaptive design in the NHIS. For 2017, smaller-scale special projects are anticipated to build on and extend the findings from these previous efforts. A series of short, web and/or mail assessments is planned to test new and/or updated questionnaire items, evaluate the impact of different categorical response option formats on answer choices, and measure respondent comprehension of health care-related terms and concepts in various contexts is included in Attachment 6.

3. Use of Improved Information Technology and Burden Reduction

The survey will be conducted by Computer Assisted Personal Interview (CAPI), using Blaise software, which reduces the time required for collecting, transferring, processing, and releasing data. CAPI usually reduces the average duration of interviews compared to a paper questionnaire with identical content.

The web-based methodological and cognitive testing activities planned for 2017 will be informed by and build on the findings from the NHCIS follow-back survey. Carried out in 2013, the NHCIS included a component testing the feasibility of administering web-based surveys to prior NHIS respondents as well as members of commercial survey panels. The convenience to respondents of self-administered web surveys, along with government savings from lower survey administration costs, significantly reduce public burden—both to respondents and taxpayers.

4. Efforts to Identify Duplication and Use of Similar Information

NHIS is the primary source of information for DHHS regarding the U.S. noninstitutionalized civilian population’s health status, health care access, and progress toward achieving national health objectives. The Core items of the NHIS are not duplicated in their entirety in any other national data system. In fact, other surveys borrow questions from the NHIS. To the extent that there is some overlap in content of the Core Module with other surveys, it is necessitated to ensure that the full range of covariates are included for complex analyses of data on the NHIS sample.

NCHS participates in interagency workgroups on mental health, sexual orientation, health insurance, and tobacco use that were established to harmonize content on major DHHS surveys.

5. Impact on Small Businesses or Other Small Entities

Information collection for the NHIS does not involve small businesses or other small entities.

6. Consequences of Collecting the Information Less Frequently

The continuous nature of the NHIS is necessary for several reasons. First, many of the data items collected in the NHIS are used for annual tracking of health events and circumstances, including the National Objectives for Health Promotion and Disease Prevention and the health status of sexual minority populations. Second, the continuous design makes it possible to aggregate data over longer periods of time to include enough cases to study rare events and small populations, such as population subgroups or persons with certain conditions. Third, the Medical Expenditures Panel Surveys (Household Component and Medical Providers Component, OMB No. 0935-0118, expires 12/31/2018) now depends on the NHIS for their sample, and failure of the NHIS to collect data annually may cause this survey to be postponed or canceled. Fourth, a continuous survey is more cost-effective because it makes possible a stable interviewing staff, which increases the quality of the data and avoids start-up and shut-down costs. Reducing the frequency of data collection would undermine all of these desirable features of the NHIS.

There are no legal obstacles to reducing the burden.

7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

This request fully complies with the regulations 5CFR 1320.5.

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

A. Public Comment
A 60-day Federal Register Notice was published in the Federal Register on 07/26/2016, Vol. 81, No. 143, pp. 48802 (see Attachment 7a). Six comments were received (see Attachment 7b) and the standard CDC response was sent to the 5 commenters who included contact information with their submission.

B. Other Consultations Outside the Agency
In 2008, the Board of Scientific Counselors (BSC) of NCHS commissioned a panel to review the NHIS. The panel issued a report, in which it states that, “The NHIS is the gold standard for U.S. survey data. The size, scope and the quality of the NHIS data set it apart from the vast majority of other U.S. health surveys.” The full report may be found at:
http://www.cdc.gov/nchs/data/bsc/NHISFinalReportwithexecsumm112108.pdf

For the 2016 NHIS sample redesign, sampling experts at NCHS collaborated with their counterparts at the U.S. Census Bureau to develop a timeline and procedures for implementing the new sample. Workgroups at NCHS and the Census Bureau conducted methodological and procedural research on approaches to creating a new sample, with specific focus on the new source of sample addresses (e.g., accuracy, geocoding quality, coverage of college dormitories, etc.) and the anticipated flexibility to alter overall sample size and/or shift sample allocations between States from year to year.

9. Explanation of Any Payments or Gifts to Respondents

No payments will be made to respondents.

10. Protection of the Privacy and Confidentiality of Information Provided by Respondents

The NCHS Privacy Act Coordinator has determined that the Privacy Act is applicable because information in identifiable form is being collected. The Privacy Act System of Records relevant to this data collection is entitled Health and Demographic Surveys Conducted in Probability Samples of the U.S. Population (09-20-0164). The Office of the Chief Information Security Officer (OCISO) has a current copy of the Privacy Impact Assessment.

Confidentiality assurances to respondents are shown in Attachment 1. The collection, transfer, processing, storage, and release of NHIS data are conducted in compliance with section 308(d) of the Public Health Service Act (42 USC 242m), the Confidential Information Protection and Statistical Efficiency Act (CIPSEA; PL-107-347), the Privacy Act of 1974, 5 U.S.C. § 552a, and the Federal Cybersecurity Enhancement Act of 2015. NCHS will use the data for statistical purposes only, and will grant data access to NCHS staff, contractors, and agents for this purpose only when required and with necessary controls.

All NCHS employees and agents who access NHIS data are subject to the confidentiality procedures set forth in section 513 of CIPSEA, which states:

> “Whoever, being an officer, employee, or agent of an agency acquiring information for exclusively statistical purposes, having taken and subscribed the oath of office, or having sworn to observe the limitations imposed by section 512, comes into possession of such information by reason of his or her being an officer, employee, or agent and, knowing that the disclosure of the specific information is prohibited under the provisions of this title, willfully discloses the information in any manner to a person or agency not entitled to receive it, shall be guilty of a Class E felony and imprisoned for not more than 5 years, or fined not more than $250,000, or both.”

Information in Identifiable Form

Information in identifiable form (IIF) is collected for linkage with other federal sources of data and to enable the MEPS and NHIS follow-back surveys to develop a sampling frame from NHIS data. All of these items have been routinely approved and collected in the past. The identifiable information includes:

- Name
- Date of birth
- Last four digits of the Social Security Number
- Mailing address
- Phone numbers
- Medical information

The NHIS continues to collect, on a confidential basis, data needed to recontact respondents for additional information and for participation in the Medical Expenditure Panel Survey, NHIS follow-back surveys and other special projects, as well as to match respondents to administrative records such as the National Death Index. This ability to track respondents and match to other records greatly expands the usefulness of the data at very low cost.

The collection of information in identifiable form requires strong measures to ensure that private information is not disclosed in a breach of confidentiality. Only those NCHS employees, those specially designated agents (including staff at the U.S. Census Bureau), and those NHIS research partners who must use the personal information for a specific purpose can use such data.
All NCHS employees as well as all contract staff, receive appropriate training and sign a "Nondisclosure Statement." Staff from collaborating agencies are also required to sign this statement, and members of outside agencies are required to enter into a more formal agreement with NCHS. Everyone else who uses NHIS data can do so only after all identifiable information is removed (as described below). In addition, the Cybersecurity Act of 2015 permits monitoring information systems for the purpose of protecting a network from hacking, denial of service attacks and other security vulnerabilities.[1] Monitoring under the Cybersecurity Act may be done by a system owner or another entity the system owner allows to monitor its network and operate defensive measures on its behalf. The software used for monitoring may scan information that is transiting, stored on, or processed by the system. If the information triggers a cyber threat indicator, the information may be intercepted and reviewed for cyber threats. The cyber threat indicator or defensive measure taken to remove the threat may be shared with others only after any information not directly related to a cybersecurity threat has been removed. In addition, sharing of information can occur only after removal of personal information of a specific individual or information that identifies a specific individual.

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[1] To "monitor" means "to acquire, identify, or scan, or to possess, information that is stored on, processed by, or transiting an information system"; "information system" means "a discrete set of information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of information;" "cyber threat indicator" means information that is necessary to describe or identify security vulnerabilities of an information system, enable the exploitation of a security vulnerability, or unauthorized remote access or use of an information system.

To aid interviewers in guarding the confidentiality and security of data, all data collected for the NHIS will be collected on official laptops that are secured with encryption software. This software encrypts data contained on the computer, and has two levels of password protection. In the event of computer theft or other loss of the computer, the software prevents unauthorized access to any data on the computer, thereby adding an extra layer of security and confidentiality to the data. The transmission of confidential data from the Census Bureau to NCHS will be protected through procedures such as encryption and carefully restricted access, as is the storage of confidential data on both agencies' servers. In addition, a routine set of measures will be taken to safeguard confidentiality, including the following: all Census Bureau and NCHS staff who have access to confidential information are given instruction by NCHS staff on the requirement to protect confidentiality, and are required to sign a pledge to maintain confidentiality; only such authorized personnel are allowed access to confidential records, and only when their work requires it; and when confidential information is not in use, it is stored in secure conditions.

It is NCHS policy to make NHIS data available via public use data files to the scientific community. However, confidential data will never be released to the public. For example, all personal identifiers are removed from the public release files; this includes participant name, address, survey location number, sample person number, and so forth. A concerted effort is made to avoid any disclosures that may allow a researcher to go back and find individuals in the general population. All data releases are reviewed by the NCHS Disclosure Review Board to avoid data breaches, such as release of detailed geographic information that may allow someone to identify practices or individuals in the general population. Researchers wishing to conduct analysis on variables not available in the public use data files may submit a research proposal to use the NCHS Research Data Center. Procedures for submitting the proposal and other important information can be found here http://www.cdc.gov/rdc/.

The process of informing respondents of the procedures used to keep information confidential begins with the advance letter and information brochure mailed in advance (Attachments 8a and 8b), and will carry through to interviewer training and all communications with potential respondents. The advance letter includes all elements of informed consent, including the purpose of the data collection, the voluntary nature of the survey, with whom the information will be shared, and the effect upon the respondent for not participating. It, along with the thank you letter (Attachment 8c) and other supplemental mailings that Census Regional Offices may use to contact prospective respondents (Attachment 8d) have been revised from their prior-approved versions to reflect the Federal Cybersecurity Enhancement Act of 2015.

11. Institutional Review Board (IRB) and Justification for Sensitive Questions

The 2017 questionnaires were approved by the Institutional Review Board (the NCHS Research Ethics Review Board) on November 8, 2016 (Attachment 9).

Some of the NHIS research topics include potentially sensitive questions. In the informed consent procedure, all sample persons are advised of the voluntary nature of their participation in the survey or any of its components. Sample persons are informed that they can choose not to answer any questions they do not wish to answer and that they may stop the interview at any time.

All questions and procedures are reviewed by the NCHS Research Ethics Review Board. The potential sensitivity of questions was an evaluation criterion in determining content of the survey. The multi-purpose nature of the NHIS makes it necessary to exclude topics so sensitive that they may interfere with participation.

Questions asked about the following are thought to be of a sensitive nature:

- Social Security and Health Insurance Claim Number (last four digits)
- Citizenship Status
- Intentional Injuries
- Sexual Orientation

Social Security Number and Health Insurance Claim Number: The last four digits of the social security number is asked on the NHIS questionnaire to allow linkage with administrative and vital records such as the National Death Index (NDI; OMB# 0920-0215, expires 10/31/2016The NDI is a computerized central file of death record information. It is compiled from data obtained by NCHS from the State vital statistics offices. The data contain a standard set of identifying information on decedents from 1979 to the present. Records are matched using Social Security Number and other variables such as name, father's surname, date of birth, sex, state of residence, and marital status. Of these, social security number is the most important identifier for successful matching. The last four digits has been shown to be nearly as effective for matching as the full number.

The last four digits of the social security number are also used by the Medical Expenditure Panel Study (OMB# 0935-0118, expires 12/31/2018 to help track the location of respondents who have changed residence since their NHIS interview. Finding a correct address for respondents is essential to maintaining response levels at an acceptable level in linked surveys, and the social security number is a key item for establishing a correct address.

Medicare beneficiaries are given a health insurance claim number that is their (or their spouse’s) social security number with an alphabetic prefix. The NHIS also asks for the last four digits of that number so that the NHIS data can be linked to Medicare claims information for purposes of statistical research.

Before the questions on social security and health insurance claim number are asked, respondents are informed of their purpose and given an assurance of confidentiality:

> “Finally, we would like the last four digits of your Social Security Number and the last four numbers and any letters of your Medicare number. This information will help us link your survey data with health-related records of other government agencies, and allow us to conduct additional research without taking up your time with more questions. The National

> Center for Health Statistics uses this information for research purposes only. Providing this information is voluntary. Federal laws authorize us to ask for this information and require us to keep it strictly private. There will be no effect on your benefits if you do not provide this information.
>
> * Read if necessary: The specific federal laws are the Public Health Service Act (Title 42, United States Code, Section 242K) and the Confidential Information Protection and Statistical Efficiency Act (Title V of Public Law 107-347)."

If the respondent asks for more information about the purpose and confidentiality of these questions, the interviewer can display a standard help screen on his or her computer and read it to the respondent.

Citizenship Status: Because changes in welfare legislation affect the health care coverage of some U.S. residents who are not citizens, it is useful to obtain information about the citizenship status of NHIS sample persons. For that reason, since 1998 the NHIS has asked the following question about all members of sample families as part of the Family Core: {Are/Is} {you/subject name} a CITIZEN of the United States?

The respondent will be asked to select a response from this printed list on a flashcard:

(1) Yes, born in the United States
(2) Yes, born in Puerto Rico, Guam, American Virgin Islands, or other U.S. territory
(3) Yes, born abroad to American parent(s)
(4) Yes, U.S. citizen by naturalization
(5) No, not a citizen of the United States

If necessary, the Field Representative will read the following statement:

> "Information about citizenship is being collected by the Department of Health and Human Services to perform health-related research pertaining to place of birth and length of time in the United States. Providing this information is voluntary and is collected under the authority of the Public Health Service Act. There will be no effect on pending immigration or citizenship petitions."

Intentional Injuries: The questions on injuries and poisoning are intended to elicit a full account of the circumstance surrounding such events, including whether or not they were intentionally caused by another person. Although no direct questions are asked about intentionality or the identity of other persons, it is possible that respondents would report incidents of child abuse to an interviewer. Legal counsel advised NCHS that if that were to occur, Federal law protecting the confidentiality of the interview would take precedence over a State law requiring that evidence of child abuse be reported to authorities. Furthermore, by analyzing previously-collected NHIS data, it was determined that reports of child abuse are extremely rare in NHIS interviews, and that when they occur they almost always refer to events many years past. For those reasons, NCHS decided that it is not necessary to inform respondents in advance that the questions about injury and poisoning could lead to disclosure of child abuse. The NHIS Research Ethics Review Board reviewed and concurred in that decision.

Sexual Orientation: Beginning in 2013, questions on sexual orientation were added to the NHIS. Extensive testing occurred prior to this addition to examine the impact of the questions on interview break-off, nonresponse or refusals, and other possible negative reactions. Multiple rounds of cognitive testing and three rounds of field testing were conducted. Treating the questions as sensitive by offering ACASI administration did not alter the results. Since introducing the questions on the NHIS in January 2013, there have been no complaints or negative outcomes.

12. Estimates of Annualized Burden Hours and Costs

A. Time Estimates

This submission requests OMB approval for three years of data collection, to occur within the context of ongoing data collection activities (OMB# 0920-0214, expires 01/31/2019). The average burden for each survey component for one complete survey cycle is shown in the table below.

The estimated overall average annual burden for 2017-2019, including the core questions, the supplemental questions, the follow-back and other special projects, questionnaire redesign activities, and the reinterview component, is 49,000 hours.

Lines 1-3 of the burden table describe the various sections of the core questionnaire (Attachments 2a, 2b, 2c). Line 4 contains the supplemental questions (Attachment 3a). Line 5 covers the planned web- and/or mail-based methodological and cognitive testing activities (Attachment 6). A small quality control resurvey of about 5,000 participating households is conducted, described in line 6 (Attachment 5).

Estimated Annualized Burden Hours

Type of Respondent	Form Name	Number of Respondents	Number of Responses per respondent	Average Burden per Response (in hours)	Total Burden Hours
Adult Family Member	Family Core	45,000	1	23/60	17,250
Sample Adult	Adult Core	36,000	1	15/60	9,000
Adult Family Member	Child Core	14,000	1	10/60	2,333
Adult Family Member	Supplements	45,000	1	20/60	15,000
Adult Family Member	Methodological Projects	15,000	1	20/60	5,000
Adult Family Member	Reinterview Survey	5,000	1	5/60	417
Total					49,000

Not all questions apply to each person, and the questionnaire instrument automatically skips over questions that do not apply, based on earlier information given by the respondent. Thus, no respondent is ever asked all of the questions in the questionnaire.

The estimate of response burden above is based on an average length of interview per household. Variations occur in individual household interview times primarily because of differing numbers of persons in the household and variations in the number of health conditions reported in the household.

The burden on any single member of a sample family also varies according to who is designated respondent for each module. In some sample families the same adult could be the respondent for all of the major components: Family, Adult, and Child; in other families there could be a different respondent for each of the Core Modules. In the first case, the total average burden on the single respondent would be about one hour; in all other cases the burden on a single respondent would be less.

For the 2017 NHIS, the average total burden is estimated to be about 49,000 hours. This is the same as the estimated burden for the 2016 survey, as the supplements added to the 2017 questionnaire are approximately the same length as those removed from its 2016 version.

B. Cost to Respondents

At an average wage rate of $21.00 per hour and an average length of interview of about 29 minutes for the 100,000 respondents, the average cost per respondent is about $10. (Wage rate information is from the Bureau of Labor Statistics: http://www.bls.gov/ncs/ocs/sp/nctb1344.pdf). This estimated cost does not represent an out of pocket expense, but represents a monetary value attributed to the time spent doing the interview. Estimated Annualized Burden Costs

Type of Respondent	Form Name	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
Adult Family Member	Family Core	17,250	$21.00	$362,250
Sample Adult	Adult Core	9,000	$21.00	$189,000
Adult Family Member	Child Core	2,333	$21.00	$48,993
Adult Family Member	Supplements	15,000	$21.00	$315,000
Adult Family Member	Methodological Projects	5,000	$21.00	$105,000
Adult Family Member	Reinterview Survey	417	$21.00	$8,757
Total				$1,029,000

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

None.

14. Annualized Cost to the Federal Government

As shown in the table below, the total cost of the 2017 NHIS is estimated to be about $42 million, which includes costs to NCHS directly and to its fieldwork contractor, the Bureau of the Census. For NCHS, the estimated cost for the 2016 data collection is about $9 million. This cost includes work on survey design, evaluation, analysis, comparability studies, coding, processing, questionnaire design laboratory testing, field pretests, weighting, and estimation, printing of survey materials, and staff observation costs (travel and per diem). It is estimated that Census Bureau costs for survey planning, design, and data collection for the 2017 NHIS will be about $33 million, which is transferred to the Census Bureau through an Interagency Agreement.

Total 2017 Survey Costs	42 million		
U.S. Bureau of the Census (Interagency Agreement)		33 million	
Sampling			4.5 million
Survey Management			1.5 million
Field Operations			23.5 million
Data Editing			1.5 million
Programming and IT			2.0 million
National Center for Health Statistics		9 million	

Approximately $9 million of these costs are provided to NCHS through Interagency Agreements with survey sponsors.

15. Explanation for Program Changes or Adjustments

For the 2017 NHIS, the average total burden is estimated to be about 49,000 hours, staying flat compared to the 2016 survey. Thus, no changes in burden hours were made to Lines 1-6 of the burden table.

Program changes that do not affect the burden hours include: addition of new and removal of discontinued Supplementary Questions (Attachment 3c), and new aims of Methodological Projects (Attachment 6).

16. Plans for Tabulation and Publication and Project Time Schedule

The following are key activities and projected completion dates for the 2016 NHIS:

Activity	Projected Completion Date
2017 data collection	Following OMB approval, for 12 months
Early release of selected estimates (Quarter 1)	Eight months after OMB approval
2017 data file available	18 months after OMB approval

Publication of Summary Statistics	Two years after OMB approval

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

N/A. Not requesting exemption.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.