Paperwork Reduction Act Submissions Supporting Statement for
Consumer Assistance Program Grants
CMS-10333/OMB Control No.: 0938-1097

A. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (ACA). On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was also signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act (ACA) includes a wide variety of provisions designed to promote accountability, affordability, quality, and accessibility in the health care system. The Affordable Care Act also includes significant grant funding for States to work with the Federal government to implement health reform.

Section 1002 of the ACA added section 2793 of the Public Health Service (PHS) Act, which provides for federal grants to States[1] to establish, expand, or provide support for the establishment of independent offices of health insurance consumer assistance or ombudsman programs. Section 2793 of the PHS Act requires that, as a condition of receiving grant funds, consumer assistance or ombudsman programs must: assist consumers with filing complaints and appeals regarding health insurance coverage with respect to Federal and state health insurance requirements, assist consumers with enrollment into group health plans and health insurance coverage, educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage, and help resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986. These programs must also collect data on consumer inquiries and complaints to help the Secretary identify problems in the health insurance market and strengthen enforcement. Additionally, grantees of Navigator programs established pursuant to section 1311(i) of the ACA are required to refer enrollees with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage to various entities, including Consumer Assistance Programs.

Consumers will need to understand new programs, avail themselves of new protections, and navigate health coverage options to find the most affordable coverage that meets their needs. As noted in the Affordable Care Act (ACA) – Consumer Assistance Program Grants Funding Opportunity Announcement (FOA) posted on July 22, 2010, the U.S. Department of Health and Human Services (HHS) interprets Section 2793 of the PHS Act to require grantees to accept the inquiries and problems of uninsured consumers. On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was also signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act (ACA) includes a wide variety of provisions designed to promote accountability, affordability, quality, and accessibility in the health care system. The Affordable Care Act also includes significant grant funding for States to work with the Federal government to implement health reform.

Section 1002 of the ACA added section 2793 of the PHS Act, which provides for federal grants to States[2] to establish, expand, or provide support for the establishment of independent offices of health insurance consumer assistance or ombudsman programs. Section 2793 of the PHS Act requires that, as a condition of receiving grant funds, consumer assistance or ombudsman programs must: assist consumers with filing complaints and appeals regarding health insurance coverage with respect to Federal and state health insurance requirements, assist consumers with enrollment into group health plans and health insurance coverage, educate consumers on their rights and responsibilities with respect to group health plans and health insurance coverage, and help resolve problems with obtaining premium tax credits under section 36B of the Internal Revenue Code of 1986. These programs must also collect data on consumer inquiries and complaints to help the Secretary identify problems in the health insurance market and strengthen enforcement. Additionally, grantees of Navigator programs established pursuant to section 1311(i) of the ACA are required to refer enrollees with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage to various entities, including Consumer Assistance Programs.

Consumers will need to understand new programs, avail themselves of new protections, and navigate health coverage options to find the most affordable coverage that meets their needs. As noted in the Affordable Care Act (ACA) – Consumer Assistance Program Grants Funding Opportunity Announcement (FOA) posted on July 22, 2010, the U.S. Department of Health and Human Services (HHS) interprets Section 2793 of the PHS Act to require grantees to accept the inquiries and problems of uninsured consumers. Because Qualified Health Plans in the Marketplace are health insurance coverage, the statute requires Consumer Assistance Programs (CAP) to provide assistance to individuals enrolled in Qualified Health Plans (QHPs), in addition to other forms of health insurance coverage.

As part of their required data collection activities, Consumer Assistance Programs (CAP) collect data on a range of consumer inquiries related to private coverage. Section 2793(c)(2) and (d) of the PHS Act require consumer assistance or ombudsman programs to report data to the Secretary of HHS in order to strengthen HHS oversight. Programs report on the types of problems and questions consumers experience with health coverage, and how these are resolved. These programs are required to collect data on the types of problems and inquiries encountered by consumers relating to private health insurance, public coverage, and State high-risk pools. Reports help identify patterns of problems and noncompliance as well as best practices. HHS shares data reports with the U.S. Departments of Labor and Treasury, and with State regulators. Within HHS, reports can also provide the Center for Consumer Information and Insurance Oversight (CCIIO) with information about the effectiveness of State enforcement as well as help CCIIO identify opportunities to provide technical assistance and support to State insurance regulators.
The Consumer Support Group (CSG) in CCIIO will continue to provide support services for grantees, including data reporting software and technical support, trainings, resource and training materials, and assistance on casework as it relates to questions arising from Federal law.

In order to be considered for a grant, applicants must propose a plan to use grant funds to continue their Consumer Assistance Program by performing the activities authorized under section 2793 of the PHS

Act.

B .Justification

1. Need and Legal Basis

Section 1002 of the Affordable Care Act added section 2793 of the Public Health Service Act, which provides for grants to States to establish, expand, or provide support for consumer assistance (or ombudsman) programs, starting in FY 2010.

In order to strengthen oversight, the law requires programs that receive grant funds 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 identify patterns of practice in the insurance marketplaces and uncover suspected patterns of noncompliance. The law provides that HHS must use the data to determine where more enforcement is needed, and must share program data reports with the Departments of Labor and Treasury, and State regulators. Program data also can offer CCIIO 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.

2. Information Users

Pursuant to section 2793(d) of the Public Health Service Act (PHSA), as added by Section 1002 of the ACA, as a condition for receiving a consumer assistance program grant, states must provide that CAPs will 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. The statute specifies that the Secretary of HHS will use the data for oversight, and will share these reports with the Department of Labor and Treasury, and with State insurance regulators for use in enforcement.

A. Data collected and reported

All the data elements enumerated in the CCIIO-developed database would not be collected in every case. HHS expects grantees to collect information that is relevant to the specific case under consideration.

CAP grantees submit aggregate data to CCIIO through the Health Information Oversight System (HIOS) quarterly The Specialists downloaded the data submitted by grantees and analyzed it for classification. Following this analysis, Specialists transmitted a summary of the data to the grantees, who confirmed its accuracy.

They will also include four quarterly progress reports and an annual, end-of-year text document in addition to the quarterly data collection reports submitted through HIOS. See Appendix 2, Template for the Quarterly Progress Report. See also Appendix 3, Template for the Annual Report. The information to be collected for quarterly reports will be the following:

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, Personally Identifiable Information (PII) will not be reported

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. Demographic information will allow a more complete understanding of the consumer's health insurance problem.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.

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:

- Early Retiree Reinsurance Program (ERRP)
- Dependent coverage to age 26
- Rescission
- Annual benefit maximum (including mini med plans)
- Lifetime benefit maximum
- Marketplace Eligibility Appeal
- Marketplace APTC/CSR Appeal
- Out-of-network emergency care
- PCP/Pediatrician choice
- OB/GYN access
- Pre-existing condition exclusion and denial for children
- Elimination of Pre-existing condition restrictions for adults
- Pre-existing Condition Insurance Plan (PCIP)
- HIPAA Opt-out by Self-Funded Non-Federal Government Plans
- Appeals and grievances
- Premium rate increase
- CO-Ops
- Essential Health Benefits
- Summary of Benefits and Coverage (SBC)
- Student Health Plans
- Prevention Services
- Medical loss ratio rebates (MLR)
- Medical loss ratio notices
- Medical loss ratio other
- Fair premium rating factors

- Extension of guaranteed Issue to all Markets
- Guaranteed Renewability in all Markets
- Wellness programs
- Waiting period of over 90-days
- Coverage of Clinical Trials
- Discrimination based on salary
- Limitation on out-of-pocket cost and deductible
- Shared responsibility payments (employer and employee)

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 reporting cases on appeal, 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.

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 with federal and state laws is an issue, be able to contact the appropriate agency that has jurisdiction over enforcement of such laws.

Outreach and Education

CAP grantees are encouraged to conduct outreach events and provide information to consumers in innovative and comprehensive ways, ranging from distributing brochures to the public (often in multiple languages), to more intensive outreach such as one-on-one counseling, and targeted outreach and information to specific groups of consumers such as those who reside in counties with the highest percentage of uninsured residents.

CAPs also provide education on general health insurance inquiries or provide information to consumers on how to contact the appropriate agency to help them resolve their problems. For example, Medicare or Medicaid beneficiaries having problems with their public health coverage would be provided referrals to the appropriate Medicaid or Medicare State Health Insurance Program (SHIP) office.

CAP grantees must report outreach and education efforts funded by CAP grants.

Exchange-Related Duties

CAP grantees may use the funds they receive to carry out duties that assist consumers seeking coverage through an Exchange. These duties must be within the scope of the five specific categories of duties as described in Section 2793(c). With the establishment of the Exchange marketplaces, programs must assist consumers by answering general questions about Exchanges; referring consumers to other consumer assistance programs (e.g., navigators); assisting with obtaining premium tax credits, and assisting with

eligibility and enrollment in coverage sold in the Exchange.

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.

Culturally and Linguistically Appropriate Services (CLAS)

CAPs reporting data to CCIIO shall demonstrate their ability to communicate effectively with consumers, including how they will provide services to those with limited English proficiency including, but not limited to, interpretive services and translation of materials about health insurance coverage. CAPs are also required to identify personnel who have the ability to provide assistance that is culturally and linguistically appropriate, in accordance with the guidelines on the Office of Minority health's website (http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15) for the national standards on culturally and linguistically appropriate services.

Examples of compliance with this requirement include the publication of brochures and other materials in languages of the prevalent non-English speaking population(s), and the use of language lines for real- time translation needs. See Appendix 3 for an example of how compliance with the CLAS requirement will be reported to CCIIO on the Annual Reporting form.

3. Use of Information Technology

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

Currently, many existing CAPs track cases they handle using Database software that predated the availability of the CAP grants. If their Database software can generate the types of information required to be reported to HHS, then the CAPs may continue to use their own Database software. However, CAPs may choose to use the CCIIO-provided database, or the State-Based System (SBS) offered by the National Association of Insurance Commissioners (NAIC).

The CCIIO-provided database allows CAPs to collect and track casework and required data elements. As of October 2011, the Database has been used successfully to generate data collection reports required by CCIIO. Templates for reporting will also be provided for use by CAPs that choose not to use the CCIIO database. Data collection reports sent to CCIIO will not contain personally identifiable information.

Government Paperwork Elimination Act (GPEA)

Is this collection currently available for completion electronically?

- Yes, CAPs are required to send reports to HHS electronically. Reports are uploaded to a secure government website.

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

- CAP grantees submit reports using a password-protected account through which they can only submit reports on behalf of their CAP. This process was put into place to help ensure that the submission is made only by the person authorized to submit reports on behalf of the CAP grantee. As an additional method of report verification, HHS follows up with each respondent by phone to verbally ensure that the information received through a report submission was the information the respondent intended to submit.

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 CAPs 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. We believe that quarterly collection of this information is the minimum necessary to achieve these goals.

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

7. Special Circumstances

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

8. Federal Register/Outside Consultation

A 60-day notice published in a Federal Register on November 2, 2015 (80 FR 67406). No comments were received.

- The Consumer Support Group has engaged in discussions with several consumer assistance programs that existed before the availability of CAP funds, and with one organization that, in the past, has conducted nationwide research on such programs. From this inquiry, we learned that consumer assistance programs regularly compile reports for various audiences (i.e. state insurance departments, state legislature, general public, etc.). Some of the information required in the data collection report are already collected by these programs and are reported to different agencies on either a quarterly or semi-annual basis. Other information required by CCIIO may already be collected as well; however it may be in a format that is not countable and reportable.

For example, a few of the existing programs we've spoken to capture demographic information (i.e. age and income) in the case notes as opposed to an independent data field, thus making it impossible to generate a counting report on the average age or income of consumers calling with a health insurance problem.

- Comments received and responded to following the publication of the 2011 3-year CAP PRA resulted in further enhancements to the data collection software that CCIIO provided to CAPs in the areas of appeals and recovered benefits, grandfathered plans, and statements by consumers who benefitted from contacting CAPs.

- In an effort to further enhance reporting by CAPs, the Health Insurance Resource Specialists (Specialists) within the Consumer Support Group provided a number of CAP grantees the opportunity to test new reporting tools and templates and to provide feedback. This is an ongoing effort that is implemented by the Consumer Support Group to ensure that new reporting tools and templates are beneficial and are less burdensome to CAP grantees.

Under this grant, ongoing technical support will be provided to CAPs through the Specialists. Specialists provide direct training and support to grantees as they implement their programs. Specialists conduct information sharing conference calls; conduct training programs on federal law including the ACA; instruct CAPs in how to conduct consumer assistance casework; troubleshoot and assist with difficult consumer cases as necessary; and collect, track, and analyze data on consumer inquiries and complaints to help the Secretary identify problems in the marketplace and strengthen enforcement.

CMS prepares educational materials about consumer protections in the Affordable Care Act for the public at large, to be made available on HealthCare.gov, through the State Consumer Assistance Programs, and in future, through partnerships with consumer advocates and other stakeholder groups. This group will also be working with the CAPs and stakeholder groups to broaden consumer awareness of the CAP programs and the Affordable Care Act through a variety of means and media. Among the range of resources under consideration: providing speakers for stakeholder group meetings, producing short, instructional web videos.

The Consumer Support Group provides technical assistance on non-routine questions about the Affordable Care Act, particularly the Affordable Care Act's interaction with the law of a particular state. The team does legal research, develops resource materials for the staff of the Consumer Support Group as well as the staffs of state grantees, and assists in responding directly to consumer inquiries as requested.

9. Payments/Gifts to Respondents

Incentives will not be provided to respondents.

10. Confidentiality

- The Consumer Support Group does not collect personally identifiable information from consumer assistance program awardees. Data collection reports required by the Consumer Support Group 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

- In order to conduct health insurance consumer assistance, CAPs 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 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. (OMB#: 4040-0004)

II. DATA COLLECTION REPORTING

A. Cost and Burden to Grantees

The Consumer Support Group makes the following assumptions about cost and burden to new CAP grantees associated with data collection and reporting:

Type of Personnel [3]	**Wage per hour**
Mid-Level Professional – GS-12 equivalent	$29
Mid-Level IT Professional – GS-12 equivalent	$29
Senior Executive Professional – GS 15 equivalent	$49

1. Initial Set-up of Database

The cost burden associated with the initial set up of the database will only apply to grantees that have never applied for CAP grants.

Data will be collected and reported by a mid-level professional at an hourly rate of approximately $29 per hour. The mid-level professional will devote 16 hours to the initial submission. A mid-level IT professional will spend 4 hours implementing the database system. A senior executive will devote 8 hours to overseeing the initial submission, including reviewing the system to ensure its readiness, SOPs, ensure training of the mid-level professional.

Hours: 16 hours + 4 hours + 8 hours = 28 hours
Costs: 16 hours x $29 = $464
4 hours x $29 =
$116 8 hours x
$49 = $392
Total for Initial Set-up: $464 + $116 + $392 = $972

2. *Quarterly Submissions*

Data collection reports

The cost burden associated with the quarterly Data Collection Reports will apply to all CAP grantees. There will be four quarterly reports. CCIIO estimates that a mid-level professional will take up to 24 hours to compile the report. A senior level executive will take up to 5 hours to review and grant clearance to the report. For CAP grantees that use the CCIIO-developed database, CCIIO estimates that a mid-level professional will take up to 2 hours to compile the report and a senior level executive will take up to 1 hour to review and grant clearance to the report.

CCIIO Database User:
Hours: 2 hours (mid-level time) x 4 (four quarterly submissions) + 1 hour (senior level professional time) x 4 (four quarterly submissions) = 12 hours

Costs: 8 hours x $29 (mid-level wage rate) = $232 4 hours x $49 (senior staff wage rate) = $196
Total for Quarterly Data Collection Reports (CCIIO Database User): $428

Non-CCIIO Database User:
Hours: 24 hours (mid-level time) x 4 (four quarterly submissions) + 5 hour (senior level professional time) x 4 (four quarterly submissions) = 116 hours
Costs: 96 hours x $29 (mid-level wage rate) = $2784 20 hours x $49 (senior staff wage rate) = $980

Total for Quarterly Data Collection Reports (Non-CCIIO Database User): $3764

Total for Quarterly Data Collection Reports: Ranging from $428 to $3764

Progress Report

The cost burden associated with the Quarterly Progress Reports will apply to all CAP grantees. There will be four quarterly reports. CCIIO estimates that a mid-level professional will take 16 hours to draft and compile the report. A senior level executive will take 2 hours to review and grant clearance to the report. See Appendix 2, Template for the Quarterly Progress Report.

Hours: 16 hours (mid-level time) x 4 (four quarterly submissions) + 2 hours (senior level professional time) x 4 (four quarterly submissions) = 72 hours
Costs: 64 hours x $29 (mid-level wage rate) = $1856 8 hours x $49 (senior staff wage rate) = $392
Total for Quarterly Progress Reports: $1856 + $392 =$2248 Total

for All Quarterly Submissions: Ranging from $2284 to 6012

3. Annual Report

Grantees' reporting requirements include the submission of an Annual Report due within 90 days from the end of the project/budget period. See Appendix 3, Template for the Annual Report.

Hours: 40 hours (mid-level staff wage rate) x 1 annual report + 5 hours (senior staff wage rate) x

1 annual report = 45 hours

Cost: 40 hours x $29 (mid-level wage rate) = $1160 5 hours x $49 (senior staff wage rate) = $245

Total for Annual Report = $1160 + $245 = $1405

Total for All Submissions (Quarterly Submissions + Annual Report): Ranging from $3689 to $7417

Total Cost Burden to New Grantees (Database setup + Quarterly Submissions + Annual Report): Ranging from $4661 to $8389

Total Cost Burden to Former Grantees (Quarterly Submissions + Annual Report): Ranging from $3689 to $7417

	# of Respondents	**Frequency**	**Responses**	**Annual Burden Hours Per Respondent**	**Total Annual Burden Hours**	**Annual Cost Per Respondent**	**Total Annual Cost**
Quarterly Submissions	51	8	408	188	9588	$6012	$306612
Annual Report	51	1	51	45	2295	$1405	$71655
Total	51	9	459	233	11883	$7417	$378267

13. Capital Costs

The grant announcement indicates that preference will be given to applicants with a proven track record of consumer assistance and expertise in consumer education and problem resolution. Therefore, we do not anticipate that programs will need additional capital or startup costs. Start-up programs that need capital or start-up are not likely to apply for funding based on the limited funding available under this grant opportunity

14. Cost to Federal Government

- **APPLICATION**

The review of the applications from states for consumer assistance grants will be initially performed in- house by federal employees.[4] A reviewing panel of outside experts will then be convened to evaluate applications and assist in the selection process.

A. Application Review by Federal Employees

We anticipate that 51 states will submit an application. Each application is a

maximum of 10 pages, excluding supporting documentation. Each application will require one hour for an initial review.

Total staff time for review will be 51 hours. The applications will be reviewed by mid-level staff. CCIIO assumes that all 51 eligible states will apply.

Hours: 51 (applications/states) x 1 hour (initial review) = 51 hours
Costs: 51 hours x $29 = $1479
Total for Application Review by Federal Employees: $1479

B. Outside Panel Review

1. Identification of potential reviewers

Senior staff will have to identify a panel of outside reviewers. If there is a panel of ten, senior staff will take about 2 hours to identify potential reviewers. Mid-level staff will make an estimated 40 calls to identify and confirm participation with the 10 panelists. Each call will take 15 minutes.

Hours: 2 hours (senior level staff) + 40 (15-minute calls by mid-level staff, totaling 600 minutes or 10 hours) = 12 hours
Costs: 10 hours x $29 = $290
2 hours x $49 = $98
Total for Identification of Potential Reviewers =$388

2. Training Panel of Reviewers

Two senior level staff (one CCIIO and one CMS OAGM staff) will provide one-hour training, via phone conference call, to the selected panel of reviewers to go over the process, responsibilities and expectations.

Hours: 1 hour x 2 (senior level staff) = 2 hours
Costs: 2 hours x $49 = $98
Total for Training Panel of Reviewers =$98

3. Call with Chairperson

One senior level staff from CCIIO will discuss with the Chair of the panel of reviewers the review process, CCIIO's expectations and the Chair's responsibilities. This will be a .5 hour call.

Hours: .5 hour x 1 (senior level staff) = .5 hours
Costs: .5 hour x $49 = $24.50
Total for Call with Chairperson =$24.50

4. Participation in the panel review

Outside subject matter experts will participate as panel experts to review applications. In addition, two federal employees participate in the panel review (one CCIIO senior level staff and one CMS Office of Acquisitions and Grants Management senior level staff) to answer questions from the panel

of experts. CCIIO assumes the review process will take two eight-hour days for a total of 16 hours.

Hours: 2 (senior level staff) x 16 hours (two 8-hour work days) = 32hours
Costs: 32 (senior level staff) hours x $49 = $1568

Total for Federal Employee Participation in Panel Review: $1568

C. Follow-up

Some applications will require follow-up phone calls and other attempts to clarify information or seek additional information. CCIIO estimates that 30 applications will require follow-up review. One mid-level staff from CCIIO and one mid-level staff from OAGM will require one hour each for follow-up.

Hours: 30 (follow-up applications) x 1 hour (mid-level CCIIO staff) + 1 hour (mid-level OAGM staff) = 60 hours
Costs: 60 hours x $29 = $1740

Total for Follow-up: $1740

D. Award Announcement and Grantee Notification

Mid-level staff will be devoted to developing rollout materials (factsheets, FAQs, website language, press release, etc.) and follow-up notifications to grantees. CCIIO assumes that developing rollout materials will take 16 hours. A senior level staff will take two hours review these materials. Further, mid-level staff will notify grantees of the award. This will take 30 minutes per grantee. CCIIO assumes that all eligible states will receive an award.

Development of rollout materials
Hours: 16 hours (mid-level staff) x 1 (development) + 2 hours (senior level staff) x 1 (development) = 18 hours
Costs: 16 hours x $29 = $464
2 hours x $49= $98
Total for Award Announcement: $562

Grantee notification
Hours: 51 (# of grantees) x .5 hour = 25.5 hours
Costs: 25.5 hours x $29 = $812
Total for Grantee Notification: $739.5

Total for Award Announcement and Grantee Notification: $1301.5

Total Cost for Application Review: $1479 + $388 + $98 + $24.50 + $1568 + $1740 + $1301.5 = $6,599

DATA COLLECTION REPORTING

The review of the data submitted by CAPs per question 12 will be reviewed in-house by federal employees.

A. Costs of Review of Quarterly Data Submissions

Mid-level staff will be performing a review of the quarterly data submissions, which includes discussions with the grantee about the data submitted. CCIIO assumes that it will take two hours to review each quarterly Data Collection Report and one hour to review each quarterly Progress Report. A senior level staff will take 2 hours to review the aggregate report each quarter. CCIIO further assumes that all 50 states and the District of Columbia are awarded grants and submit quarterly data.

Hours: 51 (Data Collection Reports) x 4 (submissions per budget year) x 2 hours (mid-level staff review) + 51 (Progress Reports) x 4 (submissions per budget year) x 1 hour (mid-level staff review) + 4 (aggregate reports) x 2 hours (senior level staff) = 620 hours
Costs: 620 hours x $29 = $17,980
8 hours x $49 = $392
Total for Costs of Review of Quarterly Data Submissions: $18,372

B. Costs of Review of Annual Reports

Mid-level staff will review annual report submissions from CAP grantees. CCIIO assumes that it will take 1
hour to review each annual report. CCIIO further assumes that all 50 states and the District of Columbia, are awarded grants and submit an annual report.

Hours: 51 (Annual Reports) x 1 (submission per budget year) x 1 hour (mid-level staff review) = 54 hours
Costs: 51 hours x $29 = $1479
Total for Costs of Review of Annual Reports: $1479

C. Development of CAP White Paper

Mid-level staff will draft a white paper for CCIIO leadership and the Secretary on CAP data and will use the data to facilitate senior staff discussions, initiatives and projects. CCIIO assumes that the preparation of the white paper will require 32 hours of mid-level staff time and 4 hours of senior level staff time for review.

Hours: 32 hours (mid-level staff) + 4 hours (senior level staff) = 36 hours
Costs: 32 hours x $29 (mid-level wage rate) = $928
4 hours x $49 (senior staff wage rate) =
$196
Total for Development of CAP White Paper: $1124

D. Other Data-Related Projects

Additional staff time devoted to data-related projects and initiatives is difficult to estimate. Given the importance of the data, mid-level staff may spend 80 additional hours per year on follow-up, data-related projects and initiatives. Senior staff may spend 20 hours performing review and follow-up activities.

Hours: 80 hours (mid-level staff) + 20 hours (senior level staff) = 100 hours
Costs: 80 hours x $29 (mid-level wage rate) = $2320

20 hours x $49 (senior staff wage rate) = $980

Total for Other Data-Related Projects: $3300

Total Cost for Data Collection Reporting: $18,372 + $1479 +$1124 + $3300 = $14,275

Total Cost to the Federal Government (Application Review + Data Collection Reporting) = $30,874

Description	Cost
Application review by federal employees	$1,479
Outside panel review	$2,078.50
Follow-up	$1,740
Award announcement and grantee notification	$1,301.50
Costs of review of quarterly data submissions	$18,372
Costs of review of annual reports	$1,479
Development of CAP whitepaper	$1,124
Other data-related projects	$3,300
Total	**$30874.00**

15. Changes to Burden

The reporting requirements have not changed and there are no changes to the estimated annual time burden per respondent, except to correct previous calculation errors. However, due to changes in 2014 legislation, specifically, 2793 of the PHS Act (Section 1002 of the ACA), the number of respondents is decreasing from 56 to 51 respondents, excluding five Territories. The Act excludes all five territories as they no longer fall under the definition of "state". As of 2014, these respondents are no longer eligible to apply for any programs under the ACA. As a result, the total annual time burden estimate hours decreased from 16,184 to 9,588. In addition, the estimated annual cost burden is increased per respondent to account for wage inflation, but the overall annual cost burden is decreased due to fewer possible grantees.

The estimated cost to the federal government has changed to reflect the need to review fewer quarterly and annual reports, as well as to account for wage increases due to inflation. The estimated cost to the federal government has decreased by $1,520.

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. Consumer Support Group staff will convey reports to these regulatory entities and in so doing will highlight and summarize key findings from these reports. In addition, in 2012, CMS released the CAP White Paper based on data submitted by CAPs in their first year of operations (October 15, 2012 through October 14, 2011). A PDF of the paper can be found here http://cciio.cms.gov/resources/files/csg- cap-summary-white-paper.pdf.pdf.

17. Expiration Date

- The expiration date and OMB control number will be included on each instrument.