Supporting Statement – Part A

Supporting Statement for Paperwork Reduction Act Submissions

A. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010. On March 30th, 2010, the Health Care and Education Reconciliation Act of 2010 was also signed into law. The two laws collectively are referred to as the Affordable Care Act (ACA). Section 1002 of the ACA provides for the establishment of independent offices of health insurance consumer assistance or ombudsman programs, starting in FY 2010. Federal grants will support these programs. For FY 2010, $30 million is appropriated. For subsequent years, 'such sums are authorized' but not yet appropriated.

Consumer assistance or ombudsman programs will assist consumers with filing complaints and appeals, assist consumers with enrollment into health coverage, and educate consumers on their rights and responsibilities. In addition, by law, they will collect data on consumer inquiries and complaints to identify problems in the marketplace and strengthen enforcement. Starting in 2014, programs must also help resolve problems with premium credits for Exchange coverage.

It is the priority of the consumer assistance program grants to build capacity within grantees to fulfill these duties. As health reform is implemented, consumers will need to understand new programs, avail themselves of new protections, and navigate the system to find the most affordable and secure coverage that meets their needs. Consumer assistance programs will be expected to provide the range of assistance services required by law related to private health insurance and group health plans, as well as high-risk pools and the new Pre-existing Condition Insurance Plan. At the outset, programs will not be expected to provide assistance related to Medicaid and CHIP, but will be required to demonstrate that they can and do make appropriate referrals for such inquiries. Over time, grantees will expand assistance related to Medicaid and CHIP.

Some capacity for health insurance consumer assistance exists in every state, and different models have been established. For example, state insurance departments have consumer services divisions that provide some of the help required under this program. In many states, consumer assistance programs offering a broad range of assistance have also been established within the office of the attorney general, independent state consumer assistance agencies, other state agencies, or a non-profit non-governmental organization.

The ACA requires consumer assistance or ombudsman programs to report data to the Secretary of Health and Human Services (HHS) in order to strengthen oversight. Programs must report on the types of problems and questions consumers experience with health coverage, and how these are resolved. Reports will help identify patterns of problems and suspected noncompliance as well as best practices. HHS will share data reports with the U.S. Departments of Labor and Treasury, and with State regulators. Within HHS, reports can also provide the Office of Consumer Information and Insurance Oversight (OCIIO) one indication of the effectiveness of State enforcement, affording opportunities to provide technical assistance and support to State insurance regulators and informing the need for further federal investigation.

The Office of Consumer Support, an office within OCIIO, will provide significant support services for grantees, including data reporting software and technical support, resource and training materials, and assistance on casework as it relates to questions arising from Federal law.

All States are eligible for the consumer assistance program grants. In order to receive a grant, applicants must propose a plan to use grant funds to develop or enhance their consumer assistance activities and demonstrate that eligibility criteria are satisfied.

Grant amounts for States will be determined according to a population-based formula.

On October 19, 2010, forty (40) states and territories were awarded Consumer Assistance Program (CAP) grants.

B. Justification

1. Need and Legal Basis

Section 1002 of the Affordable Care Act provides for the establishment of consumer assistance (or ombudsman) programs, starting in FY 2010. Federal grants will support these programs. For FY 2010, $30 million is appropriated. . These programs will assist consumers with filing complaints and appeals, assist consumers with enrollment into health coverage, collect data on consumer inquiries and complaints to identify problems in the marketplace, educate consumers on their rights and responsibilities, and starting in 2014, resolve problems with premium credits for Exchange coverage.

Importantly, these programs must provide detailed reporting on the types of problems and questions consumers may experience with health coverage, and how these are resolved. In order to strengthen oversight, the law requires programs to report data to the Secretary of the Department of Health and Human Services (HHS) "As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or ombudsman program shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers" (**Sec. 2793 (d)).**

Analysis of this data reporting will help identity patterns of practice in the insurance marketplaces and uncover suspected patterns of noncompliance. HHS must share program data reports with the Departments of Labor and Treasury, and State regulators. Program data also can offer OCIIO one indication of the effectiveness of State enforcement, affording opportunities to provide technical assistance and support to State insurance regulators and, in extreme cases, inform the need to trigger federal enforcement.

On October 19, 2010, forty (40) states and territories were awarded Consumer Assistance Programs (CAP) grants. CAP grant is a one year grant. Some of the programs are now operational, and most will be operational some time in January 2011. As mentioned, all grantees must track and report data on consumer complaints and inquiries under the CAP grant, pursuant to Section 2793(d) of the PHSA. Accordingly, OCIIO developed a database and made it available, free of charge, to CAP grantees for use in tracking and reporting data on consumer complaints to OCIIO.

2. Information Users

Pursuant to section 2793(d) of the Public Health Services Act (PHSA), as amended by Section 1002 of the ACA, as a condition for receiving the consumer assistance program grant, programs must collect and report data to the Secretary on the types of problems and inquiries encountered by consumers. Accordingly, program staff will need a system to maintain case files that will track these types of problems and inquiries. Problems and inquiries will be summarized and will be reported to HHS. By law, the user

of the summary data is the Secretary of HHS and will be used for oversight. Further, ACA dictates that the Secretary will share these reports with the Department of Labor and Treasury, and with State insurance regulators for use in enforcement.

3. Use of Information Technology

An awardee is required to use some type of Database software to track all cases received by the awardee. All casework must be entered into the Database. The Database will keep track of all caller information, such as caller demographics, type of coverage, problem type, and case resolution. The Database will also track cases that were referred to the Federal and State regulators, Medicaid, CHIP, and other public programs.

Currently, many existing consumer assistance programs already use Database software to track cases they handle. If their Database software can generate the types of information required to be reported by this Office, then programs may continue to use their own Database software. However, programs, at their discretion, may choose to use the OCIIO provided database.

The OCIIO provided database will allow Grantees to collect and track casework and required data elements. Starting in March 2011, the Database will allow users to generate data collection reports required by OCIIO. Templates for reporting will also be provided for use by programs who choose not to use the OCIIO database. Data collection reports sent to OCIIO will not contain personally identifiable information.

We anticipate that the Database developed by the Office of Consumer Support will alleviate some reporting pitfalls by Database software currently utilized by existing consumer assistance programs. Accordingly, providing awardees access to Database software developed specifically to satisfy the requirements under this grants program will reduce any reporting burdens.

Government Paperwork Elimination Act (GPEA)

Is this collection currently available for completion electronically?

- Yes, awardees are required to send electronic reporting to HHS. The reports will uploaded to a secure government website.

Does this collection require a signature from the respondent(s)?

- A process is still being developed that would enable states to attest to data reports submitted to OCIIO. It is unlikely that an e-signature will be required for this attestation.

If CMS had the capability of accepting electronic signature(s), could this collection be made available electronically?

- Not applicable since we will not require an e-signature.

If this collection isn't currently electronic but will be made electronic in the future, please give a date (month & year) as to when this will be available electronically and explain why it can't be done sooner.

The initial Data Collection Report will be due from awardees by late April 2011, six months after receiving the Notice of Award. The Database provided by OCIIO with the FY2010 Notice of Award will allow awardees to enter required data for tracking of caller information. We will provide an upgrade to the software in April 2011. The upgrade will allow the awardee to generate the required reporting using the Database supplied by the Office of Consumer Support.

If this collection cannot be made electronic or if it isn't cost beneficial to make it electronic, please explain.

- Not applicable since it will be made electronic.

4. Duplication of Efforts

This information collection does not duplicate any other effort and the information cannot be obtained from any other source.

5. Small Businesses

Not applicable since these are grants to States.

6. Less Frequent Collection

Many consumer assistance programs receive hundreds, if not thousands, of calls from consumers per month. Close monitoring, through data collection reports, of the nature of these calls will help identify patterns of problems and suspected noncompliance as they occur. Accordingly, this will provide early indication of the effectiveness of State enforcement, affording immediate opportunities to provide technical assistance and support to State insurance regulators and informing the need for further federal investigation.

HHS will be in close contact with awardees. Upon request by awardees, HHS may allow less frequent reporting due to burden on program activities.

7. Special Circumstances

Explain any special circumstances that would cause an information collection to be conducted in a manner:

Requiring respondents to report information to the agency more often than quarterly;

- If States report specific findings, the Secretary may require a more focused report to study the nature of these findings.

Requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;

- If States report specific findings, the Secretary may require a more focused report to study the nature of these findings.

Requiring respondents to submit more than an original and two copies of any document;

- Not applicable. We will not require more copies than an original and two copies of any document.

Requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;

- As health care reform implementation proceeds to the market reforms required in 2014, HHS may require awardees some records dating back to caseloads handled in 2010, per grant award in FY 2010.

In connection with a statistical survey that is not designed to produce valid and reliable results that can be generalized to the universe of study;

- Not applicable. Statistical surveys are not contemplated for this program. The complaints statistics that arise from this program are not generalizable, but will generate important information for regulators as they engage in oversight of the private health insurance market.

Requiring the use of a statistical data classification that has not been reviewed and approved by OMB;

- Not applicable. Statistical surveys are not contemplated for this program. The complaints statistics that arise from this program are not generalizable, but will generate important information for regulators as they engage in oversight of the private health insurance market.

That includes a pledge of confidentiality that is not supported by authority established in statue or regulation that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or

- Not applicable. The data collection authority and sharing of reports with the Departments of Labor and Treasury and with State regulators is in the statute. PHSA §2793(d), as amended by section 1002 of ACA.

Requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.

- Not applicable. This is outside the scope of our reporting requirements.

8. Federal Register/Outside Consultation

Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported.

Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years - even if the collection of information activity is the same as in prior periods. There may be circumstances that may preclude consultation in a specific situation. These circumstances should be explained.

As required by the Paperwork Reduction Act of 1995 (44 U.S.C.2506 (c)(2)(A)), the Office of Consumer Information and Insurance Oversight (OCIIO) will publish a notice in the *Federal Register* requesting public comment on its proposed extension of the information collection requirements specified in the Grants to States for Consumer Assistance Programs (OMB Control No. 0938-1097). The notice is part of a preclearance consultation program intended to provide those interested parties the opportunity to comment on OCIIO's request for an extension by the Office of Management and Budget (OMB) of the collections of information required by the grant. The Agency will respond to any comments received in response to its request.

The 60-day Federal Register notice for this submission published on March 25, 2011.

9. Payments/Gifts to Respondents

- Not applicable. We will not provide any payments or gifts.

10. Confidentiality

Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.

- The Office of Consumer Support will not collect personally identifiable information from consumer assistance program awardees. Data collection reports required by the Office of Consumer Support will include summaries of aggregate data on the types of problems and questions consumer experience with health coverage, how these are addressed, and how these are resolved.

11. Sensitive Questions

Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that we commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific use of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.

- In order to conduct health insurance consumer assistance, awardees may frequently need to ask clients information about their health status, income, employment status, citizenship and other characteristics that people might commonly consider private. Personally identifiable information will be used only to assist a client or with their permission to refer them to other assistance, but will never be forwarded to HHS. Awardees will provide HHS with aggregated data on consumer problems broken down by client characteristics.

12. Burden Estimates (Hours & Wages)

I. APPLICATION

This is already captured in SF424 authority to collect information based on funding opportunity announcement requirements.

II. DATA COLLECTION REPORTING

A. Data collected and reported

All the data elements enumerated in the OCIIO-developed database would not be collected in every case. HHS expects grantees to collect information that is relevant to the specific case under consideration. (Please refer to the database screenshots included in this package.)

In the first grant year, grantees must submit aggregate data to OCIIO three times: six months after the date of the award and quarterly thereafter.

Contact Information

CAPs will collect contact information for the consumer, so that the program may contact the consumer with any necessary follow-up information. The consumer's English proficiency and any third party information will also be collected in order best serve consumers who may have difficulty communicating. Although any personally identifiable information will not be reported, CAPs will report data on English proficiency of the consumers they serve.

Caseload

CAPs will report on the number of consumer complaints and inquiries handled by the program. Programs will report on the status of these cases, such as the number of cases that are currently ongoing and cases that have been closed. The resolution of closed cases will also be reported as either problem resolved, no help available, help available but inadequate, information only (no complaint or problem identified), or case closed due to consumer unresponsiveness. Additionally, CAPs will report the number of consumers who are insured, insured in transition, insured with other problem, uninsured and unable to re-contact at the conclusion of each case.

Caller Demographics

CAPs will report the number of cases by demographic information. (Note: For a complete list of demographic information collected, please refer to the screenshots provided.) Demographic information will allow a more complete understanding of the consumer's health insurance problem. For example, collecting a consumer's employment status provides insight into the possibility of accessing employer-sponsored insurance; and collecting household income and number in household can determine if a consumer might be eligible for a low-income program through a federal program such as Medicaid or CHIP.

Insurance Status and Recent History

CAPs will report the number of cases reported by insurance status. Insurance status is defined as Uninsured, Insured in Transition, and Insured with Other Problem. Because access to health insurance options can differ based on health insurance status and health insurance history of the consumer it is important to collect the following information about the consumer to adequately identify insurance options that may be available:

Uninsured:

- length of uninsurance
- type of coverage last had, and
- reason(s) for coverage loss

Insured, In-Transition:

- type of coverage at initial contact
- whether the consumer is the primary insured or dependent of the primary insured, and
- the reason(s) for anticipated coverage loss

Insured with Other Problem:

- type of coverage at initial contact,
- whether the consumer is the primary insured or dependent of the primary insured, and
- the problem(s) with current coverage

In every case, the name of the employer plan, issuer, and/or third party administrator must be captured. Whether the plan is fully-insured, self-insured or self-insured non-governmental plan must also be collected. This information will enable the caseworker to identify the entities that may have to be contacted to help resolve the consumer complaint, and where compliance to federal and state laws is an issue, be able to contact the appropriate agency that has jurisdiction over enforcement of such laws.

Health Insurance Options

CAPs will report on health insurance options identified for consumers who called the program, and whether the options identified were obtained when needed, and if so, whether they were obtained with associated burdens, such as affordability of premium and inadequacy of coverage due to a pre-existing condition exclusion. If health insurance options were not obtained when needed, CAPs will report the reasons why coverage was not obtained. These may be due to ineligibility, waiting periods, imposition of pre-existing exclusion periods, denial, excessive premiums, just to name a few. (Please refer to screenshots for a complete listing of health insurance options.)

Affordable Care Act

CAPs will report the number of cases involving ACA-related questions, as well as the number of cases involving ACA compliance or violation. Accordingly, CAPs will need to determine, and be able to report which of these plans are grandfathered plans. In every case, CAPs must report the type of ACA issue:

- rescission
- pre-existing condition exclusion and denial for children
- dependent coverage to age 26
- Pre-existing Condition Insurance Plan
- prevention services
- annual benefit maximum (including mini med plans)
- lifetime benefit maximum
- appeals and grievance
- premium rate increase
- medical loss ratio rebates

- discrimination based on salary
- out-of-network emergency care
- PCP / Pediatrician choice
- OB/GYN access
- Early Retiree Reinsurance
- wellness

In cases with ACA compliance or violation issues identified, CAPs must collect and report the different agencies that they have contacted for enforcement action, as well as the disposition of each of the contact to determine if enforcement action was taken.

Appeals

CAPs will report the number of cases involving internal and external appeal. Along with performing cases on appeals, it is essential that CAPs collect and report detailed information on the type of denial, the reason for the denial, the timeframe of the appeal (whether expedited or non-expedited), whether a fee is required for an external appeal, and when the appeal is successful, the amount of recovered benefits. (Please refer to the Appeals and Grievance form screenshots for a complete listing of pertinent data fields.)

In every appeals case, the name of the employer plan, issuer, and/or third party administrator must be captured. Whether the plan is fully-insured, self-insured or self-insured non-governmental plan must also be collected. This information will enable the caseworker to identify the entities that may have to be contacted to help resolve the consumer complaint, and where compliance to federal and state laws is an issue, be able to contact the appropriate agency that has jurisdiction over enforcement of such laws.

Other Assistance Referred

CAPs will report the number of cases that were referred to another agency because they were beyond the scope of the program, such as Medicaid, CHIP, Medicare (SHIP), VA, and TRICARE.

B. Cost and Burden to Grantees

The Office of Consumer Information and Insurance Oversight makes the following assumptions about cost and burden to CAP grantees associated with data collection and reporting:

Type of Personnel[1]	**Wage per hour**
Mid-Level Professional – GS-10	$22.00
Senior Executive Professional – GS 14	$41.00

I. Initial Submission

Data will be collected and reported by a mid-level professional at an hourly rate of approximately $23 per hour. The mid-level professional will devote 40 hours to the initial submission due six months after the award of the grant. A senior executive will oversee the data reporting at an hourly rate of $42. The senior executive will devote 10 hours to the initial submission.

1 Source: Office of Personnel Management, 2010 General Schedule (GS) http://www.opm.gov/oca/10tables/pdf/gs_h.pdf

Hours: 40 hours (initial submission) + 10 hours (oversee the data reporting) = 50 hours

Costs: 40 hours x $22 = $880
10 hours x $41 = $410

Total for initial submission: $880 + $410 = $1,290

II. Quarterly Submissions

OCIIO assumes that the two subsequent quarterly submissions will require less time than the initial submission. OCIIO estimates that a mid-level professional will take 30 hours to collect and report the data. A senior level executive will take 5 hours to oversee the data reporting.

Hours: 30 hours (senior level time) x 2 (two quarterly submissions) + 5 hours (mid-level professional time) x 2 (two quarterly submissions) = 70

Costs: 60 hours x $22 = $1320
10 hours x $41 = $410

Total for quarterly submissions: $1320 + $410 = $1,730

Total for all submissions: $1,290 + 1,730 = $3,020

13. Capital Costs

For FY 2011 grants have been awarded to existing entities and programs, not to start-up organizations. We anticipate that future grants will also be awarded to existing entities and programs. We have indicated in the grant announcement that preference will be given to applicants with a proven track record of consumer assistance and expertise in consumer education and problem resolution, and to programs that can demonstrate long-term sustainability. Therefore, we do not anticipate that start-up programs, who would need capital and start-up costs, will apply for funding. Therefore, we do not estimate these costs to applicants.

14. Cost to Federal Government

I. APPLICATION

The review of the applications from states for consumer assistance grants will be initially performed in-house by federal employees.[2] A reviewing panel of outside experts will then be convened to evaluate applications and assist in the selection process.

Application Review by States

We anticipate that 56 states and territories will submit an application. Each application is a maximum of

2 Source: Office of Personnel Management, 2010 General Schedule (GS) Locality Pay, http://www.opm.gov/oca/10tables/pdf/saltbl.pdf

10 pages, excluding supporting documentation. Each application will require one hour for an initial review. Total staff time for review will be 56 hours. The applications will be reviewed by senior civil servants, i.e., staff at the GS-15 and GS-14 levels, at $57/hour.

Hours: 56 (applications/states and territories) x 1 hour (initial review) = 56 hours
Costs: 56 hours x $57 = $3,192

Some applications will require follow-up phone calls and other attempts to clarify information or seek additional information from the website. The Department estimates that 30 applications will require follow-up review of one hour each.

Hours: 30 (follow-up applications) x 1 hour (initial review) = 30 hours
Costs: 30 hours x $57 = $1,710

Outside Panel Review

In addition, senior staff will have to identify a panel of outside reviewers. If there is a panel of ten, staff will make an estimated 40 calls to identify and confirm participation with the 10 panelists. Each call will take 15 minutes.

Hours: 40 (calls) x 10 hours (600 minutes/60 sec.) = 600 hours
Costs: 10 hours x $57 = $570

OCIIO assumes that 3 senior staff experts will participate in meetings with the panel of outside experts to review applications. The Department assumes the review process will take two eight-hour days for a total of 16 hours per senior level experts.

Hours: 3 (senior staff experts) x 16 hours (two 8-hours work days) = 48 hours
Costs: 48 hours x $57 = $570

Outside Review Panel Travel and Mailing Expenses

Overnight FedEx package:

$40 (overnight FedEx) x 10 (panelist) = $400

$71 (Federal Per Diem for Meals and Incidental Expenses[3]) x 2 (two-days) x 10 (panelist) = $1,420

Successful grantee notification

Senior level staff will also be devoted to follow-up notifications. This will include notifying successful grantees. OCIIO assumes that this will take an hour per grantee.

Hours: 56 (# of grantees) x 1 hour = 56 hours
Costs: 56 hours x $57 = $3,192

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3 Source: Meals and Incidental Expenses (M&IE) Breakdown Federal Per Diem for Meals and Incidental Expenses, such as parking (MIE per **www.gsa.gov/mie**).

Total cost for application review: $3,192 + $1,710 + $570 + $570 + 400 + $1,420 + $3,192 = $11,054

II. DATA COLLECTION REPORTING

OCIIO has awarded 40 grants for FY 2011. Each state/jurisdiction must report three times a year in the first year for a total of 120 submissions per year that federal staff must review. The review of the data submitted by CAPs per question 12 (II) will be reviewed in-house by federal employees.

Costs of Review of Data Submission

Federal staff at the GS-12 level with an earnings wage rate of $37.00 will be performing an initial review of the data submission. OCIIO assumes that it will take a federal employee one hour to review and record data each submission.

Costs: 120 (submissions) x 1 hour (review/recording time) x $37 = $4,440

Certain data will be brought to the attention of senior staff (level GS-14 and GS-15) with an earnings wage rate of $57 an hour. The in-depth review will occur three times a year. OCIIO assumes it will take the senior level staff reviewer 10 hours to complete an in-depth review of applicable data.

Costs: 3 (times per year) x 10 hours (time for review) x $57 (senior level wage) = $1,710

Senior staff will write an annual report for the Secretary on data and will use the data to facilitate senior staff discussions, initiatives and projects. OCIIO assumes that the preparation of the annual report will require three 40-hour weeks of senior staff time.

Costs: 3 (weeks) x (40 hours) x $57 (senior staff wage rate) = $6,840

While additional staff time devoted to data-related projects and initiatives is difficult to estimate Given the importance of the data, senior staff may spend 120 additional hours per year on follow-up, data-related projects and initiatives.

Costs: 120 hours (time for review) x $57 (senior level wage) = $6,840

Additional staff time devoted to data-related projects and initiatives is difficult to estimate.

The total cost for data submission review: $4,440 + $1,710 + $6,840 + $6,840 = $19,830.

The total cost to the federal government is therefore estimated at $11,054 + $19,830 = $30,884.

15. Changes to Burden

- Not applicable. We don't anticipate any changes to the burden.

16. Publication/Tabulation Dates

- By law, the Secretary of HHS is required to share data collection reports with the Departments of Labor and Treasury and State insurance regulators to strengthen enforcement. Office of Consumer Support staff will convey reports to these regulatory entities and in so doing will highlight and summarize key findings from these reports. As mentioned above, the initial data collection report will be due from awardees by late April 2011, six months from the date of Notice of Award.

17. Expiration Date

- We expect that the Database software we provide to awardees will be used into the future. Note that programs are authorized to continue permanently.

18. Certification Statement

- No exceptions apply.